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**Ohio Senate
Senate Judiciary Committee
SB18 Prohibit Confining Pregnancy Criminals
Testimony of David Hackney, MD FACOG
American College of Obstetricians and Gynecologists, Ohio Section**

Chair Eklund, Vice Chair Manning, Ranking Member Thomas, and distinguished members of the Senate Judiciary Committee, my name is Dr. David Hackney and I am a practicing specialist in maternal fetal medicine, also known as high risk obstetrics, in Cleveland Ohio where I am the Division Director at University Hospitals and associate professor at Case Western Reserve University. Of note, I am neither speaking on behalf of nor am I representing the views of my employers today. I received my medical degree from the University of Pittsburgh School of Medicine after which I came to Ohio for my residency training at THE Ohio State University. Of note, during my training at Ohio State I had the opportunity to staff many of the obstetric clinics in our regional women's prisons. I've been in active practice in Cleveland for 7 years. I am here today on behalf of the American College of Obstetricians and Gynecologists, Ohio Section (ACOG). As you may know, ACOG is our specialty's premier professional membership organization dedicated to the evidence-based practice and improvement of women's health. ACOG, Ohio represents over 1500 Ohio OB/GYNs and their patients.

I am grateful for this opportunity to provide proponent testimony for SB18 that would prohibit restraining pregnant incarcerated women and adolescent females. Since 1978, the number of women in state prisons has increased nine-fold, growing at more than twice the pace of men¹. Thus we are increasingly applying correctional practices to women, and particularly pregnant women, which were originally designed for violent male offenders. Additionally incarcerated women face unique barriers to health care, and those who are pregnant and postpartum are at increased risk of negative health outcomes.

One particularly inhumane practice is the use of restraints on incarcerated women and girls during pregnancy, labor, and recovery, commonly known as shackling. While federal prisons have limited the use of restraints on pregnant women since 2008, many state systems still engage in this practice.

ACOG takes unequivocal positions on the practice of shackling during pregnancy and the postpartum period. In Committee Opinion Number 511, ACOG states: "The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary." I encourage you to read both Committee Opinions, which I have attached to my testimony.

There are many important reasons to oppose the use of shackling in pregnancy, including the affront to the dignity of our pregnant mothers. In addition to the mother, shackling also

explicitly endangers her unborn fetus. The state, of course, has a vested interest in the children born to our incarcerated mothers as they are our future Ohioans. Thus they deserve every opportunity for a healthy and safe delivery regardless of the circumstances of their birth. Unfortunately, incarcerated pregnant women are already a population that is at significantly increased risk of obstetric complications secondary to factors ranging from stress to lifestyle to access of medical care. Against this backdrop, the use of shackling during pregnancy endangers the fetus in several important ways. First, it will increase the risk of the mother falling. Pregnant patients in general are at increased risk of falls due to numerous physical changes in their joints and center of gravity. Shackling will increase these risks. In Cleveland we have cold, long winters and thus every year I see many women who have slipped and fallen on ice during their pregnancies. Although most of us could trip and fall without significant injury, this is particularly dangerous in the women that I see due to the potential for abdominal injury and placental bleeding.

Additionally the use of restraints during labor can also endanger the fetus by interference in obstetric procedure. Obstetric emergencies can occur suddenly and unexpectedly during even the most routine labors, let alone those in higher risk incarcerated patients. When an emergency occurs it is of utmost importance that we intervene as quickly as possible. This often includes having to quickly move a patient out of their room and onto an OR bed for rapid Cesarean. Even under more routine circumstances, however, ambulation during early labor and the ability to change positions during labor are important for an optimal outcome.

In contrast to the risks of shackling during pregnancy, the risks posed by not shackling during pregnancy are low. To our knowledge there has been no reported case of a pregnant women attempting escape secondary to not being shackled. The proposed legislation also makes appropriate provisions for extreme or attenuating circumstances. Also, even if there was a theoretical small risk to healthcare providers this is a risk that we would be collectively willing to accept on behalf of our patients and their future children.

Simply put, SB18 is an important effort to ensure incarcerated women in Ohio maintain their basic human rights and that we optimize the delivery outcomes for their future children. This legislation is about fairness, dignity, and critical women's and maternal healthcare. I am proud to speak for ACOG in our support for this important bill. Thank you for your consideration and I'd be happy to try to answer any questions you may have.

¹ Prison Policy Initiative, The Gender Divide: Tracking Women's State Prison Growth, January 9, 2018 at https://www.prisonpolicy.org/reports/women_overtime.html#stategraphs (Last visited September 20, 2018).

Supplementals:

ACOG Committee Opinion 535

ACOG Committee Opinion 511



The American College of Obstetricians and Gynecologists

Women's Health Care Physicians

COMMITTEE OPINION

Number 511 • November 2011

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females

ABSTRACT. Clinicians who provide care for incarcerated women should be aware of the special health care needs of pregnant incarcerated women and the specific issues related to the use of restraints during pregnancy and the postpartum period. The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary.

Between 1990 and 2009, the number of incarcerated women increased 153% (1). Most women are incarcerated for nonviolent crimes, including drug and property offenses (2). On average, 6–10% of incarcerated women are pregnant, with the highest rates in local jails (3). Data on rates of pregnancy in juvenile facilities are limited, but indicate higher rates than in adult facilities (4, 5).

The women in the criminal justice system are among the most vulnerable in our society. Pregnancies among incarcerated women are often unplanned and high-risk and are compromised by a lack of prenatal care, poor nutrition, domestic violence, mental illness, and drug and alcohol abuse (6). Upon entry into a prison or jail, every woman of childbearing age should be assessed for pregnancy risk by inquiring about menstrual history, heterosexual activity, and contraceptive use and tested for pregnancy, as appropriate, to enable the provision of adequate perinatal care and abortion services. Incarcerated women who wish to continue their pregnancies should have access to readily available and regularly scheduled obstetric care, beginning in early pregnancy and continuing through the postpartum period. Incarcerated pregnant women also should have access to unscheduled or emergency obstetric visits on a 24-hour basis. The medical care provided should follow the guidelines of the American College of Obstetricians and Gynecologists (see Box 1) (7).

Special Clinical Considerations

Because of high rates of substance abuse (8) and human immunodeficiency virus (HIV) infection (9) among incarcerated women, prompt screening for these conditions in pregnant women is important. All pregnant

Box 1. Recommended Care

Intake

- Assess for pregnancy risk by inquiring about menstrual history, heterosexual activity, and contraceptive use and test for pregnancy as appropriate

During Pregnancy

- Provide pregnancy counseling and abortion services
- Provide perinatal care following guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists*
- Assess for substance abuse and initiate treatment; prompt initiation of opioid-assisted therapy with methadone or buprenorphine is critical for pregnant women who are opioid-dependent
- Test for and treat human immunodeficiency virus (HIV) to prevent perinatal HIV transmission
- Screen for depression or mental stress during pregnancy and for postpartum depression after delivery and treat as needed
- Provide dietary supplements to incarcerated pregnant and breastfeeding women
- Deliver services in a licensed hospital that has facilities for high-risk pregnancies when available
- Provide postpartum contraceptive methods during incarceration

*American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 6th ed. Elk Grove Village (IL): AAP; Washington, DC: ACOG; 2007.

women should be questioned about their past and present use of alcohol, nicotine, and other drugs, including the recreational use of prescription and over-the-counter medication (7). Identification of pregnant women who are addicted to opioids facilitates provision of opioid-assisted therapy with methadone or buprenorphine. Maintenance of opioid-assisted therapy can reduce the risk of withdrawal, which can precipitate preterm labor or fetal distress (10). In addition, substance abuse can continue during incarceration despite efforts to prevent drugs from entering correctional facilities. Effective drug and alcohol treatment programs are essential. Pregnant women universally should be tested for HIV infection with patient notification unless they decline the test as permitted by local and state regulations (7). Screening for HIV infection allows for the initiation of essential treatment to optimize maternal health and to prevent perinatal HIV transmission for HIV-positive pregnant women. Incarcerated pregnant women should be screened for depression or mental stress and for postpartum depression after delivery and be appropriately treated.

Good maternal nutrition can contribute positively to the delivery of a healthy, full-term newborn of an appropriate weight. The recommended dietary allowances for most vitamins and minerals increase during pregnancy (7). Therefore, provision of dietary supplements to incarcerated pregnant and breastfeeding women is recommended, as is access to a nutritious diet and timely and regular meals.

Pregnant women who are required to stand or participate in repetitive, strenuous, physical lifting are at risk of preterm birth and small for gestational age infants. In addition, a recovery period of 4–6 weeks generally is required after delivery for resumption of normal activity (7). This should be taken into consideration when assigning work to incarcerated pregnant women and during the postpartum period.

Pregnant women are at high risk of falls. Activities with a high risk of falling should be avoided (7). Specifically, incarcerated women should be given a bottom bunk during pregnancy and the postpartum period.

Although maintaining adequate safety is critical, correctional officers do not need to routinely be present in the room while a pregnant woman is being examined or in the hospital room during labor and delivery unless requested by medical staff or the situation poses a danger to the safety of the medical staff or others. Delivery services for incarcerated pregnant women should be provided in a licensed hospital with facilities for high-risk pregnancies when available. Incarcerated pregnant women often have short jail or prison stays and may not give birth while incarcerated. Postpartum contraceptive options should be discussed and provided during incarceration to decrease the likelihood of an unintended pregnancy during and after release from incarceration (11).

It is important to avoid separating the mother from the infant. Prison nurseries or alternative sentencing of

women to community-based noninstitutional settings should be considered for women during the postpartum period. Correctional facilities should have provisions for visiting infants for women in facilities without prison nurseries. When adequate resources are available for prison nursery programs, women who participate show lower rates of recidivism, and their children show no adverse effects as a result of their participation. In fact, by keeping mothers and infants together, prison nursery programs have been shown to prevent foster care placement and allow for the formation of maternal-child bonds during a critical period of infant development (12).

The American College of Obstetricians and Gynecologists strongly supports breastfeeding as the preferred method of feeding for newborns and infants (13). Given the benefits of breastfeeding to both the mother and the infant, incarcerated mothers wishing to breastfeed should be allowed to either breastfeed their infants or express milk for delivery to the infant. If the mother is to express her milk, accommodations should be made for freezing, storing, and transporting the milk. This can be difficult to facilitate and is another argument for prison nurseries or alternative sentencing of women to community-based noninstitutional settings.

Barriers to Care

Barriers currently exist to the provision of recommended care for incarcerated pregnant women and adolescents. Thirty-eight states have failed to institute adequate policies, or any policies, requiring that incarcerated pregnant women receive adequate prenatal care. Forty-one states do not require prenatal nutrition counseling or the provision of appropriate nutrition to incarcerated pregnant women, and 48 states do not offer pregnant women HIV screening (14).

Limiting Use of Restraints

Use of restraints, often called *shackling*, is defined as using any physical restraint or mechanical device to control the movement of a prisoner's body or limbs, including handcuffs, leg shackles, and belly chains. In 2007, the U.S. Marshals Service established policies and procedures for the use of authorized restraining devices, indicating that restraints should not be used when a pregnant prisoner is in labor, delivery, or in immediate postdelivery recuperation (15). In 2008, the Federal Bureau of Prisons ended the practice of shackling pregnant inmates as a matter of routine in all federal correctional facilities (16). That same year, the American Correctional Association approved standards opposing the use of restraints on female inmates during active labor and the delivery of a child. The standards also state that before active labor and delivery, restraints used on a pregnant inmate should not put the woman or the fetus at risk (17). More recently, in October 2010, the National Commission on Correctional Health Care, which accredits correctional facilities, adopted a position statement that opposes the

use of restraints on pregnant inmates (18). These standards serve as guidelines and are voluntary, not mandatory. State and local prisons and jails are not required to abide by either the Federal Bureau of Prisons policy or the National Commission on Correctional Health Care standards, but several state legislatures and departments of corrections have enacted antishackling policies recently. Despite progress, 36 states and the Immigration and Customs Enforcement agency of the Department of Homeland Security, which detains individuals who are in violation of civil immigration laws pending deportation, fail to limit the use of restraints on pregnant women during transportation, labor and delivery, and postpartum recuperation (14).

The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary. The apparent purpose of shackling is to keep incarcerated women from escaping or harming themselves or others. There are no data to support this rationale because most incarcerated women are nonviolent offenders. In addition, no escape attempts have been reported among pregnant incarcerated women who were not shackled during childbirth (19). This demonstrates the feasibility of preserving the dignity of incarcerated pregnant women and adolescents and providing them with compassionate care. The safety of health care personnel is paramount and for this reason, adequate correctional staff must be available to monitor incarcerated women, both during transport to and from the correctional facility and during receipt of medical care.

Physical restraints interfere with the ability of health care providers to safely practice medicine by reducing their ability to assess and evaluate the mother and the fetus and making labor and delivery more difficult. Shackling may put the health of the woman and fetus at risk (see Box 2). Shackling during transportation to medical care facilities and during the receipt of health services should occur only in exceptional circumstances for pregnant women and women within 6 weeks postpartum after a strong consideration of the health effects of restraints by the clinician providing care. Exceptions include when there is imminent risk of escape or harm. If restraint is needed, it should be the least restrictive possible to ensure safety and should never include restraints that interfere with leg movement or the ability of the woman to break a fall. The woman should be allowed to lie on her side, not flat on her back or stomach. Pressure should not be applied either directly or indirectly to the abdomen. Correctional officers should be available and required to remove the shackles immediately upon request of medical personnel. Women should never be shackled during evaluation for labor or labor and delivery. If restraint is used, a report should be filed by the Department of Corrections and reviewed by an independent body. There should be consequences for individuals and institutions when use of restraints was unjustified.

Box 2. Examples of the Health Effects of Restraints

- Nausea and vomiting are common symptoms of early pregnancy. Adding the discomfort of shackles to a woman already suffering is cruel and inhumane.
- It is important for women to have the ability to break their falls. Shackling increases the risk of falls and decreases the woman's ability to protect herself and the fetus if she does fall.
- If a woman has abdominal pain during pregnancy, a number of tests to evaluate for conditions such as appendicitis, preterm labor, or kidney infection may not be performed while a woman is shackled.
- Prompt and uninhibited assessment for vaginal bleeding during pregnancy is important. Shackling can delay diagnosis, which may pose a threat to the health of the woman or the fetus.
- Hypertensive disease occurs in approximately 12–22% of pregnancies, and is directly responsible for 17.6% of maternal deaths in the United States*. Preeclampsia can result in seizures, which may not be safely treated in a shackled patient.
- Women are at increased risk of venous thrombosis during pregnancy and the postpartum period†. Limited mobility caused by shackling may increase this risk and may compromise the health of the woman and fetus.
- Shackling interferes with normal labor and delivery:
 - The ability to ambulate during labor increases the likelihood for adequate pain management, successful cervical dilation, and a successful vaginal delivery.
 - Women need to be able to move or be moved in preparation for emergencies of labor and delivery, including shoulder dystocia, hemorrhage, or abnormalities of the fetal heart rate requiring intervention, including urgent cesarean delivery.
- After delivery, a healthy baby should remain with the mother to facilitate mother–child bonding. Shackles may prevent or inhibit this bonding and interfere with the mother's safe handling of her infant.
- As the infant grows, mothers should be part of the child's care (ie, take the baby to child wellness visits and immunizations) to enhance their bond. Shackling while attending to the child's health care needs may interfere with her ability to be involved in these activities.

*Diagnosis and management of preeclampsia and eclampsia. ACOG Practice Bulletin No. 33. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2002;99:159–67.

†Thromboembolism in pregnancy. Practice Bulletin No. 123. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011;118:718–29.

Recommendations

- Federal and state governments should adopt policies to support provision of perinatal care for pregnant and postpartum incarcerated women and adolescents that follow the guidelines of the American College of Obstetricians and Gynecologists. Mechanisms to ensure implementation of these policies and adequate funding to provide this care need to be put in place.
- Educational efforts are needed to increase the knowledge of health care providers and correctional officers about issues specific to incarcerated pregnant and postpartum women and adolescents.
- Obstetrician–gynecologists should support efforts to improve the health care of incarcerated pregnant and postpartum women and adolescents at the local, state, and national levels. Activities may include the following:
 - Advocating at the state and federal levels to restrict shackling of incarcerated women and adolescents during pregnancy and the postpartum period.
 - Partnering with other organizations in the medical community opposed to shackling incarcerated pregnant women such as the American Medical Association and the Association of Women’s Health, Obstetric and Neonatal Nurses (20, 21).
 - Gaining representation on the boards of correctional health organizations.
 - Working in correctional facilities to provide services to incarcerated pregnant and postpartum women and adolescents and continuing care after the woman’s release, when feasible.
 - Undertaking efforts to ensure that medical needs of pregnant and postpartum incarcerated women and adolescents are being addressed appropriately, such as by providing training or consultation to health care providers and correctional officers in prison settings.

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The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

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Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Reproductive Health Care for Incarcerated Women and Adolescent Females

ABSTRACT: Increasing numbers of women and adolescent females are incarcerated each year in the United States and they represent an increasing proportion of inmates in the U.S. correctional system. Incarcerated women and adolescent females often come from disadvantaged environments and have high rates of chronic illness, substance abuse, and undetected health problems. Most of these females are of reproductive age and are at high risk of unintended pregnancy and sexually transmitted infections, including human immunodeficiency virus (HIV). Understanding the needs of incarcerated women and adolescent females can help improve the provision of health care in the correctional system.

Background

Between 1990 and 2009, the number of incarcerated women increased 153% (1). Most women in correctional facilities are incarcerated for nonviolent crimes. Drug offenses are the most common felonies committed by women in both federal (72%) and state (34%) prison systems, and are the second most common offense committed by women in local jails (30%) (2). By the middle of 2009, 106,362 women (6.9% of all prison inmates) were incarcerated in federal or state prisons, and by the middle of 2011, 93,300 women (12.7% of all jail inmates) were incarcerated in local jails (3, 4). In 2010, 306,498 females younger than 18 years were arrested, representing 29% of all juvenile arrests (5). Juvenile offenders may be housed in juvenile detention homes or residential correctional facilities or, in some cases, in adult prisons or jails.

Incarcerated women and adolescent females often come from economically, educationally, socially, and emotionally disadvantaged environments; a disproportionate number have acute and chronic illnesses, substance abuse problems, and undetected health issues, including reproductive health needs. In one study, 27% of incarcerated women had chlamydia and 8% had gonorrhea, compared with rates of 0.46% and 0.13% in the general population, respectively (6). In 2008, 2% of women in state and federal prisons were known to be infected with human immunodeficiency virus (HIV) (7). Fifty-six percent of women in federal prisons and 62% of women in state prisons were

parents of one or more minor children, and 19% of these children were in the care of someone other than a family member during the mother's incarceration (8).

Approximately 6–10% of incarcerated women are pregnant, and are mostly incarcerated in local jails (9, 10). There are few studies about birth outcomes for women who continue pregnancies during incarceration. Although a woman retains her legal right to an abortion during incarceration, a woman's experience in attempting to obtain an abortion varies widely by state, region, and individual prison (11, 12). In a survey of correctional health officials, 68% indicated that women in their prisons were allowed to have an elective abortion, but only 54% helped arrange appointments (11).

Sexually transmitted infections and pregnancies may result from sexual victimization of women during incarceration. In a survey of local jail inmates using audio computer-assisted self-interviews to maximize confidentiality and reliability, 5.1% of female inmates reported sexual victimization (13). Of these, 3.7% of women experienced sexual victimization by another inmate and 2.0% reported sexual victimization by a staff member (13). In a similar survey of state and federal prison inmates, the rate of sexual victimization among men and women was 4.5% (14). Total rates for women were not presented, but rates were as high as 10.8% at some prisons, with sexual victimization by a staff member reported by up to 5.3% of women (14).

Mental health disorders and substance abuse are common among incarcerated women. Sixty-nine percent of women admitted to local jails met the criteria for substance dependence or abuse (not including tobacco use); dependence was diagnosed more commonly among women than among men (15). Rates of mental health problems among women inmates ranged from 61% in federal prisons to 75% in local jails (16). Incarceration is an important risk factor for suicide by adolescent inmates (17). More than 50% of women in jail reported a history of physical or sexual abuse, and this rate is as high as 92% among female juvenile offenders in California (18, 19).

Medical Care Availability and Access

Although most state and federal prisons provide some level of care to prisoners, availability and access to medical care in jails is variable. The short and often unpredictable duration of incarceration in local jails often makes provision and continuity of care difficult. In addition, systems of care vary in state and local prison and jail settings. Services at state prisons and jails may be provided on site by health care providers, by arrangements with local hospitals or clinics either on site or by inmate transport, or by an on-site health care provider contractor. Historically, health care was delivered by way of a “sick call,” where an inmate notified a guard or other designated authority of the need for medical attention. A sick call system does not allow for provision of primary or preventive care and health education. Although many

facilities have moved to systems that provide primary care, the increase in the number of inmates makes provision of adequate care difficult. In addition, women are often housed in facilities with predominantly male populations, which limits the availability of health services tailored to women’s needs. Financing of correctional facilities, including health care, depends on legislative appropriations that compete with other priorities. In general, Medicaid funding cannot be used for care for adults and adolescents in secure confinement.

No federal or state mandates require correctional health facilities to obtain accreditation, and there is no organization to which all facilities are accountable. Several organizations accredit prisons, but their standards only serve as guidelines and are followed voluntarily. These organizations include The Joint Commission, the National Commission on Correctional Health Care, and the American Correctional Association. Health care standards for jails, prisons, and juvenile facilities have been developed by the National Commission on Correctional Health Care, the American Correctional Association, and the American Public Health Association (20–23).

In general, care for incarcerated women and adolescent females should be provided using the same guidelines as those for women and adolescent females who are not incarcerated, with attention to the increased risk of infectious diseases and mental health problems common to incarcerated populations. Health care for incarcerated women and adolescent females is outlined in Table 1 (23, 24).

Table 1. Recommended Care for Incarcerated Women and Adolescent Females

Type of Care	Adult Jail or Prison*	Juvenile Facilities
Entering facilities	<p>Ask about any current medical problems and care and safety of minor children at home.</p> <p>Obtain a medical history—immunization status; sexual activity, contraceptive use, and menstrual cycle to assess the need for a pregnancy test; number of pregnancies and outcomes; history of medical problems, chronic illness, hospitalizations, breast disease, and gynecologic problems; and domestic violence, sexual abuse, and physical abuse</p> <p>Mental health assessment</p> <p>Physical examination¹—pelvic and breast, Pap test, and baseline mammography based on College guidelines</p> <p>In a jail setting, Pap test and mammography should only be done if there is enough time to obtain results before release.</p> <p>Laboratory work—STIs, HIV, pregnancy, hepatitis, and tuberculin skin tests based on College guidelines</p> <p>In a jail setting, tuberculin skin tests should only be done if incarceration is expected to be for at least 48 hours to see if any reaction occurs.</p>	<p>Same as in adults, but also screen for eating disorders</p> <p>Same as in adults</p> <p>Same as in adults, bearing in mind that adolescents in correctional facilities are at higher risk of suicide than those in the general population</p> <p>Same as in adults, except mammography and Pap test are unlikely to be needed. Pap test should be performed on adolescents according to College recommendations.</p> <p>Same as in adults</p>

(continued)

Table 1. Recommended Care for Incarcerated Women and Adolescent Females (*continued*)

Type of Care	Adult Jail or Prison*	Juvenile Facilities
Pregnancy care	Pregnancy counseling, perinatal care, and abortion services should be offered based on College guidelines	Same as in adults
Preventive care	Any additional tests, examinations, and care based on College guidelines	Same as in adults
	Health education on contraception and pregnancy; tobacco, alcohol, and substance abuse cessation; and parenting	Same as in adults
	Comprehensive HIV and STI treatment and prevention programs	Same as in adults, bearing in mind that adolescents are at higher risk of STIs than the adult population
	Contraceptive services, including emergency contraception, based on medical need or potential risk of pregnancy	Same as in adults
Care for older women	Provide immunizations as necessary based on College guidelines, with particular focus on influenza and pneumococcal vaccination	Same as in adults, but with particular focus on HPV, meningococcal, and influenza vaccination
	Hormone therapy, if indicated	Not applicable
	Screening, treatment, and prevention programs for osteoporosis	Osteoporosis prevention programs may be useful
Mental health care	Screening for depression and dementia	Screening for depression
	Medication management, suicide prevention, crisis intervention, substance abuse programs, and linkage to social services and community substance abuse programs upon release	Same as in adults, noting that incarceration is a risk factor for suicide among adolescents

Abbreviations: College, American College of Obstetricians and Gynecologists; STIs, sexually transmitted infections; HIV, human immunodeficiency virus; HPV, human papillomavirus.

*If a juvenile is housed in an adult prison or jail, the recommendations under the juvenile facilities column should be followed.

[†]The request by either a patient or a physician to have a chaperone present during a physical examination should be accommodated regardless of the physician's sex.

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Recommendations

- Obstetrician–gynecologists should support efforts to improve the health care of incarcerated women and adolescent females at the local, state, and national levels. Activities may include the following:
 - Gaining representation on the boards of correctional health organizations.
 - Working in correctional facilities to provide services to incarcerated women and adolescent females and continuing care after the woman's release, when feasible.
 - Undertaking efforts to ensure that medical needs of incarcerated women and adolescent females are being addressed appropriately, such as by providing training or consultation to health care providers and correctional officers in prison settings.
- Advocating at the local, state, and federal levels for increased funding to provide access to necessary health care for incarcerated women and to restrict shackling of women and adolescents during pregnancy and the postpartum period (10).
- Facilitate care provision by health care providers to incarcerated women and adolescent females (eg, allowing incarcerated women and adolescent females to enter through alternate entrances to avoid stig-

matization in the waiting room or to be seen during off-hours).

- Ensure that adolescents only be detained or incarcerated in facilities with developmentally appropriate programs and staff trained to deal with their unique needs. If they must be housed in adult correctional facilities, they should be separated from the adult population into an environment that is able to address their specific developmental needs (24).
- Ensure that adolescents with serious mental disorders are not placed in detention when they do not face criminal charges. The placement of adolescents with mental disorders who have been charged with crimes and are able to be released from incarceration into a community mental health facility should be completed in a timely fashion.
- Facilitate collaboration between medical schools and other health care professional schools and correctional facilities to improve care to inmates.
- Obtain and support funding for research on the health needs of incarcerated women and adolescent females, the services they receive, the qualifications of the health care provider, the location of the service, and the outcomes of these services.
- Support state and federal funding that increases access to necessary health care that includes not only disease-specific treatment, but also preventive services and access to qualified health care providers for incarcerated women and adolescent females.

Specific medical recommendations include the following:

- Correctional facilities should be adequately funded to provide a continuum of care model providing female inmates with initial screenings, in-house services or referrals for preventive and curative care, including Pap tests and appropriate follow-up, health education, and adequate planning before release from correctional facilities.
 - Health care providers and other correctional facilities staff should receive appropriate training to provide care for female inmates, including the care of pregnant women (10).
 - Incarcerated women of all ages should receive reproductive health care, including access to adequate contraception, prenatal care, and abortion services (9, 10).
 - Appropriate and adequate care should be provided for pregnant women and adolescents, including opioid dependence treatment, avoiding the use of restraints, and promoting breastfeeding (10).
 - If hospitalization or other off-site health care occurs, prescribed treatments, such as medications, must continue once the patient returns to the correctional facility.
- Incarcerated women and adolescents' mental health needs should be addressed.
 - Incarcerated women and adolescents should be protected from sexual abuse. If sexual abuse occurs, the guilty party should be punished to the full extent of the law.

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