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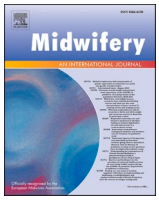

Complexities of midwifery care delivered to perinatal women in prison: A qualitative study

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ABSTRACT

Purpose: To provide insight into the challenges faced by imprisoned perinatal women in accessing appropriate information, support, and care and the importance of the midwife's role in this context.
Method: This paper draws on two studies conducted in one United Kingdom (UK) women's prison over two separate time points (2019, 2021). In both qualitative evaluative studies that were descriptive in nature, semi-structured interviews were conducted with perinatal women and professionals involved in their care.
Participants: 17 women participated across the two qualitative studies, six were pregnant, nine were on the Mother and Baby Unit (MBU) and two had given birth in the last 12 months but were not on the MBU. 12 professionals participated across the two studies.
Results: The studies highlight the specific challenges that perinatal women in prison face compared to their community counterparts in being able to access reliable information on pregnancy, birth, and parenting; having access to appropriate and reliable peer support and mental health support not only in terms of provision but also in terms of accessibility; and in being able to advocate for themselves or having people that can advocate for them.
Conclusion: These challenges arguably heighten the importance of, as well as the pressure on the midwife in this context. The authors therefore highlight the need for consideration of three factors for midwifery in this context: (1) Resourcing (2) Information provision to, and information sharing between, midwives to increase awareness of challenges faced by this cohort, and (3) Strengthening the midwife's position to support and advocate for women's perinatal mental health in prison.

Introduction

As of March 2023 there were 3,206 women in prison in England and Wales, constituting approximately 4 % of the prison population (Beard, 2023). The relatively small number of women imprisoned compared to men has contributed to a lack of focus on the gender-specific health and wellbeing needs of women in contact with the wider criminal justice system until relatively recently (Corston, 2007; HMPPS, 2018; Ministry of Justice, 2018; Peden et al., 2018). Evidence shows women prisoners experience higher levels of mental health issues than males, being twice as likely to suffer from depression at 65 % compared to 37 % of male prisoners (Light et al., 2013) and five times more likely to self-harm (Ministry of Justice, 2019). Within this vulnerable minority in prison there is a further vulnerable minority which is perinatal women. According to the HMPPS Annual Digest (MOJ, 2023) in the period April 2022 to March 2023 there were 194 pregnant women in prison and 44 births. These figures should be treated with caution as they relate to women who have self-declared as pregnant and consented to sharing this information.

There is a body of evidence in the UK that recognizes poorer outcomes for both babies and mothers in prison (Price, 2005; Edge et al., 2006, Abbott, 2016). Price (2005) identified significant variance in the standards of care for women in prisons which were largely determined by the prison in which they were located. 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. They found that imprisoned women experience significant levels of emotional and psychological distress during the perinatal period with two-thirds experiencing depression, and their experiences of pregnancy,

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childbirth, and early motherhood were generally negative because they reported feeling unsafe and uncared for (Edge et al., 2006). More recently, Abbott's research conducted in the UK (2016) identified that pregnant women in prison were unable to access basic comforts, acceptable nutrition, and fresh air. Being disconnected from supportive networks created a high risk of developing or exacerbating mental ill health (Abbott, 2016). Abbott et al. (2020) highlighted sensory overload from the noise of the prison environment and women also spoke of a desire not to show weakness or draw attention to their pregnancy fearing degradation, leading to disempowerment. Abbott et al. (2022) highlight an absence of care equivalence for pregnant UK prisoners with them unable to choose their care provider, birth companion, or their place of birth and having limited access to information about their rights. Bard et al. (2016) conducted a systematic review of perinatal health care services for imprisoned pregnant women which included 18 studies, 15 of which were in the United States, two in the UK and one in Germany. The review found evidence that women in prisons where some specific effort had been made to improve conditions or care for pregnant women were less likely to have inadequate antenatal 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 (Bard et al., 2016).

An influential document in the improvement of the care of women in prison in the UK is Birth Companions Birth Charter for Women in Prison (Kennedy et al., 2016), informing policy and practice as regards to the care of perinatal women both within criminal justice services and public health provision (Her Majesty's Inspectorate of Prisons; 2021; HMPPS, 2018; Peden et al., 2018). It sets out 15 principles of care relating to pregnancy, birth and the postnatal period in prisons. The Royal College of Midwives (RCM) advised Birth Companions on the Charter, and in their position statement on the perinatal care of women in the criminal justice system they asserted that all UK women's prisons should implement the Charter in full (RCM, 2019).

This paper provides a qualitative evaluation of the perinatal care provided in one UK prison benchmarked against the Charter, across two time points in 2019 and 2021 (Cahalin et al., 2022; Callender et al., 2019). The qualitative study in 2019 focused on the research questions outlined below, which reflect three elements of care that pregnant women and new mothers in prisons should receive according to the Charter (Kennedy et al., 2016).

(1) Are perinatal women able to access the same standard of antenatal care as women in the community?
(2) Are perinatal women encouraged and supported in their chosen method of infant feeding?
(3) Are perinatal women able to access counselling?

The 2021 qualitative study revisited these three research questions to ascertain whether service improvements put in place to address the feedback from perinatal women and professionals had led to perceived improvements in care in these domains. This paper presents findings from across both qualitative studies and reflects on the importance of the midwife and the unique challenges for this role in the prison context. The number of female prisoners has increased globally by up to 60 % since 2000 including in Anglophone countries such as Australia and the USA which has the highest female prison population rate (Fair and Walmsley, 2022). There is, therefore, theoretical generalisability from this paper for other countries which have similar legislative processes and sentencing for pregnant women to the UK.

Research methodology

This paper is based on a qualitative evaluative study which seeks to understand the implementation of policy from the perspective of the participants targeted by it (Tayabas et al., 2014) in order to influence future policy and practice. It is descriptive in nature involving semi-structured interviews with women in one UK prison who had been identified as being pregnant, had given birth in the last 12 months, or who were on the Mother and Baby Unit (MBU). The studies were commissioned by NHS England to determine how perinatal services could be improved within the prison related to the three identified areas of the Birth Charter (Kennedy et al., 2016). Therefore, the scope of the study was determined by the Commissioner. Through the course of the project, important and original knowledge on an under researched/reported population of perinatal prisoners was created and reported on in this paper.

Design

Semi-structured interviews were used to ensure that all topics that were relevant to the research questions were covered, but also allowed the interviewer flexibility to cover related topics as they arose that were pertinent to the women's perspectives of pre- and postnatal provision (Braun and Clarke, 2013). 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 was important that the women were asked open ended questions so that assumptions were not made by imposing fixed response questions about what was important and salient to them. Additionally, semi-structured interviews were conducted with professionals who were involved in the perinatal care of women in the prison. The themes of questions asked of the women and professionals are contained in Tables 1 and 2 below.

Participants and recruitment

In both studies perinatal women in the prison on the MBU that were pregnant and those that had 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 a prison officer, who acted as a gatekeeper, if they wished to participate who then scheduled interviews for the research team with them. Overall, across the two time points, this study draws on the lived experience of 17 perinatal women (Table 3).

Demographic data of the participants was not requested in either study for the following reasons: (1) On such a small sample of women reporting demographic detail could have the potential to identify specific women that participated (Morse, 2008; Morse and Coulehan, 2015). Maintaining anonymity is of paramount importance particularly as women are reliant on the system to meet their needs and it would be unethical to undermine this key principle by publishing demographic data. (2) The primary objective was to ensure as many of the women who wanted to participate as possible felt comfortable to participate. The collection of their personal data could have been a barrier to their willingness to participate.

In Study 1 five professionals took part and seven took part in Study 2. Professionals that were involved in the perinatal care of women in the prison were provided by the NHS Commissioner. These professionals were then sent invites to participate in an interview by the research team via email along with Participant Information Sheets (PIS). Thereafter a snowballing approach was used to ensure that any other relevant professionals were invited for interview. Professionals invited included the midwife, members of the prison health care team, the health visitor, external providers of antenatal classes, and mental health support and prison staff involved in the perinatal care of women.

Setting

In Study 1, all interviews with women on the MBU were conducted in an office in the MBU and all interviews with pregnant women were conducted within a visitor room on the main prison site. In Study 2, five women took part in face-to-face interviews. However, the Covid-19 restrictions changed during the research which meant that researchers

Table 1
Perinatal women interview schedule themes:

Ante-natal care

- Do/did you attend the antenatal clinic in the prison? (Prompt: How often do you visit the clinic? Are you happy with how often?)
- What contact do you have with the midwife and midwifery team during your pregnancy?
- Do/did you attend any ante-natal classes? (Prompt: Do/Did you find them useful?)
- Have you completed a birth plan? (Prompt: were you supported in this?)
- Have you had scans or appointments at hospital? (Prompt: what was the experience like for you?)
- How is your experience of healthcare support whilst in prison, such as for medical emergencies or seeking assistance at night?
- How were your additional needs supported during pregnancy? (Prompt: such as access to sunlight/ vit D, clothing, food, medical care and family support)
- What are your overall views on the ante-natal care you received, do you think it is equivalent to support within the community?

Infant feedingFor those that were pregnant:

- Have you received information on infant feeding choices?

For those that had given birth and were on the MBU with their baby:

- Are you breast feeding/ bottle feeding?
- Do you feel you received the information and support you needed on choices?
- Do you have access to the appropriate equipment?
- Do you feel supported in your chosen method of feeding?
- Did you change your choice of feeding and why?
- Are there barriers to your chosen form of feeding in prison?

Counselling

- Have you been offered counselling/ talking therapies and support since the birth of your child or whilst pregnant?

If answered yes (follow-on questions):

- What were you offered?
- Was it useful?
- Did it happen when you needed it to, and did you have it as long as needed?
- Could it have been improved in any way?

If answered no (follow-on questions):

- Would you have liked to have been offered anything?
- Would you know how to request support if you needed it?
- Apart from counselling or talking therapies have there been any other people that you have been able to talk to when you have needed support?
- Are you aware of who you can get support from whilst you are in prison?
- Do you feel comfortable asking for help or support?

Table 2
Professional interview schedule themes.

Ante-natal care

- What is your role in perinatal care in the prison?
- Are regular antenatal clinics provided in the prison?
- What are the processes when women have scans (Prompts: are women provided with scan photos, are women able to apply for permission for a partner or family member to attend?)
- What are the policies, processes and practices when appointments happen in hospital?
- What are the communication channels with the midwife and midwifery team?
- Are prison staff trained to understand the needs and support of perinatal women? (Prompt: Including understanding the role of the midwife and reacting in cases of emergency?)
- What support do women receive in the prison whilst pregnant? (Prompt: such as ante-natal classes)
- Are there any improvements that they think are needed?

Infant feeding

- What support is provided in terms of bonding with baby and responding to babies needs incl. feeding?
- Is there access to appropriate equipment whether breast or formula feeding?
- What sort of access to breastfeeding information and support is there?
- Does the environment support and encourage breastfeeding? (Prompt: Any barriers?)
- Is the support similar to that received in the community?
- Are the staff in the MBU trained so that they can support women in infant feeding choices?

Counselling

- Are pregnant and postnatal women offered confidential counselling and support?
- What is the process of referral to an appropriate health care professional if perinatal mental illness is suspected?
- Are all women who are separated from a baby offered pre- and post-separation counselling?
- Are women who lose babies offered counselling?
- Are there other talking therapies available to women?

were no longer allowed to enter the prison and therefore two interviews were conducted over the phone. In both studies there was a mixture of online and in person interviews with professionals. This was based on professional preferences and was designed to maximise participation.

Ethical considerations

Both studies (2019, 2021) were reviewed and approved by the University of Northampton, Faculty of Health, Education, and Society Research Ethics Committee and the HM Prison & Probation Service National Research Committee (HMPPS NRC).

Table 3
Number and type of perinatal women by review.

	Review 1	Review 2	Total
Pregnant women	3	3	6
Women on the MBU with their babies	7	2	9
Women that had been pregnant in the last 12 months but were not on the MBU (but in the main prison)	0	2	2
Total	10	7	17

Data analysis

Thematic analysis was conducted on the interview data[1], which involved coding the data to seek out the emergent themes for each of the three research questions. An inductive approach was used so as not to apply pre-existing conceptions of what themes might arise. Two members of the research team were involved in the process, first by coding alone and then coming together to discuss and refine categories, ensuring reliability and that the analysis was as close to theoretical saturation as possible. The researchers adopted semantic coding, coding on the basis of the explicit meaning of what participants said rather than latent coding which also aims to identify hidden meaning or underlying assumptions ideas or ideologies (Braun and Clarke, 2013).

Limitations

There are unique challenges of conducting research in prison which impact on sample size and on the quality of data collected. Firstly, there are issues of power within the prison environment. Women's daily lives are entirely in the control of the prison setting, which may have impacted their willingness to talk to researchers and to speak openly about concerns and experiences. Additionally, the women were in an environment in which their ability to make autonomous decisions was limited, and it was therefore important that it was made 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 PIS which they received prior to agreeing to take part. The researchers were reliant on prison staff to relay this information initially, therefore great care was taken verbally and by email to impress upon the prison staff the importance of explaining the key points of the PIS when inviting women to take part and ensuring that they knew that participation was voluntary. As it is acknowledged that the researchers did not have full control of the information that was relayed initially, they also took women through the PIS at the start of the interview and women were encouraged to ask questions to ensure informed consent was being given.

Secondly, the capacity for interviews was aligned and influenced by the prison routine meaning that access to the women was limited to short windows such as days researchers could attend the prison, and aspects of the prison routine meant that some women could not participate, for example some women from the MBU were on temporary release. Where possible the researchers offered more than one opportunity to participate but the ability to do this was limited due to resourcing and, particularly in Study 2, when the Covid-19 restrictions changed and meant that researchers were no longer allowed to enter the prison. Prison staff were required to act as gatekeepers for access to the women and it is difficult to determine whether this had an impact on participation. However, the researchers worked closely with prison staff through regular communication and the research team felt that the prison showed flexibility and determination in offering the opportunity to women and arranging appropriate times.

Thirdly, in both studies, researchers took written notes from the interviews with perinatal women as recording equipment was not permitted in the prison. This meant that data could not be captured and transcribed verbatim. To mitigate this, two researchers were engaged in data collection with one concentrating solely on note taking.

Fourthly, only two women were recruited across the studies who had been pregnant in the past 12 months and who were, at the time of the interview, separated from their babies limiting insight into their experiences.

Finally, it is important to acknowledge that this paper reflects the experiences of perinatal women in one prison. Whilst findings cannot be assumed to be generalisable to other settings, qualitative research seeks to produce theoretical transferability (Braun and Clarke, 2013). The two studies therefore can add to the growing literature on perinatal women's experiences in prison by providing insight specifically into women's experiences of antenatal care, choice and support of feeding their babies, and access to counselling in a prison environment. Further this paper considers these issues in relation to the role of the midwife.

Findings

The findings draw on the perspectives of both perinatal women and professionals from both studies (Cahalin et al., 2022; Callender et al., 2019). Findings are presented in relation to the three principles of the Birth Charter (Kennedy et al., 2016) below, using extracts from the interviews to illustrate the themes.

Access to Antenatal Care

In both studies (Cahalin et al., 2022; Callender et al., 2019), most women spoke very highly of the midwife and considered them to be very supportive, accessible, and helpful.

> *She is absolutely amazing* (Study 1, Woman 5),

> *[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…* (Study 2, Woman 1)

During Study 1, due to the women experiencing additional complex social needs, the midwife held two clinics a week and saw women more regularly than is recommended in NICE guidelines (NICE, 2014), which are evidence-based recommendations for antenatal health and care provision in England and Wales. However, it was concluded in Study 1 that women did not have equivalent care in terms of their access to the midwife as this was inhibited because of their environment, with barriers including limited credit on their phone or having to go through internal staff to access the midwife.

> *You have to go through the nurse to see the midwife. Some nurses go above and beyond but it varies on who you see. To get an appointment with a nurse can take weeks.* (Study 1, Woman 6)

Study 2 highlighted that there had been significant development in perinatal care since Study 1 with the introduction of a documented perinatal pathway. Reports from women suggested that they did have good access to the midwife and could call the local labour ward free of charge when the midwife was not available. However, the twice weekly midwife clinic that was present in Study 1 had been reduced to a weekly clinic by Study 2. It was stated that this was due to changes in the midwife's role and commitments in the community, although it was also stated that the frequency of attendance was within statutory requirements.

> *It used to be more frequent than that but there's some pressures in the community that she's having to support with.* (Study 2, Professional 1)

[1] Due to ethical/commercial issues, data underpinning this publication cannot be made openly available. Further information about the data and conditions for access are available from the Institute for Public Safety, Crime and Justice, University of Northampton, at ipscj@northampton.ac.uk.

Study 1 highlighted the strength of the provision of antenatal classes in the prison with women finding them to be extremely useful and informative.

The wealth of knowledge is unbelievable…my whole experience would have been completely different without it (Study 1, Woman 1)

…(you) get so much information on all different subjects including birthing plans, drugs can take, infant feeding etc (Study 1, Woman 5)

However, women interviewed in Study 2 reported there were no antenatal classes, which negatively impacted their ability to access current information, discuss information with others, or ask questions. One professional commented:

…All that really specific stuff that is empowering women to make choices and to have autonomy over their choices is missing at the moment. (Study 2, Professional 4)

Spiby et al. (2022) highlight that antenatal classes are important for information provision. A further function they serve is for women to meet other pregnant women to normalise feelings or worries and to develop ongoing support and friendship. The importance of the ability of women to support each other as well as to receive appropriate information is illustrated in the comment from one woman below.

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. (Study 2, Woman 1)

A clear message from women, particularly in Study 1, was that they felt powerless. Women talked about feeling that they were not being listened to and as a result they would stop trying to get what they needed.

I just don't bother with them. Don't feel like you can ask because you don't get nowhere (Study 1, Woman 6)

If you ever need anything you are told to stop nagging (Study 1, Woman 3)

One of the women in Study 2 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*' (Study 2, Woman 3). She felt that they might not ask questions, get the help they need, or fully understand their rights. She provided an example of needing to be persistent when engaging with both prison systems and individual staff to gain information about the MBU. She provided further examples, of repeatedly asking if a family member could attend a scan and for a test she felt she needed due to a health concern.

Women's accounts in Study 1 demonstrated that in the context of being disempowered in prison they were highly reliant on the midwife and providers of the antenatal classes to follow things up and come back to them with information.

I get along very well with the midwife, she is lovely I couldn't ask for better support. She always chases stuff up, but she is the only one that does (Study 1, Woman 3)

First helped with what to expect, advice, leaflets and paperwork, brought in pregnancy books. They were really helpful and I still see them now. They help you out as much as possible. If they don't know something or you ask them to find out something they will always come back to you. (Study 1, Woman 2).

In Study 2 the women did not have the antenatal class provision but, as in Study 1, their reliance on the midwife was also clear in providing this function.

[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. (Study 2, Woman 1)

This woman commented that there should be 'proper' antenatal classes, and that they were particularly important for those that had not had a baby before.

Infant feeding, bonding and attachment

The midwife and health visitor were the primary sources of support and information for women. One barrier, noted by one of the professionals, was that there may be confusion amongst women as to what is available to them and from whom.

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. (Study 2, Professional 6)

They stated that they were not sure whether this was due to a lack of awareness of prison staff of what support is available from whom, although they commented that nursery nurses were aware of support options and also felt that communication about support available could be improved. One woman in Study 2 spoke of feeling misled about what support was available and that she consequently switched from breast to bottle feeding. This was because the officer had told the hospital that they received help with breastfeeding and so she assumed that she would get help on returning to prison.

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… (Study 2, Woman 2)

Nursery nurses on the MBU were also considered by professionals as a resource for women although they were mentioned less by women themselves. It was recognised that further training for nursery nurses in supporting women with breastfeeding would be beneficial.

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. (Study 2, Professional 6)

Out of hours the women had to rely on prison officers for support and their gender was suggested as a potential barrier:

… 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 nurse has gone home. (Study 2, Professional 6)

Additionally, women spoke about the variability in the extent to which prison staff would support or help them, with some being seen as highly supportive whilst others being viewed as obstructive and unhelpful.

One of the members of staff here is great, she has all the time in the world for us (Study 2, Woman 1)

Some officers you can talk to about anything but one officer you can't talk to. They are snappy and will tell officers and other prisoners what you have said (Study 1, Woman 2)

One of the women in Study 1 felt that she had to stop breastfeeding because she requested nipple cream to ease severe pain and she was denied it by staff. As a result, she felt she had no choice than to stop breastfeeding. She was disappointed as she felt breastfeeding was an important connection between mother and baby and something she had done with her other children. One mother in Study 2 spoke of her choice to breastfeed, but stopped after a few weeks due to limited support, discomfort about being watched breast feeding by officers, and

increasing feelings of stress.

> *I chose breastfeeding, it was so uncomfortable being watched by guards when trying to learn how to do it. So stressful. Arriving on the MBU, and not knowing the place, not knowing anyone here, and not knowing what I was doing. It was too stressful and I stopped after 3 weeks…* (Study 2, Woman 2)

In both studies there were comments about women on the MBU supporting each other with feeding.

> *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 access to that.* (Study 2, Professional 4)

In Study 1 one of the women commented that another prisoner had 'given her confidence to breastfeed' (Study 1, Woman 1).

Study 2, however, highlighted some significant improvements since Study 1 in terms of availability of appropriate equipment such as breast pumps. Additionally, a policy had been put in place to support women to express, store and transport their breast milk if they are separated from their baby as per one of the 15 elements of the Charter (Kennedy et al., 2016, p. 14).

Mental health support

Access to timely and effective counselling services was highlighted as an area for concern in Study 1 by professionals and perinatal women, including lack of specialised perinatal mental health provision, no support package for women separated from their babies, and an absence of training on perinatal mental health for professionals. Three women interviewed in Study 1 stated that they needed counselling, one of which was receiving it. She had been referred by the midwife and reported that the midwife had to really push for it. She commented:

> *Unless you are actually self-harming you are not taken seriously* (Study 1, Woman 5)

In Study 2, the perinatal mental health pathway was still under development, but significant progress had been made to improve the provision of and access to these services including specialist perinatal mental health provision. However, women were still facing institutional barriers to accessing appropriate and timely mental health support.

> *If you want support you have to put an application in at the kiosk, takes ages to get a response. It puts you off* (Study 2, Woman 1)

In addition, asking for help was seen as fundamentally difficult when experiencing mental ill-health. Responsibility was placed on perinatal women to self-refer mental health concerns which is not in line with wider HMPPS guidance (2018) which recommends that a member of the mental health team carries out routine mental health 'check ins' for perinatal women.

> *There is an open-door policy, but you have to feel comfortable enough to use it, to just go in and ask for help. They could come to us, approach us and offer help, rather than waiting for us to ask them.* (Study 2, Woman 2)

When some women did ask for help, they did not always receive an appropriate response:

> *… [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.* (Study 2, Professional 2)

There were also issues with accessing appropriate clinical spaces with the room on the healthcare wing described as not 'therapeutically viable', and there being significant barriers to accessing other spaces. Computer systems did not link with each other resulting in rooms being double booked and officers were needed to escort women to other areas which, on occasion, led to confusion and missed sessions. Additionally, IT issues with booking systems meant that the perinatal mental health team could book a woman an appointment for therapy, which would then be booked over by another appointment.

A strong message received from women was that they would like to be able to talk with other women, as well as the opportunity to escape briefly into a place where they could think about their pregnancy or motherhood.

> *Pregnancy groups would be good, especially for the girls who are at risk of losing (their) baby to the social care system* (Study 2, Woman 4)

Another commented that it would be beneficial if there were relaxation classes to ease stress, particularly of the trauma of not knowing whether they would be able to keep their child and the chaotic nature of prison life (Study 2, Woman 3).

Discussion

This research aimed to answer three research questions, which reflect three elements of care that pregnant women and new mothers in prisons should receive according to the Birth Companions Birth Charter (Kennedy et al., 2016). The first question was 'are perinatal women able to access the same standard of antenatal care as women in the community?' Although there was a reduction in clinics run by the midwife from the first study to the second due to changes in the midwifes role in the community, women in Study 2, were more positive about being able to access the midwife and the maternity helpline than those in Study 1. There had been significant development in perinatal care since Study 1 with the introduction of a documented perinatal pathway. However, a lack of provision of antenatal classes was noted in Study 2, a provision that women in Study 1 had access to and found extremely useful in providing them with information, support, and advocacy.

Research by Spiby et al., (2022) in the community concluded that women's information needs are not fully addressed during antenatal clinics and therefore women look to antenatal classes to provide reliable, face to face, first-hand information from facilitators with expertise. This increases their confidence in their knowledge about childbirth and reduces anxiety. The provision of reliable information is important as Fenwick et al. (2015) found that the quality of information and support woman receive during their pregnancy moderated their strength of birthing fear and anxiety.

Studies show that the midwife and other health professionals play a primary role as an information source for pregnant women in the community, but other key sources of information are family, friends, and the internet (Vogels-Broeke et al, 2022; Ghiasi, 2021; Bjelke et al., 2016). Research has shown that having access to close friends and family creates a sense of security and comfort and alleviates anxiety whereas the absence or uncertainty around support systems for pregnancy and labour exacerbated women's fears (Fenwick et al., 2015). Having peer support can contribute to reducing low mood and anxiety by overcoming feelings of isolation, disempowerment, and stress, and increasing feelings of self-esteem, self-efficacy and parenting competence (McLeish and Redshaw, 2017).

While it is important to acknowledge that the availability of antenatal classes in the community may also be an issue, with 29 % of 17,151 women who gave birth in February 2019 responding that they had not been offered antenatal classes (Care Quality Commission, 2020), this paper emphasises the importance of antenatal classes for imprisoned women. Firstly, because it helps to address the disadvantage that they have in accessing reliable information sources. Secondly, because they are at higher risk than their community counterparts of suffering poor mental health (Plugge et al., 2006; Offender Health Research Network, 2009; Tyler et al., 2019) and feeling disempowered (Abbott, 2020). Thirdly, women in prison have limited access to their own support networks (Abbott, 2021; Marshall, 2010; Sleed et al., 2013; Windham

Stewart, 2016). In an evaluation of perinatal and peer support provision in two prisons in the UK, Thomson et al. (2022) concluded that the access to the provision helped women to improve their confidence, their ability to communicate their needs and provided opportunities for positive social connections.

The second research question was 'are perinatal women encouraged and supported in their chosen method of infant feeding?' It was found that between the two studies there had been significant improvement in relation to infant feeding including the availability and quality of equipment such as breast pumps, and a policy to support women to express and have their breast milk transported if they were separated from their babies. However, there were barriers to breastfeeding noted by women including a lack of timely support and expertise. Adapting to breastfeeding is time specific and the midwife or health visitor may not be available at the times that they felt they needed that support. Women talked about their own or others reliance on other prisoners to help them, an avenue of informal peer support which relies on them being with women with experience of breastfeeding. This echoes research by Abbott et al. (2022) which found that women in one prison in the study did not have access to antenatal classes and reported a reliance on other prisoners. This reliance on other prisoners should be of some concern, as perinatal women in prison are less able than their peers to corroborate information using other sources. They are also then reliant on being around other women with relevant experience, which also may not reflect best practice. Women's ability to maintain breastfeeding was also influenced by their comfort in feeding their baby in a prison environment, the support they received from staff, and learning to breast feed in the presence of male officers. The discomfort of breastfeeding in front of male officers was also highlighted in research by Abbott (2017), research which also highlights the positive benefits of pregnancy and early parenting classes on women's likelihood of starting and maintaining breast feeding.

The third research question was 'are perinatal women able to access counselling?' In Study 1 access to timely and effective counselling by a professional with perinatal mental health experience was raised as an area of concern by both professionals and women. In Study 2, the perinatal mental health pathway was still under development, but significant progress had been made in the provision of support including the introduction of specialist perinatal mental health provision. However, women still reported institutional barriers to accessing appropriate and timely mental health support. MBRRACE-UK[2] (Knight et al,. 2023) has highlighted that in 2020 women were three times more likely to die by suicide during or up to six weeks after the end of pregnancy compared to 2017-19. The RCM have recently described perinatal mental health support as being on the precipice and has launched a 'roadmap' to ensure women receive the support they need (RCM, 2023). It is important to acknowledge the significance and relevance of this in relation to perinatal women in prison. Firstly, because they are at higher risk of mental health issues (Plugge et al., 2006; Offender Health Research Network, 2009; Tyler et al., 2019). Secondly, the experience of being imprisoned is traumatic (Kelman et al., 2022) and for perinatal women experiencing pregnancy and childbirth in a prison environment results in feelings of degradation, disempowerment and fear for the safety of their baby (Abbott, 2016; Cahalin et al., 2021) whilst also fearing being considered 'troublemakers' if they raise concerns or make repeated requests. Thirdly, they face multiple institutional barriers to accessing the perinatal mental health support that should be available to them as is highlighted above in this paper. It was particularly notable in one case that the midwife was instrumental in ensuring that one of the women received counselling.

[2] MBRRACE-UK stands for Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK and is responsible for looking at information about mothers and babies who die during pregnancy or soon after in the UK.

In summary this study adds to the evidence that imprisoned perinatal women face multiple disadvantages in their ability to access support, information and advocacy from sources other than the midwife. This arguably heightens the importance of, as well as the pressure on the midwife. Therefore, the three research questions/ topics have significant implications for the midwife in this context and highlight the need for consideration of the following factors.

(1) *Resourcing:* This research highlighted different resourcing was applied to the midwife's role across the two time points. This is important to note and deployment of midwives to prisons should consider the enhanced needs of women in prison given their complexity as well as the very specific issues and barriers they face in accessing support, information and advocacy compared to community counterparts. Abbott et al. (2022) highlighted that in some cases midwifery care was compromised by the reliance on one midwife. They have recommended that, alongside a specialist prison midwife with experience in prison maternal health, there should be a small team to ensure appropriate coverage and support for perinatal women. This aligns with the objective in the wider population of providing a continuity of care model in maternity care to provide 'safer care based on a relationship of mutual trust and respect in line with the woman's decisions' (NHS, 2016).

(2) *Information and understanding*: It is important that midwives have access to training and resources that enhance their understanding and ability to meet the needs of perinatal women in prison. The RCM highlights the Birth Charter as an important guide for both prisons and midwives in meeting their specific needs, and having an awareness of the specific challenges, faced by perinatal women in prison (Delap et al., 2016). Additionally, there is a growing body of UK based research in this area, and which this paper contributes to, that would be particularly beneficial to midwives (Abbott et al., 2022; Pitfield et al, 2023). Information and support networks may also be useful in allowing midwives to learn from one another and share experience. Additionally, it may allow them to seek support for themselves when working within a challenging environment with women with complex needs.

(3) *Strengthening midwives position to support and advocate for women's perinatal mental health in prison:* Perinatal women in this study highlighted the difficulties they faced in advocating for their own mental health needs. It is therefore particularly important that the RCM 'Strengthening Perinatal Mental Health Roadmap' (2023) is considered in relation to provision of support provided to midwives working with women in prison, given the particularly high level of mental health need in this population (Plugge et al., 2006; Offender Health Research Network, 2009; Tyler et al., 2019). Recommendations of the roadmap include all midwives having access to a specialist midwife in perinatal mental health and receiving regular training in perinatal mental health including trauma informed care. The midwife's role is seen as the pivotal role in perinatal care by other professionals in the prison system and therefore has the ability to exercise particular influence when it comes to advocating for the perinatal mental health needs of these women and therefore it is imperative that they are fully equipped to do so. Consideration could also be given to how joint working between midwives and mental health service provision within and outside prisons can be strengthened further, for example in the form of joint clinics.

Conclusion

The purpose of this paper was to provide insight into the challenges faced by imprisoned perinatal women in accessing appropriate information, support, and care. It was found that significant positive changes

had been made in this prison across the two time points in all three areas of the Birth Charter examined, those being access to the same standard of antenatal care as women in the community, support in their choice of infant feeding and having access to counselling and mental health support. However, the study does add to the evidence that imprisoned perinatal women face multiple disadvantages in their ability to access support, information, and advocacy from sources other than the midwife. These challenges arguably heighten the importance of, as well as the pressure on the midwife in this context. The authors therefore highlight the need for consideration of three factors for midwifery in this context: (1) Resourcing (2) Information provision to, and information sharing between, midwives to increase awareness of challenges faced by this cohort, and (3) Strengthening the midwife's position to support and advocate for women's perinatal mental health in prison. From a research and evidence perspective key components to improving care for all perinatal women are to have (1) continued research in this area, particularly of the lived experience of perinatal women in prison including those that are less easily identified as they have been separated from their babies either whilst in prison or the community, or they have had a termination or miscarriage and (2) further progress in the provision of data on the number of perinatal women, not just pregnant women, in prison to allow services to adequately cater for this group.

Declarations

Data availability

Due to ethical/commercial issues, data underpinning this publication cannot be made openly available. Further information about the data and conditions for access are available from the Institute for Public Safety, Crime and Justice, University of Northampton, at ipscj@northampton.ac.uk.

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Ethics approval

The study was approved ethically by the University of Northampton's Faculty of Health, Education and Society Research Ethics Committee and HM Prison & Probation Service National Research Committee (HMPPS NRC).

Consent

Participants were provided with a Participant Information Sheet and completed an informed consent form before being interviewed.

CRediT authorship contribution statement

Kathryn Cahalin: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Claire Clews:** Writing – review & editing, Writing – original draft, Conceptualization. **John Pendleton:** Writing – review & editing, Writing – original draft, Conceptualization. **Matthew Callender:** Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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