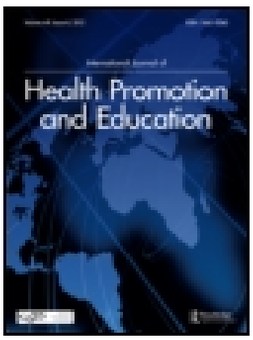

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Evaluation of Birth Companions perinatal support in prisons during the COVID-19 pandemic

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ABSTRACT

Women in prison who are pregnant or recently had a baby are a highly vulnerable population due to complex histories, increased risks of poorer outcomes, and mother-infant separation. During the COVID-19 pandemic, these women faced additional challenges due to infection risks and enforced social isolation. In England in March 2020, the Ministry of Justice and Her Majesty's Prisons and Probation Service prioritised the early release of pregnant women and mothers living with their babies in Mother and Baby units (referred to as compassionate release on ROTL – Release On Temporary Licence). Birth Companions, a UK-based charity that works with pregnant and post-natal women in prison, were commissioned to extend its reach to help coordinate care and post-release support to women released under ROTL, and those released as 'business as usual' in all English women's prisons during the pandemic. Here we report insights from an evaluation of this work. Interviews were undertaken with nineteen participants (six women, eight Birth Companions, and five health/social care professionals) and thematic analysis was undertaken. Two themes and associated sub-themes emerged. 'Facilitating support' outlines how women benefitted from the support via engendering trust, promoting coping strategies, and facilitating positive change. 'Challenges in support provision' describes key barriers that Birth Companions faced in accessing and supporting women due to communication barriers and difficulties in coordinating wider support. This study highlights a unique, service model that enabled woman-centred care, despite limitations. Prisons need to revisit existing policies and guidelines to ensure that equitable care is provided during future crises.

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Perinatal support; prison; COVID-19; pregnant

Background

Women in prison are an increasing minority of prisoners worldwide, with a recent report identifying the number of women being jailed globally has increased by 33% over the past 20 years (Penal Reform International 2022). While robust evidence on the numbers of perinatal women – those who are pregnant or who have recently had a baby – is generally lacking, available data suggests that many women in prison are childbearing age, and

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most are mothers (Bard, Knight, and Plugge 2016). A snapshot of data from the UK in 2019 reported that ~2% of the women's prison population were pregnant (Ministry of Justice (Ministry of Justice 2020).

Women prisoners are more likely to have complex backgrounds including histories of poverty, poor mental health, exposure to violence and sexual abuse, and lack of family support (Baldwin, Sobolewska, and Capper 2020; Fowler et al. 2021). Those who are pregnant or have a child while in custody can also face additional challenges such as increased risks of depression and anxiety (Baldwin, Sobolewska, and Capper 2020), substantial barriers in seeking an abortion (Sufrin et al. 2021) and more likely to have poorer outcomes due to an increased likelihood of preterm delivery or caesarean section (Baldwin, Sobolewska, and Capper 2020; Bard, Knight, and Plugge 2016; Walker et al. 2014).

A recent integrative review reported that incarcerated pregnant women's experiences tend to be characterised by risk and vulnerabilities, rather than how prisons can address women's perinatal needs (Baldwin, Sobolewska, and Capper 2020). A USA-based cohort study found that women in prison were significantly less likely to receive adequate antenatal care when compared to women in the general population (Ramirez et al. 2020). Pregnant women in Abbott's et al. (2020) ethnographic prison-based study were described as having an existential crisis due to denying their pregnancy as a means of coping while experiencing frustration and a sense of injustice when they did not receive any specialist treatment. These negative findings are also reflected in a qualitative systematic review that reports the dehumanisation of prenatal care, lack of privacy, stigma and trauma experienced by incarcerated pregnant women (Kirubarajan et al. 2022). Currently, there are several guidelines concerning the care of pregnant women in prison. For example, the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (referred to as The Bangkok Rules) sets out minimum standards for the needs of pregnant women and children (United Nations Office on Drugs and Crime 2011); although a review of the international guidelines identified several key gaps, such as maternal and fetal health assessments and mental health support (Alirezaei and Roudsari 2020).

Pregnant women in prison are often separated from their infant after birth due to being housed in prisons without a Mother and Baby Unit (MBU) (currently only six of the 12 women's prisons in England have an MBU), or when infants reach the upper age limit allowed in an MBU setting (e.g. up to 18 months) (Ministry of Justice 2020). An MBU is a separately designed living area of the prison staffed by nursery nurses and often with suitably trained prison staff and is designed to promote positive child development (Ministry of Justice 2020). Although mothers placed in MBUs still raise concerns about a loss of autonomy and agency to practice motherhood in this setting (Sapkota et al. 2022). Spaces on MBUs are also under-utilised due to reasons such as women not meeting the criteria, applications being refused, and, on some occasions, women being discouraged from applying (Sikand 2017; Thomson et al. 2022). This separation inevitably creates high emotional distress and grief (Cavanagh et al. 2022). A study with women in nine UK prisons found that those admitted to MBUs had lower depression and higher quality-of-life scores compared to those not admitted to MBUs (Dolan, Shaw, and Hann 2019).

Birth Companions (BC) is a UK-based charity founded in 1996 (www.birthcompanions.org.uk) that supports women (those who are pregnant or have separated from their

infants or experienced a pregnancy/neonatal loss within two years) in prison via groups or one-to-one support. BC operate within a woman-centred, trauma-informed ethos to form trusting relationships with women; empower women to make informed choices; provide doula support where needed; advocate for women's rights (e.g. applying for MBU placement); provide maternity and infant-related items, and signposting. BC developed the Birth Charter (Birth Companions 2016) and an associated toolkit (Birth Companions 2019) that provides best practice standards for perinatal women in prison. These standards include the need for equitable and woman-centred maternity care and resettlement support, and for prison staff to have appropriate training.

At the start of the COVID-19 pandemic BC and others campaigned for the release of pregnant women and mothers of infants from prison (Goddard 2020). On 31 March 2020, the Ministry of Justice and Her Majesty's Prisons and Probation Service (HMPPS) prioritised the early release of pregnant women and mothers living with their babies on MBUs (referred to as compassionate release on ROTL – release on temporary licence) where they were assessed as low risk and had suitable accommodation in place (GOV.UK 2020). These women were subject to licence conditions including a requirement to stay at home, and wear an electronic tag, where appropriate, with immediate recalls for breaching conditions or committing further offences (GOV.UK).

In April 2020 Birth Companions received funding from NHS England and NHS Improvement Health & Justice (Liaison & Diversion) to support women in any women's prison in England before and post-release (those on ROTL and those released as 'business as usual') during the COVID-19 pandemic. A COVID-response telephone line, generic email address and referral process were established, with details of the service distributed across HMPPS and third-sector organisations. Support provision was to include developing appropriate care and resettlement plans, and providing practical, information and emotional support to women via telephone/text/email contact (an overview of the support model is detailed below).

Here we provide insights into a commissioned evaluation of this work undertaken between July 2020 – May 2021. The agreed aims were to capture the types of support that BC provided, the experiences and impact of the support on women's health and wellbeing, and any barriers or facilitators to providing the support.

Methodology

Design

A qualitative exploratory design was used (Hunter, McCallum, and Howes 2019) for this evaluation. This approach was chosen as it is considered suitable when exploring a topic with limited coverage and developing new knowledge (Hunter, McCallum, and Howes 2019).

BC intervention model

As all prison-based face-to-face contacts ceased during the pandemic, BC established a remote model of trauma-informed support that was designed to demonstrate care, build trust-based relationships, provide information on BC services, and connect with

women pre-release so resettlement needs could be organised. An overview of the types of support and how it was delivered is outlined as follows:

(a) *Postal-related* – following receipt of a referral, the woman was posted an introductory pack containing information on BC (i.e. BC *Inside Guide* that provides insights into pregnancy and early motherhood in the prison system and applying for MBUs); twice a month, women were sent a craft pack (e.g. origami, frame making, sketching) or other activities, such as word searches, colouring pads, journaling materials. Bespoke pregnancy-related information could also be posted following direct requests.
Parenting-related items were offered to all women including maternity wear, underwear, shoes, bras, nappies, clothes, prams, cots, slings, and infant-feeding equipment. At Christmas, all women received presents of a mindfulness colouring book, a craft pack, and a personal item (e.g. toiletries, socks).
(b) *Email* - Every week BC emailed women (via the Email a Prisoner system) to introduce themselves, offer support, enquire as to their wellbeing, etc, with women able to respond indirectly via HMPPS staff. In prisons without the reply service, BC would write to women and send stamped addressed envelopes to enable them to reply.
(c) *Phone*: BC would attempt to coordinate a pre-release call with women to help facilitate their resettlement needs, and post-release BC would continue to offer support via text and phone.

Ethical considerations

University ethics approval was obtained (project: 0085). As HMPPS stopped research during the pandemic, we were unable to interview any HMPPS staff, or women in prison/under licence conditions.

Participant recruitment

Three participant groups were targeted – BC staff, health/social care professionals (HSCPs), and perinatal women who had finished their prison sentence and received BC support during the pandemic. The BC Head of Services forwarded an introductory email to a) BC staff who were organising or supporting women in prison during the COVID-19 pandemic, b) HSCPs whom she felt would be able to provide insights into the work BC had been undertaking during the pandemic and c) women BC had supported whilst in prison and who were not currently under licence conditions. Participants were asked to contact the evaluation team direct if they were interested in taking part in an interview. These individuals were then forwarded a participant information sheet and consent form and asked to respond within 2 weeks if willing to participate.

Data collection

Data collection methods involved:

Audio-recorded interviews undertaken by telephone (women) or Microsoft Teams (BC and HSCPs) explored participants' awareness, experiences and perceived impact of BC support and any recommendations to develop the service further. While remote data collection has been a necessity due to the pandemic (Marques et al. 2021), this project would have required virtual methods due to where participants were located. All the interviews with women were undertaken via telephone and while this modality can be less personal and limits the opportunity to pick up on non-verbal cues, conversations via the telephone can allow participants to relax and be more able to disclose sensitive information (Novick 2008).

Consent was audio-recorded and stored separately from the interview recording. Interviews were undertaken by one researcher, lasted between 25–60 minutes and were transcribed verbatim. Women were sent a £10 E-voucher to thank them for their involvement.

b) Regular meetings (n = 7) with the BC Head of Services to monitor progress on service delivery.

Data analysis

Data were uploaded to MAXQDA (a qualitative software programme that helps in managing and organising qualitative data sets - www.maxqda.com/). Braun and Clarke's (2019) reflexive thematic approach was used to analyse the data set. This creative, flexible, and inductive approach involved prolonged data immersion by reading and re-reading the tests, identifying key codes, and then grouping codes into sub-themes and themes that represented particular patterns of meanings. Following analysis, all the candidate themes were reviewed against the whole data set to ensure that all the views had been represented.

Findings

Overall, nineteen participants contacted the evaluation team to take part in the study comprising six women, eight BC staff, and five HSCPs from midwifery (n = 2), prison (n = 1 - currently employed elsewhere), or third-sector backgrounds (n = 2).

The findings are reported in two themes and associated sub-themes. The first theme describes how BCwere 'facilitating support' through developing trust, strategies for positive coping and helping women to enact positive changes. The second theme 'challenges in support provision' describes the communication and coordination difficulties faced by BC in providing support to women during the pandemic.

Facilitating support

In this theme, we report on three sub-themes that describe how BC supported women through 'facilitating trust', 'facilitating positive coping' and 'facilitating positive change'.

Facilitating trust

BC drew on various interpersonal approaches in attempts to forge relational bonds with women. This involved active listening, being non-judgemental, demonstrating empathy,

and providing consistent care (such as contacting them when agreed). Overall, these approaches were found to be effective, as, despite remote working, positive relational care was described:

> [I] never met X [Birth Companions] and we've only literally spoke on the phone, email, or WhatsApp. And it's just such a lovely vibe about them, about the whole charity. Yeah, I just think it's beautiful work that they do *(Woman_2)*

Women spoke of how BC had 'engendered trust', which led them to be more open to trusting others, thereby widening their opportunities for needs-led support:

> I wouldn't trust people very much, [. . .] but they [BC] have changed my view of people, and just being able to trust someone *(Woman_5)*

One professional who collaborated with BC to provide support to a foreign national reflected on how the trust they developed as providers meant they could offer *'better'* support:

> I think it was like building up – between us. It was a good relationship of trust. And then because everything worked so well between us, the client was very easy to work with. *(HSCP_1)*

Facilitating positive coping

Women described how the craft and well-being activities had helped them to develop positive coping strategies:

> X [BC] advised me to write down how I was feeling and every day as soon as I woke up to when I went to sleep, if I was ever feeling down or low or anything just to write it down. *(Woman_3)*

The activities also provided women with a positive means of distraction at a time when prison visits and activities were suspended, and women were usually spending 23 hours in their cells due to COVID restrictions; *'They* [distraction packs] *kept my mind free from the madness to be honest* [. . .]' (Woman_2).

The regularity of contacts (via post/email/phone/text) helped to reduce social isolation, and provided women with a lifeline of support post-release:

> And it's lovely to know that people are there for you. I could drop a text or WhatsApp or an email, and I automatically get a reply or phone call, which is nice when you're in addiction. You are alone and it's nice that people give you their time. I left prison and I've been in touch with them ever since. *(Woman_2)*

Some women reflected on how the support was designed to give them *'what I needed'* to cope. On one occasion this involved a specific request to acquire photos of their children – '*I asked her if she could contact my Mum and ask if I could have a few pictures* [. . .] *and she did'* (Woman_3).

Facilitating positive change

Women reflected on various ways BC had helped them to achieve positive change. First, BC was reported to provide women with access to social, health, emotional and/

or financial support as needed. BC was recognised as providing essential items to women who '*literally had nothing*' (Woman_1):

> Anything really anything I needed help with. They helped me. They were there for me when I needed some time to just talk to someone. Everything, anything I needed. So, stroller and prams. When I left prison, they made sure I had milk, nappies things like that for the kid. Then I moved to my placement and they got in touch with somebody who got me loads of stuff like donations, birthday presents, everything. *(Woman_5).*

Women also reported on how BC support facilitated personal positive changes due to feeling recognised and validated as pregnant women with specific needs: '*They treated us as pregnant women*' (Woman_5). Others reflected on how the support helped them to release self-blame, '*I was starting to love myself again. I wasn't hating myself from the past*' (Woman_3), to develop self-belief and confidence, [They helped me to have] '*a lot more confidence*' (Woman_2), and for some, the ongoing encouragement and praise provided the motivation for sustained behaviour change:

> Emotional support, especially when I was in rehab, praise as well, [. . .] to keep going. I kept giving her [BC] updates and then she mailed me back saying it's so great to hear your determination and strength is still thriving, and it gives you more motivation. Oh, it's beautiful really. It's priceless. *(Woman_2)*

Challenges in support provision

Here two sub-themes describe key challenges faced by BC in providing support to women during the pandemic, namely 'communication challenges' and 'coordinating wider support'.

Communication barriers

Following receipt of a referral, BC strove to communicate with HMPPS staff. These communications were perceived as essential to: disseminate postal packs; *'piece the jigsaw'* (BC_6) of women's needs; elicit whether women were accessing appropriate maternity support, e.g. post-birth checks; tailor the communications and information that BC provided, e.g. '*whether or not I send pregnancy-related information*' (BC_8); log women's key dates (release, expected delivery), and use this information to prompt staff, e.g. in supporting women to develop birth plans, or initiate post-release support. Overall, while data-gathering was generally *'easier'* in prisons where BC had pre-existing relationships, an over-reliance on named individuals was problematic when they became unavailable (e.g. due to illness); in unfamiliar settings, capturing this information was described as *'complex'* and '*time consuming*'.

Other challenges in BC providing support concerned confusion over who was eligible for release; '*we didn't always get to know why they were refused*' (BC_ 6). Some women were released under ROTL with no clear instructions '[she was told] *we don't know when you'll be coming back but do expect to be recalled at some point*' (BC_7). A lack of consistency and transparency was considered to leave women in *'horrible limbo – always kind of waiting, waiting, waiting*' (BC_ 7). There were issues of women being released without BC being notified; BC being provided with an incorrect contact telephone

number for women, and women being released without a phone or contact number. Identifying eligible women was also problematic, e.g. due to women refusing a pregnancy test, or not detecting women who had separated from their infants or experienced a perinatal loss.

A further challenge related to some prisons not using the 'Email a prisoner' system, and having to rely on postal communication. However, even where the email system was in operation, responses could be very delayed, compromising support provision:

> An email had been sent [from the mother] requesting support before being separated from her baby. As the email was a month delayed in being sent, by the time it was received the mother had already been separated and was too late. *(BC_1)*

There were also challenges concerning telephone communications – BC were unable to converse with women for prolonged periods due to where the phone was located, or women only being allocated one hour of non-cell time. Furthermore, while BC was a registered PIN (priority identification number) in some prisons, one woman explained they were only allowed three PINs, which meant that the approved numbers kept changing, creating inevitable delays.

Coordinating wider support

The pandemic caused severe disruptions to how 'usual' services operated, with statutory services operating in a reduced or altered way, which ultimately led to a '*stark absence*' of resettlement support for women. BC also reported on how HMPPS offered women different resettlement packages, whereby women released under ROTL were to receive a mobile phone, safe transport, a discharge grant of £80.00 and a commitment for secure accommodation; those released as 'business as usual' were to receive a discharge grant of £46.00, with additional support provided at the prison's discretion. These disruptions in 'usual' care and variations in resettlement support led to women being released without a phone or safe transportation and to poor and/or inappropriate accommodation; women having insufficient funds to cover basic needs; prescriptions not being arranged; delays in registering women with appropriate healthcare; women's bank accounts not being organised, and appointments being organised that were impossible for women to attend (due to times and/or locations) placing them at risk of breaching their licence requirements. BC described how these gaps meant they had to *'step-up'* to provide additional support (e.g. provide a phone and credit, top-up the discharge grant, organise transportation) and provide a much more *'intensive'* liaison-based role than anticipated to ensure that women's needs were being met:

> I think [we have been] genuinely shocked at how little the resettlement teams in the prisons have done and how little probation services have done. *(BC_ 6)*

Interdisciplinary working was perceived as essential. While multidisciplinary team (MDT) meetings were taking place (virtually) in some prisons, in others they had not been established. This meant that BC spent prolonged periods liaising with a wide range of individuals and organisations to coordinate the care required. However, a key positive feature of remote support meant BC were able to extend its reach (geographically and with individual women). While previously post-release support was only offered to those

who lived within proximity to BC staff, the pandemic demonstrated how community support could be offered irrespective of the women's locality:

> We've discovered that, whereas perhaps if a woman was being released to X [geographical area], we wouldn't have thought we could continue to support her. But what this has taught us is that we can still support by phone, and we can also help link her in with her local support *(BC_1)*

Discussion

In this paper, we report on an evaluation of Birth Companions (BC) support provision to perinatal women both within prison and post-release during the COVID-19 pandemic. Overall, the numbers of women released from prison in England were low, similar to other global statistics (Pont et al. 2021), compounded by confusion and lack of transparency in eligibility criteria. In every sphere of life, the pandemic has led to uncertainty and readjustment. However, in a prison setting, the implications were punitive and violated basic human rights. In the UK, there are minimum standards concerning the care of pregnant and postnatal women both in prison and post-release (MoJ, 2021), with our findings highlighting that these were not upheld during the recent pandemic. BC sought to rectify these inequalities by providing an innovative intervention designed to develop meaningful connections, provide woman-centred support, facilitate women's access to wider care and support, and provide coping tools and techniques to prevent boredom and protect their mental health.

The complexities of women's needs, and challenges identified in this study associated with overreliance on individuals to coordinate care, strengthen the arguments for multidisciplinary team (MDT) working in general, particularly during crisis situations such as the recent pandemic. MDTs offer various benefits of bringing together expertise and skills to coordinate and facilitate care, particularly for those with complex needs (Aikman 2018; Radcliffe et al. 2020). The pandemic inevitably created disrupted MDT practices due to organisational shifts in communication and operationalisation of service provision. However, in some sectors, it has helped to improve the coordination of care, with remote online working helping to facilitate connection and collaboration (Rajasekaran et al. 2021). Furthermore, for BC, the remote methods of communication enabled them to extend their reach to facilitate individualised support irrespective of where the women were located.

To our knowledge, there has been no published literature describing perinatal interventions in prisons during the COVID-19 pandemic. Furthermore, while BC provided a different and remote model of support than was usual, it was adapted from what they knew worked well. Women's reflections on the support echo those from other BC evaluations, and findings from wider prison-related perinatal interventions, including how the support enabled women to communicate their needs, receive information and guidance and enhanced their emotional well-being (Balaam and Thomson 2018; Thomson et al. 2022; Wilson et al. 2022). BC worked to address key inequalities identified in the wider literature in terms of helping women to receive appropriate prenatal care (Kirubarajan et al. 2022), to form connections with their fetuses (Abbott et al. 2020; Cavanagh et al. 2022) and provide woman-centred support (Abbott, Scott, and Thomas

2022; Sapkota et al. 2022). Previous research highlights how a lack of social support is a key risk for women prisoners (Bartlett and Hollins 2018), and relationship-based support is a key need for incarcerated prisoners (Muentner et al. 2022). BC helped to address these needs by offering a consistent and regular lifeline of support, that helped to reduce social isolation and loneliness. Furthermore, the fact that trust was established between BC and women as well as BC and wider providers under pandemic-related conditions is a testament to their ethos of care; with trust believed to be an essential conduit for individual and needs-led support (Brown et al. 2011).

The strengths of this study relate to describing a unique model of service provision, and while the number of participants involved were low, it captures insights from different stakeholder perspectives. A key limitation relates to being unable to interview current HMPPS employees or women in prison/currently on licence. As we managed to consult with women who were no longer on licence (but had received BC support while still incarcerated) and staff who had previously worked in prison is, therefore, a strength. As BC sent invites to those who were deemed to be suitable to participate, these insights may only offer a partial and potentially biased perspective. Moreover, as women only offered positive insights, this may be indicative of BC being the only meaningful form of support available to them.

In conclusion, while this is a small-scale evaluation, it offers insights into a unique, woman-centred model of support for perinatal women in prison during the COVID-19 pandemic. BC worked hard to address key gaps in care by building remote relationships with perinatal women, providing coping strategies to help women endure prolonged social isolation, ensuring women's maternity needs were being met, and that suitable and equitable resettlement support was being provided; with social, emotional, and parenting-related benefits being highlighted. While this support model addresses the call for interventions to improve prison-related perinatal support (Kirubarajan et al. 2022), it also emphasises the need for prisons to revisit existing policies and guidelines to ensure that equitable care is provided during future crises.

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