

# Legislative Advisory Committee on the Care of Pregnant Incarcerated Women (SF2423/HF2833)

Committee Report – January, 2015

## Summary

Between October and December, 2014, a group of key stakeholders from corrections, health, human services, and community organizations met to discuss SF2423/HF2833, as well as implications of the law for subsequent policy and practice. This successful collaboration has led to specific recommendations for modifying the existing legislative language, as outlined below.

## Introduction

Minnesota law SF2423/HF2833 (Appendix A), authored by Senator Barbara Goodwin (DFL, District 41) and Representative Carolyn Laine (DFL, District 41B), mandated the creation of an advisory committee to review the existing correctional standards for incarcerated pregnant and postpartum women and, after such review, make recommendations for the 2015/2016 legislative session. This report serves as a summary of the committee's work and subsequent recommendations.

In addition to this report, several members of the committee hosted and participated in a one-day conference on October 20, 2014 at the University of Minnesota (The Interdisciplinary Institute on the Reproductive Health of Incarcerated Women in Minnesota). Videos and training materials are available on the Center for Leadership in Maternal and Child Public Health's [website](#). Proceedings from the institute were also published in *Healthy Generations*, a publication of the Center.

## Committee Members

SF2423/HF2833 directed the committee to be convened by a representative from the University of Minnesota's Department of Pediatrics. Dr. Rebecca Schlafer – an Assistant Professor in Pediatrics and a national expert on incarcerated women and their children – served as the committee's chair. The law further outlined key stakeholder groups to be represented on the advisory committee, namely corrections, human services, correctional health, and public health; Isis Rising, Prison Doula Program; the Minnesota Better Birth Coalition; Children's Defense Fund, Minnesota; and the Minnesota Sheriffs' Association (MSA).

To identify representatives from corrections and correctional health/public health the committee chair contacted senior administrators at the Minnesota Department of Corrections (MnDOC) and the Executive Director of the MSA. To identify representatives from health, Dr. Schlafer contacted Minnesota Department of Health (MDH) Commissioner Edward Ehlinger. Several other individuals were contacted directly about their participation, given their particular expertise and work with incarcerated women.

At the first committee meeting (September 12, 2014), the committee considered stakeholder groups that were not currently present, but whose perspectives should be included. Additional recommendations were made to include representatives representing child protection and

obstetrics/gynecology. As of December 2014, the following individuals were on the advisory committee (Appendix B contains a contact list with additional information for each committee member):

<i>Committee Member</i>	<i>Agency</i>
Jessica Anderson	Children's Defense Fund-Minnesota
Sara Benning	University of Minnesota, School of Public Health
Joshua Berg	Meeker County Jail
Monette Berkevich	Nobles County Jail
Guy Bosch	Minnesota Correctional Facility-Shakopee
Brad Colbert	William Mitchell College of Law
Holly Compo	Carlton County Public Health
Paul Coughlin	Carlton County Jail
Renee Dahring	Ramsey County Adult Detention Center and Corrections
Ruthie Dallas	Minnesota Department of Human Services
Margaret (Peg) Gemmell	Minnesota Department of Corrections
Erica Gerrity	Isis Rising Prison Doula Project
Diane Haugen	Saint Paul-Ramsey County Public Health, Correctional Health Program
Wendy Hellerstedt	University of Minnesota, School of Public Health
Colleen Holst	Minnesota Correctional Facility-Shakopee
Sarah Hutto	University of Minnesota, Department of Obstetrics, Gynecology and Women's Health
Erika Jensen	Hennepin County Project CHILd
Susan Lane	Better Birth Coalition
Todd Leonard	MENd Care
Katie Linde	Minnesota Department of Health
Kathleen Lonergan	Minnesota Department of Corrections
Rebecca Shlafer	University of Minnesota, Medical School
Robin Sikkila	McLeod County Public Health
Tim Thompson	Minnesota Department of Corrections

A recommendation was made that incarcerated women's perspectives be included. Given the inherent barriers of including individuals who are currently in custody, the committee opted to have Dr. Shlafer interview several incarcerated women about their perspectives on this issue. Six interviews were conducted and were summarized at the meeting on November 7, 2014. Interview notes and audio recordings are available upon request.

### **Committee Meetings**

The committee met four times: September 12, October 8, November 7, and December 12, 2014. Meeting agendas and minutes are appended to this report.<sup>1</sup> The committee meetings took place at different community locations: Wilder Foundation, Minnesota Correctional Facility (MCF)-Shakopee, William Mitchell College of Law, and Saint Paul-Ramsey County Public Health.

### **Identification of Key Issues**

Many key issues related to the care, treatment, and education for incarcerated pregnant women were discussed. Several of those issues are summarized below:

<sup>1</sup> The meeting on October 8 was a tour of the Minnesota Correctional Facility (MCF)-Shakopee. There was no agenda for or minutes from this meeting.

- Committee members acknowledged critical differences between the state’s only women’s prison (MCF-Shakopee) and the 84 county jails that house both male and female inmates. The facilities differed in critical ways (e.g., size, staffing, resources, inmate characteristics), and these differences have important implications for the care of pregnant women in custody. Further, county jail administrators discussed important differences between large, urban counties (e.g., Hennepin, Ramsey) and small, rural counties (e.g., Meeker, Nobles). While MCF-Shakopee houses women at all stages of pregnancy, including women who deliver their infants in custody, this is not the case for county jails. Most county jails have very few pregnant women each year and nearly all are released before their infant is born.
- There are considerable challenges in supporting the health and development of the fetus in the corrections environment. The vast majority of the jails in Minnesota are not equipped to house pregnant women. For example, while providing the infant with access to his mother’s milk may be ideal for infant health, this must be weighed against the structural barriers and priorities (i.e., safety and security) of a corrections environment.
- Committee members recognized that incarcerated pregnant women face considerable health risks before and during incarceration, and that the corrections environment complicates many of these risks. Although there is value in early identification of pregnancy and initiating prenatal care, education, and services, this is difficult given the realities of the population and the structural barriers of correctional facilities. For example, committee members discussed how substance use compromises both maternal and fetal health, but that detoxing a pregnant woman is incredibly complicated and often cannot be done in a correctional facility because the facilities do not have the necessary resources (e.g., methadone, trained staff) on site, nor can they safely support the detoxification process in the facility. Further complicating this issue is that incarcerated women (particularly those cycling in and out of county jails) may not self-disclose their pregnancy status or the chemical health use.
- There are inherent challenges in trying to balance the safety of a pregnant woman, her fetus, corrections staff, health care providers, and other inmates. A law that limits the use of restraints on pregnant women in custody is needed, but must also consider broader safety and security concern (e.g., risk of escape during transport). Our committee reviewed several state’s policies and position statements by national organizations (e.g., American Congress of Obstetrics and Gynecologists). Specific recommendations for modifying the restraint language are presented below.

### Current Recommendations and Rationale

The committee recommends the following changes to the existing legislative language (Appendix C):

1. Add language about how wrist restraints, if used, should be applied

In making this recommendation, a restraint subcommittee (Joshua Berg, Guy Bosch, Paul Coughlin, Rebecca Shlafer) reviewed restraint policies from other states (e.g., Colorado, Vermont, Washington), as well as relevant reports from the Bureau of Justice Administration (*Best Practices in the Use of Restraints with Pregnant Women and Girls Under Correctional Custody*), the National Commission on Correctional Health Care, and the American Civil

Liberties Union. The committee's recommended addition reflects language outlined by the National Commission on Correctional Health Care and is considered a best practice in the use of restraints with pregnant incarcerated women.

2. Add a reporting requirement on the use of restraints on pregnant women in custody

The restraint subcommittee again reviewed restraint policies from other states and relevant reports from key federal agencies and organizations. This recommendation was also discussed with members of the Inspection and Enforcement Unit at the Minnesota Department of Corrections, which is responsible for inspection of all county jails in the state. The committee's recommended addition of a reporting requirement reflects a best practice outlined by the Bureau of Justice Administration.

3. Modify requirements on pregnancy testing, such that a woman is tested on or before Day 14 of incarceration (Line 2.25)

This recommendation came after extensive discussion with members of the committee and correctional health care workers. Several concerns were raised about the feasibility of testing all women, as mandated in SF2423/HF2833. Representatives from county jails discussed concerns about the rapid turnover of inmates and how such turnover limited their ability to test, inform, and/or intervene with pregnant women before they were released from the facility. Additional concerns – particularly among individuals working in rural counties – related to limited resources. Many rural county jails do not have medical staff at the facility on a daily basis, thus limiting their capacity to test, inform, and/or intervene with pregnant women. “Day 14” was chosen to coincide with existing mandates on the screening of inmates for tuberculosis.

4. Modify language around testing and treatment for sexually transmitted diseases, and instead mandating that correctional facilities follow the prevailing standard of care for pregnant women (Line 2.26)

The committee agreed that incarcerated pregnant women should be receiving the same standard of prenatal care as pregnant women in the community. To reflect this position, the committee recommends including language about the “prevailing standard or current practice by the provider's peer group”.

5. Change “breastfeeding” to “lactation” (Line 2.29)

Lactation describes the secretion of milk from the mammary glands and is relevant to all pregnant women, regardless of whether or not a woman chooses to feed her infant with breast milk. As such, “lactation” is more accurate and appropriate, than “breastfeeding”. Information about lactation would include material on breastfeeding, but it could also include information about other topics relevant to postpartum women, in general (e.g., engorgement mastitis).

6. Add “or has given birth in the last six months” to Line 3.7.

Much of SF2423/HF2833 pertains to pregnant *and* recently postpartum women. As such, this change is recommended to ensure that pregnant and postpartum women are informed of applicable laws and policies.

### Long-term Recommendations

In addition to our committee's recommendations for modifying the existing legislative language, members of the committee also identified a number of additional recommendations to be considered in the future. These include:

- Fund and support the development of a system for electronic medical records that would be compatible across all county jails and the MnDOC. Such a system would promote continuity of care for inmates within and across facilities. This is particularly relevant for incarcerated pregnant women, whose pregnancy status changes over the course of their incarcerations and transfers between facilities (e.g., from a county jail to MCF-Shakopee).
- Provide resources for training and staff development on the unique needs of pregnant women in custody to corrections staff and correctional health care providers. On the basis of our committee's discussion, training topics could include the use of restraints, prenatal care, doula support, nutritional needs, mental health, and chemical health.
- Identify ways for correctional facilities to actively collaborate with local departments of public health to support the needs of pregnant women during incarceration and post-release. Such collaborations could include nurse-home visiting with pregnant women in jail, home visits with recently released women and their infants, MNsure navigators to assist with health insurance enrollment, etc.
- Support a study on alternatives to incarceration for pregnant women. This study should examine the use of furlough (a common practice in county jails), electronic home monitoring, other stipulations for conditional release, and/or unique treatment/housing models for substance abusing pregnant women (e.g., Drew House in New York City), and the implications of these alternatives to incarceration for maternal and child health, including short- and long-term outcomes such as cost savings related to improved child development and health outcomes, as well as the effects on relapse rates for chemical use and/or re-incarceration.
- Provide funding to support doula care for pregnant incarcerated women across the state.

### Next Steps

Committee members have identified several areas that require additional effort and ongoing work. Members of the committee are working to accomplish these goals:

- Provide training to jail administrators, jail programmers, and correctional health staff at the Minnesota Sheriff's Association annual meetings on the care and treatment of pregnant women in custody.
- Develop educational materials for dissemination to pregnant women and jails and prisons.
- Share existing policies and protocols affecting pregnant women across county jails.

### Contact Information

For inquiries about the committee or this report, please contact Dr. Rebecca Shlafer at [shlaf002@umn.edu](mailto:shlaf002@umn.edu) or (612) 625-9907.

**SENATE**  
**STATE OF MINNESOTA**  
**EIGHTY-EIGHTH SESSION**

**S.F. No. 2423**

(SENATE AUTHORS: GOODWIN, Lourey, Rosen, Johnson and Pappas)

DATE	D-PG	OFFICIAL STATUS
03/06/2014	6002	Introduction and first reading Referred to Judiciary
03/27/2014	6880a 6937	Comm report: To pass as amended Second reading
05/02/2014	8640a 8640	Special Order: Amended Third reading Passed
05/05/2014	8711	Author added Pappas
05/08/2014	8966	Returned from House Presentment date 05/09/14
05/14/2014	9316 9316	Governor's action Approval 05/13/14 Secretary of State Chapter 234 05/13/14 Effective date Sec. 1-3 07/01/14; Sec. 4 05/14/15

A bill for an act

relating to public safety; addressing the needs of incarcerated women related to pregnancy and childbirth; authorizing an advisory committee; proposing coding for new law in Minnesota Statutes, chapter 241.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[241.87] DEFINITIONS.**

As used in sections 241.88 and 241.89, the following terms have the meanings given:

(1) "certified doula" has the meaning given in section 148.995, subdivision 2;

(2) "correctional facility" has the meaning given in section 241.021, subdivision 1;

(3) "doula services" has the meaning given in section 148.995, subdivision 4;

(4) "postpartum" means the period of time following the birth of an infant to six

months after the birth; and

(5) "restrain" means the use of a mechanical or other device to constrain the

movement of a person's body or limbs.

Sec. 2. **[241.88] RESTRAINING AN INCARCERATED PREGNANT WOMAN.**

Subdivision 1. **Restraint.** (a) A representative of a correctional facility may not restrain a woman known to be pregnant unless the representative makes an individualized determination that restraints are reasonably necessary for the legitimate safety and security needs of the woman, correctional staff, or public. If restraints are determined to be necessary, the restraints must be the least restrictive available and the most reasonable under the circumstances.

(b) A representative of a correctional facility may not restrain a woman known to be pregnant while the woman is being transported if the restraint is through the use of waist

2.1 chains or other devices that cross or otherwise touch the woman's abdomen or handcuffs  
 2.2 or other devices that cross or otherwise touch the woman's wrists when affixed behind  
 2.3 the woman's back.

2.4 (c) A representative of a correctional facility may restrain a woman who is in labor  
 2.5 or who has given birth within the preceding three days only if:

2.6 (1) there is a substantial flight risk or some other extraordinary medical or security  
 2.7 circumstance that dictates restraints be used to ensure the safety and security of the  
 2.8 woman, the staff of the correctional or medical facility, other inmates, or the public;

2.9 (2) the representative has made an individualized determination that restraints are  
 2.10 necessary to prevent escape or injury;

2.11 (3) there is no objection from the treating medical care provider; and

2.12 (4) the restraints used are the least restrictive type and are used in the least restrictive  
 2.13 manner.

2.14 (d) Section 645.241 does not apply to this section.

2.15 Subd. 2. **Required training.** The head of each correctional facility shall ensure that  
 2.16 staff members of the facility who come in contact with pregnant women incarcerated in  
 2.17 the facility are provided training on the provisions of this section.

2.18 Sec. 3. **[241.89] REQUIREMENTS FOR AN INCARCERATED WOMAN.**

2.19 Subdivision 1. **Applicability.** This section applies only to a woman:

2.20 (1) incarcerated following conviction; and

2.21 (2) incarcerated before conviction beyond the period specified for the woman's initial  
 2.22 appearance before the court in Rules of Criminal Procedure, rules 3.02, 4.01, and 4.02.

2.23 Subd. 2. **Requirements.** The head of each correctional facility shall ensure that  
 2.24 every woman incarcerated at the facility:

2.25 (1) is tested for pregnancy, if under 50 years of age unless the inmate refuses the test;

2.26 (2) if pregnant and agrees to testing, is tested for sexually transmitted diseases,  
 2.27 including HIV;

2.28 (3) if pregnant or has given birth in the past six weeks, is provided appropriate  
 2.29 educational materials and resources related to pregnancy, child birth, breast feeding,  
 2.30 and parenting;

2.31 (4) if pregnant or has given birth in the past six weeks, has access to doula services if  
 2.32 these services are provided by a certified doula without charge to the correctional facility  
 2.33 or the incarcerated woman pays for the certified doula services;

2.34 (5) if pregnant or has given birth in the past six months, has access to a mental health  
 2.35 assessment and, if necessary, treatment;

3.1 (6) if pregnant or has given birth in the past six months and determined to be  
3.2 suffering from a mental illness, has access to evidence-based mental health treatment  
3.3 including psychotropic medication;

3.4 (7) if pregnant or has given birth in the past six months and determined to be  
3.5 suffering from postpartum depression, has access to evidence-based therapeutic care for  
3.6 the depression; and

3.7 (8) if pregnant, is advised, orally or in writing, of applicable laws and policies  
3.8 governing incarcerated pregnant women.

3.9 Sec. 4. **ADVISORY COMMITTEE.**

3.10 (a) An advisory committee of stakeholders may be convened by a representative  
3.11 from the University of Minnesota Department of Pediatrics. The committee shall consider  
3.12 standards of evidence-based care, treatment, and education for incarcerated women and  
3.13 girls who are pregnant or have recently given birth.

3.14 (b) The advisory committee may consist of representatives from corrections, human  
3.15 services, and health; Isis Rising, Prison Doula Program; the Minnesota Better Birth  
3.16 Coalition; Children's Defense Fund, Minnesota; and the Minnesota Sheriffs' Association.

3.17 (c) By January 15, 2015, the advisory committee shall report the committee's  
3.18 findings to the chairs and ranking minority members of the senate and house of  
3.19 representatives committees with jurisdiction over criminal justice policy.

3.20 Sec. 5. **EFFECTIVE DATE; APPLICABILITY.**

3.21 Section 4 is effective the day following final enactment. Sections 1 to 3 are effective  
3.22 July 1, 2014, and apply to state correctional facilities on and after that date, and apply  
3.23 to other correctional facilities on and after July 1, 2015.



Legislative Advisory Committee  
Contact List

<b>Last Name</b>	<b>First Name</b>	<b>Title</b>	<b>Agency/Organization</b>	<b>Email</b>
Anderson	Jessica	Legislative Affairs and Communications Director	Children's Defense Fund - Minnesota	janderson@childrensdefense.org
Benning	Sara	Outreach and Communications Director	University of Minnesota, School of Public Health	sbenning@umn.edu
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Berkevich	Monette	Jail Administrator	Nobles County	msoderholm@co.nobles.mn.us
Bosch	Guy	Associate Warden of Operations at MCF-SHK	MCF - Shakopee	guy.bosch@state.mn.us
Colbert	Brad	Adjunct Faculty	Legal Aid for Minnesota Prisoners	Brad.Colbert@wmitchell.edu
Compo	Holly	Correctional Health Division - Nurse	Carlton County	holly.compo@co.carlton.mn.us
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Dahring	Renee	Correctional Health Nurse	Ramsey County Adult Detention Center	mindthegaps@comcast.net
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Gemmell	Margaret (Peg)	Director of Nursing at Central Office	Minnesota Department of Corrections	margaret.gemmell@state.mn.us
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Haugen	Diane	Clinical Services Manager	Saint Paul-Ramsey County Public Health	diane.haugen@co.ramsey.mn.us
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Holst	Colleen	Health Services Director at MCF-SHK	MCF - Shakopee	colleen.holst@state.mn.us
Hutto	Sarah	Assistant Professor	University of Minnesota, Department of Obstetrics, Gynecology, and Women's Health	hutt0066@umn.edu
Jensen	Erika	Senior Chemical Health Counselor	Hennepin County Project CHILD	erika.jensen@hennepin.us
Lane	Susan	Coordinator	Better Birth Coalition	salane@visi.com
Leonard	Todd	Correctional Health Division - Contract Nurse	MEND Care	tleonard@mendcare.com
Linde	Kate	Women and Infant Health Supervisor	Minnesota Department of Health, Division of Community and Family Health	kathryn.m.linde@state.mn.us
Lonergan	Kathleen	Director of Government Relations	Minnesota Department of Corrections	kathleen.lonergan@state.mn.us
Shlafer	Rebecca	Assistant Professor	University of Minnesota Department of Pediatrics	shlaf002@umn.edu
Sikkila	Robin	Correctional Health Division - Nurse	McLeod County Public Health	robin.sikkila@co.mcleod.mn.us
Thompson	Tim	Corrections Alternative Program Manager	Minnesota Department of Corrections	Timothy.thompson@state.mn.us

1.1 A bill for an act  
1.2 relating to public safety; addressing the needs of incarcerated women related to  
1.3 pregnancy and childbirth; authorizing an advisory committee; proposing coding  
1.4 for new law in Minnesota Statutes, chapter 241.  
1.5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.6 Section 1. **[241.87] DEFINITIONS.**

1.7 As used in sections 241.88 and 241.89, the following terms have the meanings given:

- 1.8 (1) "certified doula" has the meaning given in section 148.995, subdivision 2;  
1.9 (2) "correctional facility" has the meaning given in section 241.021, subdivision 1;  
1.10 (3) "doula services" has the meaning given in section 148.995, subdivision 4;  
1.11 (4) "postpartum" means the period of time following the birth of an infant to six  
1.12 months after the birth; and  
1.13 (5) "restrain" means the use of a mechanical or other device to constrain the  
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2.1 chains or other devices that cross or otherwise touch the woman's abdomen or handcuffs  
2.2 or other devices that cross or otherwise touch the woman's wrists when affixed behind  
2.3 the woman's back. **Wrist restraints, if used, should be applied in such a way that the pregnant  
woman may be able to protect herself and her fetus in the event of a forward fall.**  
2.4 (c) A representative of a correctional facility may restrain a woman who is in labor  
2.5 or who has given birth within the preceding three days only if:  
2.6 (1) there is a substantial flight risk or some other extraordinary medical or security  
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2.8 woman, the staff of the correctional or medical facility, other inmates, or the public;  
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2.10 necessary to prevent escape or injury;  
2.11 (3) there is no objection from the treating medical care provider; and  
2.12 (4) the restraints used are the least restrictive type and are used in the least restrictive  
2.13 manner.  
2.14 (d) Section 645.241 does not apply to this section.  
2.15 Subd. 2. Required training. The head of each correctional facility shall ensure that  
2.16 staff members of the facility who come in contact with pregnant women incarcerated in  
2.17 the facility are provided training on the provisions of this section.  
**Subd. 3. Require reporting. On an annual basis, the Department of Corrections shall provide a  
report on any use of restraints on pregnant women incarcerated under the Commissioner of  
Corrections and in county jails in the State of Minnesota.**

2.18 Sec. 3. **[241.89] REQUIREMENTS FOR AN INCARCERATED WOMAN.**

2.19 Subdivision 1. Applicability. This section applies only to a woman:

- 2.20 (1) incarcerated following conviction; ~~and~~ **or**  
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2.27 including HIV; **is provided the prevailing standard of care or current practice by the provider's  
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- 3.1 (6) if pregnant or has given birth in the past six months and determined to be  
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- 3.4 (7) if pregnant or has given birth in the past six months and determined to be  
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3.6 the depression; and
- 3.7 (8) if pregnant **or has given birth in the last six months,** is advised, orally or in writing, of  
applicable laws and policies
- 3.8 governing incarcerated pregnant women.

3.9 Sec. 4. ADVISORY COMMITTEE.

- 3.10 (a) An advisory committee of stakeholders may be convened by a representative  
3.11 from the University of Minnesota Department of Pediatrics. The committee shall consider  
3.12 standards of evidence-based care, treatment, and education for incarcerated women and  
3.13 girls who are pregnant or have recently given birth.
- 3.14 (b) The advisory committee may consist of representatives from corrections, human  
3.15 services, and health; Isis Rising, Prison Doula Program; the Minnesota Better Birth  
3.16 Coalition; Children's Defense Fund, Minnesota; and the Minnesota Sheriffs' Association.
- 3.17 (c) By January 15, 2015, the advisory committee shall report the committee's  
3.18 findings to the chairs and ranking minority members of the senate and house of  
3.19 representatives committees with jurisdiction over criminal justice policy.

3.20 Sec. 5. EFFECTIVE DATE; APPLICABILITY.

- 3.21 Section 4 is effective the day following final enactment. Sections 1 to 3 are effective  
3.22 July 1, 2014, and apply to state correctional facilities on and after that date, and apply  
3.23 to other correctional facilities on and after July 1, 2015.

**Legislative Advisory Committee on Standards of Care for  
Incarcerated Pregnant Women**

Friday, September 12, 2014

1-3pm

Location: Wilder Foundation, Rm. 2510

1. Introductions
2. SF 2423 History & Overview
3. Purpose, Goals, & Timeline of the Advisory Committee
4. Current Practices and Policies Affecting Incarcerated Pregnant Women
  - a. Minnesota Correctional Facility - Shakopee
  - b. Minnesota County Jails
5. Identification of Key Issues
6. Interdisciplinary Institute (October 20) at the University of Minnesota
7. Next Steps

**Legislative Advisory Committee on Standards of Care for  
Incarcerated Pregnant Women  
MEETING SUMMARY  
9/12/2014  
1-3pm  
Wilder Foundation, Rm. 2510**

PRESENT: Jessica Anderson, Sara Benning, Guy Bosch, Brad Colbert, Holly Compo, Ruthie Dallas, Erica Gerrity, Peg Gemmell, Barb Goodwin, Wendy Hellerstedt, Coleen Holst, Susan Lane, Katie Linden, Kathleen Lonergan, Todd Leonard, Rebecca Schlafer, Robin Sikilla, Monette Soderholm, Steve Troust

**1. Who is Missing from the Advisory Committee?** To make this Advisory Committee the most effective, some additional people will be added. Suggestions included:

- a constituent who has been within the system
- an Ob/Gyn provider (practitioner, midwife or MD)
- a juvenile detention worker
- someone who works with girls, such as Cathy Powers
- an individual who has cared for a child while mother was incarcerated
- Timothy Thompson, an inspector for the Department of Corrections (DOC)
- Jeff Holreist, pioneer of Release Advanced Programming (RAP)
- workhouse staff
- someone from Project Baby

Committee members will send their suggestions, along with contact information, to Rebecca Schlafer.

**2. SF 2423 History & Overview** Jessica Anderson (Children's Defense Fund) provided an overview of the bill. The focus of the Doula Program and Isis Rising's work is to create a national model of excellent care for women and unborn children, including for incarcerated women and their children. The Children's Defense Fund (CDF) elevated the issue at the capitol late last year, and Senator Goodwin and Representative Lane championed the bill. The bill currently focuses on use of restraints and care during and after birth and treatment and education for women (see CDF handout). The creation of this Advisory Committee was also a part of this bill.

**3. Identification of Key Issues:**

- Concerns about the current language in the bill include:
  - There is ambiguity around "restraints," so the legislation needs to be clearer since it is currently open to interpretation (does it include handcuffs, shackling leg or arms, include use of mace and tasers, etc.?).
  - There are inconsistencies in existing MnDOC policies regarding use of restraints for inmates with special health care needs (e.g., an inmate with open heart surgery is restrained, but a pregnant woman in labor is not).
  - Escapes and safety are major concerns, especially when 60-70% of inmates have mental health issues and are a threat to themselves and/or others.
  - There are security issues with allowing women to breastfeed. Operationally it's virtually impossible to ask officers for one-on-one time with offender because it puts the facility at risk, and is costly and staff intensive. For example, inmates would need to request a female officer, who would need to stay with the inmate while breastfeeding. This takes

away a correctional officer from other areas of a prison and is one less officer to supervise offenders. This would happen several times a day and during the night. In addition, a breast pump could be used to create a weapon.

- There is a question about mental health and chemical dependency and why it was taken out of the bill. Many women who are close to release have transition and chemical dependency treatment programs during the last 6-10 months of incarceration. To make them better mothers when they return home, they need to get off of drugs. Treatment works to help them be better parents, and lowers recidivism.
  - There is the concern that any time inmates are using to breastfeed is time away from other programming and not getting other help, such as chemical dependency treatment.
- Therapeutic abortion is not addressed in the legislation but is a concern for health providers, particularly those in county jails. If an inmate is pregnancy tested and wants to have an abortion, there aren't options for them and it becomes an uncomfortable situation for the provider. At the state-level, MnDOC representatives indicated that if someone wants an elective abortion, medical staff can assist with making an appointment, but the state won't provide the procedure. Brad noted that not providing access may be in violation of the law.
- Other issues and concerns include:
  - There is no systematic process to know how many pregnant women are incarcerated.
  - Often jails and prisons are providing the first or best prenatal care some women have gotten.
  - There are some concerns around Lexipol Manual policies, which should be addressed. The DOC and jails are adhering to policies, but implementing them in different ways. MnDOC provides educational materials to pregnant women, but in jails this isn't part of their procedures.
  - Judges, particularly those in rural counties, are keeping people in jail until the baby is delivered in order to keep the baby safe. Brad notes that this practice is illegal and that pregnancy status cannot be considered at the time of sentencing.
  - The issue of furlough should be discussed. County jail administrators are told to get pregnant inmates out. In facilities, furlough is granted if it's *medically* a good idea for the inmate. The administrators and courts also weigh the offense, sentence, etc. Additionally there is the concern that some jail inmates lie about their pregnancy status to get on furlough or to access other privileges (e.g., additional food).
    - More discussion with counties around changing release dates after birth is warranted. For women in prison, there is no consideration of pregnancy status as it relates to their release date. Currently an inmate can have a baby and be released two weeks later, but those first two weeks after birth are critical for attachment and bonding.
    - Rebecca noted that 65% of women who delivered in custody with Isis Rising initiate breastfeeding at the hospital, and 60% of moms are released within 6 months of birth, so there are implications for breastfeeding or attachment on these children. Are there ways for women to promote women's milk production until they leave (hand expression, breast pumps, etc.)?
    - Crime victims and victims' rights committees may take issue with this issue. If a woman is pregnant during incarceration, it's a tragedy for that child but the

reality is that victims won't be happy seeing women released for any reason, especially for breastfeeding.

- There is some concern about legislating the practice of medicine. Doctors have to live according to boards and community practice standards, and there's worry about potential for lawsuits.
  - As a public health issue, incarcerated pregnant women are a high risk population. There was a question about the difference between testing newborn babies versus testing incarcerated women for pregnancy. There is an opportunity to intervene so that the mother and child have the best outcome possible.
- It is optimal to identify pregnant women entering correctional facilities but who don't yet know they're pregnant. There is the additional challenge that some women don't know the basics about reproduction and what's happening with their bodies (including the symptoms of pregnancy). The time to get to prison from jail can be lengthy, so women may get tested at jail, but become pregnant before their sentencing while they're in the community. Additionally, some women enter custody claiming they're pregnant when they aren't.
- Release planning is difficult for counties, especially for rural counties, because there aren't resources for it.
  - Women are afraid of their child going to foster care after birth, yet Child Protective Services (CPS) is often better at facilitating kids' visits with incarcerated mothers than family members do (perhaps because of more stable resources/life circumstances). During discharge planning, CPS isn't necessarily involved or contacted because an inmate may go to court and then be released and not return to the medical unit, so the nurse and other medical staff never see the inmate again. Once the inmates are released, they're out - there's no discharge plan.
  - At larger facilities, there are RAP programs but inmates need to be carefully selected and commit to working with everyone.
  - Inmates can get help enrolling in MNsure, but getting care is up to them.
  - Medicaid may pay for some services since children of incarcerated parents may end up in foster care.

### **3. Current Practices and Policies Affecting Incarcerated Pregnant Women** Representatives from the MnDOC and jails discussed their facilities, inmate demographics, challenges, policies and more:

- Minnesota Correctional Facility – Shakopee:
  - Shakopee is classified as minimum to maximum level security, with inmates ranging from ages 18-80. There is currently no fence but there will be one next year. Buildings are residential-grade so it feels more like college campus. There is currently one empty bed. Shakopee's biggest concerns are around safety and escapes.
  - Shakopee is program-rich. Most inmates are working or in programs.
  - It is a Transition from Prison to Community (TPC) Phase 1 facility:
    - There is a risk and needs assessment done at intake
    - Effective interventions are evidence-based
    - There are collaboration with stakeholders
    - Case planning helps transition inmates from prison to community
  - Of the 660 incarcerated women, on average there are eight pregnant inmates at a time.
    - Some inmates come in pregnant and leave pregnant.

- Pregnant women are not housed any differently than other inmates unless they want to be on the parenting unit:
      - Offenders get extended 4-hour visits with their children in Shakopee’s core building, but they can no longer visit overnight. Overnight visits were very well received but contraband was found, posing a serious risk to children.
      - During extended visits, mothers can have a meal with their children but inmates can’t breastfeed baby during that time.
      - Transition courses are offered so that those enrolled in parent program get help on transitioning into parenting again.
    - Pregnant inmates work the same as other inmates, though there may be some modifications. New mothers get 6 weeks off of work if they’d like, though some might want to go back because they need to earn money.
    - Pregnant inmates get a lower bunk, a modification that’s generated by nurses, and a pregnancy snack bag is authorized by a dietician.
    - Prenatal care is provided from intake and up until 28 weeks, then a mother’s first appointment is at St. Francis, where they receive care until 36<sup>th</sup> week.
    - Breastfeeding is not authorized because, operationally, it’s difficult to do (no refrigeration or labeling options) and they don’t get a lot of requests from inmates to do so. There is no policy on breastfeeding, but if a baby is premature, for example, there would be some discussion about how breastfeeding might be made possible.
  - Shakopee has a do-not-restrain list that is not limited strictly to pregnant inmates (some inmates don’t want to be identified as pregnant), which is updated daily, and officers receive restraint training. When offenders go to the hospital they maintain two security staff at a time because the women are not restrained. Women were restrained after birth (prior to the bill).
- St. Paul Jails:
  - There are 40 women in jail every day; most are there for misdemeanors. They are rarely in jail for 14 days. If they are, they go to the workhouse.
  - In the last six years, no one has delivered while in custody in jail.
  - They have highly developed policies for pregnant inmates.
    - Upon intake, women are asked if they are or could be pregnant, then tested if they indicated they are or may be.
    - The routine pregnancy testing occurs once a week.
    - Pregnant women are considered high risk and seen by a nurse practitioner the day after they’re identified as pregnant. If they’re in 8<sup>th</sup> or 9<sup>th</sup> month it’s better for county to deliver outside of jail. All are sent to HealthPartners for other care, who follow them from that point on.
    - Medical staff are able to verify drug abuse or other issues the same day as testing. Women receive methadone treatment or some other substitute if needed.
    - Nurse offers sexually transmitted infection (STI) testing.
    - There are requests for abortions and medical staff can’t perform them. This was described as a “very uncomfortable” situation, because staff do not know how to respond.



- The workhouse does a lot of furloughing, but any workhouse births would go to United Hospital.
  - St. Paul Jails allow breast milk pick up by the family after labor and delivery.
- Carlton County Jail:
  - There are 35 beds.
  - The hospital won't do blood draws and no one in jails does blood draws, thus certain testing is very difficult.
  - A doctor comes once a week.
  - Fond du Lac Reservation services can be offered, if appropriate.
  - There haven't been any deliveries in Carlton County Jail.
  - Carlton encourages manual expression, especially for women having problems, but storage of breastmilk is an issue. Otherwise breastfeeding is taken on a case by case basis.
  - There is no funding for transition planning.
- McLeod County Jail:
  - Inmates answer a booking questionnaire. If they indicate they're pregnant, McLeod can do pregnancy tests, but they rely on community partners when they have pregnant inmates.
  - Nurses come in to jail to provide care, or inmates are referred out, depending on what they need for their care.
  - A doctor comes to the jail twice a month.
  - Pregnant inmates get additional food to supplement nutritional needs, a lower bunk, prenatal vitamins, etc.
  - Breastfeeding would be taken on case-by-case.

**4. Advisory Committee Tasks** The overall goal is to improve birth outcomes, reduce infant morbidity and mortality, and reduce disparities for women coming out of incarceration. Keeping this in mind, the Committee will meet several times over the course of the next several months to create a report for the Legislature, due in early January. The Committee won't be able to address all of the critical issues in three months. Instead, the report will:

- include Advisory Committee member make-up and selection
- identify changes to make to current bill language in order to clean up and develop some of the items already in the legislation (such as "restraint")
- outline short, interim and long-term goals and recommendations for what should be done legislatively
- consider language about community of care by addressing what is considered standard care in a prison or jail for pregnant women, as well as case follow-up for pregnant women
- examine and share relevant policies and materials, including common policies, existing educational resources, unique policies and determine what policies are missing (for example, Rikers has extensive policies regarding breastfeeding that may help guide the Committee's next steps on this issue)

The Committee should consider writing a white paper that includes best practices, how to operationalize in own jail and how it would be paid for.

**5. Interdisciplinary Institute (October 20) at the University of Minnesota:**

- The topics include preconception health, prenatal health and postpartum care for afternoon small group work.
- The intent is for the Advisory Committee to help guide the day in terms of content and discussions: what will energize and inform the audience?
- The event planning team is exploring CEUs for RNs, LPNs, lawyers and social workers.
- There is the desire to have people working in the front lines there, so please share.

**6. Next Steps**

- ~~Rebecca will share an updated contact list with the Committee.~~
- ~~Todd will send Rebecca suggestions for ob/gyn folks to add to the Committee.~~
- ~~Rebecca will send out Doodle poll to schedule the next meeting in Shakopee.~~
- ~~Rebecca will send an updated PDF about the October 20th event.~~

**Legislative Advisory Committee on Standards of Care for  
Incarcerated Pregnant Women**

Friday, November 7, 2014

10am-12pm

Location: William Mitchell, Rm. 240 (875 Summit Ave. | St. Paul)

1. Update from Restrain Subcommittee
2. Update from Breastfeeding Subcommittee
3. Update on interviews with pregnant/postpartum women in custody
4. Reflections/Recommendations from the November 20<sup>th</sup> Institute
  - a. Pregnancy testing
  - b. Collaboration with public health/transition from prison to community models
  - c. Others
5. Writing plan for legislative report

**Legislative Advisory Committee on Standards of Care for  
Incarcerated Pregnant Women**

**SUMMARY**

Friday, November 7, 2014

10am-12pm

William Mitchell, Rm. 240

875 Summit Ave., St. Paul, MN

Present: Jessica Anderson, Sara Benning, Joshua Berg, Guy Bosch, Brad Colbert, Holly Compo, Paul Coughlin, Renee Dahring, Erica Gerrity, Diane Haugen, Mike Hennen, Colleen Holst, Erika Jensen, Todd Leonard, Katie Linde, Kathleen Lonergan, Rebecca Shlafer, Sydney Silko

**1. Interviews with Pregnant/Postpartum Women in Custody** – Rebecca Shlafer interviewed four women at Shakopee (two pregnant, two postpartum), and two women at county jails to get a sense of their experiences in order to address the unique needs of pregnant women who are incarcerated. The participants were not a representative sample but there were crosscutting issues identified in all six interviews.

- Many discussed challenges in the timing of care and the quality of care. Women weren't sure when they were going to be seen or why, and they also reported long delays between visits. There was also variability in the quality of care: women felt that some nurses were kind to them, but others weren't.
- A recent situation involved an incarcerated woman who was 7.5 months pregnant in a county jail. A judge ordered the jail facility to take her to a routine prenatal appointment. Per the woman's report, the corrections staff parked at the back of the parking lot, and made the woman walk the distance to the front door with ankle irons on. She was not offered the use of a wheelchair, or an elevator to get to the clinic several floors up. She fell onto her stomach while walking across the lobby. The fetus was monitored for half an hour. When asked about the incident, the jail administrator called it "nothing remarkable." The fetus was not harmed.
  - Jail representatives noted that this situation violates existing Lexipol policy. In this case, the woman was not a flight risk. After this occurrence, the jail allowed her boyfriend to take her to her medical visits. She's now free to come and go for medical appointments, so it was unclear why she needed to be restrained in the first place.
- Transparency and timing considerations came from the interview process, resulting in changes to MCF-Shakopee's care model. Isis Rising staff are asking question about pregnancy because they want to know how to best care for the women and their babies – that point can be difficult to communicate to the women, especially if they see staff as the enemy. A big part of the Isis Rising program is steering the conversation so that women don't perceive staff as the enemy. The group of pregnant women that they are discussing these changes with is also young, and may first-time moms. However, Isis Rising data has shown that through their participation, women report more support 12 weeks later, and can help provide a different view for other inmates to see. Eventually it would be nice to have administrators talk to pregnant

- women and let them know what's going on so that they have expectations for the type of care they will receive during their incarceration.
- A lot of the women's frustration and additional stress has potentially been averted because of increased transparency at MCF-Shakopee around their care and adjustment of policies to ensure the best care for women. For example:
    - Meetings are being set up to bring together more staff than has typically been involved in pregnancy care. In the past it would have just involved the medical service. In this and other situations, health services, food services, safety directors, work assignment personnel, and correctional officers are being brought together so there is collaboration around the experience of pregnant women while they are incarcerated.
    - Staff are also checking processes for pregnant women – for example, can Shakopee's kitchen staff be less rigid if a pregnant woman wants two scoops of peas instead of one (do they get special consideration)?
  - Women have identified needing more time with nurses because they have different (and more) needs than the general inmate population. Now women are receiving a schedule so they know what to expect during pregnancy and the frequency and type of care they will receive.
    - A new computer system had caused scheduling issues, but now pregnant women are audited weekly to make sure they have their next appointment scheduled and they are being taken care of.
  - A pregnancy kit is also being developed and will be given to offenders. It has a care schedule to help women figure out when they need certain medical appointments. It gives pregnant offenders a voice – they know that Shakopee staff are reacting to them, and that women have a voice in the process.
    - Expecting them to read and comprehend the kits may not happen. Staff may need to supplement and communicate in other ways. Some of the incarcerated women may have learning disabilities or other issues that prevent them from understanding the material.
  - At the county level, scheduling care the way the Shakopee does is almost impossible, though it is easier in work release facilities. At jails there are lock downs, critical incidents, and daily sick call lists, so jail staff have to be responsive to what happens at the facility when getting inmates to care. An added concern is the need for inmates to not know exactly when their appointments are if they have to go off-site for care, for safety concerns.
    - There are inconsistent protocols between jails. Eventually, every county is going to have some type of Electronic Medical Records (EMR), but they may not communicate or be similar systems. As more counties contract with EMR groups, the data collection should become more standardized. The Department of Corrections (DOC) currently does not have an EMR system, so data is going to be poor. The federal government mandates having an EMR system by January of 2015, but the mandate has not funded by the state.
      - A recommendation that the committee can make to the legislature is to provide money to the jail and prison systems to get EMR. Money is

desperately needed, has relevance for this specific population, and can have an impact on the healthcare of offenders in general. The Minnesota Sheriffs' Association (MSA) is trying to build something, but the DOC thinks it will cost as much as \$8 million just to interface the EMR systems. The DOC is not trying to force people into one system; instead they are trying to create a cloud-based system where medical records can be shared. This is currently done through the Health Information Exchange (HIE). There is no opposition to recommending that money be allocated for EMR systems.

- With 84 county jails, each with different providers and needs, county staff have different notions and ideas about quality of care, but the American Congress of Obstetricians and Gynecologists (ACOG) has clear recommendations for tests done at local levels.

**2. Medical Furlough is an Issue Needing Further Consideration** – Corrections staff often encounter furlough-related problems. Flight risk is not the only consideration when determining how to best provide care for pregnant women. Furlough recipients sometimes come back high, they bring contraband into the facility, etc. Medical staff are asked if furlough should be offered during prenatal care and often staff says yes.

- In most situations, the jail does not want a pregnant woman to be incarcerated in their facility when she is close to term. In most situations, county attorneys would be approached to look for other options. The DOC is the authority – it's no longer the courts. In jails, the judge is final authority for every furlough. The judge can't be sued, so jails want the judge to decide on furloughs. The inmate is there legally; the only question is whether they should be let out on furlough. They will or won't give her a break based on what extra-judicial considerations: the accounts of probation officers, jail administrators, and defense attorneys all help to inform the decision. Many times they choose to push people to treatment for delivery.
- There was a question around what jail staff do with offenders that refuse care, and whether the DOC is liable when they deny care. There is a process, and staff attempt to determine why women are refusing. It's a choice for the prisoner: the staff may be seen as enemies to the inmates. Staff wear uniforms, and have the power and authority. The prisoner can go to their own physician if they pay for it, but they typically can't afford it.
  - In Ramsey's Jail Level-One, a motivation for not complying is that women may think that, if they get sick enough, they'll be able to leave jail to go to hospital or that a judge will simply release them.
  - More than 70% of women have mental health considerations as well, which can complicate provision of care.
  - Women don't want to see a male doctor, or a DOC doctor, which may limit their willingness to utilize care.

**3. Legislative Language: "Restraints" and "Use of Force"** – The restraints subcommittee (Paul, Josh, Guy, and Rebecca) have been working to update the proposed legislation:

- The subcommittee crafted a more inclusive definition of “restraint” in their list of recommendations to the Minnesota Sheriff’s Association (MSA). MSA’s attorney strongly objected to the revised language because it included language on the “use of force.”
  - “Use of force” is defined by MSA as a response to resistance, whereas “restraint” is a preventive action. The MSA objected to the combination of the two definitions in the language because they believe they are separate actions from a law enforcement perspective, and they would oppose it at the state legislature. The committee can leave the revisions as-is, or can use the language from last year’s bill.
  - After bringing it to the group of 84 sheriffs, it appears that effectively legislating “use of force” is difficult because it is a subjective response by the officer based on the resistance they encounter from an offender. Restraint can be legislated by defining situations where restraint can be used as a preventive measure.
  - Following MSA’s misgivings about the new definitions:
    - Line 119 on “absolute necessity and imminent risk”: There is ambiguity around this line, because there is not a clearly defined point when use of force is sanctioned. For example, is it just before an officer is punched, or before physical violence becomes an issue? MSA thinks line 119 could put law enforcement at risk if someone is violent and they do not know when to respond.
      - 90-95% of women will be just fine with restraint. However, MSA deals with unstable incarcerated individuals who actively fight guards and the system.
    - Item 113 (fourth line): MSA is opposed to language “or any device...” But the first three lines can be left the way they are.
    - Lines 119-122 (highlighted in green): “Absolute necessity” may be redundant. The language was taken directly from the Bureau of Justice Administration (BJA), as was the language on wrist restraint. MSA has an issue with the language from the BJA, and objected to the inclusivity of the language. MSA members worry that the language increases the likelihood of lawsuits.
- Does the committee push suggested revised language, or does it maintain the original as it is? The committee isn’t sure that changes warrant a confrontation with MSA. The original language still has the point about not restraining pregnant women.
  - The last two lines of the revised language can be removed. Taking out the last two lines, while keeping the revised language on restraint, is an easy compromise with the MSA.
  - In the committee’s revised language, it is acceptable to define “restraints.” The MSA’s objection is to the “absolute necessity” and “use of force” language (last two lines of revised language define “use of

force” and “incapacitation”). Legally, “use of force” versus “restraint” language is very different.

- The responsibility of jail personnel is to protect everyone. “Reasonable” force language gives defensibility to the facility. Language that is cleaner is helpful in situations so the focus can be on legislation and training. From the officers’ point of view, the primary consideration is figuring out what tools they have to help produce the best outcome during situations where the use of force is warranted. When considering the use of force, it is important to remember that a pregnant woman can still be the biggest threat in the room.
  - Lexipol is suggesting narrowing the focus of best practices. When the committee started, it was thought that more descriptive language was better because it allowed agencies to avoid legal gray areas. However, the original restraint language was open for a lot of interpretation on “restraints.” The MSA is a little bit more concerned about language around deterrents like Tasers, etc., but those are considered to be part of the “use of force” provisions, not “restraint.”
  - Reporting requirements for use of force or use of restraints could illuminate where further training might be needed. Jails produce many reports, and a report on the use restraints on pregnant women could easily be included. Reports won’t be able to cover the entire situation requiring restraint, such as what the trigger was or if someone had to see a doctor, but it will give aggregate information.
    - If the jails are able to document chemical or mental health issues, there may be greater community response to the data. The statistics in the report will allow a county facility to be inspected if there is an abnormality in the number of restraint situations they report.
      - This should be doable through the current reporting system, S3. Tim Thompson, and the DOC staff person who runs the S3 system, may have questions about programming, changing data systems, etc. during implementation. There may also be issues around updates to S3 systems to track these issues – there are 125 items that need to be changed so some issues may arise.
      - A reporting requirement should be left in there – that’s standard. The report should specify how many instances there were in which a pregnant women was restrained over the course of the last year. This will allow the committee to see how big of a problem this is, and determine how much more training may be required.
- An recent example of a restraint situation was provided: A pregnant woman at Shakopee began acting out of control in her cell, which she had flooded. The options were to either physically challenge her by restraining her or spraying her with chemical



irritant to subdue her. It would be safer for the officers to spray her. In this situation, it was important to consider what was best for the baby. The prison staff met and quickly talked to behavioral staff, who then sent up a male doctor to calm her down. This was unsuccessful, so they tried sending up a female doctor and had a similarly negative result. At this point the cell was still full of water, the woman was screaming and kicking the door. The staff finally decided to go in and use restraints, but was able to avoid an altercation because by the time they entered, the woman had fallen asleep. Corrections staff had decided to enter because they did not want her to harm herself or the baby by slipping in the water. Still, she could also have been harmed when the officers went in - there was no good answer in this situation.

- It is important to note that there is no legal liability either way. Qualified immunity prevents facilities from being sued by giving their discretion to do what is necessary to run the facility.
- If the decision is made to use a chemical irritant, oftentimes the purpose of its use is enough to make the offender stop her behavior. In the above case, after the woman has been removed from the wet cell, she can be placed in a safe cell with a padded door, floors, and walls and where the water can be turned off. Even if chemical is used, exposure typically isn't long, and correctional staff are in favor of its use over other restraints. There is a short two-second burst that typically stops the behavior. In these situations corrections staff must protect the offender, the developing fetus, and themselves.
- Few of the 84 correctional facilities outside of the Twin Cities have 24-hour physician or nursing staff. Jails do not have full-time medical staff. For the all-female Shakopee Correctional Facility, there is no 24-hour provider either.
  - At jail facilities, the woman is placed in a restraint chair, where she is checked every fifteen minutes to ensure normal blood flow. If they struggle, typically they are spent after a half an hour. After being in the restraint chair, women are given a medical smock to wear and placed in a clean cell. The smock replaces their normal clothing to reduce suicide risk. They are then checked the next morning by medical staff.
- The committee felt that a better definition of restraints is needed. Lexipol language was used to develop the revised language because it was stronger and better than what the committee had originally developed. Does Jim have recommendations for the language? The attorney will ask Jim for recommendations.
- The restraint subcommittee will make additional changes, meet with Jim from MSA, and ask him for his suggestions. The subcommittee will come back to the committee with recommendations.

#### **4. Breastfeeding and the Provision of Breast Milk to Infants**

- The breastfeeding subcommittee has not yet met. However, Erica went to Nobles County and had a 3-hour conversation with the jail staff to get their perspective about

breastfeeding in jails and prisons. To the staff, breastfeeding in jails and prisons is totally different. The recommendations this subcommittee will make won't be in the suggested legislation but will instead focus on what jails are doing that is successful.

- Legislators who want a breastfeeding law should look at creating policies for jails and workhouses because the locations are different. Length of stay and other factors may affect breastfeeding between the two locations. The committee doesn't need to revise the current changes in breastfeeding policy, but it is important to keep it at the forefront because there are legislators that want to vote on the issue. The subcommittee may also want to share information across county jails and elsewhere.
- The presence of a newborn in a jail setting is problematic for a variety of reasons. Instead a focus should be on helping increase access to areas in jail for breast milk expression to help maintain supply versus in-person breastfeeding may be more feasible for facilities and families. Jails can help women express and dump their breast milk to maintain supply, but storing breast milk and sanitizing breast pumps becomes a larger issue.
  - An exception to this may be in the case of premature infants who really require their mother's breast milk rather than formula. In situations where mothers are serving old sentences, they would more likely be furloughed by a judge for 6-8 weeks to help nurture their newborn, then return to the jail facility to finish out their sentence. During the time that they are furloughed, women can be monitored with electronic monitoring, and parole officers can check on them to make sure they are adhering to the rules of their furlough.
    - By increasing acceptance of at home service of sentence using electronic monitoring, we can avoid the negative effects of maternal incarceration.
    - At the October 20 institute, prison nurseries were discussed as an alternative. By partnering with non-profits like the Drew House (in NY), where successful participation results in a felony being taken off a record, negative outcomes can potentially be prevented. The problem is that small counties do not have those options because of limited resources. It may be useful to study some alternatives to separation, especially in smaller counties.
    - When this bill went to the legislature there was a lot of talk about prison nurseries. It seems like people are interested in what other alternatives to separation are available. One recommendation was to consider an 'alternatives to separation' study in Minnesota.
      - This is a useful area for judge training: from a child psychology and public health perspective, children should not be separated from their mothers for any protracted period while they are young.

- Even in the situation where a jail is safeguarding milk for the incarcerated mother’s child, there are significant issues that arise. The milk would have to be tested for addictive or dangerous substances before giving it to the child’s caretaker. This opens up the possibility for significant liability for the jail. Even if jail staff start testing breast milk, it is extremely expensive and seems unrealistic for jails to take this on. That is why dumping breast milk to maintain supply through release is the best option. The alternative is simply too risky for the baby, even if jails do everything right. If a family member looks to sue later, they could potentially find a reason to do so.
  - New York has a huge initiative to encourage incarcerated women to breastfeed, and they encourage correctional officers to provide support. There are also some educational materials that help women.
    - The big issue is funding, because essentially all pregnancy-related services is expensive.
      - Increased use of doulas in the prison system may be helpful. There is a state registry of doulas from which certified and trained doulas could be hired to work in the correctional system. Jails shouldn’t be responsible for finding doulas.

**5. Pregnancy Testing** – At the October 20 institute, there were many discussions about pregnancy testing, and about what an alternative sentencing model for pregnant women might look like.

- For jail facilities, there needs to be clearer time guidelines for pregnancy testing. Administering the test during the first three days women are incarcerated is important because inmates often come in high or drunk.
- Erica and Rebecca met with 30 nurses, who thought pregnancy testing on day 14 of incarceration would be the most consistent with other testing since TB testing is also done at 14 days. There could be a voluntary opt out, or women could request a pregnancy test sooner (on or before day 14) if she has a legitimate reason to think she’s pregnant. The workhouse might institute it within the first 24 hours.
- The legislative language might read that “each women in an incarceration facility is offered a pregnancy test if under 50 years of age, unless the inmate refuses the test.” There are a number of questions that are being asked anyway, so it makes sense to consider asking women if they want a pregnancy test. From a medical standpoint it will be more accurate because there are fewer false positives after two weeks.
  - The big difference is asking if there is a *chance* that the woman could be pregnant. If they answer yes, additional precautions need to be taken just as they are if women answer “yes” to four or more mental health questions. There are not funds available for a lot of additional testing. There were unofficial fiscal notes from the last legislative session that estimated costs, but the mentality during the session was to get the bill passed and think about budgets later.

- The Rural AIDS network is willing to come and test for HIV and Hepatitis. Testing is built into the schedule of prenatal care, and it must adhere to community standard of care. This testing should be done at outpatient visits anyway because it is considered the standard of care.
- Testing for women that are in the jail facility for less than 72 hours is complicated. Their needs could be better addressed by public health once they're released. By day 14 corrections staff have a better idea about what women are incarcerated for, what they need, how long they'll be there, etc. For testing and interventions to be worthwhile, it was felt by some that the women who should be targeted for testing are those who are there for 60-90 or more days.

**NEXT MEETING:**  
**Friday, December 12, 2014**  
**10-12noon**  
**Ramsey County (Plato Building, 2<sup>nd</sup> Floor)**  
**90 West Plato Boulevard**  
**St. Paul, MN 55107**

**Legislative Advisory Committee on Standards of Care for  
Incarcerated Pregnant Women**

Friday, December 12, 2014

10am-12pm

Location: Ramsey County, Plato Building

90 West Plato Boulevard

St. Paul, MN 55107

1. Update from Restraint Subcommittee (TL, GB, RS, JB)
2. Subcommittees
  - a. Breastfeeding (EG)
  - b. Medical (TL, RD, DH)
    - i. Concerns regarding 'legislating care'
    - ii. 14 day language
  - c. Education (proposed; MS)
3. Opiate withdrawal (EJ, RD)
4. Writing plan for legislative report

LEGISLATIVE ADVISORY COMMITTEE MINUTES  
Friday, December 12<sup>th</sup>, 2014

**Present:** Sara Benning, Holly Compo, Erika Jensen, Erica Gerrity, Rebecca Schlafer, Guy Bosch (by phone), Paul Coughlin, Todd Leonard, Renee Darhling, Ruthie Dallas, Jim Franklin, Diane Haugen, Kathleen Lonergan, Susan Lane, Jessica Anderson, Monette Soderholm, Josh Berg, Katie Linde

**Restraint language**

Prior to today's meeting, Jim Franklin from Minnesota Sheriff's Association (MSA) and Paul Coughlin reviewed the revised restraint language. They expressed concerns regarding the use of force language and made revisions for consistency. Their suggested language was distributed to the sub-committee (Paul, Guy, Josh, and Rebecca).

Paul, Guy, Josh and Rebecca met on December 11, 2014 and finalized language, based on concerns raised by MSA. Paul brought these revisions back to MSA, but there were additional concerns. In preparation for today's meeting, Mr. Franklin communicated with the Minnesota Counties Intergovernmental Trust (MCIT) and legal councils who reviewed the restraint language. From their perspectives, some of language poses problems that could lead to jails getting sued. Mr. Franklin provided a summary of such problems for the committee.

To provide context, the language discussed was not created by this advisory group. Rather, it came from Bureau of Justice Administration. A large stakeholder group disseminated a report with recommendations for restraint and reasonable force language at the federal level. Still, it is important to critically analyze the proposed language to ensure that the jails will not be at risk for subsequent litigation.

The first problem occurs on line 1.19 after, "Correctional staff where public..." The old language stated "...if restraints are determined to be necessary, the restraints must be the least restrictive available, the most reasonable available." This phrasing relates to the issue presented by Graham vs. Connor regarding the release of a subject into custody, using the least amount of force necessary to handle the problem.

The proposed language uses the following phrase: "use of restraints is considered reasonably necessary only when there is an imminent..." There was concern with the use of "only" and "imminent." "Harm" and "escape" could also present issues; the order should be reversed. The question was also raised regarding the definitions of "girl" and "woman." There was also issue with, "these risks cannot be managed by other reasonable means." This statement suggests that additional personnel would be required to handle a problem, which may not be feasible, particularly in small county jails. This syntax could lead to legal ramifications, from the jails' perspectives.

There was also concern with, "If restraints are determined to be necessary, the restraints must be the least restrictive available under the reasonable circumstances..." The Susan Smith case

was mentioned, as the public was hostile towards her. It is difficult to define reasonable for law enforcement. There was concern that if a high-profile case like Susan Smith was pregnant, law enforcement requires the means to keep her safe.

Minnesota has not had cases wherein pregnant women have experienced unreasonable restraint. Still, legal cases are not a good indicator of whether unreasonable restraint is being used, especially among this population. Women may still be experiencing shackling and improper restraint. Last month, in an interview conducted with a currently incarcerated pregnant woman, Dr. Schlafer learned of a clear violation of existing Lexipol policy (and the new state law). This woman is not likely to sue, given her financial resources. This example demonstrates that just because no one has sued does not mean that these issues are not currently happening.

Mr. Franklin suggests we do not focus on whether a woman will sue or not, but rather on the agency and correct the behavior. This is a training issue. Collaboratively, everyone needs to know so behavior can be corrected. The sub-committee has discussed having this as a training topic at next year's MSA trainings.

On the document with the new language, everything that is in black and underlined is in statute. Red is the new text. The following question was raised: are the changes necessary? The Department of Corrections (DOC) is training staff under what was passed last year. Should we be working with the law that stands and see how that works? After this, we could determine whether or not the definition of restraint is clear or not. The suggested language may make this too onerous.

Last meeting, it was a near unanimous decision by the group to clean up the language. Hence a sub-committee was created to make these changes. The goal of the sub-committee was to make the language more clear. If this did not happen, perhaps the old language should be used. The purpose was to make the language less vague.

If the group reverts to the initial language, the reporting mechanisms and policy needs to be made explicit. 1.22 is a great addition; it indicates that it is best practices and okay to restrain, as long as it is not a belly chain. This is very important piece that was not in original language. Sub B is in conflict with Sub A in the original language. One section states, "you shall not," and the other indicates, "you can." This language needs to be changed. 1.22 includes this change.

If people need to reference previous versions of the document, they should use the green version.

In addition, 2.25 and 2.26 are vital to jails. The jails are wasting a lot of money, time, and limited resources if they are not allowed the limit the testing to individuals incarcerated at fourteen days. Mandated reporting must occur if a pregnant woman presents a positive drug test. The problem is, what authority will jails have to drive treatment? Doing nothing this year has been a challenge for the jails: what needs to happen to clarify this bill? When this bill was drafted, this

committee was not around to inform the language. Now, the committee needs to provide some revised language.

It has been noted that the narrower the language is revised, the more likely problems will occur. It is almost necessary to leave it for interpretation. Based on this premise, it was suggested to go back to the original language that states, "...least restrictive available and most reasonable under the circumstances," therefore leaving 1.20 and 1.21 as the original. Still, 1.22 would be added. Also, "pregnant woman/girl" will be changed to "pregnant female."

For 1.13, "i.e." cannot be used. We should avoid presenting a list, as something will likely be missed that could be used (i.e., duct tape, wire, rope). This information should be included in training material but not statute. Still, we would rather have a product that is serviceable to the legislature.

The edits to 1.22, sub 3 should be included to some degree in order to help identify money for training. 2.25 and 2.26 also need to be included. Under sub 3, "Shakopee" should be changed to "Under the Commission of Corrections."

From Guy's perspective, the language was created through the lens of drafting policy. The statement regarding restraints was made to keep facilities out of litigation. If members of the group think the new statement will make litigation more likely, the statement should be deleted or revised again. Restraints did not seem like a solid definition. A better definition could be formed and used through policy and training, however, if that is a better solution. Other states have more thorough and similar definitions of "restraints" as proposed in the new language.

If nothing that gets changed, know that Shakopee has made significant changes in the past year in policies, procedures, training, and the way Shakopee addresses this issue.

The following question was posed: will jails be expected to use the same policies as DOC? DOC and jails typically have separate policies and procedures. The guidelines for the DOC inspection unit (contact: Tim Thompson) is 2911. Change in policy affects all jails in the state.

Regarding the mechanisms for complaints, there are four avenues of contact: a jail administrator or sheriff; the DOC inspection unit (Tim Thompson); MSA; and the insurance trust for the 87 counties. One can seek out and examine potential claims to request additional training and reduce risk through four points of contact. One can go to the DOC and see their reports of complaints; speak with the county sheriff, attorney, or county administrator to ask about complaints; examine what has risen to litigation; and investigate what has been found in cases that have been charged out through the county attorney. MSA uses risk management-based principles. MSA meets monthly with the MCIT trust and county attorneys to see where problems have or can occur. If one would like to take an aggregate view of where, when, and how often this happens, MSA would be happy to work with this group, especially if it means more training to reduce risk and address issues.



A committee member brought up concerns with line 2.11, which currently suggests that a doctor can object to restraints. Does the doctor trump everyone else? This places a lot of responsibility on the provider who may not have the knowledge or experience to make decisions regarding restraints. If we do not indicate that the doctor has this power, however, we could have problems. If there is an emergency and the woman is restrained, she and her infant are at risk for injury. Major lawsuits occur in the US regarding restraints and pregnant/birthing women's pain and suffering. The Corrections representatives focus on safety, not the medical situation or infant's health.

This language currently exists in the Lexipol policy system. Medical lawsuit trumps basically everything. If a birthing mother is moved to the medical facility and the doctor says she/he will not restrain her, this is the responsibility of the care provider at the hospital. If the birth occurs at the jail, the medical provider at the jail uses her/his discretion. If the birth occurs at the hospital, it is the hospital providers that make the decisions regarding restraints.

Another issue to consider is furlough, which is not always the best choice. For example, a potentially dangerous and aggressive woman recently obtained furlough to give birth. The medical providers, doula, and the mother were the only individuals in attendance, which may not have been a safe option for everyone involved. One of the unintended consequences of making language too narrow, however, results in jails furloughing everybody, which could present problems. We must find a balance between care and custody.

Because jails tend to furlough most women giving birth, Lines 2.4 and 2.5 relate to women in custody, notably women in prison. When a woman delivers in custody, her doctor must be able to articulate medically why restraints should not be used. Corrections must explain why restraints are necessary. In the end, however, the doctor's decision supersedes everyone else's perspectives. Given this context and that line 2.11 has been used in other states, this criteria can be included. Liability essentially switches once the woman is in the medical facility. The remaining issue is training and policy; the medical provider needs to know the risk. We should leave the conversation open between medical providers and the Corrections staff to make appropriate decisions in each case.

Final language with these changes can go to Jim Franklin and MSA's attorneys for review. The committee will review the language revisions and help catch anything that has been missed prior to sending the edited version to MSA.

### **Lactation consultation and breastfeeding policies**

We need to articulate the importance of breastfeeding and lactation consultation at the MSA annual meeting.

### **Education components**

DOC is moving quickly on training. From an education standpoint (line 3.7), we have resources available for materials for corrections, jail, and health staff. MDH has training suggestions; Isis

Rising (the prison doula program at MCF-Shakopee) has a comprehensive pregnancy packet; Dr. Ferszt from the Reproductive Health Institute conference has information; and the UMN has resources to help with layout, graphic design, and content. Furthermore, we can follow the Sesame Street-type mass distribution. One of the next steps is solidifying these resources to create attractive materials to fit the jails' needs and ensure that the materials will benefit the staff and women. This may be a good project for the medical subcommittee.

The resources need to be written at a low literacy level and provided in multiple languages to ensure that all women receive the information. Isis Rising has these resources; the materials have bullet points for specific topics. This would be beneficial for jails. Women can review the resources rather than rely on a corrections officer to explain the information.

These resources can be targeted to jail programmers. The materials must have multiple mechanisms for dissemination (i.e., paper, DVD) and languages; the resources must be accessible to all women. Some resources need to be updated, especially regarding the chemical health information, from the medical providers' standpoints. We could utilize and promote Women, Infants, and Children (WIC), which provides resources in multiple languages. This information will have to be tailored for incarcerated women, however. There is a new health consultant at MDH who could help with this.

There should be coordination between health providers at Shakopee and Isis Rising regarding materials. It is important to avoid duplication of effort; Rebecca, Coleen, and Erica will meet to share resources. In addition, Rebecca's student has been working on resources regarding nutrition for pregnant women prison.

Todd and the medical subcommittee will take on the medical side of these materials, Cecilia from MDH will provide materials that have been disseminated in the community, and Rebecca will provide what has been shared in New York and Rhode Island. The goal is to have resources finished for mothers by the end of the summer/July.

#### **14-day language and pregnancy testing**

Tying together pregnancy testing with the Tuberculin skin test (TST) is convenient, especially for jails in greater Minnesota, whose nurses are not working five days a week. The following question was raised: Is there some responsibility for the woman to seek help through the orientation process or signage? The point is to avoid a situation wherein facilities do not intervene and the woman does not understand that she can ask for testing. Part of the booking process includes the question, "Are you or do you think you may be pregnant? Would you like to be pregnancy tested today?" If a woman says yes, she is referred to nursing for a test (the officer asks these questions and nurses provide the tests). We need to determine the timeline for testing and consistency in these questions across facilities.

If facilities offer the test on day 14, when would a woman receive the test? This would fall under access to care, which is dependent on facility protocol. Some nurses perform pregnancy tests once a week.

There may be a lot of incentive to be pregnant (i.e., additional food), but people are still hiding their pregnancies (Isis Rising at MCF-Shakopee has experienced this). There is no way to force anyone to take a test. There is no way to know how and why women choose or do not choose a pregnancy test without systematic data collection. In the end, pregnancy testing proves beneficial to both parties; prison/jail staff can document that a test was offered and women have the knowledge and opportunity to receive a pregnancy test and early care.

It is important to have defined pregnancy test standards and collaborate with public health professionals, especially as women range in how and why they react to pregnancy testing and results. Some women may come in high, stop using substances, enter treatment, experience a change in attitude, and benefit from the pregnancy test and extra services. Others have experienced children being taken away and may not be cooperative upon discovering a positive pregnancy test. There is always a range; there is no one way in which a woman reacts to pregnancy in this context.

In regards to the Day 14 language, the syntax came down to the distinction between “is offered” versus “is tested.” “Is offered” suggests that a woman can opt out of a pregnancy test, while “is tested,” indicates that the woman did not have an active decision in the manner. The DOC has backed away from mandatory 14 day medical testing. Most facilities try to test sooner rather than later; 14 days is the maximum wait period. The pregnancy test may be something that could be offered at intake. This is a policy issue, however. It is impossible to put something in paper that will apply to 84 jails. 14 days is the national standard; this should continue to be used in order to align with the needs of all jails in Minnesota.

Could a woman be in jail for 10 days, indicate at intake she would like a test, and never be given a test? What are the implications for such situations? This is why it is best to leave the language to 14 days; it will be up to jails and their facility procedures. Perhaps if instances like this occur, county-specific resources can be developed and disseminated to women being released prior to the 14 day period. This places some of the responsibility back on the inmate. This would most likely not be a violation on the jail’s end.

The group agrees to keep language as it currently stands.

### **STI testing**

In reference to 2.26, some members of the group have concerns with sexually transmitted infection (STI) testing language. The jails would be duplicating resources; the women receive testing upon being identified as pregnant. Within the American Congress of Obstetricians and Gynecologists (ACOG) standards, STI testing would be one of first screens for any pregnant woman. Perhaps the current language is unnecessary, as testing is already a standard in facilities. The following statement could be added, “If pregnant, every facility is required to provide, whether on or off site, a reasonable community standard of care.” With this addition, the facilities are required to maintain standards. This could be added around line 2.27.

The remaining issue is: how do we define community standard? Can it be defined? Medicaid uses this language all the time. The DOC adheres to such community standards. Lawyers might take issue with this language. Rebecca can pull some language from Medicaid to include in this section. Perhaps “as defined by...” can be added to this section and reference where this language originates. Medicaid is a government-paid program, and therefore is widely accepted. This is a positive solution, as the facilities are held to standard of care but the definition is not too narrowly presented.

### **Mental and chemical health care**

Facilities are already mandated to have a plan addressing mental health care. In reference to 2.34 and 2.35, does mental health include chemical health? This is already part of jail intake and health screening. A pregnant inmate is always considered high-risk by definition. Medical personnel are immediately looking for chemical dependency through drug screening. ACOG lists drug screening and treatment recommendations. The “community standards of care” will also apply to mental and chemical health.

There is controversy surrounding chemical testing and mandatory pregnancy testing. If a woman test positive for drug use and pregnancy, mandated reporting must occur.

A recent clinical example presented a similar issue. A heavy heroin user was pregnant and placed in inpatient care at the hospital. It is too risky for the hospital to send the women back to facility when they are substance dependent. Some Emergency Rooms do not know how to manage pregnancy and chemical use, let alone with an incarcerated woman. Opiate-addicted pregnant women experience extreme risk. Facilities experience barriers to care for these women, struggling to find substitutes for chemical use allowed within jails and prisons. This problem stems from the DEA, pharmacists, and Minnesota law. Opiate-dependent pregnant women require a substitute, not a slow detox. This is hard to uphold in the jail/prison context. A new problem arises as a substance dependent woman is released; she may experience withdrawal by the end of the day and seek out drugs. Issues accelerate as some jails take individuals into custody from other counties. Further, jails do not allow substances; they are benzoid free. Overall, it is a very risky situation, especially in the first 72 hours. These inmates need inpatient care in a hospital. This is not always an option in rural areas.

There is a committee looking into the complexities of this issue (infant mortality, substance-addicted infants, etc.) at the state level from the Health and Human Services Department. Perhaps a sub-subcommittee from the medical subcommittee can seek out this group and resources. More training of health care providers is needed. Ruthie and Erika are planning a summit in May around neonatal abstinence syndrome, opiate withdrawal, and prenatal exposure. This issue is not being discussed in research literature but is closely related to the health care needs and language in the statute. Rebecca suggests a conference call with those interested in this problem. The group could write a position paper for a corrections journal to raise attention and elevate these types of issues.

### **Reporting back to the legislature**

The group must decide what should be included in the report. The report could suggest:

- Funding for electronic medical records
- Dollars for training focused on evidence-based practices for stakeholders, including medical staff, jail administrators, and jail staff to bring everyone up to the same, high standard of care
- Navigators need to be made available in the jails, as such positions relate to ensuring services provided by the Affordable Care Act
  - The complexities of health insurance and barriers to health must be examined. There is a gap in care regarding who pays and how women are enrolled. This is true for every inmate, whether pregnant or not. Women are eligible for Medicare only while in inpatient care. They can be covered and reimbursed. This issue also relates to the conversation about providing services to opiate-dependent women.

The report will also include the Healthy Generations publication from the conference this fall. The committee is invited to fill in the details and get in contact with Rebecca.

The group will present the report to the legislator. There are no plans to meet in the near future. The group will continue to collaborate, but hold on subsequent in-person meetings at this time.