MEMORANDUM

TO DC Justice Lab

FROM Orrick, Herrington & Sutcliffe, LLP

DATE October 14, 2024

RE Proposed Measures to Improve Pregnancy and Birth Outcomes for Incarcerated Women in the District of Columbia

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This memorandum addresses solutions to pregnancy and birth outcomes for incarcerated women in the District of Columbia. The conclusions contained herein are based only upon our examination of published statutes, regulations, administrative guidance, and scholarly articles. In addition, we have not researched case law in connection with these requirements. This memorandum is rendered for the sole benefit of DC Justice Lab, and no other person or entity is entitled to rely hereon, and no attorney-client relationship is created or formed by receipt of this memorandum by any party other than DC Justice Lab. Copies of this memorandum may not be furnished to any other party or entity, nor may any portion of this memorandum be quoted, circulated, or referred to in any other document without our prior written consent. Any copy of this memorandum reviewed or received by such other party or entity shall be for informational purposes only and such recipient should consult and rely upon the advice of such recipient's own counsel.

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I. EXECUTIVE SUMMARY

Nationwide, three-quarters of incarcerated women are of childbearing age, and a great majority of them have minor children. The American College of Obstetricians and Gynecologists' ("ACOG") Committee on Health Care for Underserved Women recommends that prenatal care for incarcerated women "be provided in accordance with the same guidelines and recommendations as for those who are not incarcerated, with attention to the increased risk of infectious diseases and mental health conditions common to incarcerated populations."[1]

Yet, only about a half of pregnant women in prisons receive any type of pregnancy care. It is not surprising then that, compared with women in the general population, incarcerated women are more likely to have poor perinatal outcomes, such as medical interventions and

[1] ACOG, Committee on Health Care for Underserved Women, *Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals*, Number 830 (Replaces Committee Opinion 511, November 2011, and Committee Opinion 535, Aug. 2012; Reaffirmed 2024), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/07/reproductive-health-care-for-incarcerated-pregnant-postpartum-and-nonpregnant-individuals. The reasons for this are simple: (1) incarcerated individuals have a constitutional right to receive medical care, *see Estelle v. Gamble*, 429 U.S. 97 (1976); and (2) incarcerated pregnant women need more care—not less—than women in the general population, due to a higher prevalence of sexually transmitted infections, mental health and substance abuse issues, and poor nutrition.

preterm and small-for-gestational age newborns.[2]

But it does not have to be this way. Solutions are available. In instances when the pregnant individual remains incarcerated for the duration of the pregnancy or gives birth in custody, a number of measures have been shown to significantly mitigate risks and improve outcomes for both mother and child. They include early testing, access to obstetric or midwifery care, a specialized diet, access to doula, family support during labor and delivery, sufficient time for mother-infant bonding, breastfeeding support, and postpartum care.

Some states, including California, Minnesota, Missouri, Texas, and Wisconsin, have gone a step further. They offer community-based alternatives to incarceration. Evidence suggests this approach helps "reduce intergenerational trauma, improve maternal self-image, promote secure attachment, encourage sustained breastfeeding, and may reduce rates of recidivism."[3] It also helps keep children out of foster care.

The District of Columbia can—and should—implement measures to improve pregnancy and birth outcomes for individuals in custody, as outlined below. Additionally, the District should consider making conditional release into the community an option for qualifying individuals. In this regard, the District should consider following the example of Minnesota, which offers this option to eligible individuals who are pregnant or have given birth within eight months of the commitment date. Under the Minnesota Healthy Start Act, eligible individuals can stay in a community-based alternative setting during for the duration of the pregnancy and up to one year postpartum.[4]

These measures are not only beneficial for the health and well-being of incarcerated women and their infants, but they also contribute to broader social and economic benefits by reducing recidivism, lowering labor and delivery costs, and promoting healthier families.

To safeguard access to this specialized support and conditional release, the District should consider enhanced grievance procedures that provide an avenue for timely and meaningful recourse in the event of denial.

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[2] Rebecca Shlafer, et al., *Maternal and Neonatal Outcomes Among Incarcerated Women Who Gave Birth in Custody*, BIRTH, Dec. 27, 2020 Vol. 48:122-31, at p. 123, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8246999/.

[3] The Center for Leadership Education in Maternal & Child Public Health, University of Minnesota—Twin Cities, School of Public Health, *a State Policy Brief from the National University-Based Collaborative on Justice-Involved Women and Children* (JIWC) (Spring 2023), https://mch.umn.edu/wp-content/uploads/2023/03/JIWC-Policy-Brief-Alternatives-to-Sentencing-3.2023-1.pdf.

[4] Minnesota Department of Corrections, *Implementation Update: Healthy Start Act*¸ MINN. STAT. § 3.197, Apr. 2, 2022, at p. 1. https://mn.gov/doc/assets/2022%20Healthy%20Start%20Implementation%20Update%20Legislative%20Report_tcm1089-523761.pdf.

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II. MEASURES SHOWN TO IMPROVE PREGNANCY AND BIRTH OUTCOMES FOR INCARCERATED PREGNANT INDIVIDUALS

A. Measures for Pregnant Individuals Who Remain in Custody

There are solutions that can significantly improve birth outcomes for incarcerated women. Several states, including Minnesota, Alabama, Washington, New York,[5] Ohio,[6] and Illinois,[7] allow for a variety of measures aimed at decreasing the risks for incarcerated pregnant women and their infants.

Their experience, as well as recommendations from leading health care providers in these communities, suggest that certain measures decrease risks related to giving birth while incarcerated. If the pregnant woman remains in custody, before, during, or after birth, these measures include early testing, access to obstetric or midwifery care, specialized diet, access to a doula, family support, mother-infant bonding, breastfeeding support, and postpartum care.

1. Pregnancy, Addictions, and Mental Health Testing

As a first step, it is important to identify women in need of pregnancy-related services. Pregnant women should also be tested for sexually transmitted diseases ("STDs") and drug addictions.

Incarcerated women have higher prevalences of STDs, compared to non-incarcerated women, and STDs can lead to complications such as preterm birth, low birth weight, and neonatal infections.[8] Further, 69% of female inmates meet criteria for drug dependence or abuse, and 65% report regularly using alcohol prior to incarceration.[9] Substance abuse during pregnancy is associated with poor perinatal outcomes, including preterm birth and low birth weight.[10] Pregnant inmates with opioid use disorders require a special approach: medical professionals recommend, and evidence shows, that—instead of forcing them into opioid withdrawal—they should receive medication treatment. "Withdrawal in pregnancy is associated with high rates of recurrence, and other obstetrical and infectious risks, whereas [medication] is associated with improved engagement in prenatal care and addiction treatment."[11]

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5 Susan Hatters Friedman, MD, et al., *Realities of Pregnancy and Mothering While Incarcerated*, THE JOURNAL OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, Nov. 3, 2020 Vol. 48(3):365-75, at p. 368-69. https://jaapl.org/content/early/2020/05/13/jaapl.003924-20.

6 *Id*. at p. 368.

7 *Id*.

8 Barbara A. Hotelling, MSN, *Perinatal Needs of Pregnant, Incarcerated Women*, Journal of Perinatal Education, 2008 Vol. 17(2):37-44, at p. 37, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409166/.

9 Brenda Baker, *Perinatal Outcomes of Incarcerated Pregnant Women: An Integrative Review*, JOURNAL OF CORRECTIONAL HEALTH CARE, 2019 Vol. 25(2):92-104, at p. 94, https://www.liebertpub.com/doi/10.1177/1078345819832366.

10 *Id*. at p. 94.

11 Chris Ahlbach, et al., *Care for Incarcerated Pregnant People With Opioid Use Disorder: Equity and Justice Implications*, OBSTETRICS & GYNECOLOGY (Sept. 1, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7483637/.

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Incarcerated women are also more likely to experience psychiatric disorders, including major depression (22%), bipolar disorder (8%), and posttraumatic stress disorder (29%).[12] The emotional implications of being pregnant and giving birth in prison can exacerbate these conditions, if women's needs are not attended to. Thus, early identification and treatment of mental health issues are key.

The District of Columbia should offer women pregnancy tests to determine who needs special support as early as possible, preferably within 48 hours of admission.[13] It should also test pregnant inmates for STDs and drug addictions and offer medication for opioid use disorders, if detected. Treatment for mental health issues should be offered under professional supervision, if possible. These conditions, while not directly related to pregnancy, may have a negative effect on pregnancy and birth, if left untreated.

2. Access to Obstetric or Midwifery Care

Incarcerated women who wish to continue their pregnancies should have access to regular obstetric or midwifery care, "beginning in early pregnancy and continuing through the postpartum period." They should also have access to "unscheduled or emergency obstetric visits on a 24-hour basis, and on-site heath care staff should be trained to recognize concerning signs and symptoms in pregnancy."[14]

Further, correctional facility staff and clinicians "must not dismiss symptoms that can signal miscarriage, preterm labor, labor, preeclampsia, or other pregnancy conditions, and pregnant people should be evaluated in a timely fashion by a qualified clinician."[15]

3. Specialized Diet

A specialized diet is crucial for the health of both the mother and the baby, before and after birth.[16] Many incarcerated women experience chronic food insecurity and poor nutrition, which are associated with poor perinatal outcomes, including gestational diabetes, preterm birth, and low birth weight.[17] Inadequate nutrition can delay recovery and increase the risk of postpartum complications.[18] At least one study reported that incarcerated women who had a proper diet experienced less maternal and fetal complications than incarcerated women that did not.[19]

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[12] *Supra* Friedman, note 5, at p. 373.
[13] Carolyn Sufrin, *Pregnancy and Postpartum Care in Correctional Facilities* (Jan. 2018), https://www.ncchc.org/wp-content/uploads/Pregnancy-and-Postpartum-Care-2018.pdf.
[14] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.
[15] *Id.*
[16] Rebecca J. Shlafer, et al, *Justice for Incarcerated Moms Act of 2021: Reflections and Recommendations*, SAGE JOURNALS, Apr. 19, 2022, at p. 3, https://journals.sagepub.com/doi/10.1177/17455057221093037.
[17] *Supra* Baker, note 9, at p. 94; Bethany Kotlar, et al., *Meeting Incarcerated Women's Needs for Pregnancy-Related and Postpartum Services: Challenges and Opportunities*, PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH, Dec. 2015 Vol. 47(4):221-25, at p. 221, https://www.guttmacher.org/sites/default/files/research_article/file_attachments/4722115.pdf. .
[18] *Supra* Kotlar, note 17, at p. 221.
[19] Somayeh Alirezaei, *The Needs of Incarcerated Pregnant Women: A Systematic Review of Literature*, INT'L COMMUNITY BASED NURSE MIDWIFERY (Jan. 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8724729/.

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Several states, including Arizona, California, Maine, Montana, and Pennsylvania have statutes that expressly require correctional facilities to provide inmates additional nutrition or vitamins during pregnancy and in some instances postpartum.[20]

The District of Columbia should follow their example. A pregnant inmate's diet should be rich in whole grains, calcium, fruits, and vegetables.[21] As pregnant women "often experience nausea, cravings, and have smaller gastric capacity," women in custody should also "receive healthy snacks outside of scheduled mealtimes."[22] In the second and third trimesters, pregnant women's calory intake should increase by 300.[23]

Additionally, pregnant women should receive prenatal vitamins, which, among other essential vitamins and minerals, contain folic acid, which is important for the prevention of neural tube defects.[24]

4. Access to a Doula

Incarcerated pregnant women "often feel isolated, especially during birth."[25] Doulas can alleviate these feelings by providing continuous physical, emotional, and informational support during labor and delivery, as well as before and after birth. One woman incarcerated in Seattle's King County Jail noted that doula support during the birth of her child made all the difference in the world: "I would have been absolutely petrified if I had been by myself." Another woman said that doula support made her feel "like there was somebody on my side."[26] A former leader of the Prison Birth Project in Massachusetts noted that, "finding people in those moments and helping transform their experience from one of trauma to one of support in a dark time is so incredibly powerful."[27]

Numerous clinical trials "provide sound evidence that continuous supportive care during labor produces a number of positive obstetric outcomes."[28] Doula care is "associated with a decrease in the rate of preterm birth and low birthweight infants, two major risk factors for infant mortality."[29] Studies have also shown that labors attended by doulas tend to be of shorter duration, have lower rates of Cesarean births and other medical interventions, and infants born have higher infant Apgar scores.[30] For example, the Minnesota Prison Doula

[20] Roxanne Daniel, *Prisons Neglect Pregnant Women in Their Healthcare Policies*, Prison Policy Initiative (Dec. 5, 2019), https://www.prisonpolicy.org/blog/2019/12/05/pregnancy/.

[21] *Supra* Sufrin, note 13, at 3.

[22] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.

[23] *Supra* Sufrin, note 13, at 3.

[24] *Id.*

[25] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.

[26] Marilyn Moses, et al., *The Use of Doulas for Inmates in Labor: Continuous Supportive Care with Positive Outcomes*, CORRECTIONS TODAY, June 2008 Vol. 70(3):58-73, at p. 59, https://www.ojp.gov/ncjrs/virtual-library/abstracts/use-doulas-inmates-labor-continuous-supportive-care-positive.

[27] Mary Ann Lieser, Birth Behind Bars: The Difference Trauma-Informed Doula Can Make, MIDWIFERY TODAY (Summer 2019), https://www.midwiferytoday.com/mt-articles/birth-behind-bars/.

[28] *Id.*

[29] Ami Wynne Hanna, *Access to Doula and Midwifery Support for Washington State's Incarcerated Population: A Qualitative Policy Assessment*, UNIVERSITY OF WASHINGTON, 2020, at p. 10. https://digital.lib.washington.edu/server/api/core/bitstreams/84a2e3f5-36ce-4da9-a9d6-3b10c1c8dea0/content.

[30] *Supra* Kotlar, note 18, at p. 221; Shlafer, note 2, at p. 122; Kenneth J. Gruber, PhD, *Impact of Doulas on Healthy Birth Outcomes*, THE JOURNAL OF PERINATAL EDUCATION, 2013 Vol. 22(1):49-58, at p. 330.

Project has shown a 60% reduction in Cesarean sections from baseline measurements.[31] Doulas also help in reducing the incidence of postpartum depression.[32]

Minnesota was the first state in the United States to pass a law that that expressly permits doula support for incarcerated pregnant women. It requires correctional facilities to grant doula services to incarcerated individuals during pregnancy and up to six weeks postpartum. At least two states followed suit, passing similar legislation. The state of Washington requires the Department of Corrections to provide "reasonable accommodations for the provision of available midwifery and doulas services to inmates who are pregnant or who have given birth in the last six weeks."[33] Oregon has recently passed legislation to establish a doula program at one of its correctional facilities.[34] At least two states, New York and Ohio, have proposed bills that would mandate correctional facilities to provide doula access.[35] And several correctional systems rely on doula support without a statutory requirement to do so. They include Alabama, Michigan, New York City, Pennsylvania, and Virginia.[36] The District of Columbia should join the states that expressly allow incarcerated women to receive doula support.

5. Family Support During Labor and Birth

In addition to a doula, and especially when doulas are not available, having a family member or friend attend the delivery and birth can significantly improve outcomes for both the mother and the baby.[37] The lack of family support during labor and delivery compounds the stress experienced by incarcerated mothers.[38] The presence of a supportive companion during labor and delivery has been shown to provide emotional, physical, and informational support, which can lead to better birth experiences and outcomes.[39]

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

[31] *Supra* Baker, note 9, at p. 94.

[32] *Supra* Kotlar, note 18, at p. 221.

[33] *Supra* Hanna, note 29, at 11-13. To make clear, neither state pays for the doula services, but it allows for nonprofits to provide these services.

[34] 2023 Oregon Revised Statutes, Section 421.173, Doula Program for Pregnant and Postpartum Adults in Custody, https://law.justia.com/codes/oregon/volume-11/chapter-421/section-421-173/.

[35] New York A8097, TrackBill, https://trackbill.com/bill/new-york-assembly-bill-8097-provides-doula-services-at-all-correctional-institutions-and-local-correctional-facilities/2461457/; Ohio Legislative Service Commission, S.B. 328, https://www.legislature.ohio.gov/download?key=14543&format=pdf; *see also* Dhara Patel and Amy Chen, National Health Program, State and Federal Legislative Proposals (Feb. 6, 2019), https://healthlaw.org/wp-content/uploads/2019/02/Doula-Care-State-Fed-Bills-2.6.19.pdf (listing legislative initiatives).

[36] Mattie Quinn, *Pregnant in Prison? Some States Deliver Doulas*, GOVERNING, July 18, 2016, at p. 1, https://www.governing.com/archive/gov-prison-pregnant-doulas.html; The Michigan Prison Doula Initiative, https://mpdi.org/; Women's Community Justice Association, *Issue Brief: Pregnancy and Birthing in Jails and Prisons* (Feb. 21, 2022), https://www.womenscja.org/issue_brief_pregnancy_and_birthing_in_jails_and_prisons#:~:text=New%20York%20City%20Council%20has,as%20during%20labor%20and%20delivery; Jewish Healthcare Foundation, *Doula Care and Lactation Support Made Available in Two Pennsylvania State Prisons* (Oct. 30, 2023), https://jhf.org/news/doula-care-and-lactation-support-made-available-in-two-pennsylvania-state-prisons; Virginia Prison Birth Project, https://virginiaprisonbirthproject.org/who-we-are.

[37] Alexandria Sobczak, et al., *The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review*, CUREUS, May 24, 2023 Vol. 15(5):1-13, at p. 1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292163/.

[38] *Supra* Friedman, note 5, at p. 373.

[39] *Id.*

Overall, continuous support during childbirth has been shown to promote a more positive birth experience.[40] The presence of a familiar and trusted person can help reduce the mother's anxiety and stress during labor.[41] Reduced stress levels can lead to lower levels of catecholamines, which are stress hormones that can negatively impact labor progress.[42] Having a supportive companion can increase the mother's confidence and sense of control during labor. This empowerment can lead to a more active participation in the birthing process, which is associated with better outcomes.[43]

Studies have shown that continuous support during labor, whether from a doula or a family member, is associated with lower rates of medical interventions such as Cesarean sections, forceps deliveries, and the use of epidurals.[44] The presence of a supportive companion can help the mother cope with labor more effectively, reducing the likelihood of complications that require medical intervention.

6. Mother-Infant Bonding

Separation from the newborn immediately after birth can lead to emotional trauma and postpartum depression.[45] Incarcerated women "should be allowed maximum time for parent-infant bonding while in the hospital after delivery."[46] The ACOG Committee on Health Care for Underserved Women finds that policies or practices that separate the newborn from their bother "for nonmedical indications while in the hospital or that expedite postpartum hospital discharge for carceral facility convenience are punitive, medically unnecessary, and can have detrimental effects on parent–infant bonding, breastfeeding, and psychological well-being."[47]

7. Breastfeeding Support

Breastfeeding has numerous benefits for both the mother and the baby, including reduced risk of postpartum depression and lower rates of infant mortality.[48] The ACOG Committee on Health Care for Underserved Women "strongly supports breastfeeding as the preferred method of feeding for newborns and infants."[49] The American Academy of Pediatrics ("AAP") points to the "unequivocal evidence that breastfeeding protects against a variety of diseases and conditions." For the infant, these conditions include otitis media, diarrhea, respiratory tract infection, necrotizing enterocolitis, SIDS, atopic dermatitis, asthma, celiac disease, Crohn's disease and ulcerative colitis, late-onset sepsis in preterm infants, Type 1 and type 2 diabetes, leukemia, and childhood overweight and obesity. Breastfeeding reduces the mother's risk of breast, ovarian, endometrial and thyroid cancers; hypertension, Type 2

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[40] *Supra* Shlafer, note 2, at p. 122.
[41] *Id.* at p 6.
[42] Marilyn Moses, et al., *The Use of Doulas for Inmates in Labor: Continuous Supportive Care with Positive Outcomes*, CORRECTIONS TODAY, June 2008 Vol. 70(3):58-73, at p. 59. https://www.ojp.gov/ncjrs/virtual-library/abstracts/use-doulas-inmates-labor-continuous-supportive-care-positive.
[43] *Supra* Sobczak, note 37, at p. 4.
[44] *Supra* Moses, note 42, at p. 59.
[45] *Supra* Kotlar, note 18, at p. 221.
[46] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.
[47] *Id.*
[48] *Supra* Shlafer, note 16, at p. 3.
[49] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.

diabetes, and rheumatoid arthritis.[50] For this reason, the AAP recommends exclusive breastfeeding for up to the first six months of an infant's life, "followed by continued breastfeeding as complementary foods are introduced."[51]

In accordance with these recommendations, when an inmate desires to breastfeed, she should be allowed to do that directly or to express milk for delivery to the infant.[52] If it is the latter, the ACOG Committee on Health Care for Underserved Women recommends that accommodations be "made for equipment and a private place to pump, safe storge, and transport of the milk to the infant's caregiver."[53] Research shows that programs that facilitate the safe storage and transportation of breast milk support maternal-infant bonding and promote better health outcomes for the child and the mother.[54]

8. Postpartum Care

During the 6- to 8-week postpartum, women may experience bleeding, cramping, and pain.[55] Women should be provided opportunities to rest and be free from restraints. Facilities should also provide them post-recovery recovery products. Especially for breastfeeding mothers, continued specialized diet is important both for the health of the mother and the infant. Breastfeeding mothers "should receive a well-balanced diet with additional calories, calcium, vitamin D supplementation, prenatal vitamins, no more than three cups of caffeinated beverage per day, and increased fluid intake."[56]

B. Community-Based Alternatives to Incarceration

Programs that allow pregnancy and postpartum release to unsecured facilities or community-based programs can provide a much more supportive environment for new mothers than any of the measures above combined. These programs often include parenting education, substance abuse counseling, and other resources that help mothers bond with their infants and reduce the risk of recidivism.[57]

Nine states currently have laws providing alternatives to incarceration for pregnant and postpartum women.[58] Six states provide community-program alternatives: California,

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[50] AAP, Breastfeeding Overview, https://www.aap.org/en/patient-care/breastfeeding/breastfeeding-overview/.

[51] AAP, Policy Statement, Breastfeeding and the Use of Human Milk, https://publications.aap.org/pediatrics/article/129/3/e827/31785/Breastfeeding-and-the-Use-of-Human-Milk?autologincheck=redirected#content-block.

[52] *Supra* ACOG Committee on Health Care for Underserved Women, note 1..

[53] *Id.*

[54] *Supra* Shlafer, note 16, at p. 3.

[55] *Supra* Sufrin, note 13, at 3.

[56] National Commission on Correctional Health Care, *Breastfeeding in Correctional Settings* (2023), https://www.ncchc.org/position-statements/breastfeeding-in-correctional-settings-2023/.

[57] *Supra* Baker, note 9, at p. 94.

[58] The Center for Leadership Education in Maternal & Child Public Health, University of Minnesota—Twin Cities, School of Public Health, a State Policy Brief from the National University-Based Collaborative on Justice-Involved Women and Children (JIWC) (Spring 2023). https://mch.umn.edu/wp-content/uploads/2023/03/JIWC-Policy-Brief-Alternatives-to-Sentencing-3.2023-1.pdf. Four more states—New York, Ohio, West Virginia, and Washington—authorize prison nursey programs that allow infants to reside with their mothers at the facility. *Id.*; *see also* Washington State Department of Corrections, *Residential Parenting Program Fact Sheet* (July 2024) (noting that "keeping mothers and children together" results in "lower rates of recidivism").

Minnesota, Missouri, Texas, and Wisconsin.[59] Three states—Illinois, Maryland, and Tennessee—have laws that allow permanent or temporary alternative sentences that can be granted for pregnant women or women with young children.[60] "While limited, evidence suggests that these types of policies and programs reduce intergenerational trauma, improve maternal self-image, promote secure attachment, encourage sustained breastfeeding, and may reduce rates of recidivism."[61]

Eligibility for these programs varies from state to state. When it comes to alternatives to incarceration, some states base eligibility on the length of a woman's sentence, such as Ohio and California, which require participating women to have a sentence of less than three years.[62] Other states, like Missouri, for example, conditions eligibility on the type of offense or the length of sentence.[63] Many states limit participation to women serving sentences for non-violent crimes and having no history of child abuse.[64]

The Minnesota Healthy Start Act is an example of legislation aimed at keeping mothers and infants together in a supportive setting that the District of Columbia should follow.[65] In recognition of "both the public interest and community safety," the Minnesota Department of Corrections "may conditionally release pregnant or post-partum incarcerated persons to community-based programming." The purpose of such release is to allow pregnant women and young mothers to participate "in prenatal or postnatal care programming and to promote mother-child bonding." The eligible women must be pregnant or have given birth within eight months of the commitment date. The women can stay in a community-based alternative setting during "for the duration of the pregnancy and up to one year post-partum."[66]

Such programs have been shown to reduce recidivism rates and promote long-term success for both the mother and the infant.[67] The ACOG Committee on Health Care for Underserved Women strongly support community-based alternatives to incarceration, noting that an incarcerated mother's separation from her newborn "can potentially have devastating maternal effects."[68]

C. <u>These Same Measures Have Societal Benefits</u>

The measures discussed above are beneficial not just for the mothers and their children, but the society at large. For example, programs that provide comprehensive support, such as postpartum release to unsecured facilities, have been shown to reduce recidivism rates. The

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https://www.doc.wa.gov/docs/publications/fact-sheets/400-FS003.pdf.

[59] *Id.*

[60] *Id.* In Maryland, the Governor can grant parole to a pregnant woman, reduce her sentence, or allow for an alternative residential setting for pregnancy. However, upon giving birth, the woman is to be returned to the facility. *Id.*

[61] *Id.*

[62] *Id.*

[63] *Id.*

[64] *Id.*

[65] *Supra* Shlafer, note 16, at p. 3.

[66] Minnesota Department of Corrections Policy Manual, Policy Number 205.123, *Healthy Start Placement for Pregnant and Post-Partum Persons*. https://policy.doc.mn.gov/DOCPolicy/.

[67] *Supra* Baker, note 9, at p. 94.

[68] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.

Minnesota Healthy Start Act aims to reduce recidivism by providing a supportive environment and addressing the underlying issues that contribute to criminal behavior.[69]

Other measures, such as doula support, have also had a positive effect on recidivism rates. For instance, the recidivism rate for women who participated in the Minnesota Prison Doula Project was significantly lower compared to those who did not receive such support.[70] Of the 300 women who received doula support as part of the Prison Birth Project in Massachusetts, "only one has ended up back inside."[71]

In contrast, women who do not receive specialized support and care are more likely to reoffend. The lack of comprehensive care, emotional support, and resources to address underlying issues such as substance abuse and mental health problems contributes to higher recidivism rates. Nationally, the recidivism rate for women within three years of release is over 50%, and within five years, it is approximately 73%.[72]

There are cost benefits too. Healthier pregnancies are more likely to lead to easier births, without many interventions, if any, and fewer interventions mean less expensive medical care.[73] Because Medicaid and Medicare benefits are typically suspended during incarceration, payment for health services falls on the prison, jail, or correctional facility.[74] The fewer medical interventions a woman needs to receive during labor and delivery, the lower medical costs will be.

D. Grievance Procedures Providing Meaningful Redress Are Necessary

When the District of Columbia begins mandating measures discussed above, it should provide inmates an avenue for meaningful redress, if any of the measures are denied. The current grievance procedure allows incarcerated individuals to submit grievance issues related to access to and quality of health care,[75] but it does not expressly contemplate that time-sensitive issues that may arise in the context of pregnant women in prisons—for instance, denial of access to a doula for labor and delivery.

The grievance procedure consists of four steps. First, an incarcerated individual may attempt resolution using the Informal Resolution Complaint Form or by discussing a grievance issue with staff. Second, if the informal resolution is unsuccessful or it is an emergency grievance, an incarcerated individual may use the formal grievance process. Third, after an initial pass through the grievance process, incarcerated individuals have one level of appeal.[76]

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[69] *Id.*
[70] *Supra* Shlafer, note 2, at p. 122; *see also* Washington State Department of Corrections, *Residential Parenting Program Fact Sheet* (July 2024) (noting that "keeping mothers and children together" results in "lower rates of recidivism"). https://www.doc.wa.gov/docs/publications/fact-sheets/400-FS003.pdf.
[71] *Supra* Lieser, note 27.
[72] *Supra* Baker, note 9, at p. 130.
[73] *Supra* Shlafer, note 2, at p. 122.
[74] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.
[75] District of Columbia Department of Corrections, Policy and Procedure, Inmate Grievance Procedure (IGP) – 4030.1N, April 25, 2024 (hereinafter "DC IGP"), at p. 6. https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/PP%204030.1N%20Inmate%20Grievance%20Procedure%20%28IGP%29%2004-25-2024.pdf.
[76] *Id.* at p. 20.

Fourth, after exhausting this grievance procedure, incarcerated individuals seek relief in court.[77]

While well-thought-out, this procedure does not account for the realities of pregnancy and childbirth. Just step one (informal complaint) and step two (formal grievance process) each take up to 15 days.[78] Together, and especially with step three (administrative appeal), it can be several weeks, if not months, before the incarcerated woman receives a response.

This timeline could easily create a situation in which a grievance, such as a denial of doula assistance at birth, is not resolved prior to the woman giving birth. Similarly, grievances related to, for example mother-infant separation following birth or the lack of breastfeeding support, could be decided well past the critical time when accommodations could have made a difference. As such, the grievance procedure would be meaningless in many instances.

The Grievance Policy's emergency grievance procedure has a shorter timeline as it does not require inmates to utilize the informal grievance process, skipping to the second step of the grievance procedure outlined above. However, on its face, the emergency grievance procedure may not provide a meaningful avenue for relief either. The Policy defines an emergency grievance as "matters in which an inmate would be subjected to substantial risk of personal injury or serious and irreparable harm if the inmate filed the grievance in the routine manner with the normally allowed response time."[79] The Policy offers no examples of what constitutes an "emergency," and it is foreseeable that many of the anticipated grievances outlined herein (i.e., lack of access to a doula, denial of postpartum release, breastfeeding support, etc.) would not satisfy the criteria for an emergency grievance.

Because the current grievance process does not adequately account for harms that may be suffered by pregnant women that are incarcerated, the methods for recourse should be revised accordingly. One way to address the inadequacy would be to expressly specify that pregnancy-related grievances constitute emergency grievances. This would shorten the grievance process by at least 15 days. But because even an emergency grievance may take 15 days, alone, this change may be insufficient. An even a shorter timeframe may be appropriate for higher-priority measures, such as doula or family support in labor and breastfeeding accommodations.

III. CONCLUSION

The measures discussed in this memorandum have been proven to lead to better outcomes for mothers and infants. They are the basic services and accommodations that women in the general population receive. As the ACOG Committee on Health Care for Underserved Women has emphasized, "[e]nsuring that incarcerated individuals receive respectful, consistent, high-quality reproductive health, pregnancy, and postpartum care is essential for ameliorating inequities and affirming these individuals' dignity."[80] Besides the numerous health benefits to the mother and infant, these measures also have significant societal benefits,

[77] *Id.* at p. 4.
[78] *Id.* at p. 16.
[79] *Id.* at p. 18.
[80] *Supra* ACOG Committee on Health Care for Underserved Women, note 1.

including lower labor and delivery costs and a lower rate of recidivism. The incarcerated women of the District of Columbia and the District's residents at large would benefit from implementing these measures.