

BEST PRACTICES IN THE USE OF RESTRAINTS WITH PREGNANT WOMEN AND GIRLS UNDER CORRECTIONAL CUSTODY



Purpose of the Best Practices Statement

The *National Task Force on the Use of Restraints with Pregnant Women under Correctional Custody*, initially convened by the U.S. Department of Justice in 2011, created this best practices statement to articulate a set of principles to guide agencies and jurisdictions in the development of local policy and practice. These best practices are relevant across a variety of settings including criminal justice, juvenile justice, psychiatric and forensic hospitals, law enforcement transport, and others. This document refers and applies to both women (age 18 years and older) and girls (younger than age 18) who are pregnant, laboring and delivering, or in the post-partum period.

This statement is not a proscribed policy. Rather, it should serve as a starting point for individual organizations to use in developing effective internal policies, procedures, and practices that maximize safety and minimize risk for pregnant women and girls, their fetuses/newborns, and correctional and medical staff.



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BACKGROUND

The convening of the *National Task Force on the Use of Restraints with Pregnant Women under Correctional Custody* resulted from a series of meetings of federal agencies, national associations, state and local policymakers, practitioners, and non-profit and advocacy partners on the topic of use of restraints with pregnant women under correctional custody. The Task Force is co-sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Promoting Alternatives to Seclusion and Restraint through Trauma-Informed Practices and National Center for Trauma-Informed Care, and the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance's National Resource Center on Justice-Involved Women (NRCJIW). The meetings of the Task Force were facilitated by the Center for Effective Public Policy.

The Task Force was convened to develop a best practices statement regarding the use of restraints with pregnant women and girls under correctional custody, regardless of the stage of pregnancy, as well as a broader set of tools, resources, and strategies that will make dissemination and implementation of policy and practice in this important area both possible and likely. Task Force members were selected to ensure a balance of corrections practitioners (jails and prisons), federal agencies, advocates, and medical professionals with expertise in this topic.¹

The Task Force's planning team conducted a comprehensive literature review and scan of the resources available on the topic of the use of restraints with pregnant women and girls under correctional custody. Before meeting in person in August 2012, Task Force members became acquainted with this material and participated in a series of online surveys to determine areas of consensus and divergence among individual Task Force members. This groundwork allowed the Task Force to more efficiently reach consensus on a set of core principals and key recommendations for the best practices statement during their face-to-face meeting.

¹ A list of Task Force members and the organizations they represent appears in Appendix 1.

DEFINITION OF TERMS USED IN THIS DOCUMENT

We recognize that language may vary across settings and organizations. For the purposes of this document, we use the following terms and definitions:

Pregnant women—Adult women ages 18 years and older as well as adolescent females younger than 18 years (girls) at any stage of pregnancy, labor and delivery, and the post-partum period.

Post-partum period—The period of recovery immediately following childbirth, miscarriage, or termination of a pregnancy. Although this recovery period is typically recognized as 6 weeks (for a vaginal birth, or uncomplicated pregnancy loss or termination) to 8 weeks (for a cesarean birth, or complicated vaginal delivery, loss, or termination), it often lasts longer. The end of the post-partum period is usually defined by release from the care of a medical professional rather than a specific amount of time.

Correctional custody—Detention and confinement by law enforcement and correctional agencies for any reason, including transportation to and from detention and confinement. Individuals who are detained are detainees. Individuals who are confined are prisoners.

Restraint—Any physical hold (physical restraint; i.e., using one's hands or other body parts to restrain another person) or mechanical device (mechanical restraint; e.g., flex cuffs, soft restraints, hard metal handcuffs, a "black box," club cuffs, ankle cuffs,² belly chains, security chain, or convex shield) used to limit the movement of a prisoner or detainee's body and limbs.³

Trauma-informed care—An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

Gender-responsive approaches—Services, supports, systems, policies, and practices that take into account the differences between the characteristics and life experiences of men and women, and address and respond to their unique needs, strengths, and challenges.⁴ Elements of gender-responsive practice for women include being relational, strengths-based, trauma-informed, holistic, and culturally competent.⁵

² Sometimes referred to as leg irons or shackles in different settings and geographic locations.

³ The use of chemical restraints is outside the scope of this document.

⁴ Adapted from Bloom, Owen, & Covington, 2003.

⁵ From Benedict, 2008, in *Reentry Considerations for Women Offenders*:
<http://www.cepp.com/documents/Reentry%20Considerations%20for%20Women.pdf>

CONTEXT AND NEED

Exhibit 1. Pregnant Women in Correctional Custody			
POPULATION	TOTAL NO. OF FEMALES	PREGNANT AT INTAKE	
		No. of Intakes	Percent of Intakes
Jails	94,000	4,700	5
State prisons	101,300	4,052	4
Federal prisons	13,700	411	3
TOTAL	209,000	9,163	4.4

Historically, correctional policies and practices were designed to ensure safety and security for staff and inmates in correctional institutions with predominantly male populations.⁶ However, demographics of the justice-involved population are shifting to include women and girls in growing proportions,⁷ creating a need to reevaluate policies and procedures to ensure that they serve the whole population.⁸ General statistics on justice-involved women ages 18 and older include:

- Approximately 1.3 million women are under the authority of the criminal justice system.⁹
- Whereas the majority of justice-involved women are under some form of community supervision, approximately 209,000 women are held in prisons and jails nationwide. In institutional settings, about half are held in jails (approximately 94,000)¹⁰ and half (approximately 115,000)¹¹ are held in state or federal prisons (Exhibit 1).
- Almost three-quarters of the women in state and federal prisons are mothers.¹² This number reflects a 122-percent increase over the number of mothers in prison in 1991.¹³
- As shown in Exhibit 1, among female prisoners, 4 percent of state and 3 percent of federal inmates said they were pregnant at the time of admission.¹⁴ Approximately 5 percent of women in jails reported being pregnant at intake.¹⁵

⁶ Ney, Ramirez, & Van Dieten, 2012.

⁷ According to 2010 arrest data, there was an 11.4 percent increase in the number of female arrests from the preceding decade, whereas male arrests dropped 5 percent (Federal Bureau of Investigation [FBI], 2010). In the same decade, the number of women in state and federal corrections facilities grew 22.3 percent (West, Sabol, & Greenman, 2010).

⁸ Bloom, et al., 2003; Covington & Bloom, 2007.

⁹ Glaze, 2010.

¹⁰ Minton, 2010.

¹¹ West, 2010.

¹² Glaze & Marushak, 2010. In 2004, 65,600 women in prison were mothers. Percentage is calculated based on the total population of women prisoners in 2004 when the survey was conducted.

¹³ Change is calculated based on populations 1991-2007.

¹⁴ Maruschak, 2006a.

¹⁵ Maruschak, 2006b.

- Pregnant inmates in state prisons were more likely to receive an obstetric exam (94 percent) and other pregnancy care services (54 percent) than were pregnant inmates in jails (48 percent and 35 percent, respectively).¹⁶

These statistics refer only to adult women; there are no concrete figures on the number of pregnant girls (younger than age 18) who are justice involved. Many juvenile justice facilities do not track the number of pregnant girls in detention. Girls are the fastest-growing segment of the juvenile justice population.¹⁷

PRINCIPLES & RECOMMENDATIONS

The Task Force recognizes that there is significant variation in state and local policy governing the use of restraints in correctional settings including with pregnant and post-partum women and girls.¹⁸ However, the Task Force believes that the principles and recommendations that follow are relevant regardless of jurisdictional differences.

PRINCIPLES

Task Force members reached consensus on the following key principles, which underpin the best practice recommendations that follow.

1. Corrections agencies encompassing adult and juvenile systems, forensic hospital settings, and transport to and from correctional settings should have written policies and procedures on the use of restraints on pregnant, laboring, birthing, and post-partum women and girls.
2. Policies and procedures on the use of restraints on pregnant women and girls under correctional custody should be developed collaboratively by correctional leaders and medical staff who have knowledge about the potential health risks to pregnant women or girls and their fetuses/newborns that can result from the use of restraints at any stage of pregnancy, labor, birth, or the post-partum period.

¹⁶ Maruschak, 2006a; Maruschak, 2006b.

¹⁷ Edelman & Watson, 2012.

¹⁸ See Appendix 2 for links to state legislation, as well as other resources.

3. Pregnant women and girls under correctional custody (and their fetuses/newborns) have unique healthcare needs that are not addressed by most standard custody management policies. Additionally, women and girls in correctional settings are more likely to have high-risk pregnancies for a variety of reasons that can include lack of obstetric care, lack of adequate nutrition, use of substances (e.g., tobacco, alcohol, prescription medications, illicit drugs), physical and emotional abuse, traumatic experiences, mental health issues, sexually transmitted infections, and other issues requiring careful medical management.¹⁹ Policies and practices specific to the needs of pregnant women and girls are necessary to ensure their health and safety and the health and safety of their fetuses/newborns. The following factors should inform such policies and practices:

- a. The use of restraints can interfere with maternal and fetal health care during pregnancy, labor, delivery, and maternal and newborn health care during the post-partum period.²⁰
- b. The use of restraints can pose health risks for pregnant women or girls and their fetuses/newborns, not only by limiting movement that is necessary for balance, circulation, and safety, but also by potentially interfering with urgent medical examinations and procedures.²¹

“The health risks associated with shackling include increased likelihood of falls, trauma and limited access for treatment during medical emergencies. Similarly, minor forces may be sufficient to shear the placental attachments and increase the risk of a placental abruption after blunt abdominal trauma.”

—American Congress of Obstetricians and Gynecologists (ACOG),
District IX (California) Vice Chair Philip Diamond, MD²²

- c. Trauma-based symptoms of pregnant and post-partum women and girls in custody may be exacerbated by the use of restraints, leading to significant maternal and fetal/infant stress.^{23,24}

¹⁹ Baldwin & Jones, 2000; Covington, 2000; Fearn & Parker, 2004; LaLonde & George, 2002.

²⁰ Committee on Health Care for Underserved Women (ACOG), 2011; Committee on Health Care for Underserved Women (ACOG), 2012; Amnesty International, 2011.

²¹ Ibid.

²² American Congress of Obstetricians and Gynecologists (ACOG) District IX, 2011.

²³ Justice-involved women report higher rates of childhood abuse compared with women in the general population (Harlow, 1999). Women in state prisons also report higher rates of physical abuse compared with men in state prisons; up to nearly 50 percent of women in correctional facilities have experienced physical and/or sexual abuse (Harlow, 1999; Harlow, 1998).

²⁴ Covington, 2000; Johnsen, 2006.

- d. Women and girls are particularly vulnerable to behavioral health conditions such as depression and post-traumatic stress disorder (among other psychiatric diagnoses) during pregnancy and the post-partum period; these conditions are also disproportionately prevalent in the corrections population. Use of restraints during and immediately following pregnancy can lead to these conditions, or exacerbate them where they already exist.^{25,26,27}
 - e. Restraints can inhibit physical contact between the post-partum woman or girl and her newborn and limit her ability to safely handle and quickly respond to her newborn's needs, which can be detrimental to the health and well-being of the infant.²⁸
4. Policies and their associated procedures with regard to the use of restraints with pregnant women and girls under correctional custody should clearly reflect the need to balance the safety, health, and well-being of the pregnant woman or girl and her fetus/newborn with that of all other parties involved (including care givers, corrections staff and medical staff), and should be gender responsive.²⁹
 5. The use of restraints on pregnant women and girls under correctional custody should be limited to absolute necessity. The use of restraints is considered absolutely necessary only when there is an imminent risk of escape or harm (to the pregnant woman or girl, her fetus/newborn, or others) and these risks cannot be managed by other reasonable means (e.g., enhanced security measures in the area, increased staffing, etc.).

²⁵ For a discussion of the emotional impact of restraints on women, see Amnesty International, 1999.

²⁶ ACOG estimates that 14-23 percent of pregnant women will experience symptoms of depression during pregnancy and approximately 5-25 percent will experience depression after birth (post-partum depression). Maternal depression can have a negative effect on babies and children, as well as increase risk for serious medical issues during pregnancy, including pre-eclampsia, preterm delivery, and low birth weight (ACOG, 2010).

²⁷ Up to 80 percent of women in correctional custody meet criteria for one or more lifetime psychiatric disorders, most commonly substance use, post-traumatic stress disorder, and depression (Teplin, Abram, & McClelland, 1996; Jordan et al., 1996). Justice-involved women are more likely than their male counterparts to have experienced psychiatric hospitalization, suicidal thoughts/feelings, and suicide attempts (Clements-Nolle, Wolden, & Bargmann-Losche, 2009).

²⁸ Early maternal-child bonding has critical and long-lasting benefits for mothers and newborns (Bergman, Linley, & Fawcus, 2004; Bystrova, Matthiesen, Widstrom, et al., 2007; Bystrova, Widstrom, Matthiesen, et al., 2007; Christensson, et al., 1992; and others). Separation of mother and infant after birth can cause critical impact to the child (Baldwin & Jones, 2000).

²⁹ Women typically enter the criminal justice system as the result of nonviolent crimes (Bureau of Justice Statistics [BJS], 1999; Deschenes, Owen, & Crow, 2006; FBI, 2010; West et al., 2010). Violent crimes committed by women typically occur in a different context than those committed by men and are less severe, are reactive or defensive, and are targeted at family members or intimates; violent crimes committed by men tend to focus more on strangers or acquaintances and be more severe in nature (Mordell, Viljoen, & Douglas, 2012; Blanchette & Brown, 2006; Chesney-Lind & Paramore, 2001; Greenfeld & Snell, 1999). As a group, justice-involved women pose a lower public safety risk than do men in the correctional population, and policies should reflect this difference (Ney, Ramirez, & Van Dieten, 2012).

RECOMMENDATIONS FOR OPERATIONAL PRACTICES

“A synthesis of the medical and legal literature, as well as the case law, suggests that any default rule should incorporate the positions of the American Medical Association and American Bar Association, which would prohibit the use of restraints for pregnant inmates during transport to delivery, during labor and childbirth, and during the immediate recovery from childbirth. Any exception to this policy should require prior written approval based on a documented showing that the specific inmate presents a compelling security or flight risk, and should be given only in exceptional circumstances in light of the general medical evidence to the contrary.”

—Myrna Raeder, J.D., Professor of Law at Southwestern Law School

Based on the five consensus principles, the Task Force identified 11 best practice recommendations for use of restraints with pregnant women and girls under correctional custody.

1. The following types of restraints and restraint practices are expressly prohibited under all circumstances:
 - a. Abdominal restraints, because they pose a danger to the fetus resulting from the risk of physical trauma, dangerous levels of pressure, and restriction of fetal movement.³⁰
 - b. Leg and ankle restraints, which increase the pregnant woman’s or girl’s pre-existing elevated risk of a forward fall.
 - c. Wrist restraints behind the back, because they restrict the pregnant woman’s or girl’s ability to protect herself and the fetus in the event of a fall.
 - d. Four-point restraints, whether a pregnant woman or girl is placed face down or on her back, because being restrained face down poses a danger to the fetus due to pressure on the pregnant woman’s or girl’s abdomen³¹ and because being restrained on her back inhibits blood circulation to both the pregnant woman or girl and her fetus and delivery of oxygen to the fetus.³²
2. Wrist restraints, if used, should be applied in such a way that the pregnant woman or girl may be able to protect herself and her fetus in the event of a forward fall (i.e., in front of her body).

³⁰ Committee on Health Care for Underserved Women (ACOG), 2011; Committee on Health Care for Underserved Women (ACOG), 2012; Amnesty International, 2011.

³¹ American Congress of Obstetricians and Gynecologists (ACOG) District IX, 2011.

³² Committee on Health Care for Underserved Women (ACOG), 2011; Committee on Health Care for Underserved Women (ACOG), 2012; Amnesty International, 2011.

3. Restraints should never be used on a woman or girl during labor and delivery because they a) inhibit her ability to be mobile during labor and delivery and b) may interfere with the prompt administration of medical evaluation and treatment during normal and emergency childbirth.
4. The use of restraints should be avoided during the post-partum period; if restraints are deemed absolutely necessary, they should not interfere with the woman's or girl's ability to safely handle and promptly respond to the needs of her newborn.
5. When transporting a pregnant woman or girl, restraints should not be used except where absolutely necessary (i.e., when there is a current likely risk of escape or harm to the woman or others, and these risks cannot be managed by other reasonable means).³³
6. Standard operating procedures should outline a clear process and frequency for reassessing the use of restraints when they have been deemed absolutely necessary. If upon reassessment it is determined that the risk of imminent harm has changed, the use of the restraints should be reevaluated.
7. Standard operating procedures should be in place to address emergency and non-emergency decisions around the use of restraints. The Task Force recommends the following procedures at a minimum:
 - a. Advance planning among members of the woman's care team (i.e., health care and corrections professionals) should be conducted before hospital admittance.
 - b. When reasonably possible, the facility administrator (or the most senior ranking corrections professional in the absence of the administrator) will collaborate with the health authority to determine whether the use of restraints is necessary.
 - c. The senior ranking person on site will immediately notify the facility administrator if restraints are deemed necessary and are used.

³³ The Task Force does not refer here to the use of vehicle safety belts, but rather to only those restraints used in correctional settings, as defined previously. A discussion of safety belts and pregnant women and girls is outside the scope of this document.

- 8.** All uses of restraints should be documented. The Task Force recommends the following documentation at a minimum:
 - a. Rationale for use or conditions that led to the conclusion that restraints were necessary (specify whether and what kind of alternatives were tried/considered);
 - b. Individuals who reviewed these conditions and concluded that restraints were warranted;
 - c. Type of restraints used and in what manner;
 - d. How frequently the use of restraints was reevaluated and by whom³⁴ and result of such reassessments;
 - e. Change in conditions that led to the conclusion that restraints were no longer necessary;
 - f. When restraints were removed; and
 - g. Length of time or total duration of restraint use.
- 9.** The facility administrator, senior ranking person present during the use of restraint, and health authority should debrief after the use of restraints occurs to review documentation and determine whether proper procedures were followed.
- 10.** Correctional staff should universally receive training on restraint policy, procedures, and specific variations for use with pregnant women in custody before they are in a situation where they need to refer to the policy or potentially need to use restraints.
- 11.** Quality control and assurance methods should be in place to track adherence to policy and procedure, the impact/effectiveness of the restraint policy, and the need for adjustment in policy or practice over time. These methods should include clear accountability measures.

³⁴ This might include the use of an assessment log indicating when the reevaluation took place, who performed it, and what he or she observed during the assessment leading to the continuation or discontinuation of restraint use.

RATIONALE

In developing these principles, recommendations, and the rationale supporting them, the Task Force carefully reviewed a broad body of literature and legal actions related to the use of restraints with pregnant women under correctional custody. These included relevant research findings on pregnant women under correctional custody, resolutions and policy statements from medical organizations such as the American Congress of Obstetricians and Gynecologists (ACOG), American Medical Association (AMA), and National Commission on Correctional Healthcare (NCCHC) illustrating medical experts' views on restraints on pregnant women and girls; position statements from correctional professional associations such as the Association of State Correctional Administrators (ASCA), American Correctional Association (ACA), and American Jails Association (AJA) on the use of restraints with pregnant women; various reports on the use of restraints with pregnant women; reviews of medical research; state legislation; and summaries of legal actions related to this issue.³⁵

Critical areas informing these recommendations include legal considerations, the need for gender-responsive and trauma-informed policies and practices, and the view of the international community and human rights organizations. Appendix 3 discusses in more detail the history of legislation and legal actions related to the use of restraints with pregnant women under correctional custody.

Legal Considerations

There are legal issues associated with the use of restraints on pregnant and post-partum women and girls under correctional custody that compel correctional leaders to carefully examine current policy and practice in this area. A forthcoming legal bulletin from the National Institute of Corrections written by Southwestern Law School Professor of Law Myrna Raeder, J.D., outlines these legal issues in some detail. Several lawsuits have been filed, with damages awarded to the plaintiffs. Claims have been made against the staff who restrain a pregnant, laboring, or post-partum woman, as well as administrators and policymakers. Notable suits have alleged violations of human and Constitutional rights (particularly the Eighth Amendment), inadequate or delayed medical care for pregnant women, and wrongful death of an infant in cases of miscarriage or stillbirth related to the use of restraints. As a result, there is a growing body of case law on this topic. For instance in 2012 the Cook County Jail (Chicago, Illinois) reached a \$4.1 million settlement with 80 plaintiffs who were restrained during labor and/or delivery between 2006 and 2011.³⁶ Appendix 3: The Legal Lens discusses current legislative trends and describes two foundational cases in some detail.

Gender Responsiveness

The needs of women and girls under correctional custody are different from those of men and boys, and the needs of pregnant women are particularly unique due to their health status. Men and women

³⁵ See Appendix 2 for a comprehensive listing of resources the Task Force reviewed.

³⁶ Mastony, 2012.

have different pathways into the criminal and juvenile justice systems, experience and respond to correctional custody differently, and represent different levels of security risk within institutions and in community settings. Gender-responsive policies need to take these differences into account,³⁷ and additionally need to account for the medical needs of pregnant women and girls, and their infants.

Trauma-informed Policy and Practice

Reduction of the use of seclusion and restraint is increasingly a priority across systems, driven in part by SAMHSA's Trauma and Justice strategic initiative and a growing national focus on trauma-informed care. Reducing seclusion and restraint improves outcomes and increases safety for both service recipients and staff.³⁸ A disproportionately high number of justice-involved women and girls have a history of physical, sexual, and emotional trauma.³⁹ Use of restraints can exacerbate trauma symptoms and significantly retraumatize women and girls, who are particularly physically and emotionally vulnerable during pregnancy.⁴⁰ Eliminating the use of restraints in all but the most extreme circumstances reduces the risk of retraumatizing expectant and post-partum women and girls under correctional custody as well as the risk of traumatizing staff who must restrain them. Injuries can occur to both women and staff during restraint, and staff across multiple settings (including corrections, hospitals, and schools) anecdotally report in large numbers that restraining individuals in any setting is extremely traumatizing to staff regardless of whether they are injured. However, research indicates that avoiding the use of restraint results in lower incidence of staff injury.^{41,42}

Human Rights

Evolving standards around the world denounce the practice of restraining pregnant women and girls under correctional custody. Organizations such as Amnesty International, Human Rights Watch, the ACLU and the United Nations Special Rapporteur on Violence Against Women vocally oppose the use of restraints for pregnant women and girls. International treaties also prohibit the use of restraints on this population in all but the most extreme of circumstances. For example, the United Nations' Bangkok Rule 24, which was adopted in December 2010, states "instruments of restraint shall never be used on women during labour, during birth and immediately after birth." These and other international treaties that the United States has signed and ratified (e.g., United Nations Standard Minimum Rules for Treatment of Prisoners; United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; International Covenant on Civil and Political Rights; and International Covenant on Economic, Social and Cultural Rights)—combined with our nation's status as a global leader that other nations look to as an example—obligate a reexamination of institutional policies around the use of restraints to ensure that our approach remains informed by the available evidence base.

³⁷ Bloom, et al., 2003; Covington & Bloom, 2007.

³⁸ Substance Abuse and Mental Health Services, 2006; Forster, Cavness, & Phelps, 1999.

³⁹ Harlow, 1999; Harlow, 1998; Teplin, Abram, & McClelland, 1996; Jordan, et al., 1996; Clements-Nolle, Wolden, & Bargmann-Losche, 2009.

⁴⁰ ACOG, 2010.

⁴¹ SAMHSA, 2006.

⁴² Forster, Cavness, & Phelps, 1999.

CONCLUSION

“The opposition of medical, legal, and international communities to routine shackling during childbirth establishes that it is better policy to limit restraints to extreme cases in which a record can be established justifying the practice. This view also reflects the safer course for correctional administrators to avoid litigation.”

— Myrna Raeder, J.D., Professor of Law at Southwestern Law School

Development of effective, gender-responsive, and trauma-informed policies on the use of restraints with pregnant women and girls under correctional custody requires the input and cooperation of professionals in the corrections, medical, and behavioral health fields. One effective way to maximize safety and minimize liability is through consistent and comprehensive training for staff working with women and girls who are or could possibly be pregnant. Clearly written policies and procedures governing evaluation for pregnancy, provision of prenatal care, and modifications of policies and procedures that apply to the general population to better suit the unique needs of pregnant women and girls are essential. Experts in these areas hold knowledge critical to understanding the needs; requirements; and security, health, safety, and behavioral health risks of pregnant women under correctional custody. By working together, these professionals can maximize physical and psychological safety while minimizing risk of harm to the staff, detainees and prisoners, and fetuses/newborns involved.

The principles and best practice recommendations outlined herein reflect the current state of the intersection between the fields of corrections and health care, and represent a growing recognition of the need for clear standards for the treatment of pregnant women and girls under correctional custody based on medical evidence and evolving standards of care. They are also a timely response to the growing interest in alternatives to seclusion and restraint in corrections and behavioral health settings, particularly for pregnant women and girls. The Federal Bureau of Prisons and the U.S. Marshals Service banned the practice of restraining pregnant women in custody on the federal level in 2008 after Congress adopted the Second Chance Act.⁴³ The Act requires that if and when federal correctional facilities use restraints on pregnant women during childbirth, they justify the use of such restraints by showing documentation of security concerns.⁴⁴

The Task Force urges localities across the U.S. responsible for the management of women and girls under correctional custody to consider, draft, and adopt policies governing the use of restraints as described in this best practice statement. This document may serve as not only a guide, but also a tool for creating uniformity across correctional facilities nationwide.

⁴³ U.S. Department of Justice, Federal Bureau of Prisons, Program Statement: Escorted Trips, at § 11 [Oct. 6, 2008].

⁴⁴ Second Chance Act of 2008, Pub. L. No. 110-199, 122 Stat. 657 [2008].

APPENDIX 1: MEETING PARTICIPANTS

TABLE 1—TASK FORCE MEMBERS

NAME	TITLE & ORGANIZATION
Dan Abreu	Senior Project Associate, Policy Research Associates, Inc.
Mary Blake ⁴⁵	Public Health Advisor, SAMHSA/CMHS/DSSI/Community Support Programs Branch
Maureen G. Buell	Correctional Program Specialist, National Institute of Corrections
Tonier Cain	Team Leader, National Center for Trauma-Informed Care
George Camp ⁴⁶	Co-Executive Director, Association of State Correctional Administrators
Kelli Garcia	Senior Counsel, National Women's Law Center, Health and Reproductive Rights
Abigail Harris	Administrator, Female Offender Programs Branch, Correctional Programs Division, Federal Bureau of Prisons
Tae Johnson	Assistant Director, Detention Management, Office of Enforcement and Removal Operations, Immigration and Customs Enforcement (ICE), U.S. Department of Homeland Security
Robert J. Kasabian ⁴⁷	Executive Director, American Jail Association
Jennie Lancaster	Former Chief Deputy Secretary, North Carolina Department of Public Safety, Division of Adult Correction
Ronaldo Myers, CJM	Director, Alvin S. Glenn Detention Center (South Carolina)
Becki Ney	Director, National Resource Center on Justice Involved Women (NRCJIW), and Principal, Center for Effective Public Policy
Maureen G. Phipps, MD, MPH	Associate Professor of Obstetrics & Gynecology and Epidemiology, Alpert Medical School of Brown University, Women & Infants Hospital of Rhode Island

⁴⁵ Participated for Susan Salasin, Director, Trauma-Informed Care Program, Substance Abuse and Mental Health Services Administration

⁴⁶ Participated for Gary Maynard, Secretary, Maryland Department of Public Safety and Correctional Services

⁴⁷ Participated for Bobbi Luna, Lieutenant, Multnomah County Sheriff's Office

TABLE 1—TASK FORCE MEMBERS (CONTINUED)

NAME	TITLE & ORGANIZATION
Patricia Reams, MD, MPH, CCHP	Certified Correctional Health Professional, National Commission on Correctional Health Care
Dora Schriro	Commissioner, New York City Department of Correction
Eric Schultz	Director of Government and Public Affairs, American Correctional Association
Yasmin Vafa ⁴⁸	Director of Law and Policy, Human Rights Project for Girls
Danyell Williams	Site Coordinator, Maternity Care Coalition, Riverside Correctional Facility (Pennsylvania)
Frank Hecht	Corrections Administrator, Tohono O’odham Nation Correctional Facility
Bobbi Luna*	Lieutenant, Multnomah County Sheriff’s Office
Gary Maynard*	Secretary, Maryland Department of Public Safety and Correctional Services
Dr. Hugh E. Mighty*	Vice Chancellor for Clinical Affairs, LSU Health-Shreveport
Malika Saada Saar*	Executive Director, Human Rights Project for Girls
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- Association of State Correctional Administrators (ASCA)
- Center for Effective Public Policy (CEPP)
- Federal Bureau of Prisons (BOP)
- National Resource Center for Justice-Involved Women (NRCJIW), a resource center funded by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance
- Human Rights Project for Girls
- Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center Promoting Alternatives to Seclusion and Restraint through Trauma Informed Practices (Alternatives)
- U.S. Department of Justice, National Institute of Corrections (NIC)
- U.S. Department of Justice, Office of Justice Programs (OJP)

APPENDIX 2: SUPPORTING DOCUMENTS AND ADDITIONAL RESOURCES

Below are resources that informed the Task Force in developing the principles and recommendations contained in this document. The inclusion of a document/report is not intended to express endorsement of the material. All resources deemed relevant to this topic were included as part of a comprehensive literature review.

National Symposium on the Use of Restraints on Pregnant Women Behind Bars

- A Call to Action: The National Symposium on the Use of Restraints on Pregnant Women Behind Bars
- The National Symposium on the Use of Restraints on Pregnant Women Behind Bars: Symposium Notes

Association of State Correctional Administrators

- Policy: Resolutions, Legislation & Legal Issues: Pregnant Inmates (<http://asca.net/projects/16/pages/160>)
- Survey on Prison Births (http://www.asca.net/system/assets/attachments/2456/Prison_Births_Survey_Sheet1.pdf?1299879343)
- ASCA's resolution on the Health and Well-Being of Pregnant Inmates (#23) (<http://www.asca.net/system/assets/attachments/2946/ASCA%20Resolution%20%2323%20-%20Health%20and%20Well-Being%20of%20Pregnant%20Inmates%20.pdf?1307558355>)

SAMHSA

- SAMHSA National Technical Assistance Center to Promote Trauma-Informed Practices and Alternatives to Seclusion and Restraint (http://www.samhsa.gov/matrix2/seclusion_matrix.aspx)
- The National Association of State Mental Health Program Directors (NASMHPD) position statement on seclusion and restraint <http://www.nasmhpd.org/docs/policy/S&R%20position%20statement.Forensic%20Div.%20prop.%20approved%20by%20NASMHPD.07.07.final.pdf>

Position Statements, Policy Statements, and Resolutions

- American College of Obstetricians and Gynecologists: Letter on the Shackling of Incarcerated Pregnant Women (See Attachment 3)
- American Correctional Association:
<http://www.aca.org/government/policyresolution/view.asp?ID=78>
- American Correctional Health Services Administration: Position Statement on the Use of Shackles on Pregnant Inmates
<http://www.achsa.org/resources/positionstatements/positionstatements.html>
- American Jail Association Resolution: Use of Restraints on Pregnant Inmates (see page 45)
http://www.aja.org/assets/cms/files/Membership/Resolutions%2004_2012.pdf
- American Medical Association: <https://ssl3.ama-assn.org/apps/ecom/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-420.957.HTM>
- Association of State Correctional Administrators: <http://www.asca.net/projects/16/pages/160>
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN):
<http://onlinelibrary.wiley.com/doi/10.1111/j.1552-6909.2011.01300.x/pdf>
- National Association of State Mental Health Program Directors (NASMHPD) Position Statement on Seclusion and Restraint: <http://www.nasmhpd.org/docs/policy/S&R%20position%20statement.Forensic%20Div.%20prop.%20approved%20by%20NASMHPD.07.07.final.pdf>
- National Commission on Correctional Health Care (NCCHC):
http://www.ncchc.org/resources/statements/restraint_pregnant_inmates.html
- The Rebecca Project Policy Statement

ACOG Committee Opinions

- Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females (2011). http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Health_Care_for_Pregnant_and_Postpartum_Incarcerated_Women_and_Adolescent_Females
- Reproductive Health Care for Incarcerated Women and Adolescent Females (2012).
http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Reproductive_Health_Care_for_Incarcerated_Women_and_Adolescent_Females

Legislation

As of May 2012, the following states had introduced or passed laws banning or limiting the use of restraints on pregnant women:

- Arizona (SB 1181) <http://www.azleg.gov/legtext/50leg/2r/bills/sb1184s.pdf>
- California (AB 2530) http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB2530
- Colorado (SB 193) <http://aclu-co.org/bill/sb-193-restraints-used-pregnant-inmates>
- Florida (SB 524) http://laws.flrules.org/files/Ch_2012-041.pdf
- Hawaii (SB 219) http://www.capitol.hawaii.gov/session2011/Bills/SB219_hd1_.pdf
- Idaho (code 20-902) <http://legislature.idaho.gov/legislation/2011/H0163.pdf>
- Illinois (HB 1958) <http://www.ilga.gov/legislation/fulltext.asp?DocName=09700HB1958ham002&GA=97&SessionId=84&DocTypeId=HB&LegID=&DocNum=1958&GAID=11&Session=>
- New Mexico (33-1-4.2) <http://law.justia.com/codes/new-mexico/2011/chapter33/article1/section33-1-4.2/>
- New York (S375-2011) <http://open.nysenate.gov/legislation/bill/S375-2011>
- Pennsylvania (code 5905) <http://law.justia.com/codes/pennsylvania/2010/title-61/chapter-59/5905/>
- Rhode Island (2011-S 0165 A, 2011-H 5257 A)
- Texas (HB 3653) <http://www.legis.state.tx.us/tlodocs/81R/analysis/html/HB03653E.htm>
- Vermont (code 801a) <http://law.justia.com/codes/vermont/2005/title28/section00801a.html>
- Washington (RCW 72.09.651) <http://apps.leg.wa.gov/rcw/default.aspx?cite=72.09.651>
- West Virginia (code 31-20-30a) <http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=31&art=20§ion=30A>
- Nevada (AB408) http://www.leg.state.nv.us/Session/76th2011/Bills/AB/AB408_R1.pdf

The Rebecca Project has developed model state legislation.

The National Women's Law Center has developed model federal legislation.

Case Law on the Use of Restraints with Pregnant Women

- A forthcoming National Institute of Corrections legal bulletin developed by Myrna Raeder provides a review of case law relevant to pregnant women in prison. An excerpt of the full bulletin was made available for the Task Force members in draft form.

- An earlier legal review by Myrna Raeder is available: *Appendix A: Legal Considerations With Regard to Women Offenders*, Professor Myrna Raeder, See pages 131-132 in Owen, Bloom, & Covington (2003), *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*. <http://static.nicic.gov/Library/018017.pdf>

Other Documents and Reports

- *Abuse of Women in Custody: Sexual Misconduct and Shackling of Pregnant Women* (<http://www.amnestyusa.org/pdf/custodyissues.pdf>)
- *Laws Banning Shackling During Childbirth Gaining Momentum Nationwide*. http://www.wpaonline.org/pdf/Shackling%20Brief_final.pdf
- *Implementation of Laws Regarding Treatment of Pregnant Women in Texas County Jails: A Review of the Shackling Ban and Pregnant Inmate Care Standards*. www.aclutx.org/download/6/
- *Mothers Behind Bars: A State-by-State Report Card and Analysis of Federal Policies on Conditions of Confinement for Pregnant and Parenting Women and the Effect on Their Children*. <http://www.nwlc.org/sites/default/files/pdfs/mothersbehindbars2010.pdf>⁴⁹
- *Stop Shackling: A Report Written on the Policies of California's Counties on the Use of Restraints on Pregnant Women in Labor*. http://www.prisonerswithchildren.org/wp-content/uploads/2013/01/stop_shackling.pdf
- *Submission to the Special Rapporteur on Torture regarding human rights abuses of incarcerated women in the U.S.* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR_Submission_on_Human_Rights_Abuses_of_US_Incarcerated_Pregnant_Women.pdf

⁴⁹ It should be noted that the Association of State Correctional Administrators has taken exception to the data in this report and there are unresolved questions about the completeness and accuracy of its content; please see <http://asca.net/projects/16/pages/160> for responses from state Departments of Corrections.

APPENDIX 3: THE LEGAL LENS

In the last decade, a growing number of states have introduced legislation prohibiting the use of restraints during labor and delivery in the absence of a significant security or flight risk. At least ten states (Illinois in 2000, and later New York, California, New Mexico, Texas, Vermont, Washington, West Virginia, Florida, and Pennsylvania) have enacted legislation that generally prohibits the use of restraints on incarcerated women and girls during labor and delivery. Some legislation (e.g., Vermont's) goes further, indicating that restraints should not be used on pregnant women after their first trimester. Several other states have introduced legislation on this topic. Some of this legislation more specifically addresses the use of restraints during transportation to medical facilities and immediately after delivery, as well as during labor and delivery. In addition, the District of Columbia, the U.S. Bureau of Prisons, and the U.S. Marshall's Service have, by policy, indicated that restraints shall not be used during labor and delivery. In total, through legislation or policy, more than 20 states and federal authorities now prohibit the use of restraints on women during labor and delivery. These prohibitions generally allow for the use of restraints during labor if there is an individualized determination that concludes that there are substantial and compelling reasons to believe that the woman is a security or flight risk.

Aside from the legislative and policy changes noted above, there are two federal court cases that have spoken directly to this issue. These courts have considered the two broad legal issues that come into conflict here—the responsibility that correctional authorities have to ensure security and safety, and the responsibility of correctional authorities to not interfere with medical care nor inflict wanton or unnecessary suffering on those who have been placed in the State's care (see, e.g., *Estelle v. Gamble*, 429 U.S. 97, 1976). As the Supreme Court said in the case of *Helling v. McKinney*, “When the State takes a person into its custody, and holds him there against his will, the Constitution imposes on it a corresponding duty to assume some responsibility for his safety and well-being” (*Helling v. McKinney*, 509 U.S. 25, at 32, 1993).

The Eighth Amendment to the Constitution forbids the use of cruel or unusual punishment. In interpreting this amendment in cases involving prisoners and medical care, the Supreme Court has indicated that officials act contrary to the Eighth Amendment if they act with “deliberate indifference to a serious medical need” (*Estelle, supra, Farmer v. Brennan* 511, U.S. 825, 1994). An official acts with deliberate indifference when he or she knows of, and disregards, a serious medical need or a substantial risk to an inmate's health or safety. The U.S. Supreme Court in *Estelle* found that it would be a violation of the Eighth amendment for correctional staff to intentionally deny or delay access to medical care or intentionally interfere with the treatment prescribed for the inmate. A serious medical need is one that “is sure or very likely to cause serious illness and needless suffering” (*Helling*, 509 U.S. 25, at 33, 1993).

Nelson v. Correctional Medical Services

The leading federal case involving the use of restraints on a woman during labor and delivery is *Nelson v. Correctional Medical Services* (583 F.3d 522, 8th Cir., 2009). This federal appellate decision involved a case from Arkansas in which a female prisoner had her legs cuffed to a hospital bed by an officer while she was in labor. Her case was initially dismissed by a federal district court, but the Court of Appeals for the Eighth Circuit reversed this decision, concluding that there were sufficient reasons to believe that the case should be returned to the trial court for a hearing.

In making its decision, the Court of Appeals made several significant findings. First, the court found that restraining a woman during labor created potential harm to the mother and fetus and might interfere with responses required by medical personnel. Secondly, the court indicated that there was no apparent safety or security reason that compelled the use of restraints during labor. Having found that placing the restraints could have caused harm or interfered with medical care, and that there was no safety or security reason for applying the restraints, the court then concluded that “a jury could find that a reasonable official would have known that shackling a woman’s legs while she was in labor, without regard to whether or not she posed a security or flight risk, violated her Eighth Amendment rights” (*Nelson, supra*).

Having found that using restraints to confine a woman to a hospital bed during labor, without any overriding safety or security concerns, could violate her Eighth Amendment rights, the Court then turned to the issue of whether the state officer involved in this case would be entitled to “qualified immunity.” Qualified immunity serves to protect state officials against claims if they can demonstrate that their acts were not contrary to the law, or that their impermissible act or actions did not violate a “clearly established statutory or constitutional right of which a reasonable person would have known” (*Harlow v. Fitzgerald*, 457 U.S. 800, 1982). This particular defense may result in the dismissal of actions unless the official has acted with an impermissible motivation or with such disregard of the person’s clearly established constitutional rights that the action cannot be reasonably characterized as having been in good faith. For local officials, the question is not whether they violated a clearly established Constitutional right, but simply whether their actions violated the Constitution (see, e.g., *Owen v. City of Independence*, 445 U.S. 622, 1980).

Relying on the U.S. Supreme Court decision in *Hope v. Pelzer*, the Court in *Nelson* found that the officer’s actions in this case did not entitle her to qualified immunity (*Hope v. Pelzer*, 536 U.S. 730). Although there were no federal appellate court cases with “materially similar facts,” and only a single federal district court case from another district (discussed below), the Court nevertheless found that the officer’s actions (cuffing a woman to a bed during labor without a compelling safety or security reason for doing so) did violate a “clearly established” right.

This finding is particularly important for corrections policymakers and practitioners because, although the case only has precedential value in the Eighth Circuit, it clearly holds that restraining a prisoner during labor not only could violate constitutional protections against cruel and unusual punishment (by constituting deliberate indifference to a serious medical need), but that it also would violate a “clearly established right.” This means that such actions would not be entitled to qualified immunity defenses and could expose officials to potential liability. In light of the court’s findings in this case, agencies with correctional/detention responsibilities should revisit and carefully review their policies and practices regarding the use of restraints on women and girls who are pregnant.

Women Prisoners of D.C. Department of Corrections v. District of Columbia

In the federal case of *Women Prisoners of D.C. Department of Corrections v. District of Columbia* (877 F.Supp. 634, 1994), the Federal District Court found that the use of restraints on incarcerated women during labor and delivery was both inhumane and unconstitutional, and found the actions of officials to be contrary to the Eighth Amendment. The District Court in the *Women Prisoners* case ordered:

Defendants shall use no restraints on any woman in labor, during delivery, or in recovery immediately after delivery.

During the last trimester of pregnancy up until labor, the defendants shall use only leg restraints when transporting a pregnant woman prisoner, unless the woman has demonstrated a history of assaultive behavior or has escaped from a correctional facility.

Although various aspects of this case were reversed, the ruling regarding the use of restraints on pregnant women was not appealed, and therefore remained in effect. This case was relied on substantially by the Court in *Nelson*, and its recognition by that Court of Appeals serves to further highlight its importance in this area.

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BJA

Bureau of Justice Assistance
U.S. Department of Justice