Abstract Pregnant incarcerated women have been identified as a particularly high-risk group and among the most vulnerable women in the United States. The use of shackling or restraints poses health risks to pregnant women and their fetuses. Currently, only 22 states have legislation prohibiting or limiting the shackling of pregnant women. Here we provide an overview of the potential negative health outcomes that can result from shackling pregnant women, especially during labor and birth, and suggest strategies for nurses who wish to promote optimal health care for incarcerated women and to advocate for anti-shackling legislation in their states. 

Keywords correctional facilities | legislation | pregnant incarcerated women | restraints | shackling

Where Does Your State Stand on Shackling of Pregnant Incarcerated Women?

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The United States has the highest incarceration rate of women in the world, with approximately 112,000 women in federal and state prisons (Maruschak, Berfzosky, & Unangst, 2015) and another 110,000 in jails (Vera Institute of Justice, 2016). These figures do not account for the number of women who are housed in private correctional facilities. Accurate figures on the prevalence and incidence of pregnant women behind bars are difficult to obtain given inconsistent reporting requirements and inconsistent pregnancy testing when women enter jail or prison (Dignam & Adashi, 2014). However, it is estimated that 6% to 10% of women...
All women deserve the right to a safe, healthy, and dignified childbirth experience

are pregnant when they enter prison or jail and that approximately 1,400 newborns are born to women in custody (Sufrin, 2014).

Women in the criminal justice system are among the most vulnerable in our society. Pregnant women are a particularly high-risk group (American College of Obstetricians and Gynecologists [ACOG], 2011; Sufrin, 2014). The health of these women is often compromised by lack of prenatal care, poor nutrition, sexually transmitted infections, history of sexual abuse, intimate partner violence, untreated or under-treated chronic medical and psychiatric illness, and drug and alcohol dependence (Bronson & Berzofsky, 2017; Carson, 2015; Lynch et al., 2014; Sufrin, 2014).

**Shackling and Restraints**

In 1999, Amnesty International published an alarming report about the use of shackles and restraints with pregnant incarcerated women in the United States. The practice of shackling (also called restraints) includes the use of a mechanical device (e.g., ankle cuffs, belly chains, soft restraint, hard metal handcuffs) that is used to limit the movement of an inmate (U.S. Department of Justice, 2012).

Since 1999, there have been persistent efforts by a number of human rights organizations and lobbyists resulting in anti-shackling legislation in a number of states. Despite public outcry, currently only 22 states and the District of Columbia have some form of anti-shackling legislation. States vary in their legislation. For example, some ban the use of shackles while women are transported to medical facilities, during childbirth, and in the immediate postpartum period. Other states ban shackling only during labor and birth. Even in states that do have anti-shackling legislation, it has been difficult to monitor implementation of laws, largely because of the absence of strict reporting requirements.

According to Amnesty International (1999), the use of restraints with pregnant incarcerated women is a cruel and inhumane practice. It is a violation of a woman’s civil rights and is potentially harmful to the woman and her fetus. In 2016, the Federal Court of Appeals for the Ninth Circuit in the United States stated, “Shackling while in labor offends contemporary standards of human decency such that the practice violates
the Eighth Amendment’s prohibition against the unnecessary and wanton infliction of pain . . . it poses a substantial risk for serious harm” (Mendiola-Martinez v. Arpaio, 2016, p. 24). Shackling during pregnancy and childbirth is medically unsafe, emotionally traumatizing, and unnecessary (Clarke & Simon, 2013).

The initial purpose of using restraints with pregnant incarcerated women was to prevent women from escaping or harming themselves or others. There are no data to support this reasoning. In fact, no escape attempts have been reported among pregnant incarcerated women who were not shackled during childbirth (Feinauer, Lee, Park, & Walker, 2013).

Potential Negative Health Outcomes
Restrains prevent a pregnant woman from breaking a fall, which can lead to abdominal trauma, potentially resulting in placental abruption, maternal hemorrhage, and even stillbirth (Sufrin, 2014). When a woman is restrained, the ability of health care providers to assess and evaluate her and her fetus is compromised (ACOG, 2011; Sufrin, 2014). In the prenatal period, shackling can delay the prompt assessment for vaginal bleeding. Shackling limits mobility during labor (ACOG, 2011). Walking and moving around with the freedom to change positions in labor can result in less discomfort and a shorter, less painful labor with less need for medication, thereby decreasing risks for women and newborns (ACOG, 2011).

Hypertensive conditions are relatively common, and shackled women with hypertension may encounter problems, particularly if they experience an eclamptic seizure, during which they may suffer injuries directly related to the restraints. Unnecessary delays of potentially lifesaving measures in the event of an obstetric emergency, including hemorrhage or abnormalities of the fetal heart rate that require prompt intervention and possibly urgent cesarean birth, can also occur from the use of shackles (ACOG, 2011).

The critical importance of mother-newborn bonding in the initial hours and days after birth has been noted in the literature (ACOG, 2011; Johnson, 2013). Shackling limits a woman’s ability to be in contact with her newborn and may also interfere with her safe handling of her newborn (ACOG, 2011). After giving birth, most incarcerated women are allowed only 24 hours with their newborns in the hospital; this separation can be psychologically traumatizing for them (Clarke & Simon, 2013). Nearly three quarters of incarcerated women have psychiatric illnesses, including depression and posttraumatic stress disorder (Sufrin, 2014). Shackling can lead to or exacerbate these and other disorders, causing an increase in distressing symptoms (American Medical Association, 2015).

In light of these potentially serious physical and mental health outcomes, a pregnant incarcerated woman should be restrained only under unusual circumstances, such as being a flight risk or attempting to harm herself, her fetus, or others. In these situations, the least restrictive measures should be taken and should not interfere with a woman’s leg movement or the ability to break a fall (National Commission on Correctional Health Care [NCCHC], 2015). Documentation of the need to use restraints and the type of restraint used is strongly recommended (NCCHC, 2015).

Positions Against the Use of Shackles/Restrains

Legislation and Policies
It has been difficult to obtain accurate information from numerous state prisons and jails regarding their policies related to health care of pregnant women and the practice of shackling. In 2010, The Rebecca Project for Human Rights and National Women’s Law Center conducted a survey to shed light on the current conditions faced by pregnant women in prisons across the country. Their report was titled 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. Despite their noble effort to collect accurate data, some states did not have their policies on their Web sites, nor did they respond to telephone requests. “States were therefore penalized for either failing to respond to our calls and surveys or to make their policies readily available” (Rebecca Project for Human Rights & National Women’s Law Center, 2010, p. 40).

Ferszt and Clark (2012) conducted a survey research study to obtain information from women’s state prisons across the country related to health care practices for incarcerated women, including the use of shackles or restraints. Although the researchers contacted each warden three times, only wardens from 19 prisons chose to participate. Of these, eight reported continuing to use some form of shackles/restraints and some even during labor, birth, and the postpartum period. Kelsey, Medel, Mullins, Dallaire, and Forestell (2017), using Ferszt’s and Clarke’s (2012) survey, explored health care practices of pregnant women in jails. They contacted 384 facilities;
Department of Justice convened a task force on the use of restraints with pregnant women under correctional custody. In 2012 they published *Best Practices in the Use of Restraints with Pregnant Women and Girls Under Correctional Custody*. These best practices focus solely on the use of restraints and include potential dangers to a woman and her fetus that could result from the use of restraints. Although these recommendations and best practices are excellent resources, correctional facilities are not obliged to use them or other standards that have been developed.

**A Call to Action**

Our plea is simple: Protect the women. At the point of care, nurses must protect women’s safety and well-being. Nurses and other clinicians can demand that shackles be removed. Using the chain of command within an institution to develop and implement or uphold existing policies that advocate for women’s safety and dignity is paramount. If a policy is unclear, using the ethics review board is another option. Nurses can also educate correctional officials on best practices for the health care of incarcerated pregnant woman. Then nurses must notify hospital and nursing administration if policies have not been upheld or if they are unclear and

![Figure 1. States With Anti-Shackling Legislation](image-url)
### Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>ACOG</th>
<th>NCCHC</th>
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<tbody>
<tr>
<td>Prenatal screening and laboratory work (including testing for HIV)</td>
<td>✓</td>
<td>✓</td>
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<td>Identification and referral for high-risk pregnancy</td>
<td>✓</td>
<td>✓</td>
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<td>Medical examinations by licensed provider</td>
<td>✓</td>
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<tr>
<td>Pregnancy counseling and abortion services</td>
<td>✓</td>
<td>✓</td>
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<td>Assessment and treatment for mental health disorders</td>
<td>✓</td>
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<tr>
<td>Assessment and treatment for alcohol and substance dependence</td>
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<td>Nutrition counseling</td>
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<td>Bottom bunk for safety</td>
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<td>Adjusted work assignments</td>
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<td>30 minutes or more of moderate exercise a day</td>
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<tr>
<td>Breastfeeding support</td>
<td>✓</td>
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<tr>
<td>Access to contraception including emergency contraception</td>
<td>✓</td>
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<tr>
<td>Childbirth services in a licensed hospital Specifications a facility for high-risk births when available</td>
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<td>Offer of doula services</td>
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<td>Postpartum screening for depression</td>
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<tr>
<td>Ongoing visitation with newborn</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Prohibition of restraints</td>
<td>During labor, birth, and postpartum</td>
<td>During transport, labor, birth, and postpartum</td>
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<tr>
<td>The senior ranking officer on site will immediately notify the facility administrator if restraints are deemed necessary and are used</td>
<td>✓</td>
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<tr>
<td>All uses of restraints shall be documented (specific guidelines)</td>
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<tr>
<td>The following restraints are prohibited: abdominal restraints, leg and ankle restraints, wrist restraints behind the back, four-point restraints</td>
<td>✓</td>
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<tr>
<td>Training and consultation to health care providers and correctional officers</td>
<td>✓</td>
<td>Training of correctional staff</td>
</tr>
<tr>
<td>Quality control measures with clear accountability</td>
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<td>✓</td>
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</table>

*Note: ACOG = American College of Obstetricians and Gynecologists; NCCHC = National Commission on Correctional Health Care. Sources: ACOG (2011); Sufrin (2014); U.S. Department of Justice (2012).*
need to be revised. Some specific action steps that nurses can take are outlined in Box 2.

Conclusion
All women deserve the right to a safe, healthy, and dignified childbirth experience. Giving birth in shackles is a devastating emotional experience for many women. Nurses are in a pivotal position to advocate for pregnant incarcerated women whether they work in hospitals, community agencies, obstetric practices, correctional facilities, or state governments. Given the reports of potential negative health outcomes on mothers and their fetuses resulting from shackling, one must ask, Why does this practice continue? As members of nursing organizations, we can have a larger voice in the political arena to enact legislation in the remaining states without anti-shackling laws. NWH

References


