Prison: Pipeline to Women's Preventative Health

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Women detained in prisons, jails and juvenile centers represent an underserved population. In her highly acclaimed book *Jailcare*, Dr. Carolyn Sufrin explores how and why prison can paradoxically serve as a place where women find healthcare.[1] As the rate of incarceration for women continues to increase, it is prudent to assess the current state of healthcare in correctional facilities and leverage this institution to link more women to care.

In December of 2017, women accounted for approximately 7% of the national detained population.[2] While the rate at which women are incarcerated varies greatly from state to state, the number of women in prison has been increasing at a rate 50% greater than men since 1980. Notably, Rhode Island is the state with the lowest incarceration rate with 12 out of every 100,000 women incarcerated in 2014.[3] As the smallest state with the lowest incarceration rate, Rhode Island is uniquely positioned to make large gains with optimization of healthcare for incarcerated women.

Incarcerated women disproportionately suffer from alcohol and drug abuse, sexually transmitted infections (STI), sexual and physical abuse, and mental illness, with rates of these conditions higher than those of incarcerated men.[4] This paper will highlight the major disparities in women's health care in the prison population nationally, the current interventions within the Rhode Island Department of Corrections (RIDOC), and the future steps needed to improve healthcare in incarcerated populations.

Ideally, healthcare in prison should serve as a safety net alongside a pipeline for preventative health to help women on the margins of society climb onto integrated, quality healthcare once they leave the system. The National Commission on Correctional Health Care (NCCHC) guidelines recommend several standards of OB/GYN care for detention centers including: systematic screening for gynecologic problems and pregnancies; initial health assessments including pap smears and pelvic exams; caring for the pregnant woman throughout her prenatal course; and assessing pregnant inmates for opioid use disorders.[4] These encounters should strive to provide care and counseling that does not infringe on the reproductive rights of these women who are already marginalized when considering the poverty, addiction, violence, and racial oppression that characterize their lives.[1] Importantly, this counseling should foster principles of reproductive justice allowing pregnant women to choose whether or not they desire contraception or if pregnant, continuation of a pregnancy, abortion, or adoption services.

The NCCHC recommends that correctional institutions recognize community standards for women's health services.[4] Accordingly, all women entering correctional facilities should be offered screening for sexually transmitted infections (STIs). In a 2008 study of women entering jail in Rhode Island, 33% tested positive for an STI at admission and 26% of all women had trichomoniasis.[5] Detecting and treating women in correctional settings has an impact on community prevalence of these infections. For example, in 2011, correctional facilities accounted for up to 6% of reported syphilis cases in the United States.[4] One correctional facility was able to demonstrate that prompt treatment of all syphilis cases in a jail can lead to a substantial decrease in the prevalence in the local community.[6] RIDOC is currently working with the Rhode Island Department of Health (RIDOH) to offer urine-based STI testing to every woman who enters the facility, exemplifying the partnership between the RIDOC and the RIDOH in providing public health services to this population. In addition to STI screening, all women should be offered pregnancy testing within 48 hours of entering a correctional facility. According to the American College of Obstetricians and Gynecologists (ACOG), at any given time, approximately 6% to 10% of incarcerated women are pregnant and many first learn they are pregnant when they enter a correctional facility.[7] In 2004, a federal survey found that 3% of women in federal prisons and 4% of those in state prisons were pregnant upon arrival.[8] In a cohort of Rhode Island inmates, only 28% of sexually active women used birth control consistently and 83.6% had unplanned pregnancies.[9] This speaks to the need of improving family planning services both inside correctional facilities as well as in the community. This population tends to have complicated pregnancies and is inconsistently provided counseling on options or access to termination services nationwide.[10]

Women in prisons and jails disproportionately suffer from mental health disorders with up to 75% of incarcerated women having a mental health disorder.[11] Additionally, more than 40% of female prisoners are found to abuse drugs at the time of their entry to correctional facilities. When incarcerated women with opioid use disorders are pregnant, they should be offered medication for addiction treatment (MAT) in correctional facilities. Although pregnant women

incarcerated in Rhode Island have access to MAT, this is not a reality in most prisons and jails.[7]

Whether taken individually or as a whole, these disparities lead to poor outcomes and missed opportunities to address the healthcare needs of this marginalized population.[11] The RIDOC has implemented multiple initiatives to address these disparities in an effort to foster incarceration as an access point for intervention. In Rhode Island, all women who are incarcerated have a medical intake that provides their medical history, medications and drug history, providing opportunities to address unmet health needs. A multidisciplinary team of healthcare providers, including nurse practitioners and physicians from various specialities provide necessary medical care. With respect to routine women's healthcare, the RIDOC has onsite OB/GYN services, including prenatal care, contraceptive counseling, STI testing and treatment, breast and cervical cancer screening, and routine gynecologic care. Female inmates have access to LARC contraception, including hormonal implants and intrauterine devices as part of the RIDOC's receipt of Title X funding for family planning and preventative health services, another example of the partnership between the RIDOC and the RIDOH. Since 2017, cervical and breast cancer screening has been facilitated by the Department of Health's participation in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funded by the Centers for Disease Control (CDC). This program provides low-income, uninsured, and underserved women access to timely breast and cervical cancer screening and diagnostic services.

As the rest of the nation contends with the opioid epidemic, prisons and jails have been identified as potential areas of access to addiction treatment. Rhode Island has been particularly affected by the opioid epidemic with rates of overdose deaths reaching 23.5/100,000, the 8th highest in the country.[12] Rhode Island has been hailed as a model for how correctional facilities can offer therapies to incarcerated women. Specifically, a screening process during initial intake identifies inmates with opioid use disorders who are then offered treatment. Medication Assisted Treatment (MAT) programs such as those offered by the RIDOC are considered the most effective therapy for opioid addiction and Rhode Island leads the way in demonstrating why MAT should be the standard of care in correctional facilities.[2, 19]

The antepartum period poses unique challenges in the care of incarcerated women. The RIDOC provides onsite obstetrical care by a board-certified OB/GYN. Their collaboration with Women & Infants Hospital, the 9th largest stand-alone obstetrical service in the country, allows for continuity of that care which also spans the peripartum and postpartum periods respectively. In the postpartum period, once they return to their correctional facility, inmates are allowed to express breast milk which may be provided to the infant by family members. Additionally, along with only 21 other states, Rhode Island outlawed the practice of shackling pregnant prisoners during labor and antepartum transport.[3]

While the RIDOC has set the bar high, barriers to providing comprehensive OB/GYN care for incarcerated women remain. Notably, the challenge of time is a factor, since the majority of women are only incarcerated for a short period. The Department of Corrections 2017 Annual Report shows an average pretrial length of stay of 23 days in Rhode Island, making it difficult to establish continuity of care and further perpetuating the cycle of loss to follow-up.[13, 20]

Efforts are underway to improve the pipeline to continuation of care by collaborating with local healthcare organizations. An example of a successful model in continuity of care can be seen in the Human Immunodeficiency Virus (HIV) positive prison population in Rhode Island.[11] A clear and direct pipeline to continuing HIV treatment and follow-up through strong collaborations with hospitals in the community, such as The Miriam Hospital, with expertise in the treatment of HIV, improved continuity of care with treatment post-release.[21]

The NCCHC recognizes that the number of female inmates is large and growing. Although delivery of quality healthcare that achieves community standards seems impractical in a system with limited resources, the RIDOC has made significant strides to comply with the standards of care that the NCCHC promotes. Similarly, correctional institutions nationwide have put forth initiatives to improve access to gynecologic care.[10]

There are many future opportunities that can help transition healthcare in prison into a pipeline to preventative care, starting from intake. The customized health form is an example of how newly incarcerated women should be screened (**Table 1**). Future endeavors could include engaging community providers to take care of these women once they leave the system. Correctional health services and women's advocacy groups need to collaborate to provide leadership for the development of policies and procedures that address women's special healthcare needs in Corrections with provision of pre- and post-release services.[16] Perhaps a task force that encourages strong partnerships among public health, community, public assistance, and correctional agencies are needed to move forward with these initiatives. If gynecologic healthcare services are offered in correctional institutions in a streamlined manner with minimal barriers, healthcare in the prison setting may not only become comparable to standard community gynecologic care, but may, in fact, serve as a model to engage incarcerated women in their own health maintenance, truly establishing a pipeline to preventative care.

Table 1. Example intake form (Based on the Standards for Health Services, the basis of NCCHC's accreditation program for jails and the NCCHC Position Statement: Women's Health Care in Correctional Setting).[16]

Taking a thorough history	Inquiry into current women's healthcare issues including the Menstrual cycle, pregnancies, gynecologic problems, contraception, current breastfeeding, sexual and physical abuse, and a nutritional assessment.
Health maintenance exams	Adherence to clinical practice guidelines for breast and cervical cancer screening.
STI screening	CT/GC laboratory testing on women up to age 25, and when possible 35, and among pregnant women regardless of age, at receiving or as soon as possible unless the inmate is transferred from a facility where the testing was done. Facilities should review the yield of active syphilis screening within their institutions to determine whether laboratory testing is appropriate. Facilities should consider additional STI testing (i.e., HIV, Trichomonas vaginalis) for persons testing positive and newly diagnosed for CT/GC or syphilis.
Pregnancy test	All women at risk for pregnancy should be offered a pregnancy test within 48 hours of admission.
Menopause	Considering the aging of the prison population, correctional institutions need to address the unique health care needs of older women including menopausal symptoms.
Pregnancy counseling	Comprehensive counseling and assistance are given to pregnant inmates in keeping with their desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child. It also addresses prenatal care and the nonuse of restraints during childbirth.
Contraception	Women should be provided with nondirective contraception counseling, access to emergency contraception, and continuation of current contraceptive method while incarcerated.
Postpartum	Correctional facilities need to facilitate contact visits for mothers with their infants to promote mother-infant bonding.
Breastfeeding	Correctional facilities should make arrangements for postpartum women to either breastfeed or to pump, freeze, and transport breast milk for their infants.[8]
Postpartum depression	Women who deliver while in custody and who enter a facility within 1 year of childbirth should be screened for and educated about postpartum depression and psychosis.
Parenting	Counseling on parenting and child custody issues should be available.
Mental health	Counseling and treatment needs to be available to address mental health issues including alcohol and/or drug use disorders.
Opioid use disorders	Screen for opioid use disorders and offer MAT.
Counseling	Considering the incidence of sexual and physical violence among the female inmate population, counseling to resolve issues of victimization and perpetration of violence against intimates needs to be available (e.g., conflict resolution and parenting skills).

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