



Institute for
**Public Safety
Crime and Justice**

**NHS England - East
Health and Justice Commissioning**

**Evaluation of Healthcare Services Provided
to Women at HMP Peterborough 2021**

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About the Institute for Public Safety, Crime and Justice

Established in 2014, the Institute for Public Safety, Crime and Justice (IPSCJ) at the University of Northampton delivers high quality research and evaluation, insight, and innovation in the fields of public safety, crime and justice. The IPSCJ is situated at the interface between practice, policy, and academia, adopting an evidence-based approach to enhance public service delivery models, organisational strategy, and outcomes for service users. The IPSCJ collaborates with partner organisations at local, regional, national, and international scales to address key global challenges of the 21st century. The core mission of the IPSCJ is to support positive evidence-based policy and practice change for the benefit of society.

The IPSCJ has five research and evaluation portfolios:

Health and Justice: We explore intersections between health and justice, working with a wide range of partners and agencies in community and prison settings. Example projects include:

- Evaluating Community Sentence Treatment Requirements in England, funded by NHS England and NHS Improvement and local CSTR Programme Boards
- Assessing the Effectiveness of Mental Health Street Triage in the East Midlands, funded by Northamptonshire Office of Police, Fire and Crime Commissioner

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- National evaluations of the Mini Police and Volunteer Police Cadets, funded by the Home Office Police Transformation Fund
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- Place-based leadership development in Kenya and Uganda, funded by the Danish Institute Against Torture
- Workforce engagement in Leicestershire Police and Northamptonshire Police, funded by Leicestershire Police and Northamptonshire Police

Equality, Vulnerability and Inclusion: We empower individuals and communities whose voices are not often heard to take part in research and evaluation. Example projects include:

- Understanding serious violence in Nottingham City and Nottinghamshire, funded by Nottinghamshire Office of Police and Crime Commissioner
- Evaluation of Women's Health Services for Perinatal Female Offenders in HMP Peterborough, funded by NHS England and NHS Improvement – East of England



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1. Introduction

In 2019 NHS England commissioned the Institute for Public Safety, Crime & Justice (IPSCJ) at the University of Northampton to review the effectiveness of healthcare services provided to women who have recently given birth or who are pregnant at HMP Peterborough. Two years on NHS England have re-commissioned the IPSCJ to review progress made against the recommendations of the 2019 review. This chapter of the report provides a broad overview into the background of care of women in the criminal justice system and particularly the healthcare of perinatal women followed by an overview of the 2019 review at Peterborough and the rationale for the current revisit of that review.

1.1 Meeting the needs of women within the Criminal Justice System and perinatal care of women in prison

It is recognised that women in prison are some of the most vulnerable members of society. More than half (53%) have experienced emotional, physical or psychological abuse as a child (Williams et al., 2012) and 57% of women prisoner's report having experienced domestic violence (Prison Reform Trust, 2017). In the Surveying Prisoner Crime Reduction longitudinal cohort study of prisoners, Light et al. (2013) identified that females were more likely than male prisoners to report that they needed help with a drug problem (49% compared with 29%) on entry to prison. Women are also more likely to experience poor mental wellbeing compared with men. For instance, women are nearly twice as likely as men in prison to be identified as suffering from depression 65% compared to 37% (Light et al., 2013) and more than three times more likely as women in the general population at 19% (McManus et al., 2009). It is recognised, therefore, that women in prison have heightened needs comparative to men and have unique vulnerabilities that need to be identified and managed. Women nevertheless represent a minority within the prison system, constituting approximately 4%¹ and have been described as 'correctional afterthoughts' (Prison Reform Trust, 2017). Following the deaths of six women at Styal prison, the Home Secretary asked Baroness Jean Corston to conduct a review of vulnerable women in the criminal justice system. The report (2006) concluded that:

"Women have been marginalised within a system largely designed by men for men for far too long and there is a need for a "champion" to ensure that their needs are properly recognised and met."

In more recent years, government policy has sought to develop a stronger strategic focus on the needs of women in the Criminal Justice System. In 2013 the Ministry of Justice (Ministry of Justice, 2013) published its first Strategic Objectives for Female Offenders. A cross-departmental Advisory Board for Female Offenders (ABFO) was established in March 2013 and this was accompanied by a National Offender Management Service (NOMS) Stocktake of Women's Services for Offenders in the Community². In 2018 the Ministry of Justice published

¹ In July 2021 there were 3,170 female adults in prison in the UK, constituting 4% of the total UK prison population.



the Female Offender Strategy (Ministry of Justice, 2018) which recognises that vulnerability can be a driver of offending behaviour and prevent people from breaking out of crime. It acknowledges that vulnerability factors are particularly 'stark' for female offenders, with there being a high prevalence of mental and self-harm and that many have experienced a life of 'abuse and trauma'. The Strategy sets out the Government's commitment to a new programme of work with female offenders, with three key priorities: early intervention, an emphasis on community-based solutions, and an aim to make custody as 'effective and as decent as possible for those women who do have to be there'

In 2018 Public Health England (Peden et al., 2018) published 'Gender Specific Standards to Improve the Health and Wellbeing for Women in Prison'. The implementation and achievement of the standards is a joint objective of Her Majesty's Prison and Probation Service (HMPPS), NHS England and Public Health England. The standards highlight the need for a whole systems approach to improving health and wellbeing for all women in prison. The public health standards have 12 specific standards that relate to pregnant women and babies in the prison setting.

NHS England outline their commitment to improve the health and care outcomes for those in secure and detained settings and narrowing health inequalities between those in the Criminal Justice System (CJS) and the general population, in the document 'Our Strategic Direction for health services in the Justice System 2016-2020'. NHS England Health and Justice teams commission to the principle of equivalence, meaning that the health needs of a population constrained by their circumstances should receive an equitable service to that offered to the rest of the population.

The NHS England Long Term Plan (NHS England, 2019) sets out how the NHS will support wider social goals, some of which relate directly to the care of women in prisons. These include:

- Additional investment in services for people experiencing a mental health crisis will make a real difference for people who need support, and will help ease pressures on police services; which includes people in prisons;
 - This will be supported by a health and justice digital patient record information system which will be rolled out in all adult prisons, and increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis, to benefit an additional 24,000 women per year by 2023/24, in addition to the extra 30,000 women getting specialist help by 2020/21;
- Health and justice services are provided to some of the most vulnerable members of our society.
 - This includes a focus on improving continuity of care. The care after custody service, RECONNECT, will commence its work with people before they leave prison and helps them to make the transition to community-based services.
- Continuity of carer teams are being developed and launched across the country;



- The focus here is to deliver more personalised care plans for pregnancy, where by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.

HMPPS has recently released a new policy paper ‘Pregnancy, Mother and Baby Units (MBUs), and Maternal Separation from Children up to the Age of Two in Women’s Prisons’ (2021a). HMPPS’ policy (2021) sets out the Ministry of Justice’s requirements for prisons caring for women who are pregnant or have experienced pregnancy within 12 months of entering the prison, women on mother and baby units and their babies, and women who have been separated from children up to the age of two years in the 12 months before entering prison, as a result of prison, or after time on an MBU with the child(ren). The policy was developed following a fundamental review by the Ministry of Justice (July 2020) of operational policy on pregnancy, Mother and Baby Units and maternal separation, which involved consultation with a wide range of stakeholders.

It is important to note that two tragic events occurred in prisons relating to the unexpected births of two babies at Bronzefield and Styal Prisons in recent years (2019 and 2020 respectively) since then reviews of these cases by the Prison Ombudsman have been released. These two investigations provide specific recommendations to the prisons in which they occurred, but also provide wider learning for the whole of the women’s prison estate. The details of these investigations are discussed in more depth in section 3.1.

1.2 The 2019 Review of Perinatal Care of Women in HMP Peterborough and the current review

In 2019, NHS England commissioned the Institute for Public Safety, Crime & Justice (IPSCJ) at the University of Northampton to review the effectiveness of healthcare services provided to women who have recently given birth or who are pregnant at HMP Peterborough. HMP Peterborough is a local category B prison, housing both men and women who are held in two separate parts of the prison. The female part of the prison has the capacity for 360 female residents. There is a 12 place Mother and Baby Unit (MBU).

NHS England commissioned the piece of work to gain a more in-depth understanding of the needs of perinatal women at Peterborough beyond what ‘was already known’ through commissioning of other services in Peterborough prison and through the health needs assessments. Central to this piece of work was orientating it to the service user, therefore instead of basing the review around a Public Health document² the Commissioner selected compliance with the Birth Companions Birth Charter. This was because Birth Companions are a user led organisation. They are a charity that offer emotional and practical support, advice and advocacy to perinatal women within the Criminal Justice System as well as campaigning to improve the care of women and babies who experience multiple disadvantage. The Birth Charter for women in prison in England and Wales (Kennedy et al., 2016) is a set of

² Public Health England’s framework for gender specific services



recommendations for the care of pregnant women and new mothers in prison. The remit of the 2019 review was to assess HMP Peterborough's compliance with three of the fifteen elements of the Birth Companions Birth Charter³, which are most closely aligned with clinical care.

- Access to the same standard of ante natal care as women in the community
- Encouragement and support in their chosen method of infant feeding
- Access to counselling (While 'counselling' can have a range of meanings the commissioner requested that the review sought to understand what wellbeing services and talking therapies are available to women antenatally and post natally)

The findings of the 2019 review identified positive aspects of level of care provided and opportunities for improvement. The 2019 review concluded:

It is clear by talking to key individuals involved in the perinatal care of women at HMP Peterborough that they are passionate and committed to providing a high standard of care to residents. Women are recognised as receiving enhanced care in some respects compared to the community, as they can attend the antenatal clinics much more regularly than in the community. However, this enhanced care package is needed to mitigate the negative effects of the prison environment as well in recognition of a far higher level and complexity of needs compared to women in the community. There were mixed reports of practices within the establishment from residents on their received encouragement and support in their chosen method of infant feeding. Access to talking therapies for women on the perinatal pathway was problematic and there was a consensus amongst staff spoken to that mental health care was a key area for improvement.

The review provided 15 recommendations for the consideration of NHS England and HMP Peterborough in relation to the perinatal care of women, these were:

1. Develop a multiagency perinatal pathway from entry to departure (inc. resettlement responsibilities and handovers to community teams) of the establishment;
 - a. This should be co-produced with all partners and supported by policies and guidelines to define responses to and processes for different situations; and
 - b. The document should also be regularly reviewed and updated by the partnership when facing new situations or issues in practice;
2. Establish weekly perinatal meetings, with mandatory representation of different departments and partners to monitor and delivery holistic care;
 - c. Non-attendance or engagement should be communicated to senior management in the establishment and addressed; and
 - d. Each case should be reviewed on an individual basis and interactions/decisions communicated and documented;

³ The Birth Companions Birth Charter can be accessed at https://hubble-live-assets.s3.amazonaws.com/birth-companions/attachment/file/1/Birth_Companions_Charter_Online.pdf



3. Ensure that expedient two-way communication between the women and the midwife is facilitated;
4. Ensure that prison staff can access the health-related expertise they need to manage care of women at the prison;
5. Induction and ongoing provision of training should be reviewed, and bespoke packages developed to improve staff awareness and practices of staff in the care of with women on the perinatal pathway;
6. Provisions of information for women should be reviewed, with bespoke information packs developed and issued to women upon entry into the establishment; and
7. Consider mechanisms and structures within the establishment for women's voices to be heard within the establishment and identify how to utilise such information to improve processes, practices and policies.
8. Review activities which support women during and after pregnancy available to women and align with wider community provision;
9. Redefine the status of such activities as meaningful within the prison regime and not confined to a lunchtime activity;
10. Review support for women when experiencing difficulties with breastfeeding;
11. Consider the spaces in which breastfeeding occurs and allocate female staff where possible to reduce barriers to breastfeeding;
12. Establish EBM procedures and practices;
13. Increase provision of and access to specialist perinatal mental health talking therapies;
 - e. As part of this, wider staff who interact with women should be trained on signs of distress or crisis and prompt referrals and assessments should be initiated;
14. Review the assessment processes for how the risks of poor mental wellbeing for women and their babies on the perinatal pathway are triaged against the needs of the wider prison population in terms of access to mental health services within the prison; and
15. Assess the quality and content within pregnancy packs to ensure women's nutritional needs are met.

NHS England commissioned this review to identify whether progress has been made in relation to these recommendations since the 2019 review, to continue to advance understanding of the effectiveness of healthcare services provided to perinatal women at HMP Peterborough. The objectives of the commissioner were to allow the independent organisation (IPSCJ) who conducted the original review to evaluate progress that has been made and to provide the commissioner with an understanding of which services need further development and what has worked well.



2. Methodology

To achieve the aims outlined for this work, a mixed methods approach was used to collect data and produce findings. The project was reviewed by the University of Northampton, Faculty of Health and Society Research Ethics Committee and the HM Prison & Probation Service National Research Committee (HMPPS NRC). The methodology mirrored the approach taken in 2019, facilitating comparison of findings and progress made since then.

Methods included:

- Desk-based research on policy and academic evidence, to identify any new literature and evidence published since 2019;
- Semi-structured interviews with residents in HMP Peterborough; and
- Contextual interviews with staff, review of any policies and pathway documentation updated since the last review

Desk-Based Research: The review conducted for the 2019 report was updated to identify any new evidence on relevant academic databases using key words (women, prison, pregnancy etc.). The findings from this review are presented and integrated into relevant chapters below.

Semi-Structured Interviews with Perinatal women: Women on the MBU and women who were pregnant or had a baby in the past 12 months were provided with a Participant Information Sheet outlining the purpose of the research. Women were asked to notify the Mother & Baby Unit Senior Officer or a designated House block manager if they were happy to take part. These members of staff then scheduled interviews with those women that wished to participate. In total, 7 perinatal women participated in the research, 2 of the women were on the MBU (a third that was on the MBU was unavailable on the day of interview), 3 pregnant women participated and 2 women that had been pregnant in the last 12 months participated.

It is important to note that the women are in an environment in which their ability to decide is limited. It was, therefore, very important that it was clear that participation was voluntary and participation or non-participation would have no positive or negative impact on their care. This was outlined in the Participant Information Sheet which they received prior to agreeing to take part. At the beginning of the interview women were taken through the participant information sheet again and it was emphasised again that participation was voluntary. Women were given the opportunity to ask questions and the participation information sheet was outlined in full.

Due to the sensitive nature of the research, it was also outlined in the Participant Information Sheet that the interview may invoke difficult emotions and if that was the case they would be signposted to appropriate support. At the end of each interview the women were given information about support mechanisms that they could access.

Semi-structured interviews were used to ensure that all topics that are relevant to the research questions were covered, but also allow the interviewer flexibility to cover related



topics as they arise that are pertinent to the women's perspectives of pre- and postnatal provision. This approach made it easier to put the women at ease as it is potentially a very emotional subject at a difficult time in their lives. It is important that the women were asked open ended questions so that assumptions were not made by imposing fixed response questions about what is important and salient to them.

Initially, interviews were conducted with women face-to-face. Five women took part in face-to-face interviews. However, the Covid-19 restrictions changed during the research, which meant that researchers were no longer allowed to enter the prison. Therefore, two interviews were conducted over the phone. This may have restricted their opportunity to speak freely and confidentially about their views and experiences of perinatal care in HMP Peterborough.

Contextual interviews with staff, review of policies and pathway documentation, and site visits in HMP Peterborough: Staff involved in the perinatal pathway in HMP Peterborough were engaged with to identify issues affecting the perinatal pathway and discuss relevant internal documentation. In total, seven internal and external professionals took part in an interview.

Analysis

The analysis of interview data involved coding the data to seek out the emergent themes using grounded theory. Concurrent data collection/analysis allowed the researcher to become theoretically sensitive to the data. Two analysts were involved in the process, first by coding alone and then coming together to discuss and refine categories, ensuring reliability and that the analysis is as close to theoretical saturation as possible.



3. Findings

Each of the sections is organised into the three main areas of the Birth Charter that were the focus of the 2019 review, which are as follows:

- 3.1 Access to the same standard of ante natal care as women in the community
- 3.2 Encouragement and support in their chosen method of infant feeding
- 3.3 Access to counselling

Also discussed within this section are perspectives on women's wider experiences discussed in the 2019 report which were:

- Safety needs in relation to provision of healthcare and feelings of safety in the prison environment
- Physical needs, including food, clothing and other equipment
- Management of pain and discomfort
- Information needs
- Emotional support
- Dignity and Empowerment

However, unlike the 2019 report these subjects are weaved into the three main headings of this report. Within each section progress on the recommendations of the 2019 report are discussed.

3.1: Access to the same standard of antenatal care as women in the community

There is robust evidence that the quality of perinatal care for women in prison can improve outcomes for both babies and mothers. Price (2005) identified significant variance in the standards of care for women in prisons, which were largely determined by the establishment in which they were located. Moreover, noting the specific vulnerabilities, risks and extent of disenfranchisement of this population, Price (2005) argued there were significant challenges in the provision of equitable care that is both accessible and effective.

Edge *et al.* (2006) conducted a scoping review of policy and provision of perinatal healthcare in prisons and found that imprisoned women experience significant levels of emotional and psychological distress during their perinatal period, with two-thirds experiencing depression. Women's experiences of pregnancy, childbirth and early motherhood in prison were generally negative, where they reported feeling unsafe, uncared for, uncomfortable and hungry. Positively, however, pregnant women in prison responded to healthcare advice. For example, they were more likely than community controls to reduce smoking, alcohol use, and intake of illicit drugs. NICE (2010) identified the need for appropriate antenatal services for vulnerable



pregnant women with complex social factors, and that pregnant women with complex social factors may need additional support to use antenatal services.

In a systematic review of perinatal health care services for imprisoned women and associated outcomes, which included 18 studies, 2 of which were conducted in the UK, Bard *et al.* (2016) found there was some evidence that women in prisons receiving enhanced prison care (i.e. some specific effort had been made to improve conditions or care for pregnant women) were less likely to have inadequate prenatal care (15.4% vs 30.7%, $p < 0.001$), preterm delivery (6.4% vs 19.0%, $p = 0.001$) or caesarean delivery (12.9% vs 26.5%, $p = 0.005$) compared to women in prisons receiving usual care. Women participating in two prisons, which included not only enhanced care in prisons but also coordination of community care on release, demonstrated reductions in long-term recidivism rates (OR 0.37, 95% CI 0.19–0.70) compared to pregnant women in the same prisons who did not participate in the intervention. Bard *et al.* (2016) concluded that:

“Enhanced perinatal care can improve both short and long-term outcomes but there is a lack of data. Properly designed programmes with rigorous evaluation are needed to address the needs of this vulnerable population. The cost to mothers, children and to society of failing to address these important public health issues are likely to be substantial.”

Abbott (2016) conducted a study involving semi-structured interviews with 28 pregnant women in prison found that women were unable to access basic comforts, acceptable nutrition and fresh air. They found the prison environment to be threatening and were frightened about the possible threats to their unborn. Also, women feared being separated from their baby which impacted their mental wellbeing. Indeed, being disconnected from supportive networks created a high risk of developing or exacerbating mental ill health. According to Nuffield Trust’s recent report by Davies *et al.* (2020), 1 in 10 pregnant women in prison in the year 2017/2018, gave birth before they reached hospital, for example in their cells or en route.

A series of recommendations are made in the Birth Charter (Kennedy *et al.*, 2016) in relation to pregnant women having access to the same standard of antenatal care as women in the community. It is noted that whilst some of these recommendations relate directly to the health care of women and the notion of equivalence of care in the community, others relate to prison processes and, as such, have security implications that are needed to be considered. The following recommendations are made:

- Regular antenatal clinics should be provided in prisons and run by a specialist team of midwives;
- All pregnant women should, where possible, have access to a scan at a regular clinic inside the prison. The scan should be undertaken by an ultrasonographer, obstetrician or trained midwife or GP;



- Where scans or other appointments need to happen in hospital, officers should observe prison guidance which specifies that they should not be present during medical consultations;
- Women should be provided with photos from scans as women in prison are not able to purchase these. They should also be able to apply for permission for a partner or family member to be present at the scan;
- A pregnant woman in prison should be able to speak to a midwife 24 hours a day about any concerns she may have (e.g. if she has a severe headache, is bleeding or feels her baby is not moving). The midwife can then make an assessment and provide the appropriate care and support;
- If it is not possible to see a midwife in person, then a woman should have phone access to a midwife 24 hours a day; and
- At night, there should be a timely response to pregnant women's buzzers. Once a woman has been assessed by a midwife, prison staff should facilitate timely access to hospital when advised to do so.

HMPPS Guidance on Working with Women in Custody and the Community (HMPPS, 2018) highlights that staff need to be aware of the issues that affect women during pregnancy, birth and early motherhood so that they can provide appropriate care and support and states:

"It is essential that all appropriate steps are taken to care for and support women in prison throughout their pregnancy, birth and early motherhood...To this end, prisons should have a perinatal pathway in place, detailing how they manage and care for pregnant women in their custody, which may include protocols such as: an initial multi-disciplinary meeting to discuss the woman's care and support; weekly review meetings; identifying a key coordinator to ensure consistency of care; development of a separation support plan for women who don't move to an MBU."

In 2019, Birth Companions published a Birth Charter Toolkit, which acknowledges the 'promising developments' in policy relating to the care of pregnant women, new mother and babies in custody. However, it highlights that the prison environment creates significant barriers to the safety and wellbeing of women and their children and therefore the toolkit aims to bridge the gaps between what is set in policy and what is actually provided in practice. It aims to be a guide to help stakeholders 'address the gaps and implement the Birth Charter's recommendations.

In September 2019, A woman gave birth in her cell in HMP Bronzefield, and tragically the baby was either stillborn or died after birth. The baby was referred to as Baby A and the mother as Ms A. Following the case of Baby A at Bronzefield, the Royal College of Midwives' position statement on 'Perinatal women in the Criminal Justice System' (RCM, 2019), that included a number of recommendations and argued that if women do not receive equivalent maternity care in prison compared to in the community, and if they have any delays or reduced access to treatment because of it, this is 'a gross violation of women's rights'. In June 2020 there was another tragic incident where a woman who did not know she was pregnant gave birth to a



stillborn baby in the toilets at HMP Styal. The baby was referred to as Baby B and the mother as Ms B.

Between July 2019 and June 2021 the Ministry of Justice conducted a review of operational policy on pregnancy, Mother and Baby Units and maternal separation, which was published in July 2020. Following this review HMPPS released a policy paper 'Pregnancy, Mother and Baby Units (MBUs), and Maternal Separation from Children up to the Age of Two in Women's Prisons' (2021). HMPPS' policy (2021) sets out the Ministry of Justice's requirements for prisons caring for women who are pregnant or have experienced pregnancy within 12 months of entering the prison, women on mother and baby units and their babies, and women who have been separated from children up to the age of two years in the 12 months before entering prison, as a result of prison, or after time on an MBU with the child(ren).

In September 2021 the Prison Ombudsman (PPO, 2021a) published an independent investigation into the death of the baby and the care and management of the mother referred to as (Baby A and Ms A) at Bronzefield. Ms A was described as 'vulnerable' and 'fearful of engaging with maternity care' and engaged 'minimally or not at all' with the midwife team. There was a lack of clarity about Ms A's delivery date. The report concluded that overall the healthcare offered to Ms was not equivalent to that she could have expected in the community. Inadequacy of information sharing within and between the prison and health agencies; no one responsible for her care had a full history of her pregnancy; her care by the midwife was described as 'inflexible, unimaginative and insufficiently trauma informed'; prison healthcare staff were not sufficiently involved in maternity care in general and Ms A's specifically were some of the failings described. Sue McAllister concluded that the "*midwife-centric model of maternity care in the community is not appropriate to a custodial setting*" and that "*all pregnancies in prison should be treated as high risk by virtue of the fact that the woman is locked behind a door for a significant amount of time. In addition, there is likely to be a higher percentage of 'avoidant' mothers who have experienced trauma and who are fearful of engaging with maternity care.*"

In January 2021 the Prison Ombudsman published an independent investigation into the circumstances the stillborn baby at Styal. The Ombudsman was satisfied that prison staff did not miss any obvious signs that Ms B was pregnant but that there were missed opportunities to identify that Ms B needed urgent clinical attention in the hours before she gave birth. Key recommendations from the investigation related to the importance of doing all that is possible to identify pregnant women who for a variety of reasons might not know they are pregnant or might deny pregnancy and that trauma informed care should be at the heart of the prisons approach. It is stated that more could be done to make pregnancy tests available and explain the risks of not having one. In addition, women should also be offered pregnancy tests at their secondary health assessments, which should also include provision for a detailed reproductive health and obstetric history to be taken and for a discussion about sexual health, menstrual history and contraceptive history. The report further recommends that nurses in women's prisons should have training in recognising early labour, and that all staff in women's prisons need to know what to do in the event of an unexpected birth.



The policy papers and the investigation into the circumstances of Baby A highlight the issue of correctly identifying women who are pregnant and how many weeks gestation they are as some women will not want to engage with services or seek antenatal care or may be unable to (HMPPS, 2021b), this is particularly likely if she has a history of trauma (Law *et al.*, 2021). If a woman is not engaging with the services to let them know she is pregnant or to estimate by how many weeks, HMPPS (2021a) instruct a Care and Management Plan must be drawn up by prisons to safeguard the woman and baby, these plans must detail the non-engagement and the reasons why. Pregnancies presented late to antenatal services (after 24 weeks gestation) must be more closely monitored and are at greater risk than women who have received antenatal care earlier on in their pregnancy (HMPPS, 2021b). HMPPS (2021a:19) also state that additional welfare checks should be carried out:

“Prisons must give consideration to additional welfare checks for pregnant women, including those who have a high-risk pregnancy and/or are not engaging with support, to safeguard women and babies where evidence suggests this is necessary...Staff undertaking checks must be appropriately briefed, including actions to take if any concerns are identified. All decisions and reasons for them, including decisions not to perform welfare checks must be recorded, dated, and signed by the relevant Senior Managers in the prison and in healthcare. These decisions must be communicated in a trauma-informed way to the woman in question.”

Overall, women who are pregnant in prison are more likely to have much higher and challenging needs comparative to the community, which signals the need for an enhanced package of coordinated, multidisciplinary care to mitigate the effects of incarceration. There is much evidence to show that the pregnant women in prison receiving an enhanced package of care were more likely to have better outcomes compared to usual practice, though disparities are suggested between establishments. The Birth Charter identifies a series of recommendations that will be reflected upon vis-à-vis evidence from the fieldwork of this evaluation.



Antenatal Clinics and the Midwife

2019 Report: Antenatal clinics and access to the midwife

In the 2019 evaluation, it was reported that there appeared to be a good regular antenatal clinic run by a specialist midwife that the women were confident in. Due to women often having more complex needs than are seen in the community, the midwife saw women as regularly as they needed and potentially more than they would be seen in the community.

However, it was concluded that women do not have equivalent care in terms of their access to the midwife as their access was inhibited because of their environment with barriers including limited credit on their phone or internal medical staff making decisions about when they are able to see her when they have concerns or symptoms. In the community, women have the autonomy to seek the specialist advice of the midwife when they need to whereas women in prison do not. This was raised as a concern.

Relevant aspects of the Birth Charter:	2019	2021
Regular antenatal clinics should be provided in prisons and run by a specialist team of midwives.	⁴	The midwife runs a weekly antenatal clinic and women shared positive feedback about the service.
A pregnant woman in prison should be able to speak to a midwife 24-hours a day about any concerns she may have (e.g., if she has a severe headache, is bleeding or feels her baby is not moving). The midwife can then make an assessment and provide the appropriate care and support. If it is not possible to see a midwife in person, then a woman should have phone access to a midwife 24-hours a day.		The Maternity Helpline is available 24/7 for pregnant women and for 28 days post labour.

Recommendations from the 2019 review	2021
Ensure that expedient two-way communication between the women and the midwife is facilitated.	Women have 24 access to the midwife or the maternity helpline. They have the numbers on their pin and they are freephone

⁴ **Red** - Not met / not happening

Amber - Partially met / inconsistency of delivery or compliance

Light Green - Adequately met, minor room for improvement

Green - Fully met



At the time of the 2019 review, the midwife was running clinics twice a week but at the time of this report the midwife was running clinics weekly on a Thursday. However, there was general agreement amongst professionals and women interviewed that she was seeing women frequently enough and was easily accessible.

“It used to be more frequent than that but there’s some pressures in the community that she’s having to support with. But she’s always available via telephone and email etc.” (Professional)

“Yes, I’m being told basically she’s fulfilling the statutory requirement at the moment. She was previously on call for women very generously but now she’s been cross-deployed further away so it means that she’s not able to do that. And so when we went from (the midwife) being available on the phone regularly or coming in on an ad hoc basis, I think it’s just set timings, I can’t remember what they are, but it meets the framework because I checked.” (Professional)

As in the 2019 review, feedback generally was positive about the midwife, with women feeling that she is accessible, helpful and supportive. One of the professionals commented:

“Everyone loves the midwife. Every woman on every feedback I do say that they feel supported by [her]. Some of them say they want more sessions or they want longer with her but [she] is amazing.” (Professional)

Women commented:

“[The midwife] she was lovely, really good and really helpful. Midwife access is better here than on the out – outside you don’t always see the same midwife, but here it’s consistent so you can build a relationship. Sometimes [health visitor] stands in, but it’s mostly [the same midwife].” (Resident)

“Appointments were weekly with the midwife to start with. I was told once a month, but actually it was a lot more, definitely weekly, so that was really good. I don’t have any problems getting to see her.” (Resident)

“[The midwife] was literally my rock. She comes to the MBU and talks to all of us, she asks questions, we ask questions, she gives us information, and support.” (Resident)

However, there was one woman that felt that she had received mixed messages from the midwife regarding support for detoxing off drugs during her pregnancy. In the 2019 review, some of the women reported a delay in meeting the midwife after entering the prison. For instance, one reported that she only saw the midwife after having been in prison for 5 weeks, the reason for this is unclear. However, this did not appear to be the case in relation to the women spoken to in 2021/22. Women tended to see the midwife in the clinic in the week that they arrived. Professionals were also confident that the midwife is flexible enough to come in ad hoc if needed:



“They’re booked appointments but I do know that the midwife will go and see people ad hoc as well. There was somebody last week that I know personally I saw her over in MBU, she went to see her. So, she doesn’t restrict herself to seeing people in what we’d call clinics, she will go to see people if needed.” (Professional)

However, one woman interviewed that was in HMP Peterborough for about 6 weeks during her pregnancy said that she had not seen the midwife.

Overall, women appeared to have good access to the midwife and the maternity helpline for when the midwife is not available.

“We give residents that are pregnant a card and the card contains a list of all the free numbers that you have access to. So, included within that is the midwife’s mobile number and also the local labour ward, maternity unit, that they can phone directly as well and that’s free of charge.” (Professional)

Women also corroborated that they had good access to the midwife and the maternity helpline, and some had used the helpline for advice.

Healthcare Needs and Emergency Response

2019 Report Summary: Response within the prison to health needs

There was some concern among some of the women about the response to the emergency buzzer. Women raised concerns about how their symptoms had been responded to especially in relation to the potential impact on their baby. In some instances, they had suffered extreme pain or discomfort for prolonged periods of time with little or no information as to when they would be seen. Some question whether there were the resources in place to cope with demand and whether those responsible for their care in the first instance, had the necessary expertise.

Relevant aspects of the Birth Charter:	2019	2021
At night, there should be a timely response to pregnant women’s buzzers. Once a woman has been assessed by a midwife, prison staff should facilitate timely access to hospital when advised to do so.		Mixed reports of timely responses to buzzers, including immediate responses or waiting up to an hour.



Recommendations from the 2019 review	2021
Ensure that prison staff can access the health-related expertise they need to manage care of women at the prison.	Prison staff <u>can</u> access the expertise needed, but feedback from both staff and women suggest that further training could improve <u>how and when</u> prison staff escalate issues to professional health services.
Induction and ongoing provision of training should be reviewed, and bespoke packages developed to improve staff awareness and practices of staff in the care of with women on the perinatal pathway.	A bespoke perinatal training package has been designed and is being delivered to new staff. It will be rolled out to existing staff soon.
Assess the quality and content within pregnancy packs to ensure women's nutritional needs are met.	Complaints about the quality of food provided to pregnant women and breastfeeding women were made.

As mentioned in the section above, women appeared to have access to the midwife or the 24-hour maternity helpline if they needed it. However, when women had concerning symptoms, they commented that they did not necessarily get a swift, or what they felt was an appropriate, response from within the prison.

It was also mentioned that women who are pregnant are asked irrelevant questions by healthcare or prison staff that suggests a lack of knowledge. For example, one resident commented:

"You call Healthcare or you can't get an appointment and when they come to you they ask you stupid questions like, 'Are you dilated?' when you are 20 weeks pregnant. And you are like, 'Why are you asking me that? I wouldn't even know if I was dilated'."
(Resident)

A few staff members suggested that more training was needed for prison staff to prepare them for interacting with pregnant women in the main population, and for those that work on the MBU:

"More training and being open in terms of health because they don't really have any idea in terms of health and breast feeding. So definitely more information of what it might look like, maybe in the early hours and things like that because they are in their cell and there are accidents and there are leakages." (Professional)

"So one of the big things that women say to me is that Healthcare staff need to be trained more, especially as they are first response for women in labour or any kind of urgent need during the pregnancy."

One woman also talked about concern over the postnatal care she had received in relation to her six-week check-up:



“For my six-week health check, after having a baby, used the kiosk to put in that I needed an appointment, I arrived and the doctor shouted out to the nurses ‘I don’t know what to do, what’s a six-week health check?’ And some of the nurses shouted back to ‘check for bleeding’. And that’s all he did. It was really bad. No physical examination, no mood processes, checking bonding with the baby etc. In the community I know these are 45-minute appointments, and they check everything, but I didn’t get any of that.” (Resident)

The Birth Charter recommends that there should be a timely response to pregnant women’s buzzers. Once a woman has been assessed by a midwife, prison staff should facilitate timely access to hospital when advised to do so.

There is training rolling out for staff related to perinatal care for women in their third trimester. This includes ‘what to do in case of’ type information, related to emergencies, so that officers know the signs and symptoms to look out for and the importance of escalating any issues. The training includes a competency-based questionnaire that requires 100% compliance with it. The training has already begun with new staff, as part of the Initial Training Course (ITC).

“Feedback from the new officers on the training programme - I found it really interesting actually...So I think the general consensus I get is it’s quite informative. And actually, because there’s so much interest in it I think they see it as a real help to understand what they need to do as an officer in this eventuality.” (Professional)

The Director has also published a local operating procedure that includes what to do in an emergency. Cordless phones have been implemented on residential areas and the MBU so in the event that staff do need to contact 999 they can get immediate advice on the cordless phones.

It is also important to note that women in their third trimester are checked every hour, which was verified by both women and the professionals interviewed. One professional spoke of the regular checks at night being an excellent development but felt that it would be beneficial to explain the reason for them to women and also to mindful that the women are trying to sleep.

“The regular checks at night are amazing and are safeguarding women. The only thing to say on that is quite a few women haven’t understood what they are doing it for. Imagine you are trying to get to sleep and you are pregnant and you are in prison and you are constantly getting someone either opening your door or shining a torch in your face, without an explanation... So (1) the importance of explaining that. And (2), officers don’t need to unlock the doors, I don’t know why they are doing that. That then wakes up the woman. They should only be doing a visual check, which is inconsistent.” (Professional)

One woman commented about the bed watches being a positive thing but felt further support is needed after the baby is born.



“Bed watches happen when you’re pregnant, hourly checks and it’s good. But then you give birth and it just stops. But you’ve just had a baby and got here and it’s a whole different ballgame, it shouldn’t just stop completely.” (Resident)

There appear to be issues related to the capacity of the healthcare workers, who are not always available when women want to, or able to, see them.

“Because appointments are only planned a week in advance it makes it very difficult in terms of capacity. And I don’t think they are going to prioritise [health visitor appointment] on a Wednesday over going home and spending some time with their family.” (Professional)

There are differing views on whether specific training related to perinatal care is required for officers working in the MBU:

“There’s a sense of pride over there (MBU) but there’s no official training I don’t think. There may well have been little offshoots of training that they’ve all individually had and obviously you’ve got the Nursery Nurses over there as well”. (Professional)

“I think they [the women] get confused about what services are where. I don’t know if the officers are aware, the Nursery Nurses are but I think the communication on their end is not as good as it could be” (Professional)

Hospital Bags

Previously the staff would pack a ‘labour bag’ on behalf of the woman going into labour or going to hospital for a planned caesarean. This has been changed to involve the women and to help to reduce any related stress and anxiety:

“We do that with Mum prior to going to hospital and we’ve even changed the type of bag, just to make it as normal as possible. So, Mum has that input into what she wants in the bag, what she’s already got, can chose what items of clothing, for example, that she wants. And within that, that would include things like breast pads and other supportive bits, just to make that as stress free as possible, that you need to think about what you are taking.” (Professional)

Women’s Food and Nutrition

Food for women on the MBU was highlighted as an issue, impacting upon the health of women and the quality of breastmilk provided to the baby.

“The food is awful, quality is terrible. Takeaway style silver trays, often burnt food left in too long. One staff member sometimes takes them back for us and says they can’t eat



that. When you're breastfeeding there's not a lot of options to help you, and you want to be healthy." (Resident)

"Food provision could be better, I need fruit and veg, with pregnancy and breastfeeding you need fruit and veg to thrive. In the pregnancy packs you get milk, cheese, walnuts, seeds, raisins and bread. No one eats them. We want fresh food. We've asked time and time again and it doesn't come through, we don't get fresh fruit... There's no Vitamin D. They give you folic acid in a tablet, but you can't have Vitamin D because it's in a glass droplet bottle, so they got taken away from us." (Resident)

Hospital Appointments, Consultations and Scans

2019 Report Summary: Hospital appointments and scans and compliance to prison guidance in relation to attendance at medical consultations and scans

There was no scan available at the prison, women went out of the prison for scans to hospital. In terms of scan pictures women said that they received pictures. However, evidence from the women which was corroborated by professionals is that officers inconsistently observed prison guidance which specifies that they should not be present during medical consultations if the women do not wish them to be there.



Relevant aspects of the Birth Charter:	2019	2021
All pregnant women should, where possible, have access to a scan at a regular clinic inside the prison. The scan should be undertaken by an ultrasonographer, obstetrician or trained midwife or GP.		Scans are not available at a clinic inside the prison, but they are undertaken by an ultrasonographer, obstetrician or trained midwife or GP. Scans are conducted at the hospital which is just over a mile away from HMP Peterborough.
Women should be provided with photos from scans as women in prison are not able to purchase these.		Women are provided with photos from scans.
They should also be able to apply for permission for a partner or family member to be present at the scan.		There are inconsistencies in the policy and process for women applying for permission and what happens in practice. This may have been impacted by Covid-19.
Where scans or other appointments need to happen in hospital, officers should observe prison guidance which specifies that they should not be present during medical consultations.		There were inconsistent reports about officers remaining present during medical consultations.

Recommendations from the 2019 review	2021
Education of all parties concerning guidelines related to officer presence during medical consultations is imperative to achieving full compliance with the Birth Charter. Awareness raising and education needs to be continuous to ensure that it is fully embedded and caters for the turnover of staff. It is important to develop a culture in which maintaining the dignity and rights to privacy of perinatal women.	The new Perinatal Pathway is in place, and bespoke perinatal training is planned to be rolled out to all prison staff soon. This will include the guidance related to privacy and maintaining the dignity and rights of perinatal women.

As in 2019, there is no access to a scan inside the prison, rather women are taken to the hospital for scans, which is just over a mile from HMP Peterborough. All women said that they were provided with photos from scans, with positive feedback being given on this.

“They gave me pictures and also extra pictures to send to my partner.” (Resident)

However, there were some perceived issues relating to partners or family members being able to be present at scans. One woman commented that she had hoped that her partner was going to be allowed to attend but he wasn’t allowed, and she did not know why. She was told



that nobody's partners could attend at that time due to Covid-19, but she knew of other people that had partners or family members present. She felt that she was not being told the truth.

Another woman said that she had not had a partner or family member present and was not aware that she could have requested this.

One woman also raised an issue about her chosen birth partner. She had chosen a family member, however there was a risk that she might not be able to make it due to childcare issues and distance. Therefore, the woman wanted to be able to add a second family member as a back-up option but was not able to and did not understand why she could not do this.

Also, a professional commented on the challenges of risk assessing birth partners, commenting:

"It's something I've raised for policy actually quite recently. The new policy says about risk assessing, birth supporters etc but doesn't say how you risk assess. We can risk assess residents, that's our business, that's our bread and butter, but somebody out in the community, we don't have access to that information." (Professional)

Staff suggested that cuffing and escorting protocols comply with national policy and that additional improvements had been made in this area:

"An improvement we've made this year is that most of the escorting is done by MBU staff [Mother and Baby Unit staff] that have got that added layer of experience and knowledge and relationship with the women, they go out with residents. Just one today has gone out for a scan and our MBU staff have gone out with them." (Professional)

Women commented about the escorts to hospital appointments:

"The ladies are lovely that go with you." (Resident)

"Escorts are alright. Once they kept the cuffs on when they weren't supposed to." (Resident)

However, there were still examples given of where escorts had not followed policy. Women described their experiences of having officers present during hospital visits as 'awkward', 'uncomfortable' and 'embarrassing'. Some felt that their presence made hospital staff treat them differently and felt other patients 'looking at them'. They found this caused anxiety and stress.

"No, there were no confidential conversations with medical staff during my time in the hospital to give birth or afterwards" (Resident)



These experiences contrast to policy that states: 'they will be escorted to the appointment. The room will be searched and the exits secured. The woman will then attend the appointment unaccompanied unless she requests an officer in the room as support'.

A professional also spoke of instances that she been told about where policy had not been followed:

"Yes, unfortunately I've been told of, I think, two women that haven't been cuffed but have had officers that have insisted being in the room during examinations, which shouldn't be happening...Apparently the male officer stood outside but the female officer said, 'I have to be here and I'm not leaving', which shouldn't be happening."
(Professional)

A lack of sensitivity by healthcare staff at the hospital on external visits to appointments was also raised as impactful on feelings of dignity and respect:

"Went out for baby vaccine appointment, got SPL so no officers needed. And the nurse says loudly in the waiting room 'where are your officers? I've got two students with me today and I told them they'd see officers'. They don't need to know why I haven't got officers, or where I am from, it's healthcare. And it's embarrassing, the other people in the waiting room looking at me. And people in healthcare ask you what you're in for, or they ask the prison staff behind your back. It's not right, it's noseay and it's wrong. I'm a human being, and I'm here for a health check, or to be looked after. I'm still human." (Resident)



Capacity impact for healthcare appointments

An issue was raised by one staff member about the challenges of prison staff capacity where there are healthcare needs for the baby. It was unclear how prevalent this issue has been, or if it remains an issue, or if the risk has been identified.

“Everything is complex, so I’ve previously, numerous times, had to say, ‘This baby needs to go into hospital to be reviewed by a paediatrician’. And they’ve said, ‘We don’t have the staffing capacity’. And I’ve had to be, ‘That’s not really my concern; my concern is the baby, you need to find the staff’. And then they are like, ‘We can’t go until tomorrow’.” (Professional)



Perinatal Pathway

2019 Report Summary: Perinatal Pathway and Multi-agency working

Antenatal care is improved through multi-agency working and the coordination of care across the professionals involved. It was clear in the 2019 review that there were committed individuals within and outside the prison trying to work for the best interests of perinatal women. However, they were doing so without the guidance of a perinatal pathway document.

Recommendations from the 2019 review	2021
Develop a multiagency perinatal pathway from entry to departure (inc. resettlement responsibilities and handovers to community teams) of the establishment.	The new perinatal pathway was developed and is in place.
This should be co-produced with all partners and supported by policies and guidelines to define responses to and processes for different situations.	The pathway was co-produced across partners is supported by policies and guidelines.
The document should also be regularly reviewed and updated by the partnership when facing new situations or issues in practice.	The pathway is in its second iteration and is reviewed annually.
Establish weekly perinatal meetings, with mandatory representation of different departments and partners to monitor and delivery holistic care; Non-attendance or engagement should be communicated to senior management in the establishment and addressed.	Perinatal meetings are happening weekly. Sometimes attendance is not fully representative.
Each case should be reviewed on an individual basis and interactions/decisions communicated and documented.	Staff consistently stated that each case is reviewed individually.



Development of a Perinatal Pathway

At the time of the 2019 report, a perinatal pathway document was being developed. Since the report there have now been two iterations of the perinatal document. The most recent having been in operation since October 2021. The second iteration provides clarity in terms of what is available to women dependent on their pathway, and an enhanced questionnaire:

- Pathway 1 – Pregnant on arrival
- Pathway 2 – Pregnant on arrival with substance misuse
- Pathway 3 – Child in the community < 18 months
- Pathway 4 – Pregnant in the last 12 months
- Pathway 5 – Pregnancy lost while in custody
- Pathway 6 – Abortion whilst in Custody

Professionals commented:

“I think it’s easy to read compared to the previous one. And I suppose the key bit for me is we’ve ensured that there are pathways to it, which sounds a bit ridiculous saying that a Pathway document refers to pathways but I don’t think it did before. So, the pathway in is if you are pregnant in custody or if you’ve got a young child in the community, it’s really clearly defined what help we can provide in relation to that.”
(Professional)

“There is now a documented pathway and it’s in its second iteration, which is what would happen in community, that there would be a documented pathway... We felt that after a year it was appropriate to review it, which they did and they have now made it quite a lot simpler and clearer in terms of the way it’s presented.”
(Professional)

“Staff refer to it quite a lot now, which is good. I’d be confident enough to say it’s embedded... Yes, it’s just about assurance checks... I have a checklist now for every female that comes through” (Professional)

The pathway was produced by Sodexo staff in collaboration with NHS England, Cambridgeshire & Peterborough Foundation Trust (who commission health visitor provision), Cambridgeshire & Peterborough Clinical Commissioning Group, Northamptonshire Healthcare Foundation Trust and North West Anglia Foundation Trust. One professional commented:

“One of the things you recommended was about a Pathway document, which we’ve done. It was good collaborative working actually and people contributed to it and fed back on it, so that was great. It wasn’t a prison policy, it’s a multi-disciplinary policy.”
(Professional)



“Developing the pathway so everyone’s got something to follow, it has got the services in there that generally just some people don’t know about...it’s a formatted process isn’t it of everyone linking together and the multi-disciplinary working, I think is 100% better.” (Professional)

Since the perinatal framework has been put in place, some professionals said that healthcare had started doing more in-depth checks with women, which means that more women are getting identified during the perinatal period:

“So, since that’s been going on, I’ve been told of a woman that’s recently had a stillborn, one woman that’s been separated, so that’s working really well. What happened is the Lead Clinical Nurse forwards it on to all the stakeholders, which means that more women are able to get supported other than just the pregnant women.” (Professional)

This suggests an improvement in identifying women that are pregnant or have been pregnant in the last 12 months. However, there was some evidence that this did not always occur - one woman who had a baby in the community under 1 year old, said that she had not been asked on reception whether she had been pregnant in the last 12 months or at any time since. She also said that she had not offered this information as she did not know that there might be support available to her if she had. A professional also commented that she was aware of a woman that had given birth in the last few months, who was previously in Peterborough and identified as postnatal but had not been picked up on her return. It is important that women are encouraged to disclose that they are or have been pregnant in the last 12 months, not only on arrival in reception, but in the weeks and months following, to ensure that the correct care and support can be given.

Perinatal Meetings

Since the 2019 report perinatal meetings have been running for approximately 2 years but are conducted fortnightly. There was positivity about the increased collaborative working:

“I think the strengths are the collaborative approach, everyone working together. Years ago, in my old days, it was MBU staff that looked after these people but it feels really collaborative now from a health, physical and emotional element. So that’s fundamentally important and a strength I think.” (Professional)

When asked about attendance, comments included:

“Good - certainly improved more recently... Yes. There was a period of time where attendance wasn’t as good as it could be, but I really feel now we’ve got a consistent and ongoing commitment to that, which is good. You can see the benefits of that.” (Professional)



“There has been (good attendance) in the last few weeks. Yes, I think it was maybe under-represented but that was picked up on. There are particular stakeholders who are more invested than others.” (Professional)

As per the recommendation in the 2019 report, each woman is reviewed on an individual basis during the meeting. Based on some of the discussions about the perinatal meetings, suggestions included:

1. Consideration is given to the pace of the meeting and ensuring that space is given for each stakeholder to comment or make an input on each woman as needed.
2. Consideration is given to maintaining consistent representation of all parties. As well as regularly reviewing the attendee list to ensure all relevant partners are invited and there is a clear rationale for those that are not attendees.
3. If partners are not attendees, ensuring that if they are permitted to have access to the minutes that they receive these in a timely manner to allow them to be aware of developments relating to each woman that they may need to take action on.

Pregnant Women’s Substance Misuse

2019 Report Summary: The management of pregnant women’s substance misuse

In 2019 there were conflicting approaches between disciplines about addressing substance misuse. Mothers themselves were also described as being keen to detox as they may fear not doing so could be viewed negatively by social services and/or they did not want to watch their baby withdrawing from methadone. However, concern was raised that if detox is not done at the appropriate time within the pregnancy and at the right pace, it could have significant implications for the unborn baby. Therefore, it was recommended that the policy needs to be reviewed and agreed on by all professionals, to establish the most appropriate policy so that the baby is not put at risk and that the mother does not receive conflicting advice.

There was still evidence that there may be conflicting approaches over detox from substances that needs to be addressed in this review. One professional said that although it is included as a pathway, she would like to see further enhancement of the perinatal pathway in relation to managing substance misuse in pregnant women.

“I think I would have liked to have received more around the [substance misuse] recovery side of things to include... It might just feel pertinent at the minute but we’ve got so many women that are taking methadone etc currently whilst pregnant and I think I would like to see that more enhanced next time.” (Professional)



Information Needs

2019 report summary: Information needs

Women's perception of the provision of information was a common theme across interviews, which was encapsulated in phrases such as *"Nobody tells you anything around here"*. A key recommendation was:

- Provisions of information for women should be reviewed, with bespoke information packs developed and issued to women upon entry into the establishment

Most women did not feel that they had received much information on entry relating to being pregnant, although there were some positive comments. However, one woman commented that when she arrived somebody came and discussed Birth Companions, the pregnancy packs, the extra mattress and pillow and how to apply for the MBU.

"When I first got here, I should have been given information about the MBU, it would have reassured me a lot, because I didn't know what would happen. I didn't know if I could keep my baby, and that was hard...it was scary thinking about giving [baby] away." (Resident)

In 2019 the accounts of the women suggested a key strength of the provision was the antenatal classes. Those who had attended the classes were generally very positive about them, finding the classes extremely useful and informative. A couple of women also mentioned, unprompted, that if there was a question the class coordinators would always follow up with the information the next week. The loss of these groups is notable in both women being able to access current information, discuss it with others and ask questions. A professional commented:

"So, a peer support worker can provide pastoral stuff and specific information she might have access to, but we're talking about the specialist side of things like talking through birthing choices, talking through information giving like whether to get the Vitamin K injection. All that really specific stuff that is empowering women to make choices and to have autonomy over their choices is missing at the moment." (Professional)

One of the women commented:

"Antenatal support compared to the community is poor. Mums in here are not taught about breathing techniques, to help with contractions, or anything. The only support in here is the other girls. We support each other and we tell each other what we know, like [we] helped [another woman] with her breathing for early labour, and with the baby blues. Telling her it's normal and it's hard being a new Mum." (Resident)



Although, the midwife provides information and support around the issues above it was clear from the last report that women really benefitted from the antenatal classes provided. Within the perinatal pathway it states that 'The midwife will provide antenatal education and parenting classes, which will include discussions around infant feeding, labour, pain relief and the immediate postnatal period. This advice can be tailored to individual needs' (p. 24). It is not clear why antenatal classes are currently not taking place, and may be as a result of Covid-19. However, it is important to note that the Birth Charter states that 'All pregnant women in prison should be able to attend antenatal classes and prepare for their baby's birth' and that 'Antenatal classes should be delivered by trained, independent childbirth educators and should be comparable to those found in the community. They should meet NICE standards on antenatal services for vulnerable women' (p. 5).

Concern was raised that the creation of the birth plan was not really a facilitated discussion but that the midwife "just types up what she thinks the woman wants, like no painkillers etc". However, it was important that there was more discussion around what to expect and different choices.

"It's time to talk for women through what to expect, what choices and the more detailed choices, like the choices around the placenta, issues around consent, all the more detailed stuff." (Professional)

The issue was raised of women not been given a hard copy of their birth plan, which is completed by the midwife electronically at 36 weeks.

"We've had, I think, three or four women go into labour without them written down, without a hard copy of the birth plan, which can leave them quite vulnerable to then have to make last minute decisions during birth, which is obviously something we want to avoid as birth is challenging, not only for every woman but especially for those that have experienced complex trauma, it can be very triggering." (Professional)

Groups to receive information were also talked about in terms of receiving information about issues women experience after birth and child development.

"They really wanted a group on MBU to discuss issues around child development, motherhood, how to support mother's wellbeing, maybe they could do activities like postnatal yoga, things like that. Because they are saying, 'We don't get information so we could have a group that gives us information on really helpful things like how our body's changing or is this normal?'" (Professional)

"And they said they wanted to understand basic child development and have a time to socialise just for them as new mothers. Which I think is such a nice idea and I think would be so beneficial for them." (Professional)



Understanding their rights and where they can get help

One issue was raised by a staff member related to ensuring that women understand their rights, understand the information that they are being provided and where they can get help if needed.

“We had one woman who got told that her MBU place was unlikely, and she got asked to sign a Section 20. She told me she didn’t understand what it was and that she just signed it because an officer told her to... It’s about making sure that women understand what they are signing and I think from the conversation I’ve had with her, if she understood that was taking away her MBU application she wouldn’t have done that”. (Professional)

One of the women commented that ‘you have to be persistent and I will go down different avenues to get what I need however there are other girls that are timid and won’t do that’. She felt that they might not ask questions or get the information or help they need or fully understand their rights.

Whilst women understanding their rights and where they can get help is not a clinical service for service users, it is important in ensuring women are proactive in accessing care, understand what is available to them and what their rights are. A crucial difference between antenatal care in the community and in prison is that in the community a woman’s family member or partner may sometimes act as her advocate or champion, and this support should be replicated within prison.

3.2: Encouragement and support in their chosen method of infant feeding

The approach to infant feeding is a highly politicised issue and improving rates of breastfeeding is a public health priority. Levels of breastfeeding remain low compared to other countries and creating a supportive environment for women, regardless of feeding preferences, providing evidence-based advice and care are at the heart of the approach to public health strategies (Public Health England, 2015). There is significant evidence that breastfeeding improves the short and long-term health and wellbeing outcomes for both the baby and the mother. Breastfeeding is also associated with protecting children from illnesses and mothers from breast and ovarian cancers and heart disease, as well as supporting the mother-baby relationship and the mental health of both baby and mother (UNICEF, 2012). Rollins *et al.* (2016:491), in the Lancet, argue: “Breastfeeding provides short-term and long-term health and economic and environmental advantages to children, women, and society.” Paynter *et al.* (2019) highlighted how breastfeeding their babies may be particularly beneficial to mothers in prison as many of them have complex mental health histories, or are at greater risk of developing poor postnatal mental health, and it has been found to improve maternal mental health and may even act as a protective factor against postnatal depression.



Birth Companions' Birth Charter Toolkit (2019) set out practical ways of implementing the Birth Charter's (2016) recommendations. One suggestion from the Toolkit which coincides with the argument that breastfeeding is positive for maternal mental health (Paynter et al., 2019) is that once breastfeeding mothers have been identified on their first day in prison they are 'given access to breast pumps, breastmilk storage facilities and breast pads, and expert support to use them' and that 'arrangements are made to hand milk out to baby in the community if possible' (Birth Companions, 2019: 14). Considering that there are a very small number of births at prison and therefore a small number of women to support with their infant feeding choices, this may present a challenge to operationalise procedures, however, the evidence presented later in this section demonstrates good awareness of these recommendations if/when required.

The Birth Charter Toolkit (2019: 21) also made the following recommendations regarding infant feeding in a custodial setting:

- Women are encouraged and supported in their chosen method of infant feeding. Birth Charter section 10, page 13.
- Practical items for breast feeding are provided for mother and baby, including breast pads, bras, breast pumps, storage bags, dedicated breastmilk fridge and feeding bottles.
- Practical items for bottle feeding are provided including steriliser and feeding bottles.
- Specialist advice and support is provided to women on breastfeeding if required.
- Specialist advice and support is provided to women on infant feeding. (Birth Companions, 2019: 21).

Evidence suggests that breastfeeding education is effective at increasing both the rate of breastfeeding initiation and breastfeeding duration (Dyson *et al.*, 2005, Lumbiganon *et al.*, 2012). Indeed, education and support for women alongside training to staff is a key to improving breastfeeding prevalence (UNICEF 2012; NICE; 2010). Although it is advised that women are encouraged to breastfeed their babies, as it has short and long terms benefits for both baby and mother, it is also accepted that women should be encouraged and supported in their chosen method of infant feeding. In 2014, The Royal College of Midwives stated:

"We recognise that some women cannot or do not wish to breastfeed and rely on formula milk. They must be given all the advice and support they need on safe preparation of bottles and responsive feeding to develop a close and loving bond with their baby. The RCM believes that women should be at the centre of their own care ... If, after being given appropriate information, advice and support on breastfeeding, a woman chooses not to do so, or to give formula as well as breastfeeding, her choice must be respected."

This change of position of the RCM was welcomed by the National Childbirth Trust (NCT) who have in the past raised concern that women can face judgment or feel guilty if they do not breastfeed.



In relation to guidance on the care and approach to women in prison, the World Health Organisation (2009) recognises the women's needs are often unmet in prison, with the need to provide appropriate food for mothers and babies, including milk, high protein products and fresh fruits and vegetables. Moreover, the importance of flexibility is stressed, with meals being provided regularly and flexibly to the mother's preferences, not being kept to a rigid timetable. The Bangkok Rules (UN, 2010) state that "Women prisoners shall not be discouraged from breastfeeding their children, unless there are specific health reasons to do so" and that they shall receive advice on their health and diet, adequate and timely food and a healthy environment.

There is some evidence to indicate the challenges of meeting these standards, as Bastick (2005) argues women in prison are often discouraged from breastfeeding, as it is perceived to interfere with prison routines. In their paper women's experiences of breastfeeding in prison, Abbott and Scott (2017:217) outline that:

"Women are free to decide whether or not to breastfeed; however, perinatal women in prison are less able to make this choice due to systems of power and control, enforced in the prison estate which too frequently render these new mothers powerless in the decision to breastfeed".

However, there is positive evidence to suggest that women prisoners who are supported in breastfeeding and are able to attend pregnancy groups in prison can lead to positive outcomes. For example, antenatal and early parenting classes run by Birth Companions at HMP Holloway included sessions with a trained breastfeeding supporter and one-to-one breast feeding support was given to new mothers. Statistics gathered by the organisation in the period 2011-13 suggested that breastfeeding initiation and duration rates were on average 20% higher than the national average. This suggests that achieving an enabling and supportive environment in prisons, creating the best conditions for preferred infant feeding choices is possible.

Overall, the literature identifies that the culture within prisons is core to achieving a high standard of care and delivering good support in relation to infant feeding in prison. Here, creating an enabling environment that has a flexible, supportive and compassionate approach is key to meeting the needs of women at realising their infant feeding preferences.

2019 report summary:

Overall, there were mixed reports of practices within the establishment from residents on their received encouragement and support in their chosen method of infant feeding. There were positive reports of support from the midwife and Birth Companions, though access to such support was identified as being inconsistent, which limited support to develop a close and loving relationship with their baby.

The previous review also highlighted issues related to breast pump access, related costs for women purchasing their own equipment, and a risk related to ensuring all women were given the opportunity to provide expressed breast milk (EBM) to infants outside of prison.



It was suggested that more could be implemented to support the bonds between women and their babies on the MBU, to improve the knowledge and awareness of breast feeding of staff on the MBU (nursery staff, rather than prison officers) and to improve the identification of women that may wish to provide expressed breast milk (EBM) and ensuring the necessary policies and processes are in place to facilitate EBM.

Relevant aspects of the Birth Charter:	2019	2021
All mothers, irrespective of how they choose to feed their baby, should be supported to build a close and loving relationship with their baby and be guided to learn how best to respond to their babies need for food, love and comfort.		The midwife was identified as the main source of support for this and received consistently positive feedback.
Mothers who are formula-feeding should have 24-hour access to appropriate equipment and facilities to make up bottles and sterilise equipment.		24/7 access to facilities is provided.
Mothers wishing to breastfeed should have access to appropriate clothing such as breastfeeding bras and equipment such as breast pumps.		Bras and breast pumps are provided, though there are limitations on bra sizes.
They should also have regular access to specialist breastfeeding information and support, as well as an environment in which breastfeeding is encouraged and nurtured.		Some specialist support is available through the Maternity Helpline in the first 28 days, and from the midwife and health visitors when available. Nursery nurses could provide further on-hand support.
Women wishing to breastfeed should be provided with the same support as available in the community to ensure those who experience difficulties get the support they need. This can be from specialist midwives, and breastfeeding supporters from organisations such as the Breastfeeding Network, Association of Breastfeeding Mothers and the National Childbirth Trust.		As above.
Prison staff on MBUs should receive training so that they can maintain a supportive environment for women who wish to breastfeed.		Perinatal training is due to be rolled out, but it was unclear if this includes training related to supportive breastfeeding environments.



Recommendations from the 2019 review	2021
Redefine the status of supportive perinatal activities (such as opportunities to speak with other mothers, pregnancy yoga or baby massage) as meaningful within the prison regime and not confined to a lunchtime activity.	Several groups and forums are now in place to facilitate supportive discussions and activities for perinatal. Antenatal activities have been delayed or inconsistent due to Covid-19.
Review support for women when experiencing difficulties with breastfeeding.	Some specialist support is available through the Maternity Helpline in the first 28 days, and from the midwife and health visitors when available. Nursery nurses could provide further on-hand support.
Consider the spaces in which breastfeeding occurs and allocate female staff where possible to reduce barriers to breastfeeding.	Breastfeeding can take place in the 'tv lounge' or in bedrooms for privacy, and officers are more aware of the need for privacy particularly when male officers are on duty. However male officers continue to work on the MBU and to provide escort.
Establish expressed breast milk (EBM) procedures and practices.	The EBM policy and procedure is in place.

Access to equipment, facilities and clothing

The prison also now complete 'birthing plans', which is a national requirement, it was commented on that this is not useful terminology as can be confused with 'birth plans' that are completed by the midwife. The birthing plan focuses on the operational requirements around a woman who is pregnant and within it the mother's choice around what they want to do regarding feeding, whether that be breastfeeding or bottle feeding, so that everybody that needs to be aware of it such as escorting staff and so on are.

Accounts suggest that the MBU is providing all the necessary equipment and facilities for formula-feeding, including sterilisation and making up bottles. In most cases, the prison does not provide formula, instead women order it, buy it during Release on Temporary Licence (ROTL) and bring it in, or partners or family members send it in. This process appears to be working.



“We enable Mums to order what they want for their children. They may have a preference to what formula they want if they are choosing to go down that route so we would absolutely accommodate that, that’s their choice of what they want to utilise.” (Professional)

In addition, in terms of breast feeding, manual and electric pumps are available to women, and new hospital grade pumps are being purchased this year. The prison, and Birth Companions, provide clothing and bras to support women breastfeeding on the MBU. For some women, they felt this was enough and met their expectations. For others, including some staff members, they described that whilst bras were provided, they were not always meeting the diversity of sizes needed:

“From the last batch of maternity and nursing bras that were ordered were so ill-fitting they brought them in two sizes, which was non-inclusive. They were sports bras, which not all women felt fitted them...So it’s like, now we’ve got some bras but they don’t fit half the women and they are not getting given out so that’s again not meeting their direct need.” (Professional)

The new perinatal pathway clearly facilitates express breast milk (EBM) transportation to babies outside, and MBU staff state that the pathway, policies, resources and equipment are in place when the need for EBM arises. At the time of this review, no women were using the EBM service.

“We’ve got a policy because we wanted to make sure we’ve got something written down about what we need to do because it is quite rare. So, it’s more of a proactive approach of making sure we are prepared for it. I can’t remember the last time that we needed to do it, certainly not in the last year.” (Professional)

This is a positive development since the 2019 report as EBM procedures were not in place at that time. There is currently one woman whose baby is in hospital, who is expressing milk and visiting her baby daily. Staff say she is being facilitated in this choice.

Breastfeeding information, environment and support

Similar to the findings of the 2019 review, different views were held by women about the level of information received, support provided, and the wider environment related to encouraging breastfeeding.

The Maternity Helpline is available to women who have given birth for 28 days, after which there are other helplines available to support with breast feeding during the day. There was some inconsistency about these helpline names and availability from either 8am to midnight, or between 9am and 5pm.



Staff suggest that women are given leaflets with information about breast feeding and bottle-feeding support and how to access help, however this is not recalled by some women, or was not found to be helpful. One person commented about information available on the MBU:

"I ended up reading some books...They are very dated and I wouldn't necessarily say they are very accessible. Luckily the midwife came to visit because the baby was 10 weeks old and we were able to ask questions to the midwife, that was really helpful."
(Resident)

Overall, the environment on the MBU was described positively in how it facilitates breastfeeding, providing privacy in own rooms, and a 'tv room' with comfortable chairs.

"One of the members of staff here is great, she has all the time in the world for us. And [the midwife] checks on us once a week, and sometimes I'm fine and sometimes I'm not." (Resident)

"...during a review meeting with this lady it was evident she was very nervous. She's not one of these people, she said, referring to somebody else in the unit, that can just breastfeed in any environment. That's just not her. And so she requested that she wanted to do that in her room and for staff to be mindful that that may be happening in her room. So, we created a breastfeeding sign that she could put on her door while she's breastfeeding so she didn't have to worry about that. She's got enough to worry about being a new Mum but just having that sign on the door gave her that assurance that she wasn't going to be interrupted." (Professional)

However, one mother described her choice to breastfeed, but with limited support and with increasing feelings of stress, she stopped after a few weeks. Service users felt that women in the community have family and friends to support and share experiences and guidance on breastfeeding, alongside the professional support from midwives, this can be missing from the experience inside prison. Where women have spent time in the MBU prior to having their baby, they have developed relationships with the other mothers and often found that to be supportive and helpful.

"The hospital asked the guard in the front of me if we get help with breastfeeding and he said yes, so I was expecting help. Got back, and you're just on your own and that was it. I switched to bottle feeding...." (Resident)

"The Nursery Nurses really need a bit more training on [breast feeding support] so that has been discussed with [management] about how we can facilitate that."
(Professional)

Whilst weekly access to the midwife has been described as very positive, and meets the antenatal needs of women, the need for regular and timely support for breastfeeding goes beyond the role of the midwife.



“For example, one woman needed advice about breast feeding and there was no-one to go to, no-one to talk to about it and if it wasn’t for another woman on the unit who was able to talk through something, she wouldn’t have had access to that.” (Professional)

“We’ve got general information that’s available on the Mother and Baby Unit but other than that, it’s provided by the midwife and health visitor.” (Professional)

“They have midwifery support and [health visitor]. They know that, and they can access us. I don’t think they access us as often as maybe they probably could but the information is there. I think they get confused about what services are where.” (Professional)

The day-to-day support of nursery nurses was identified as the ‘gap-filler’ between the midwife and health visitors regarding provision of advice, information and support for breastfeeding. This was described as more support than is available in the community. However, the nursery nurses may not be providing adequate or timely support to mothers, or the mothers themselves may not be requesting support from the nursery nurses.

“Yes, I think they have access to the midwife, they have access to health visitors, possibly more so - absolutely more so than what the community get. So, if anything I’d say it’s enhanced. And with that additional support of nursery nurses within the MBU they can provide that day-to-day support as well” (Professional)

“I think it is just about the nursery nurse and the staff that work there being open to [breastfeeding] and training in it. And because a lot of the officers are male, I think it’s about them being comfortable with the male staff isn’t it? I don’t know whether they would be comfortable then going to a male member of staff when the nursery nurses have gone home.” (Professional)

One professional also spoke of an area where they felt there was a gap in knowledge or a pathway in relation to the benefits of breastfeeding for babies exposed to methadone.

“There’s a gap in another area in that I don’t know how well-known it is about the benefits of breastfeeding when a baby’s been exposed to methadone in-utero, so there are recovery workers who will be aware but I think it could be a better pathway and not all women seem to be informed. But there are stakeholders who are aware of that and would like it to improve.” (Professional)

Ensuring a supportive environment to facilitate bonding

The physical environment was described by women and staff as largely supportive to enabling women and their babies to feel comfortable, to nurture and facilitate feeding and a strong relationship. However, women raised some concerns about some prison staff highlighting



how 'lucky' they are to be on the MBU, and that they don't understand the need for a different environment for the babies:

"They assume because you've had your baby and you're here with them you're ok. Feels like 'us and them' with the prison staff, they tell you you're fortunate and lucky to be here, and it's an open-door policy, but it feels different in reality. They don't all help create a different culture or feeling to the main population. It's supposed to be different for the babies, they're innocent in all this." (Resident)

"It depends who is on shift some don't want to be here, and some don't understand. Some interact with the babies and they get it, that it needs to be different here, it's not the main population, it's a different atmosphere for the babies." (Resident)

In 2019, it was suggested by women and professionals that more could be implemented to support the bonds between women and their babies on the MBU. HMP Peterborough has recently introduced baby massage, which was seen as something that would be beneficial from a mental health and bonding perspective. Whilst baby massage was described as already introduced by staff, women on the MBU suggested that they were yet to attend a class. Delays may have been caused by Covid-19. The positive takeaway is that the demand for baby massage is high, and it is likely to have a positive impact for both babies and mothers, in relation to both bonding and health.

"We were supposed to get a baby massage class, to learn techniques about how to do it. We really want it because a few of the babies have digestion problems, and it can really help apparently. But they keep promising it and it never happens. We have babies with constipation, and we really need to help them, we keep being told it will be a week, or in the next few weeks, but not happened yet." (Resident)

Provision of food and weaning for babies

Whilst the babies in MBUs are not in 'custody' and are therefore not under the care and responsibility of NHS England, the food given to them is a public health issue and one deserving of attention. This arose in the interviews with women and staff but was not identified in the 2019 review: concerns were raised about the regular provision of healthy food, and a variety food, for facilitating weaning of babies from milk to solid foods. This referred to issues with the ordering process, what food was actually received and the timing of the arrival of ordered food with leave.

During ROTL, babies are being fed three or more times a day with different types of food, and they return to prison the variety of food is minimal and often limited to 'cucumbers and peppers'. For some this is causing digestive problems, including constipation.

"The babies get used to the food they have at home on ROTL, for six days at a time they have proper food at home. So, we can bring some food back in for the babies, but



it is restricted. Some of us share what we've brought in with each other, when their orders for food don't come through. I only had cucumber and potatoes for [baby] for weeks and weeks, so [another woman] gave me some of her fruit bars and sachets... I just think I should be able to have control over the food I have for my baby. Weaning needs to be consistent, and I make him good food when we're home on ROTL and we come back to cucumber and nothing else." (Resident)

"There should be different cultural food available for babies, it's not fair if they are eating differently on the ROTL days and then given completely different food here. That's not the same as their culture... At home she has three meals a day, and here she has no choice, and not enough food. I have to ration it out, to make it last all weekend because no nursery staff here to get anything else." (Resident)

These issues also raised differences in equality of access to healthy and varied food for babies, where the financial position of some mothers (and their families) meant that ordering food online was not possible. This meant the opportunity for women to purchase food for babies online, with the supervision of nursery nurses, was taken away.

"Babies are supposed to get vitamin D drops because they don't get outside much here, but it's not happening, not sure what's happening with that. We have to get things sorted through the health visitor." (Resident)

In terms of medication or other needs for the babies, they appear to be met through ordering online and liaising with the prison staff on reception to access, which in some cases has put the reliance back on nursery nurses to complete orders.



3.3: Access to Counselling

The term ‘counselling’ has a range of meanings and the use of counselling in this report refers to ‘talking therapies’ available to women antenatally and postnatally. Mental health problems are extremely common in pregnancy and in the first year afterwards, especially if there is a pre-existing mental health problem. According to Ayers and Shakespeare (2015) between 10 and 20% of women suffer from mental health problems during pregnancy and birth. The most common mental health problems during pregnancy and after birth are anxiety, depression and posttraumatic stress disorder.

HMPPS (2021a:19) highlighted the need for access to perinatal mental health services:

“Antenatal and post-natal support and advice must be accessible for all women during and after pregnancy. Healthcare services includes access to all aspects of mental health: talking therapies, specialist perinatal mental health etc.”

Perinatal mental health care should attempt to detect mental health problems promptly after a referral to the perinatal mental health team is made or after meeting them and using a robust screening tool. There should be a perinatal care pathway produced by the mental health care provider which includes assessment, care and treatment. Similarly, the Birth Charter Toolkit (2019:29) suggests that mental health needs should be ‘reassessed and closely monitored’ within the first few days of pregnant women coming into prison and that they are able to access counselling when needed. HMPPS’ policy paper (2021a) recognised that women who did not gain a place on an MBU and were separated from their babies should particularly be offered talking therapies due to the trauma of separation. This is important as rates of anxiety and depression have been found to be higher in mothers who were separated from their children compared to those residing on Mother and Baby Units with their child(ren) (Dolan *et al.*, 2019). However, women residing on MBUs must still receive the same level of perinatal mental health care as they could in the community (HMPPS, 2021a).

In order to encourage appropriate access to talking therapies, the Birth Charter Toolkit also recommends that between days 1-3 of arrival within the prison, women have a mental health assessment and ‘timely follow up appointments’ (2019:15).

In 2014, the Maternal Mental Health Alliance (MMHA) launched a campaign for perinatal mental health services which included a map of perinatal mental health services and showed significant variation in services across the UK, with 40% of the United Kingdom having no perinatal mental health provision and where provision does exist it varies greatly (Ayers and Shakespeare, 2014). Half of women with mental health problems are not identified or treated, despite regular contact with maternity services (Baur *et al.*, 2014).

In 2014, the National Institute for Health and Care Excellence (NICE) published guidance on ‘Antenatal and postnatal mental health’ covers depression, anxiety disorders, eating disorders, drug- and alcohol-use disorders and severe mental illness (such as psychosis,



bipolar disorder and schizophrenia) in the antenatal and postnatal period. It promotes early detection and good management of mental health problems to improve women's quality of life during pregnancy and in the year after giving birth. Ayers and Shakespeare (2014:323) point out:

"So why should perinatal mental health be everyone's business? The arguments for this are compelling. There is now substantial evidence that maternal mental health problems are associated with a variety of adverse outcomes for women and children"

Grote *et al.* (2010) conducted a meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight and intrauterine growth restriction. They concluded that women with depression are at increased risk for preterm birth and low birth weight. Staneva (2015) carried a systematic review of maternal depression, anxiety and perceived stress during pregnancy on pre-term birth and concluded that there is an increased overall risk of prematurity when a woman experiences one or more of these three psychological disorders during pregnancy. Yonkers *et al.* (2014) in a study of 2,654 women in the United States found those with likely diagnoses of both PTSD and a major depressive episode are at a 4-fold increased risk of preterm birth. Research studies have also provided evidence that maternal depression, anxiety and stress can increase the risk of child emotional problems including anxiety, depression and symptoms of Attention Deficit Hyperactivity Disorder (ADHD) (Talge *et al.*, 2007; Kleinhaus *et al.*, 2013; Rice *et al.*, 2010). Prevention in Mind: All Babies Count: Spotlight on perinatal Mental Health (2014) states:

"Perinatal mental illnesses affect at least 10% of women and, if untreated, can have a devastating impact on them and their families. When mothers suffer from these illnesses it increases the likelihood that children will experience behavioural, social or learning difficulties and fail to fulfil their potential."

Women prisoners have a notably higher prevalence of mental health problems, than male prisoners and the general population. Added to this is the increased likelihood of mental health problems in the perinatal period. It is also important to note that social support is an important factor in mental health (Harandi *et al.*, 2017). However, women are imprisoned further from home and receive fewer visits than men. This adversely affects their capacity to maintain relationships and family contact. Women (51%) were more likely than men (39%) to say that getting support from their family would help them (Ministry of Justice, 2012). Their susceptibility is exacerbated further by being incarcerated in an environment in which they have little control over their care, are fearful and may be faced with the possibility of being separated from their baby. Abbott (2018) writes:

"I found that women experienced frustration and stress which impacted upon their emotional wellbeing. Being unable to access basic comfort and adequate nutrition and fresh air were commonly expressed by women. The fear of potential separation from their baby was an underlying stress...Some women want to hide their pregnancies under baggy clothes – whilst the threat of violence was often perceived, women were often frightened about the potential threat to their unborn child"



In relation to having access to counselling, the Birth Charter recommends that:

- Pregnant and postnatal women should be offered confidential counselling and support and prompt referral to an appropriate health care professional should postnatal illness be suspected;
- All women who are separated from a baby who is up to 18 months old should be offered pre-and post-separation counselling; and
- All women who lose babies, whether through miscarriage, ectopic pregnancy, or stillbirth should be offered counselling.

It also important to note the high prevalence of self-harm amongst the female prison population, in the 12 months to December 2019, there 3,130 incidents per 1,000 prisoners in the women's prisons compared with 650 incidents per 1000 prisoners in the male prisons (Ministry of Justice, 2020).

HMPPS' policy paper (2021a) also suggests when the ACCT process may be needed if the woman is at risk of harm to herself:

- termination of pregnancy
- antenatal or postnatal mental or physical health challenges, including antenatal and postnatal depression
- miscarriage
- stillbirth
- neonatal death (the death of a baby within the first 28 days of life)
- separation from children up to the age of two

In summary, there appears to be clear evidence that access to specialised mental health services in prison is vital to supporting women with needs on the perinatal pathways. The prison environment is, by design, impactful to women's wellbeing, in terms of control, fear and vulnerability with the long-term impacts of not providing adequate support to women are extremely costly. Adopting a multidisciplinary approach to care, recognising the holistic needs of women (inc. mental health, substance misuse, public health, education and circumstances) is central to achieving positive outcomes.

2019 report summary:

Overall, there were several issues that were raised that challenge compliance with the Birth Companion Birth Charter in relation to women accessing counselling or talking therapies. There were many positive examples of good compliance and achieving a high standard of care for women, though there were also a series of examples where establishments did not meet the standards outlined in the Birth Charter. Mental health provision was highlighted as an area of concern by the professionals and by the women on the MBU, highlighting that there was currently no perinatal mental health specialist, which they felt was much needed due to the high level of vulnerability amongst the women. In addition, there is no specific



support package for women who are separated from their babies. Automatic counselling is only provided in the event of a stillbirth. There was a recognised absence of training for professionals on perinatal mental health.

Referrals for support sometimes take a long time, and sometimes are not accepted, which is concerning and frustrating for the women. With the existence of perinatal mental health care in the community, it raised the question of equivalence as the women are not being provided with access to perinatal mental health specialists despite them having a significantly higher risk than those in the community of experiencing poor perinatal mental health, often having histories of trauma and/or long-standing mental health issues.

Relevant aspects of the Birth Charter:	2019	2021
Pregnant and postnatal women should be offered confidential counselling and support and prompt referral to an appropriate health care professional should postnatal illness be suspected.		This may be offered, but in practice, women say they have to make the request for counselling, and that there are long delays to receiving counselling appointments.
All women who are separated from a baby who is up to 18 months old should be offered pre- and post-separation counselling.		This may be offered, but in practice, women say they have to make the request for counselling, and that there are long delays to receiving counselling appointments.
All women who lose babies, whether through miscarriage, ectopic pregnancy, or stillbirth should be offered counselling.		Automatic referrals are made.

Recommendations from the 2019 review	2021
Increase provision of and access to specialist perinatal mental health talking therapies.	A specialist Perinatal Link Nurse (NHFT) is now in place and accepting referrals and there is specialist perinatal mental health provision
Wider staff who interact with women should be trained on signs of distress or crisis and prompt referrals and assessments should be initiated.	Training has been designed and is in the process of being implemented.
Review the assessment processes for how the risks of poor mental wellbeing for women and their babies on the perinatal pathway are triaged against the needs of the wider prison population in terms of access to mental health services within the prison.	The perinatal pathway is in place, and a specialist Perinatal Link Nurse is in place to assess referrals. These processes and roles are relatively new and need to 'bed-in'. The remaining



	issue is the time-delay between requesting counselling or support and receiving an appointment.
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Primary and Secondary Mental Health Services

Since April 2021, Northamptonshire Health Foundation Trust (NHFT) have been responsible for substance misuse and secondary mental health services, including the introduction of a Perinatal Link Nurse. Mental health services include talking therapies and art therapy, there is now a perinatal mental health specialist. Training is being delivered for healthcare staff and wider prison officers, to help identify the signs and symptoms of those with mental health support needs, and the referral process.

All pregnant women are discussed at the perinatal review meetings, and this includes assessments of birth plans and associated support needs. In the event of miscarriage, ectopic pregnancy or stillbirth, an automatic referral for counselling is made.

The perinatal pathway provides a clear outline of the process of referral for women with mental health needs. For women without a confirmed diagnosis of severe and enduring mental illness, referrals are made to the Primary Mental Health Team (PMHT) from reception or the wider prison staff. These will be assessed by the PMHT for suitability for access to psychological therapy on the perinatal pathway. If they are deemed as suitable, they can be referred to the perinatal pathway in the Secondary Care Mental Health Team. This referral will be triaged by the secondary care team and allocated to the perinatal lead if indicated. The specialist midwife and health visitor can also refer into the perinatal pathway directly following assessment and completion of the PHQ9 and GAD7 rating scales.

The NHFT is in the process of developing a new perinatal mental health pathway, which include perinatal appropriate assessments that are trauma informed, a referral pathway. This is being co-produced with 'experts by experience' via the use of art materials and verbal dialogue to allow women 'to explore what their experience with mental health was when they were in the perinatal period' this will then form the basis of a co-produced pathway. Therefore, currently the PMHT have made some referrals for women that they feel would benefit from talking therapies whilst they await formal guidance from NHFT on a referral-criteria. They also tend to double refer these women to the trauma informed service within the prison. Currently, most of the referrals to the perinatal mental health lead have come through Birth Companions. Once the perinatal pathway being produced by NHFT has been established training will be undertaken to ensure awareness for example with nurses on reception.

The Secondary Mental Health Team is also recruiting another person who will be committed two days a week to perinatal. In addition, there is an ambition to ensure that there is capacity



for short term therapy to work with clients where PTSD is present as a number of clients have quite severe PTSD, an EMDR specialist was mentioned.

Accessing support and services

On the whole women spoken to knew how to use the kiosk and how to make requests for an assessment for counselling or other support mechanisms. The use of the kiosk model means this is confidential for women, and they can access the kiosk easily. However, the time lapse between the kiosk request and a health check is long:

“If you want support you have to put an application in at the kiosk, takes ages to get a response. It puts you off.” (Resident)

Feedback from the women suggested that this model places the onus on them to know when the right time is to access help, and to make the first move. They described that when you're mentally or emotionally struggling, it's hard to choose to access help. This links to the suggestions of mental health 'check-ins' made by HMPPS in their 'Guidance on Working with Women in Custody and the Community' policy paper (2018), particularly around 'trigger points'. For example, the perinatal mental health team could carry out mental health 'check-ins' with women on a regular basis, with particular attention to 'trigger points' such as a month's anniversary of the separation of the mother and baby. In the community, they might talk informally with family and friends and there might be gentle suggestions and discussions about options and what help is available. NHS England has commissioned Birth Companions to operate a peer support scheme in HMP Peterborough where the peer supporters advise women about services available to them and how to access them. Some women felt the role falls between the midwife and the health visitor, who may have limited time to explore mental and emotional health. Others talked about receiving support from the other residents.

“No support on how to do things, we need more practical support and guidance. There is an open door policy, but you have to feel comfortable enough to use it, to just go in and for help. They could come to us, approach us and offer help, rather than waiting for us to ask them.” (Resident)

“They assume because you've had your baby and you're here with them you're ok. Feels like 'us and them' with the prison staff, they tell you you're fortunate and lucky to be here, and it's an open-door policy, but it feels different in reality. They don't all help create a different culture or feeling to the main population. It's supposed to be different for the babies, they're innocent in all this.” (Resident)

“I am supported more by the girls on the unit than by anyone else, more than the staff. They have been a bit of a life saver to be honest.” (Resident)

One issue raised was that currently there may be challenges at identifying women with mental health needs at reception to be referred.



"(One woman) expressed to me that she has mental health concerns, she has a [baby] and in reception she asked to be referred to perinatal services and they told her that she didn't fall under our remit." (Professional)

"I think there have been several incidents with reception nurses either not following a referral pathway, for example making a task on System 1 that a woman might need mental health support but not following it up, and that's lead to delays." (Professional)

As in the last report it was noted that low level mental health needs may be normalised in prison with a professional commenting.

"I have found that it's not always recognised when a woman has a mental health need because it's so prolific in prison I think low level mental health needs, which I can work with, are normalised, and if the woman seems to be coping or putting on a brave face." (Professional)

Times, Systems and Spaces

Practically, there may be blockers to receiving counselling where the days those counsellors are available fall on days when women are on ROTL or are working. This has caused delays in getting counselling sessions booked and puts extra strain on counsellors to be available on different days.

The issue was raised of the therapist being able to book appropriate spaces to conduct therapy in. The wider mental health team have one clinic room on the Female Healthcare wing to share among all practitioners so that room can be booked and that is straightforward. However, the practitioner did not believe it to be trauma informed.

"There's a lot of noise and hustle and bustle in that area and the room is completely hemmed in, as you were, there's no window out of it. It doesn't feel therapeutically viable." (Professional)

Therefore, the practitioner 'borrows' other rooms on a temporary basis, however, their current system does not allow them to book the appointment to show on the client kiosk and to the officer bringing the client and to the officer letting the client through the door.

"Yesterday I had someone who turned up, wasn't allowed into the area because she wasn't on the list to go through the door, went back to the wing. Then an officer took her to the wrong place that he anticipated the appointment was at...she was taken back and then five minutes before the end of her appointment I rang for the fourth time." (Professional)



Although an officer then offered to bring the women to the right place a few minutes before the end of the session she had given up. It was then recorded as a 'Did Not Attend'. It was noted that this sometimes occurs when an appointment is noted as a 'DNA' which could be perceived negatively (e.g. as a 'behavioural' issue when actually the patient is trying to engage or they have a valid reason for non-attendance). This could be detrimental in the future if the woman is appearing to not be engaging in support for example 'social care is very involved and might like to know about engagement'.

There is an issue with systems not talking to each other so the perinatal mental health team book a woman an appointment for therapy, however, they can't then access the system to ensure that the appointment is not booked over. In one case the perinatal mental health leads therapy appointment has been booked over by a dentist appointment one week and by a group on the following week. This results in a waste of commissioned therapy time because even if the practitioner rings the day before, it is only when they get there that they might find out that the woman has been double booked.

Understanding of Therapy Options

Feedback was provided by two women about the offer of art therapy. Both felt unsure about what it might entail, any why it had been offered to them. One had decided to try it, and the other pushed for talking therapy.

"I was offered art therapy but that's not what I want. I want to talk to a counsellor, so that's what I am going to have. Just waiting for the appointment." (Resident)

"I did get to speak to a counsellor, and we had to find a regular slot that would work for us. She's lovely. Have only seen her twice so not sure yet, and been referred to art therapy, based on my assessment. Will do 6 weeks and have a review. Not sure about it really, I don't know what it is or what it does. But after 6 weeks if you feel it's not for you, you can stop." (Resident)

It may be that the offer of art therapy needs further explanation to the women as the researchers understanding is it is actually part of a wider package of support that includes talking therapies, which is tailored to women's needs. As the women who are engaging in therapy are in the early stages it is not possible to comment on its potential efficacy currently. However, it is important that feedback is sought from women on the therapy from an independent source as times goes on to ensure that the type of therapy being offered is appropriate to meeting their needs.



Wider support available to women

There are wider support services available to women which include the in Mental Health In-Reach team, Birth Companions, Samaritans, Listeners and Family Matters. Some women talked about relying on family and friends on the outside for support, but others talked about having utilised the support networks inside. For example, Listeners were described as very helpful by one woman, being able to speak freely to them about the emotional challenges and all of the different issues that need to be handled related to being pregnant in prison, and the distress of dealing with social services and courts related to keeping custody of the baby.

The role of Family Matters was highlighted as an important part of the support system that women receive, particularly for separation cases:

“We have a Family Matters team that comprises of three staff who are phenomenal, provide a huge amount of support to women in various circumstances. Not just those that have lost children but maintaining contact and they attend final visits for women, for example. The most recent separation we had, a couple of weeks ago, the family Support Worker was there alongside the mother and baby staff to provide that support and she’s still providing that support now she’s gone back onto res. So, I think the Family Matters team are just incredible.” (Professional)

Some of the women mentioned receiving support from Family Matters and Birth Companions and were positive about the support that they had received from them.

A strong message received from women was that they would like to be able to talk with other women, which is a strength of antenatal classes, as well as the opportunity escape briefly into a place where they could think about their pregnancy or motherhood. Women commented that there are no or few groups for perinatal women and it is really important that they are able to chat, relax and bounce ideas off each other.

Another woman commented that pregnant women would chat in the waiting area, whilst waiting for their midwife appointment, she commented:

“Pregnancy groups would be good, especially for the girls who are at risk of losing baby to social care system” (Resident)

Another commented that it would be really beneficial if there were relaxation classes (such as yoga) to help them relax and to ease the stress and pressure, particular of the trauma of not knowing whether you would be able to keep your child and the chaotic nature of prison life. One woman talked about having gained therapeutic value from doing arts and crafts group commenting that it took her mind away from the trauma of being away from family and being in prison. It is understood that currently the art therapist (NHFT) is working with individuals one to one, however, art therapy groups may be an option moving forward.



Women's Voices

There was evidence that 'women's voices' are being included in relation to the design of the perinatal pathway and of work to improve perinatal care such as the use of 'experts by experience' for the design of the talking therapies pathway and in the creation of information packs for women residents that are currently in the design stage. A range of meetings, discussion groups, review meetings and questionnaires are also now in place to facilitate women sharing their views, experiences and their voices during the perinatal period (and more broadly). These include:

'Mother's Group'

A 'mums in prison' or 'mother's group' has been designed and has run a few sessions to allow mums to come together and discuss the various issues, experiences and questions about the experience of motherhood whilst in prison. Covid-19 has impacted upon the delivery of these sessions, but they are planned to take place monthly.

"What we found in some of the focus groups is that's what women wanted; they just wanted an environment to be a Mum. Not to be about 'We're having a discussion about this that happens in prison; or that happens in prison... It was about how are you maintain contact. 'I've got this situation, what can I do?'" (Professional)

One of the professionals particularly noted the Mother's Group as a positive development.

"There's the mothers' group that [name] is involved in. That will meet some level of need for perinatal clients as well as mothers in general and the fact that Sodexo have commissioned research in the field of motherhood." (Professional)

None of the women spoken to mentioned having attended the Mother's Group, although one pregnant woman said that she hadn't been because she did not have other children. However, someone she knew had been and found it useful. It is unclear as to whether women who are pregnant but do not have other children are eligible to attend. For example, a professional commented:

"So, we've had issues like a pregnant woman asking to go to a mother's group and being told by her key officer that she's not a mother so she shouldn't go, which is obviously concerning." (Professional)

Therefore, it is important that all those that are eligible to attend the Mother's group are aware of it and able to attend if these chose to. Awareness may be an issue as one woman commented:

"I went to one group for women who have babies or have given birth, but there wasn't anyone else there, just the lady running it. There's another one soon so I am hoping to talk with other mothers then. I think it will be really helpful." (Resident)



Birth Companions

Birth Companions have a powerful advocacy role and occupy a crucial space in between the service users and the more formal staff members in the prison, such as healthcare staff and officers. The Birth Companions Peer Support Co-ordinator attends the prison weekly.

“They have access to me when I go in, so I go in every week or every other week and I’m just bombarded by issues, which is not an issue at all and which is my essential role in then flagging these issues to the MBU SO and trying to signpost and get the women in contact with who they need to be in contact with.” (Professional)

Birth Companions have also been commissioned to run quarterly focus groups since January 2020 to gain insight into women’s experiences of healthcare in prison. The group has not been able to run consistently due to the restrictions and constraints caused by Covid-19. However, a group was held last year which was very well attended, another group was meant to take place at the time of this report but had to be cancelled due to one of the coordinators having Covid19 symptoms.

“The first round MBU was very well attended...I would say focus groups are the way forward. If you want to hear women’s voices, get them in a room...Women are desperately desperate to be heard and our information has been a help but you would be shocked to hear what’s going on for those women.” (Professional)

Both women and professionals expressed frustration that often issues raised did not get resolved. One professional commented:

“(They) say that things are done and then when I follow up with the women, they are not done so it causes this tension - I then am going back to them, back to them and I never really get clarity on things. So the women then feel like things aren’t being done for them.” (Professional)

This is crucial as having mechanisms for women voices to be heard could cause additional frustration if key issues are not then resolved or at least responded to appropriately. On a related issue women quite often, as in the last report, said that they had made a complaint and had not received a response to it, which also highlights the point that if women are given avenues for their voices to be heard they must receive an appropriate and timely response.

MBU Monthly Consultation

The MBUs have monthly consultation meetings with the manager and the women to find out about their views, experiences, questions or issues to be resolved. The feedback from staff suggests that this has led to improvements on the Unit, including updating decoration, or resolving issues.



8-Weekly Review Meetings

Review meetings provide space for women to talk about what matters to them, what they are experiencing and what they would like to see improved.

“We’ve also reintroduced - I say ‘reintroduced, they stopped some time ago but I’ve asked for it to come back in - our eight weekly reviews of women that are on the Unit, just to see how things are going and how their child is and so on, is there anything we need to do? Again, it’s just opening the doors of communication really.” (Professional)

Monthly or Bi-Monthly Healthcare Forum

The Head of Female Residents is also the protected characteristic, ‘Pregnancy and Maternity’ Lead and meets with the women every month or every two months and the feedback from that meeting is fed into the bi-monthly diversity and inclusion meeting.

“Monthly healthcare forum – they are really engaging, so they bring any queries about medication, or anything, just general niggles. But it’s really good to have one, so yes that’s where their voices are heard and they are represented by peers” (Professional)

Questionnaires and User Voice

Questionnaires and a ‘You Said, We Did’ board are in the process of being developed and implemented. In addition to something that was referred to as ‘User Voice’, where residents ask questions and staff answer them.

“You’ve got User Voice as well of course, so User Voice came in and again represented by residents, they turn up and attend some of their meetings and we answer all of their questions. They come through with recommendations as well that we answer to.” (Professional)



4. Conclusions and Recommendations

HMP Peterborough has made significant progress in developing and implementing the perinatal pathway and improving perinatal care for women. In particular, the introduction of the Talking Therapies Service which is delivered by Northamptonshire Healthcare Foundation Trust under a Perinatal Talking Therapies Specialist. In terms of processes this is still being developed, however, the specialist is taking referrals and working with women already. There will also be an expansion to this team, with recruitment under way at present. There appears to be some systems issues at present which if addressed will maximise the ability of this service to access women and the make the best use of time.

Additionally, there is a Perinatal Link Nurse, increased information gathering from women on arrival, and automatic referrals for counselling for specific situations is good progress. Collaborative working across prison staff, healthcare, mental health professionals and midwifery has resulted in a comprehensive pathway that ensures women with needs related to perinatal care should not fall through any gaps. There is a consensus amongst staff that the pathway is easy to follow and improved multi-agency working.

There are areas where progress has been slower for example improving on the information provision to women, possibly due to the pressures of Covid-19. However, there is currently an information pack in production for women residents, that is being produced collaboratively and will contain the relevant information on the perinatal pathway and, also mental health support, as well as wider healthcare information. Although, the midwife, health visitor and support networks such as Birth Companions were still key providers of information, a key source of information for the women note in the 2019 report of ante-natal classes was notably absent. It is noted, however, that this may be due to Covid-19.

As identified in the 2019 review, the residents interviewed shared concerning incidents of non-compliance with agreed processes or standards for high-quality perinatal care. Further, when raising such incidents, some of the women described not receiving feedback or assurance regarding mitigations made. These were perceived by the women as failing in healthcare for themselves and their baby(ies). It is critical to both robustly investigate such instances to ensure agreed standards are met and to communicate effectively with residents to provide assurances that they will receive a high quality of care.

As can be seen in the tables below, the majority of the recommendations from the 2019 review have been addressed, and new or improved practice is now in place. After the summary of progress, a further short set of recommendations is provided to ensure continued improvement in perinatal care and full compliance with the three areas of the Birth Charter which relate to this review: equivalence of care, support with chosen infant feeding method, and access to talking therapies.



4.1 Summary of Relevant Aspects of the Birth Charter

Access to the same standard of antenatal care as women in the community

	2019	2021
Regular antenatal clinics should be provided in prisons and run by a specialist team of midwives.	⁵	The midwife runs a weekly antenatal clinic and women shared positive feedback about the service.
A pregnant woman in prison should be able to speak to a midwife 24-hours a day about any concerns she may have (e.g., if she has a severe headache, is bleeding or feels her baby is not moving). The midwife can then make an assessment and provide the appropriate care and support. If it is not possible to see a midwife in person, then a woman should have phone access to a midwife 24-hours a day.		The Maternity Helpline is available 24/7 for pregnant women and for 28 days post labour.
At night, there should be a timely response to pregnant women's buzzers. Once a woman has been assessed by a midwife, prison staff should facilitate timely access to hospital when advised to do so.		Mixed reports of timely responses to buzzers, including immediate responses or waiting up to an hour.
All pregnant women should, where possible, have access to a scan at a regular clinic inside the prison. The scan should be undertaken by an ultrasonographer, obstetrician or trained midwife or GP.		Scans are not available at a clinic inside the prison, but they are undertaken by an ultrasonographer, obstetrician or trained midwife or GP.
Women should be provided with photos from scans as women in prison are not able to purchase these.		Women are provided with photos from scans.

⁵ **Red** - Not met / not happening

Amber - Partially met / inconsistency of delivery or compliance

Light Green - Adequately met, minor room for improvement

Green - Fully met



They should also be able to apply for permission for a partner or family member to be present at the scan.		There are inconsistencies in the policy and process for women applying for permission and what happens in practice. This may have been impacted by Covid-19.
Where scans or other appointments need to happen in hospital, officers should observe prison guidance which specifies that they should not be present during medical consultations.		There were inconsistent reports about officers remaining present during medical consultations.

Encouragement and support in their chosen method of infant feeding

Relevant aspects of the Birth Charter:	2019	2021
All mothers, irrespective of how they choose to feed their baby, should be supported to build a close and loving relationship with their baby and be guided to learn how best to respond to their babies need for food, love and comfort.		The midwife was identified as the main source of support for this and received consistently positive feedback.
Mothers who are formula-feeding should have 24-hour access to appropriate equipment and facilities to make up bottles and sterilise equipment.		24/7 access to facilities is provided.
Mothers wishing to breastfeed should have access to appropriate clothing such as breastfeeding bras and equipment such as breast pumps.		Bras and breast pumps are provided, though there are limitations on bra sizes.
They should also have regular access to specialist breastfeeding information and support, as well as an environment in which breastfeeding is encouraged and nurtured.		Some specialist support is available through the Maternity Helpline in the first 28 days, and from the midwife and health visitors when available. Nursery nurses could provide further on-hand support.
Women wishing to breastfeed should be provided with the same support as available in the community to ensure those who experience difficulties get the support they need. This can be from specialist midwives, and breastfeeding supporters from organisations such as the Breastfeeding Network, Association of		As above.



Breastfeeding Mothers and the National Childbirth Trust.		
Prison staff on MBUs should receive training so that they can maintain a supportive environment for women who wish to breastfeed.		Perinatal training is due to be rolled out, but it was unclear if this includes training related to supportive breastfeeding environments.

Access to Counselling

Relevant aspects of the Birth Charter:	2019	2021
Pregnant and postnatal women should be offered confidential counselling and support and prompt referral to an appropriate health care professional should postnatal illness be suspected.		This may be offered, but in practice, women say they have to make the request for counselling, and that there are long delays to receiving counselling appointments.
All women who are separated from a baby who is up to 18 months old should be offered pre- and post-separation counselling.		This may be offered, but in practice, women say they have to make the request for counselling, and that there are long delays to receiving counselling appointments.
All women who lose babies, whether through miscarriage, ectopic pregnancy, or stillbirth should be offered counselling.		Automatic referrals are made.

4.2 Summary of 2019 Recommendations and 2021 Review of Progress

Access to the same standard of antenatal care as women in the community	
Ensure that expedient two-way communication between the women and the midwife is facilitated.	Women reported no issues related to direct communication with the midwife.

Healthcare Needs and Emergency Response	
Ensure that prison staff can access the health-related expertise they need to manage care of women at the prison.	Prison staff <u>can</u> access the expertise needed, but feedback from both staff and women suggest that further training could improve <u>how</u> <u>and when</u> prison staff escalate issues to professional health services.



Induction and ongoing provision of training should be reviewed, and bespoke packages developed to improve staff awareness and practices of staff in the care of with women on the perinatal pathway.	A bespoke perinatal training package has been designed and is being delivered to new staff. It will be rolled out to existing staff soon.
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Women's Food and Nutrition

Assess the quality and content within pregnancy packs to ensure women's nutritional needs are met.	Complaints about the quality of food provided to pregnant women and breastfeeding women were made.
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Perinatal Pathway

Education of all parties concerning guidelines related to officer presence during medical consultations is imperative to achieving full compliance with the Birth Charter. Awareness raising and education needs to be continuous to ensure that it is fully embedded and caters for the turnover of staff. It is important to develop a culture in which maintaining the dignity and rights to privacy of perinatal women.	The new Perinatal Pathway is in place, and bespoke perinatal training is planned to be rolled out to all prison staff soon. This will include the guidance related to privacy and maintaining the dignity and rights of perinatal women.
Develop a multiagency perinatal pathway from entry to departure (inc. resettlement responsibilities and handovers to community teams) of the establishment.	The new perinatal pathway was developed and is in place.
This should be co-produced with all partners and supported by policies and guidelines to define responses to and processes for different situations.	The pathway was co-produced across partners is supported by policies and guidelines. Some of the details of the policies and/or guidance is not yet complied with fully – but training is being rolled out soon.
The document should also be regularly reviewed and updated by the partnership when facing new situations or issues in practice.	The pathway is continuously being reviewed.
Establish weekly perinatal meetings, with mandatory representation of different departments and partners to monitor and delivery holistic care; Non-attendance or engagement should be communicated to senior management in the establishment and addressed.	Perinatal meetings are happening weekly. Sometimes attendance is not fully representative.
Each case should be reviewed on an individual basis and interactions/decisions communicated and documented.	Staff consistently stated that each case is reviewed individually.



Encouragement and support in their chosen method of infant feeding	
Redefine the status of supportive perinatal activities (such as opportunities to speak with other mothers, pregnancy yoga or baby massage) as meaningful within the prison regime and not confined to a lunchtime activity.	Several groups and forums are now in place to facilitate supportive discussions and activities for perinatal. Antenatal activities have been delayed or inconsistent due to Covid-19.
Review support for women when experiencing difficulties with breastfeeding.	Some specialist support is available through the Maternity Helpline in the first 28 days, and from the midwife and health visitors when available. Nursery nurses could provide further on-hand support.
Consider the spaces in which breastfeeding occurs and allocate female staff where possible to reduce barriers to breastfeeding.	Breastfeeding can take place in the 'tv lounge' or in bedrooms for privacy, and officers are more aware of the need for privacy particularly when male officers are on duty. However male officers continue to work on the MBU and to provide escort.
Establish expressed breast milk (EBM) procedures and practices.	The EBM policy and procedure is in place.

Access to Counselling	
Increase provision of and access to specialist perinatal mental health talking therapies.	A specialist Perinatal Link Nurse (NHFT) is now in place and accepting referrals
Wider staff who interact with women should be trained on signs of distress or crisis and prompt referrals and assessments should be initiated.	Training has been designed and is in the process of being implemented.
Review the assessment processes for how the risks of poor mental wellbeing for women and their babies on the perinatal pathway are triaged against the needs of the wider prison population in terms of access to mental health services within the prison.	The perinatal pathway is in place, and a specialist Perinatal Link Nurse is in place to assess referrals. These processes and roles are relatively new and need to 'bed-in'. The remaining issue is the time-delay between requesting counselling or support and receiving an appointment.



4.3 Recommendations for further improvement

The following are recommendations following review of progress against the Birth Charter and the 2019 review.

Compliance with guidelines

1. Ensure compliance with guidelines related to prison officer attendance at hospital appointments and medical consultations, ensuring officers are not present in the room when they should not be, and the women are not cuffed when they should not be.
2. Robustly investigate incidents where complaints are made or procedures are not followed and communicate findings/mitigations to reduce anxiety of residents.

Mental health

3. Embed the Perinatal Link Nurse role, ensuring smooth referrals and triage that ensures perinatal women in need of support are identified quickly, assessed quickly and receive appropriate support.
4. Reduce the time it takes from a request for an assessment for mental health support to receiving support. Ensure women on the perinatal pathway are prioritised for mental health support.
5. Improve women's understanding of art therapy, why it is offered and how they may benefit from it (ensuring it is not pushed).

Culture and training

6. Review the training materials, approach and opportunity to discuss the importance of the culture and environment of the MBU, working with prison officers to reduce their perceptions of women being 'lucky' to be on the MBU, and shifting towards ensuring the environment is as supportive and nurturing as possible for the mother-baby relationship, bonding and feeding.

Food and nutrition

7. Improve the quality of food provided to pregnant and breastfeeding women, including provision of fresh vegetables and fruit.
8. Ensure access to Vitamin D for both mothers and babies.
9. Improve consistency and variety of healthy food available for weaning babies.



Appendix I

2019 Review Recommendations

1. Develop a multiagency perinatal pathway from entry to departure (inc. resettlement responsibilities and handovers to community teams) of the establishment;
 - a. This should be co-produced with all partners and supported by policies and guidelines to define responses to and processes for different situations; and
 - b. The document should also be regularly reviewed and updated by the partnership when facing new situations or issues in practice;
2. Establish weekly perinatal meetings, with mandatory representation of different departments and partners to monitor and delivery holistic care;
 - a. Non-attendance or engagement should be communicated to senior management in the establishment and addressed; and
 - b. Each case should be reviewed on an individual basis and interactions/decisions communicated and documented;
3. Ensure that expedient two-way communication between the women and the midwife is facilitated;
4. Ensure that prison staff can access the health-related expertise they need to manage care of women at the prison;
5. Induction and ongoing provision of training should be reviewed, and bespoke packages developed to improve staff awareness and practices of staff in the care of with women on the perinatal pathway;
6. Provisions of information for women should be reviewed, with bespoke information packs developed and issued to women upon entry into the establishment; and
7. Consider mechanisms and structures within the establishment for women's voices to be heard within the establishment and identify how to utilise such information to improve processes, practices and policies.
8. Review activities which support women during and after pregnancy available to women and align with wider community provision;
9. Redefine the status of such activities as meaningful within the prison regime and not confined to a lunchtime activity;
10. Review support for women when experiencing difficulties with breastfeeding;
11. Consider the spaces in which breastfeeding occurs and allocate female staff where possible to reduce barriers to breastfeeding;
12. Establish Express Breast Milk procedures and practices;
13. Increase provision of and access to specialist perinatal mental health talking therapies;
 - a. As part of this, wider staff who interact with women should be trained on signs of distress or crisis and prompt referrals and assessments should be initiated;
14. Review the assessment processes for how the risks of poor mental wellbeing for women and their babies on the perinatal pathway are triaged against the needs of the wider prison population in terms of access to mental health services within the prison; and
15. Assess the quality and content within pregnancy packs to ensure women's nutritional needs are met.



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