

PREGNANT WOMEN INMATES: EVALUATING THEIR RIGHTS
AND IDENTIFYING OPPORTUNITIES FOR IMPROVEMENTS IN
THEIR TREATMENT

KELLY PARKER¹

I.	INTRODUCTION	260
II.	CIRCUMSTANCES FACED BY PREGNANT INMATES	261
	A. <i>Women Incarcerated Today</i>	261
	B. <i>Health Care Challenges for Pregnant Inmates</i>	263
	1. Medical Needs of All Women Inmates	263
	2. Specific Needs of Pregnant Inmates.....	264
	C. <i>Quality of Treatment Provided to Pregnant Inmates</i>	267
III.	LEGAL CONTEXT OF TREATMENT OF PREGNANT INMATES: THE EIGHTH AMENDMENT AND DELIBERATE INDIFFERENCE.....	269
	A. <i>The Deliberate Indifference Standard and Establishing Its Violation</i>	271
	B. <i>Application of the Deliberate Indifference Standard to Cases Concerning the Medical Treatment of Women Inmates</i>	274
IV.	EFFECTING CONSTRUCTIVE CHANGE FOR PREGNANT INMATES	278
	A. <i>Class Action Litigation as a Tool for Improving Medical Treatment for Pregnant Inmates</i>	279
	1. Notable Settlement Agreements Before the Prison Litigation Reform Act Passage and Their Efficacy	280
	2. The Prison Litigation Reform Act and Implications for Litigation by Pregnant Inmates	282

¹J.D. 2005, University of Idaho College of Law; law clerk, Fourth Judicial District, State of Idaho, 2005-2006. I would like to thank Noelle Fearn, Ph.D., at Washington State University for her suggestions regarding the development of this article. I also thank my husband for his support and encouragement.

3. Settlement Agreements Post– Prison Litigation Reform Act: <i>Laube v. Campbell</i>	284
B. <i>Proactive Change: Avoiding Litigation Through Legislative Action</i>	287
C. <i>Innovative Programs for Pregnant Inmates</i>	289
1. Programs Serving Pregnant Inmates Within Correctional Facilities	290
2. Programs Serving Pregnant Inmates Through Alternatives to Incarceration.....	292
V. CONCLUSION.....	293

I. INTRODUCTION

Pregnant women incarcerated at the time of our nation’s founding faced the prospect of giving birth in their cells alone and a considerable likelihood that their infants would die.² This is somewhat unsurprising. At this time infant mortality rates were high.³ Given the pace of advances in the treatment of pregnant women since that time, one might expect that the experience of pregnant women incarcerated in today’s correctional facilities⁴ would have improved as it has for their peers on the outside. That, however, would be an unrealistic assumption. In addition to facing decidedly substandard environments in some facilities—inappropriate accommodations, widespread exposure to disease and unsanitary conditions, among other challenges—pregnant women sometimes still risk the possibility of giving birth without assistance. Such was the case of Louwana Yeager. Ms. Yeager, upon going into labor in May 1987, was informed by guards that she would “have to wait” because no medical staff members were available to help her.⁵ The birthing process

²Nicole Hahn Rafter, *Equality or Difference?*, FEMALE OFFENDERS: MEETING THE NEEDS OF A NEGLECTED POPULATION 8 (James L. Gondles, ed., 1993) [hereinafter Rafter, *Equality or Difference*]. An eighteenth century physician contended that a healthy woman could give birth without help and would unlikely face adverse consequences. LAUREN THATCHER ULRICH, A MIDWIFE’S TALE 170 (1990) [hereinafter Ulrich]. This fact disregards that birth, while concededly a “natural process,” is still nevertheless one that is “uncomfortable and frightening.” New England women described by Ulrich generally feared facing childbirth alone. *Id.* Whatever the case, “[h]aving medical assistance immediately preceding and during a birth is, in today’s society, taken for granted.” *Doe v. Gustavus*, 294 F.Supp.2d 1003, 1008 (E.D. Wis. 2003).

³In New England communities evaluated by Ulrich, stillbirth rates per 100 live births ranged from 1.8 to 3.3. ULRICH, *supra* note 2, at 174.

⁴For the purposes of this article, “correctional facilities” includes prisons and jails unless otherwise specified. Jail inmates may be pretrial detainees or convicted individuals with sentences of less than a year. Prisons house those individuals with longer sentences.

⁵Ellen M. Barry, *Pregnant Prisoners*, 12 HARV. WOMEN’S L.J. 189, 189 (1989) [hereinafter Barry, *Pregnant Prisoners*].

is not one amenable to being put on hold and, as such, Ms. Yeager gave birth three hours later “on a thin mat outside of the door of the clinic in the jail.”⁶

Ms. Yeager’s horrifying experience and those of her peers at the Kern County Jail led to a lawsuit that changed conditions for pregnant and post-partum women at the facility.⁷ Pregnant women incarcerated in correctional facilities that have been the subject of litigation have seen an improvement in the conditions they experience. However, most of these facilities would not have made these changes without the threat of litigation.⁸ Thus, those pregnant women incarcerated in facilities that have evaded legal scrutiny may still face conditions not much improved than those endured by Ms. Yeager and others like her.

This article illustrates the challenges faced by pregnant women incarcerated in correctional facilities, their rights, and ways in which change for these women can be effected as well as programs that have provided clear improvements for their care. The treatment of pregnant inmates merits special attention—especially in the competition for scarce correctional resources—because of the particular complications for these women and their infants which can result from *improper* care.

II. CIRCUMSTANCES FACED BY PREGNANT INMATES

A. Women Incarcerated Today

In 2000, women made up seven percent of the correctional population—86,000 women among 1.3 million total inmates.⁹ By 2003, both of these figures grew: 101,000 women among 1.4 million total inmates were incarcerated by state and

⁶*Id.*

⁷*Id.* at 199–200. The suit was *Yeager v. Smith*, in which plaintiffs alleged, *inter alia*, that they did not receive “appropriate treatment for pregnancy-related emergencies,” and that they were subject to poor accommodations requiring some women to sleep on floors into their third trimesters, unsanitary conditions at the jail, and exposure to diseases such as measles and tuberculosis. The suit eventually resulted in a settlement agreement that provided “[c]omprehensive guidelines and standard procedures for adequate treatment of pregnant prisoners....” Ellen M. Barry, et al., *Legal Issues for Prisoners with Children*, CHILDREN OF INCARCERATED PARENTS 160 (Katherine Gabel & Denise Johnston eds., 1995) [hereinafter Barry et al., *Legal Issues*].

⁸*See, e.g.*, Phyllis Harrison Ross & James E. Lawrence, *Health Care for Women Offenders*, 60 CORRECTIONS TODAY 122, 126 (1998) (stating that “[w]hile the reflex defense mechanisms of state and local governments when confronted with prison reform litigation often become impediments to improved care, the courts have prodded some jurisdictions into development and implementation of improved women’s services”) [hereinafter Ross & Lawrence]; Barry et al., *Legal Issues*, *supra* note 7, at 149.

⁹JAMES J. STEPHAN & JENNIFER C. KARBERG, U.S. DEP’T OF JUSTICE [U.S.D.J.], CENSUS OF STATE AND FEDERAL CORRECTIONAL FACILITIES, 2000 (2003) [hereinafter STEPHAN & KARBERG]. The facilities evaluated include both “confinement institutions” as well as “community-based institutions.” These figures can be contrasted with the total number of women under the supervision of the criminal justice system. In 1998, more than 950,000 women were being supervised—eighty-five percent in the community and fifteen percent in correctional facilities. LAWRENCE A. GREENFELD & TRACY L. SNELL, U.S.D.J., WOMEN OFFENDERS 6 (1999) [hereinafter GREENFELD & SNELL].

federal facilities.¹⁰ Since 1995, while the average annual increase in the number of male inmates has been 3.3 percent, the average annual growth of the population of women inmates has been five percent.¹¹ Because of their relatively small numbers—but despite the pace of increase in them—fewer facilities exist to incarcerate these women. The result, say scholars, has been “institutionalized sexism”: prisons in isolated locations, separating women from their friends and family; a justification, based on their small numbers, for providing inadequate “educational, vocational, and other programs”; and low levels of specialization in treatment and failure to separate more dangerous offenders from the general population.¹²

Women of color are disproportionately affected by this trend. African-Americans accounted for forty-four percent of women in local jails and forty-eight percent of women in state prisons; fifteen percent of women in jails and state prisons were Hispanic.¹³ The General Accounting Office has noted an increased likelihood of African-American women to be incarcerated than Hispanic and white women: in 1997, “black females were more than twice as likely as Hispanic females and eight times more likely than white females to be in prison.”¹⁴

The failure to tailor treatment to the needs of women inmates is troubling, given the increase in the numbers of women being incarcerated. It does a great disservice to this group of inmates who are largely nonviolent offenders. Of women incarcerated in state prisons in 1998, for example, only twenty-eight percent were incarcerated for violent offenses—a bulk of the women were serving time for property offenses and drug offenses.¹⁵

¹⁰PAIGE M. HARRISON & ALLEN J. BECK, U.S.D.J., PRISONERS IN 2003 (2004).

¹¹*Id.* Perhaps more startling is the increase over time in the number of women inmates in state and federal correctional facilities: from 13,400 in 1980 to 84,400 in 1998—a 500 percent increase during this period. U.S. GEN. ACCT. OFFICE [hereinafter G.A.O.], WOMEN IN PRISON: ISSUES AND CHALLENGES CONFRONTING U.S. CORRECTIONAL SYSTEMS 2 (1999).

¹²JOANNE BELKNAP, THE INVISIBLE WOMAN: GENDER, CRIME, AND JUSTICE 163 (2d ed. 2001). Rafter describes this as an “economy of scale problem” in which “smaller numbers . . . lead[] to fewer resources and greater isolation of inmates.” NICOLE HAHN RAFTER, PARTIAL JUSTICE: WOMEN, PRISONS, AND SOCIAL CONTROL 199 (2d. ed. 1990) [hereinafter RAFTER, PARTIAL JUSTICE].

¹³GREENFELD & SNELL, *supra* note 9, at 7. White women were thirty-six and thirty-three percent of the total respectively. *Id.* Some scholars argue that given the effect of this trend not only on women of color, but also on men, “crime has become a code word for race in the United States. . . . [C]orrectional supervision, especially detention and imprisonment, seems increasingly to have replaced other historic systems of racial control (slavery, Jim Crow laws, ghettoization) as a way of keeping women and men of color in their ‘place.’” MEDA CHESNEY-LIND & LISA PASKO, THE FEMALE OFFENDER: GIRLS, WOMEN, AND CRIME 175 (2d ed., 2004).

¹⁴G.A.O., *supra* note 11, at 5. In an evaluation of the lifetime likelihood of going to prison, African-American women had a 3.6 percent likelihood of being incarcerated—seven times more likely than white women. THOMAS P. BONCZAR AND ALLEN J. BECK, U.S.D.J., LIFETIME LIKELIHOOD OF GOING TO STATE OR FEDERAL PRISON 2–3 (1997).

¹⁵GREENFELD & SNELL, *supra* note 9, at 6. Fewer women incarcerated in jails had been convicted of violent crimes—twelve percent—but considerably more of them were serving time for so-called “public-order offenses.” Their rates of incarceration for property and drug offenses were more comparable to women in prisons, thirty-four percent and thirty percent respectively.

B. Health Care Challenges for Pregnant Inmates

1. Medical Needs of All Women Inmates

Women entering correctional facilities are often in very poor health for a number of reasons, including higher rates of poverty, substance abuse, and sexual/physical abuse among this population. A study of incarcerated parents conducted by the Bureau of Justice Statistics reveals startling figures in these areas for women. Twenty percent of mothers in state prisons reported homelessness in the year before being incarcerated and half had been unemployed in the month leading up to their arrest.¹⁶ With regard to substance abuse, eighty six percent of mothers reported having used drugs at some point in their lives, and sixty-five percent had used drugs in the month before the offense was committed that led to their incarceration.¹⁷ Figures regarding physical and sexual abuse among women inmates is equally sobering. Forty-three percent of women in state prisons had been physically or sexually abused—sometimes both—at some time before their incarceration.¹⁸

Lack of consistent access to health care prior to incarceration often means that these women bring with them untreated sexually transmitted diseases as well as chronic conditions such as high blood pressure and diabetes.¹⁹ These women also experience higher rates of depression.²⁰ A study of Ohio's prison system noted that many women entered the state's facilities "without having seen a physician in years, emphasizing that the women suffer from prolonged neglect and abuse of their bodies and minds. Health care delivery at this point is assessed against a background of societal problems and economic hardships and not simply in terms of the delivery of services to heal physical ailments."²¹ As noted by another scholar, "health care for women in prison is largely an effort to 'catch up' in that considerable effort is most

¹⁶CHRISTOPHER J. MUMOLA, U.S. DEP'T OF JUSTICE, INCARCERATED PARENTS AND THEIR CHILDREN 9 (2000). Eighteen percent of these women had spent some time living on the street or living in a shelter in the year before their arrests. *Id.* at 10. Inmates of both sexes who had been homeless or unemployed and those who had used needles in their drug use reported having more medical problems. LAURA M. MARUSCHAK & ALLEN J. BECK, U.S. DEP'T OF JUSTICE, MEDICAL PROBLEMS OF INMATES, 1997 (2001). Some scholars have argued that, for many women, prison has become "the social net of last resort, providing neither punishment nor deterrence, but rather respite from hopelessly untenable life situations and access to health and human service programs unavailable in their home communities." Ross & Lawrence, *supra* note 8, at 128.

¹⁷MUMOLA, *supra* note 16, at 8. Mumola also reports that one in three of these women had committed the crime in question either to get drugs or to get money for drugs. *Id.*

¹⁸TRACY L. SNELL & DANIELLE MORTON, U.S. DEP'T OF JUSTICE, WOMEN IN PRISON 5 (1994). Specifically, thirty-four percent reported physical abuse and thirty-four percent reported sexual abuse [hereinafter SNELL & MORTON].

¹⁹M. Katherine Maeve, *Adjudicated Health: Incarcerated Women and the Social Construction of Health*, 31 CRIM. L. & SOC. CHANGE 49, 50 (1999) [hereinafter Maeve].

²⁰*Id.*

²¹Nawal H. Ammar & Edna Erez, *Health Delivery Systems in Women's Prisons: The Case of Ohio*, 64 FED. PROBATION 19, 25 (2000).

often necessary to raise women's health status to legally mandated, acceptable levels."²²

For women incarcerated in these facilities, the provision of care sometimes occurs within the context of penal harm, whose proponents believe "that the incarceration experience should inflict pain and make conditions of confinement as harsh as possible."²³ As one woman commented, "I feel sorry for anyone who gets sick 'in the joint.' . . . They don't seem to care what happens to you. They just do what they have to do, you know. If it's not the right time, right day, if it's not convenient or whatever, you could suffer and die and it wouldn't really matter."²⁴ Maeve documented similar concerns among the women inmates she studied: "It was common for women to believe that members of the medical unit were withholding standard medical care and/or simply 'not caring' at all. Because health care was provided through the Department of Corrections, women understood that the protection of health care they were entitled to simultaneously included the punishment they deserved."²⁵

2. Specific Needs of Pregnant Inmates

Six percent of women admitted to prison were pregnant at the time of their admission to prison in 1991.²⁶ In a survey of correctional systems, some 1900

²²Maeve, *supra* note 19, at 51.

²³Michael S. Vaughn & Linda G. Smith, *Practicing Penal Harm Medicine in the United States: Prisoners' Voices from Jail*, 16 JUST. Q. 175, 176 (1999). Penal harm advocates stand in contrast to "deprivation of liberty" proponents who believe "the sole purpose of incarceration is to restrict the freedom of those incarcerated."

How widespread penal harm practices are is difficult to evaluate with certainty. Studies such as that by Vaughn and Smith focus on single facilities, making their findings hard to generalize. (A similar problem is present in the studies cited *supra* by Maeve and Ammar and Erez.) See Noelle Fearn & Kelly Parker, *Health Care for Women Inmates: Issues, Perceptions, and Policy Considerations* 3 CAL. J. HEALTH PROMOTION 1 (2005) [hereinafter Fearn & Parker, *Health Care for Women Inmates*].

²⁴Sue Mahan, *Imposition of Despair—An Ethnography of Women in Prison*, 1 JUST. Q. 357, 375 (1984).

²⁵Maeve, *supra* note 19, at 64.

²⁶SNELL & MORTON, *supra* note 18, at 10. Snell and Morton also report in this article that more than three-quarters of women prisoners had children, many of them minors. Another study estimates that ten percent of women are pregnant when incarcerated. Maeve, *supra* note 19, at 50. Other studies, looking more broadly, indicate that up to twenty-five percent of women in correctional facilities are or have been pregnant within the last year. Barry et al., *Legal Issues*, *supra* note 7, at 157. The difficulties that these women face as a result of separation from their infants and the social implications for their children is beyond the scope of this article; however, the literature has addressed this problem at length. See, e.g., CHILDREN OF INCARCERATED PARENTS (Katharine Gabel & Denise Johnston, eds., 1995); Liza Catan, *Infants with Mothers in Prison*, in PRISONERS' CHILDREN (R. Shaw, ed, 1992); Wooldredge & Masters, *infra* note 54.

women admitted to prison were pregnant and 1400 gave birth during 1998.²⁷ Between July 1998 and October 1999, 429 women inmates in California prisons—so often the subject of litigation—gave birth.²⁸

Given the constellation of difficulties that pregnant incarcerated women face, many of their pregnancies are considered high risk. Among the criteria for classifying these pregnancies include a history of drug addiction and sexually transmitted diseases or pelvic inflammatory disease.²⁹ Accordingly, “[a] single major medical condition, or several minor conditions, can predict a less-than-favorable birth. Such pregnancies must be termed high-risk, and these patients should be cared for in specially designed and staffed centers.”³⁰

Addressing the needs of pregnant women addicted to drugs is a critical problem cited frequently, yet one that remains overlooked despite “an increasing trend toward sentencing pregnant, substance abusing women to prison or jail in an attempt to protect the health of the fetus.”³¹ Women addicted to drugs face daunting health problems—including “excessive weight loss, dehydration, HIV/AIDS, other sexually transmitted diseases, hepatitis B, hypertension, cardiac and respiratory problems, and seizures”³²—that are compounded when those women are also pregnant. Detoxifying pregnant women requires “specialized medical personnel and treatment protocols,” largely unavailable to them in prison.³³ Failure to provide appropriate detoxification harms both the woman and her fetus: “the fetus’ brain also develops tolerance and dependence to drugs in the same manner as the maternal brain. . . . Pregnant addicts have been forced to go through withdrawal without consideration of the fetus, though withdrawal symptoms are also experienced by the fetus.”³⁴ Providing appropriate care improves conditions for the infants ultimately born and

²⁷G.A.O., *supra* note 11, at 41. Seven states, however, did not respond to the survey; therefore the numbers of women who were pregnant and/or giving birth in correctional facilities are probably greater. *Id.*

²⁸*Id.* at 60.

²⁹Anita G. Hufft et al., *Care of the Pregnant Offender in FEMALE OFFENDERS: MEETING THE NEEDS OF A NEGLECTED POPULATION* 56 (James L. Gondles, ed., 1993) [hereinafter Hufft].

³⁰*Id.*

³¹Barry et al., *Legal Issues, supra* note 7, at 157. The horrible irony with this is that confinement to correctional facilities is no guarantee that these women will remain drug-free: “[D]rugs and alcohol are readily available in many prisons and jails, for a price, and if a pregnant woman is addicted and given no opportunity to participate in an effective recovery program, she will in all likelihood continue to use.” *Id.* at 163. However, for alternative views on the overall effect of incarceration on pregnancy, see Martin, *infra* note 41. See also Lynn M. Paltrow, *When Becoming Pregnant Is a Crime*, 9 CRIM. JUST. ETHICS 41 (1990).

³²Kristine Siefert and Sheryl Pimlott, Improving Pregnancy Outcome during Imprisonment: A Model Residential Care Program, 46 SOCIAL WORK 125, 127 (2001) [hereinafter Siefert & Pimlott].

³³*Id.* at 127.

³⁴T.A. Ryan & James Grassano, *Pregnant Offenders: Profile and Special Problems in FEMALE OFFENDERS: MEETING THE NEEDS OF A NEGLECTED POPULATION* 52 (James L. Gondles, ed., 1993).

may offset the need to provide expensive neonatal care.³⁵ Also necessary for these women to succeed in abstaining from harmful illegal drugs is addressing the underlying causes of that abuse: psychological difficulties related to histories of sexual and/or physical abuse.³⁶

Pre-natal education for these women is also lacking. Outside the incarceration context, “[m]isguided advice about pregnancy impedes access to and use of prenatal care for low-income women.”³⁷ This crosses over to the prison context, where inmates form “an ‘invented family’ for the pregnant inmate. Membership in this subgroup is often attained through an inmate ‘mentor,’ who offers advice and makes recommendations regarding acceptable practices during pregnancy.”³⁸ Thus, much of what these women understand about pregnancy—“interpretation of symptoms, self-diagnosis, the need for clinical appointments, use of self-remedies, evaluation of treatment, and belief in professional explanation”³⁹—comes from individuals who may themselves be ill-informed. To combat this, scholars suggest that education about general health care and pregnancy specifically should be extended to all women inmates: “Routine counseling and education by health care providers to all inmates dispels misinformation and the stress it causes for pregnant inmates.”⁴⁰

The effect incarceration has on pregnancy outcomes is unclear. Two schools of thought exist on the matter. One, emphasizing the potential negative effects, holds that “incarceration is harmful to well-being of pregnant women and their unborn babies because of stresses caused by imprisonment,” including isolation from loved ones and distress over where to place an infant following birth.⁴¹ The other school argues that “incarceration may enhance the health of some pregnant women and may foster healthy pregnancy outcomes.”⁴² Prisons and jails can offer shelter and regular meals to those who might be homeless and hungry, as well as restricting access to illegal drugs, “limiting physically demanding work, eliminating sexual intercourse

³⁵Siefert & Pimlott, *supra* note 32, at 127.

³⁶According to some scholars “clear correlations exist between girls’ and women’s victimization and specific high-risk behaviors such as serious polydrug abuse. A fundamental reason for this close connection is the capacity of mood-altering chemicals to temporarily dull the psychological devastation wrought by experiences of physical and sexual violation.” Leslie Acoca & Myrna S. Raeder, *Severing Family Ties: The Plight of Nonviolent Female Offenders and Their Children*, 11 STAN. L. & POL’Y REV. 134, 137–38 (2000). This has been substantiated by other scholars. Shearer notes, for example, studies increasingly have found that “women with substance abuse problems frequently have a childhood trauma that may be an important contributing factor to their addictive behavior.” Robert A. Shearer, *Identifying Special Needs of Female Offenders*, 67 FED. PROBATION 46, 47 (2003).

³⁷Hufft et al., *supra* note 29, at 57.

³⁸*Id.*

³⁹*Id.*

⁴⁰*Id.* at 58.

⁴¹Martin et al., *Is Incarceration during Pregnancy Associated with Infant Birthweight?*, 87 AM. J. PUB. HEALTH 1526 (1997).

⁴²*Id.*

with male partners, and eliminating physical/sexual abuse by their male partners.”⁴³ Among women who served shorter terms of incarceration in one study, “[t]hirty-three percent of such women had stillbirths or infants with neonatal morbidity compared to 9% of women serving longer prison terms.”⁴⁴ Despite the stresses and risks incarceration can pose, for those pregnant women serving time in facilities that provide appropriate diets and some form of prenatal care, their pregnancy outcomes may be improved.⁴⁵

C. Quality of Treatment Provided to Pregnant Inmates

Pregnant inmates throughout our nation’s history have long provided correctional officials with difficulty. Nineteenth century facilities, for example, were often not equipped properly to accommodate *any* women, much less pregnant women, and this issue was compounded by officials’ perceptions of gender roles and questions of caring for the children born to women inmates.⁴⁶ Toward the latter part of the twentieth century, as more attention became focused on the conditions of all prisoners in the 1970s, the needs and legal rights of pregnant women began to receive attention as well. Basic provisions, such as diets appropriate for pregnant women, were not available to these women, nor was specialized care for women experiencing drug withdrawal symptoms.⁴⁷ General medical care available on a twenty-four-hour basis was often lacking and few facilities provided prenatal care for pregnant women.⁴⁸ Although many of the institutions surveyed by one scholar had to send these women to hospitals outside the prison to give birth, many of them neglected to begin the complex transfer process until the onset of labor itself.⁴⁹ Furthermore, some pregnant inmates also faced the prospect of lengthy travel times to delivery facilities.⁵⁰ Upon their return to prison, these women sometimes faced vaginal searches that disregarded their recent medical experience and which increased risk “of dislodging stitches when an episiotomy ha[d] been performed or

⁴³*Id.*

⁴⁴Denise Johnston, *Effects of Parental Incarceration*, in CHILDREN OF INCARCERATED PARENTS 67 (Katherine Gabel & Denise Johnston eds., 1995).

⁴⁵*Id.* Pregnancy outcomes may be worse for women incarcerated in county jails, however. A study cited by Barry found that “only 21% of the respondents had live births, with miscarriages after the 20th week of pregnancy occurring 73% of the time.” Barry et al., *Legal Issues*, *supra* note 7, at 158.

⁴⁶ANNE M. BUTLER, *GENDERED JUSTICE IN THE AMERICAN WEST* 163–68 (1997). *See also* RAFTER, *PARTIAL JUSTICE*, *supra* note 12, at 37 (discussing challenges of dealing with infants in both custodial and reformatory correctional facilities and prison nurseries).

⁴⁷Gerald Austin McHugh, *Protection of the Rights of Pregnant Women in Prisons and Detention Facilities*, 6 *NEW ENG. J. ON PRISON L.* 231, 241–42 (1980) [hereinafter McHugh].

⁴⁸*Id.* at 244.

⁴⁹*Id.* As McHugh noted, “significant delays are caused by the red tape and security clearance needed to transfer a prisoner, coupled with the need to have available security personnel to effect the transfer.”

⁵⁰Karen Holt, Note, *Nine Months to Life—The Law and the Pregnant Inmate*, 20 *J. FAM. L.* 523, 528 (1982).

[causing] a . . . severe infection.”⁵¹ McHugh attributed some of the mistreatment of these women to hostility on the part of prison staff. Where this was so, pregnant women often faced considerable resistance not only to their requests for medical care, but also to their requests for work assignments appropriate to their stage of pregnancy.⁵²

Meaningful improvements in the quality of care provided to pregnant women in a limited number of correctional facilities began to change during this era, with groups such as Legal Services for Prisoners with Children (LSPC) bringing class action lawsuits on their behalf. Some efforts by correctional facilities to help pregnant women were offset by the nature of prison conditions themselves. For example, efforts by the Massachusetts Correctional System to help these women at its Framingham facility (including a provision for high-risk pregnancies and prenatal education) were harmed by the fact that it was operating at 189 percent capacity.⁵³ By the early 1990s, conditions had improved minimally for some pregnant inmates. Only forty-eight percent of the facilities surveyed in a 1993 study had developed policies specifically for the care of pregnant inmates.⁵⁴ The services provided by these facilities were very limited. Forty-eight percent provided prenatal care, but only fifteen percent provided appropriate diets and only nine percent provided a full-time nurse to care for pregnant inmates.⁵⁵ Furthermore, “[a]lthough advancements are being made in the types of medical services available to pregnant inmates, they have yet to be implemented in the vast majority of state prisons housing women.”⁵⁶ None of the facilities had addressed other issues vital to the well-being of pregnant inmates, such as providing resources to address emergency matters like premature births and miscarriages, the use of restraints during transport to hospitals, or the

⁵¹McHugh, *supra* note 47, at 245.

⁵²*Id.* at 235–36. Sentiments such as those documented by McHugh persist today. Ellen M. Barry wrote in 2001 that “[a]lthough I acknowledge that there are correctional personnel who provide professional, high quality medical services, it’s my experience that women prisoners are often regarded as complainers, malingerers, or drug seekers who have more psychosomatic than actual illnesses. . . . [W]omen prisoners are assumed to have fewer ‘real’ medical complaints than do male prisoners.” Ellen M. Barry, *Bad Medicine: Health Care Inadequacies in Women’s Prisons*, 16 CRIM. JUST. 39, 39 (2001) [hereinafter Barry, *Bad Medicine*].

⁵³Mary Catherine McGurrin, Note, *Pregnant Inmates’ Right to Health Care*, 20 NEW ENG. J. ON CRIM & CIV. CONFINEMENT 163, 185–86 (1993) (citing BETSEY SMITH, ET AL., EXPECTANT MOTHERS IN THE MASSACHUSETTS CRIMINAL JUSTICE SYSTEM 2 (1985)). The problem of operating above capacity appears to be a persistent problem in other correctional systems. For example, a 1999 evaluation of prisons in California’s correctional system that housed women found all facilities to be operating between sixty-five and eighty-seven percent above capacity. G.A.O., *supra* note 11, at 41. As Rafter has noted in writing of all improvements in the conditions of women’s prisons, “[t]he gains of today can be eradicated by overcrowding tomorrow.” RAFTER, PARTIAL JUSTICE, *supra* note 12, at 189.

⁵⁴John D. Wooldredge & Kimberly Masters, *Confronting Problems Faced by Pregnant Inmates in State Prisons*, 39 CRIME & DELINQ. 195, 198 (1993). This study was conducted to evaluate “the prevalence and policies being implemented *voluntarily* for the care and support of pregnant inmates” *Id.* (emphasis added).

⁵⁵*Id.*

⁵⁶*Id.* at 199.

overall quality of living conditions.⁵⁷ Although some limited improvements had been achieved, “the majority of prison administrators have a long way to go before they meet the needs of pregnant inmates.”⁵⁸

The quality of care a pregnant woman will receive is probably dependent on where she serves her sentence. As Barry noted, “most jail systems and many smaller prison systems do not yet provide good quality prenatal care for the high-risk population they serve.”⁵⁹ To date the problems of adequately addressing the needs of pregnant women in correctional facilities remain only somewhat improved. No national standards exist for the proper treatment of these women. Although the American College of Obstetricians and Gynecologists has the most comprehensive standards for the treatment of pregnant women, their standards do not address the needs of incarcerated women, according to Barry, while guidelines for their care provided by National Commission on Correctional Health Care are vague.⁶⁰

Although the needs of pregnant women have long been apparent to those who incarcerate them, these women remain ignored in some facilities resulting in unnecessary abuse and in harm—occasionally fatal, perhaps preventable—to their babies. Many of the problems cited in this portion of the discussion have particular resonance within the context of the rights of pregnant inmates under the U.S. Constitution. For inmates serving sentences in correctional facilities, this implicates the Eighth Amendment. The treatment of pretrial detainees is subject to evaluation under the Due Process Clause of the Fourteenth Amendment; however, because what is expected of this treatment is vague, the Eighth Amendment remains indirectly pertinent to their treatment as well. The rights of these pregnant women are discussed in the following section.

III. LEGAL CONTEXT OF TREATMENT OF PREGNANT INMATES: THE EIGHTH AMENDMENT AND DELIBERATE INDIFFERENCE

To evaluate the care that incarcerated pregnant women are entitled to, it is important to understand the legal standards their treatment is subject to when the quality of that care is challenged. Treatment of pregnant inmates serving time following a criminal conviction must operate within the requirements of the Eighth Amendment’s provision forbidding the infliction of “cruel and unusual punishments.”⁶¹ For pregnant women who are legally confined as pretrial detainees, the standard of treatment is less clear—the woman cannot be punished, but what the deprivations the state can subject her to *short* of punishment is not explicit,⁶² although it seems that the conditions of their confinement would have to meet the standards of conditions for those with Eighth Amendment rights, at a minimum.⁶³

⁵⁷*Id.* at 200.

⁵⁸*Id.* at 199.

⁵⁹Barry et al., *Legal Issues*, *supra* note 7, at 163.

⁶⁰*Id.* at 160.

⁶¹The Amendment reads “[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” U.S. CONST. amend VIII.

⁶²*See Bell v. Wolfish*, 441 U.S. 520 (1979).

⁶³*See e.g., Boswell v. Sherburne*, 849 F.2d 1117 (8th Cir. 1988).

Constitutional standards of treatment for women who have been convicted of crimes or who are pretrial detainees are briefly addressed below, followed by a discussion of reported cases in which the care provided at a correctional facility fell below the legally required standard.

The meaning of the Eighth Amendment has not been static,⁶⁴ developing beyond notions of “physically barbarous punishment.”⁶⁵ According to Chief Justice Warren, “[t]he basic concept of the Eighth Amendment is nothing less than the dignity of man.”⁶⁶ In essence, then “[t]he Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”⁶⁷ In *Gregg v. Georgia*, Justice Stewart wrote that the critical assessment of a given penalty should be subject to a two-part evaluation into “excessiveness.”⁶⁸ Accordingly, the punishment must not involve “the unnecessary and wanton infliction of pain” nor may it be “grossly out of proportion to the severity of the crime.”⁶⁹ By the 1970s, the Amendment had come to “embod[y] ‘broad and idealistic concepts of dignity, civilized standards, humanity, and decency. . . .’ against which we must evaluate penal measures.”⁷⁰ Today, the Eighth Amendment encompasses punishment in the broadest sense. As such, “[i]t is undisputed that the treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment.”⁷¹

Within the context of the treatment of pregnant women incarcerated in correctional facilities, the words of Chief Justice Warren anticipate that their care would likewise reflect contemporary notions of appropriate treatment for pregnant women. This is unrealistic for a number of reasons. For some women it is because their medical care occurs within the context of the penal harm approach to incarceration—a taint which sometimes infects both the correctional personnel who facilitate medical care as well as the medical professionals providing that care.

⁶⁴Initial consideration of the Eighth Amendment’s meaning took the position that “the clause prohibited certain methods of punishment.” Anthony F. Granucci, “*Nor Cruel and Unusual Punishments Inflicted: The Original Meaning*,” 57 CAL. L. REV. 839, 842 (1969). (Early Supreme Court cases considering the Amendment include *Wilkerson v. Utah*, 99 U.S. 130 (1879) and *In re Kemmler*, 136 U.S. 436 (1890).) A shift toward a broader meaning came early in the twentieth century in *Weems v. Ohio*, 217 U.S. 349 (1910), in which the Court “took the position that the clause should be expanded beyond its original reach to cover any instance of disproportionate punishment.” Granucci at 843.

Provisions of the Eighth Amendment were extended to the states by the Warren Court in *Robinson v. California*, 370 U.S. 660, 666 (1962) (holding that criminalizing drug addiction “in the light of contemporary human knowledge. . . [is] an infliction of a cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.”).

⁶⁵*Estelle v. Gamble*, 429 U.S. 97, 102 (1976).

⁶⁶*Trop v. Dulles*, 356 U.S. 86, 99–100 (1958).

⁶⁷*Id.* at 101.

⁶⁸*Gregg v. Georgia*, 428 U.S. 153, 173 (1976) (plurality opinion).

⁶⁹*Id.* at 173.

⁷⁰*Estelle*, 429 U.S. at 103 (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)).

⁷¹*Helling v. McKinney*, 509 U.S. 25, 31 (1993).

Because medical personnel work in a system that subordinates their professional canons to . . . the ethical relativism of the penal harm movement, . . . some correctional health providers sympathetic to the custodial subculture abdicate their ethical obligations, and that results in the ill-treatment and torture of prisoners.⁷²

Other factors affecting their circumstances are the limited resources, financial and otherwise, devoted to the medical care of all women prisoners; the dependence of these women on personnel for all their medical needs, no matter how minor; and the staggering demands women inmates place on correctional health care systems, seeking care at higher rates than men, and the failure of officials to plan accordingly.⁷³ Thus, the care pregnant women receive in some facilities may bear more resemblance to care they might have received when the Eighth Amendment was drafted, rather than what they ought to receive in a society where standards of incarceration “evolve” and improve.

Pretrial detainees, unlike women who have been convicted of a crime for which they are serving time, exist in a constitutional limbo, “hav[ing] been charged with a crime but . . . hav[ing] not yet been tried on the charge” with regard to what is permissible during the course of that detention.⁷⁴ The Supreme Court in *Wolfish* did not offer a great deal of clarification: “[u]nder the Due Process Clause, a detainee may not be punished prior to an adjudication of guilt in accordance with due process of law. . . . [T]he government concededly may . . . subject him to the restrictions and conditions of the detention facility so long as those conditions and restrictions do not amount to punishment, or otherwise violate the Constitution.”⁷⁵ As a result, circuit courts were left to define the parameters of propriety. An example of one approach to this riddle is found in *Boswell v. Sherburne*, a case discussed in more detail below. The Eighth Circuit panel’s decision stated that pretrial detainees “are . . . accorded the due process protections of the fourteenth amendment, protections ‘at least as great’ as those the eighth amendment affords a convicted prisoner.”⁷⁶ As such, the Eighth Amendment remains meaningful in discussing the rights of pretrial detainees.

For all incarcerated women, *Estelle v. Gamble* was a decision critical to the way in which their treatment was perceived and provided through its notion of deliberate indifference. This decision and the standard it provided for the care of inmates are examined below.

A. *The Deliberate Indifference Standard and Establishing Its Violation*

Medical care provided in prisons was often shockingly grim in the era preceding *Estelle v. Gamble*. A challenge to the health care provided within the Alabama

⁷²Vaughn & Smith, *supra* note 23, at 177. Even in those facilities where penal harm may not be an issue, “medical professionals would do well to learn and adopt a less judgmental approach to their patients and trouble themselves less over whether offenders deserve their skill and effort.” Ross & Lawrence, *supra* note 8, at 128.

⁷³Fearn & Parker, *Health Care for Women Inmates*, *supra* note 23, at 18.

⁷⁴*Bell v. Wolfish*, 441 U.S. 520, 523 (1979).

⁷⁵*Id.* at 535–37.

⁷⁶*Boswell v. Sherburne*, 849 F.2d at 1121 (8th Cir. 1988).

correctional system exemplifies the near-medieval conditions under which medical treatment was provided to some prisoners—male and female—at this time.⁷⁷ At one facility, for example, “[u]nsupervised prisoners, without formal training, regularly pull teeth, . . . dispense as well as administer medication, . . . suture, and perform minor surgery.”⁷⁸ Inmates at the prison medical center went neglected. Some—such as a man unable to eat and another whose bedsores evolved into open wounds that became maggot-infested—simply died after provision of grossly insufficient nominal efforts in their last days failed to help them.⁷⁹ Pregnant women incarcerated at the Tutwiler facility endured “conditions which endanger the lives of both mother and infant.”⁸⁰ Around seven to eight infants were born each year in a facility where “[t]he delivery table has no restraints, paint is peeling from the ceiling above it, and large segments of the linoleum floor around the table are missing. There are no facilities to resuscitate the newborn or otherwise provide adequate care should any complications arise during delivery.”⁸¹ Pain management during delivery consisted of “drip ether as an anesthetic . . . despite estimates that this method had not been used after 1953.”⁸² Until the decision in *Estelle*, “courts were divided on how inadequate the state’s medical care program must be in order to justify judicial intervention.”⁸³ Some courts required evidence of “shocking or barbarous” treatment, while others required the provision of “reasonable” medical treatment. Thus, *Estelle* was a much-needed decision to “resolve[] this conflict by sanctioning use of the eighth amendment so long as ‘serious’ medical needs are at issue.”⁸⁴

In *Estelle v. Gamble*, the Court reviewed basic notions of the Eighth Amendment’s scope as set out in cases such as *Trop* and *Gregg*. These cases clearly established, according to the Court, “the government’s obligation to provide medical care for those whom it is punishing by incarceration.”⁸⁵ Shirking this responsibility could have grave implications for the inmate, ranging from the sort of “physical ‘torture or lingering death’” in the worst situations to “pain and suffering which no one suggests would serve any penological purpose.”⁸⁶ Accordingly, the Court held that “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ proscribed by the Eighth Amendment.”⁸⁷ This was true whether the indifference had its genesis in the prisoner’s treatment by

⁷⁷*Newman v. Alabama*, 349 F. Supp. 278 (M.D. Ala. 1972), *aff’d* in part, 503 F.2d 1320 (5th Cir. 1974).

⁷⁸*Newman*, 349 F. Supp. at 283.

⁷⁹*Id.* at 285.

⁸⁰*Id.* at 282. Tutwiler was also the subject of litigation in the *Laube* case described *infra*.

⁸¹*Id.* at 282–83.

⁸²*Newman*, 503 F.2d at 1323–24.

⁸³*McHugh*, *supra* note 47, at 250.

⁸⁴*Id.*

⁸⁵*Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

⁸⁶*Id.* at 103 (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)).

⁸⁷*Estelle*, 429 U.S. at 104 (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

medical staff or in a prison guard's "intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed."⁸⁸ The Court did, however, place clear limits on what would constitute deliberate indifference. "Inadvertent failure to provide" sufficient care was beyond the ambit of deliberate indifference, as was negligence and medical malpractice.⁸⁹ Instead, "to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs."⁹⁰

Requirements for successfully challenging prison conditions have changed since *Estelle* was handed down. To establish an Eighth Amendment violation, two elements must be satisfied. First, "the deprivation alleged must be, objectively, 'sufficiently serious.'"⁹¹ Specifically, said Justice Souter, "a prison official's act or omission must result in the denial of 'the minimal civilized measure of life's necessities'" thus requiring a showing on the part of a prisoner "that he is incarcerated under conditions posing a substantial risk of serious harm."⁹² A second, subjective element pertains to whether a "prison official . . . [has] a 'sufficiently culpable state of mind'"—in other words, deliberate indifference.⁹³ Deliberate indifference, however, is itself vague. "[W]e have never paused to explain the meaning of the term. . . ." conceded Souter.⁹⁴ The answer lay somewhere between negligence and intentional acts or omissions on the part of officials for the purpose of causing harm or which they know will likely cause harm.⁹⁵ In placing deliberate indifference on this spectrum, the Court equated it more with the standard of reckless disregard⁹⁶ and held that

a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.⁹⁷

Following *Estelle*, "most correctional facilities in the United States reportedly reformed their medical facilities to remove punitive and pain-inflicting mandates; however the emergence of the penal harm movement has raised questions about the

⁸⁸*Estelle*, 429 U.S. at 104–05.

⁸⁹*Id.* at 105–06.

⁹⁰*Id.* at 106.

⁹¹*Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (quoting *Wilson v. Seiter*, 501 U.S. 294, 298 (1991)).

⁹²*Farmer*, 511 U.S. 834 (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)).

⁹³*Farmer*, 511 U.S. 834 (quoting *Wilson*, 501 U.S. at 302–03).

⁹⁴*Farmer*, 511 U.S. 835.

⁹⁵*Id.*

⁹⁶The Court confided that this term is likewise vague, both in its use in civil and criminal law. *Id.* at 836.

⁹⁷*Id.* at 837.

use of correctional medical care for punitive purposes.’⁹⁸ In light of the concerns about the application of penal harm philosophies to medical treatment of prisoners and continued problems in providing medical care generally, clearly, efforts to improve the quality of care are still vital. The following section of this article addresses situations in which the quality of care provided was found to constitute deliberate indifference.

B. Application of the Deliberate Indifference Standard to Cases Concerning the Medical Treatment of Women Inmates

Prison inmates seeking to improve the conditions under which they are incarcerated often seek redress through individual and class-action lawsuits under 42 U.S.C. § 1983,⁹⁹ a law that had been largely dormant until it was used in *Monroe v. Pape*.¹⁰⁰ Many of the reported cases are brought by individuals. However, cases that have led to a systemic improvement in the treatment of pregnant women have been class action suits that went on to be settled rather than tried. Nevertheless, the reported cases establish a baseline of care for these women and it is important to understand where officials have failed and what standard must be met.

Todaro v. Ward,¹⁰¹ although not addressing treatment of incarcerated pregnant women specifically, helped set the stage for suits brought by pregnant inmates. The case was a civil rights action brought by women incarcerated at the Bedford Hills Correctional Facility pursuant to 42 U.S.C. § 1983. It was the first case to address the medical treatment of women prisoners following the Supreme Court’s ruling in

⁹⁸Vaughn & Smith, *supra* note 23, at 180.

⁹⁹The provision states in pertinent part that:

[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and its laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983 (1996).

¹⁰⁰*Monroe v. Pape*, 365 U.S. 167 (1961) (subsequently overruled by *Monell v. Dep’t of Soc. Servs.*, 436 U.S. 658 (1978)). Although issues of reproductive freedom are beyond the scope of this article, deliberate indifference with regard to this matter is also litigated. *See Monmouth Cty. Correctional Institutional Inmates v. Lanzaro*, 834 F.2d 326 (3d Cir. 1987) (holding that the policy of providing abortions only in instances of medical emergency constitutes a deliberate indifference to the serious medical needs of inmates seeking elective abortions). *But compare Bryant v. Maffucci*, 923 F.2d 979 (2d Cir. 1991) (holding that denial of an elective abortion to a pretrial detainee in her twenty-fourth week of pregnancy did not constitute deliberate indifference despite administrative delays); *Gibson v. Matthews*, 926 F.2d 532 (6th Cir. 1991) (holding that denial of an elective abortion to an inmate in her twenty-fourth week of pregnancy did not constitute deliberate indifference despite transportation delays beyond defendant’s control); *Victoria W. v. Larpenter*, 369 F.3d 475 (5th Cir. 2004) (policy requiring judicial approval for all elective medical procedures, including inmate’s abortion, did not constitute deliberate indifference when policy served legitimate penological interests).

¹⁰¹*Todaro v. Ward*, 431 F.Supp. 1129 (S.D.N.Y. 1977).

Estelle. *Estelle*'s holding figured largely in the establishment of legal standards applied to the facts of the case.¹⁰² The women alleged that the provision of medical care at Bedford Hills was "unconstitutionally defective" and thus a violation of their Eighth and Fourteenth Amendment rights.¹⁰³ Their specific charges included inadequate screening at admission, unreasonable delay in the provision of care, and insufficient follow-up care, among other things. Judge Ward characterized the question at issue as "at what point do individual failures in the overall operation of a prison medical care system add up to deliberate indifference which would render the entire system unconstitutional?"¹⁰⁴

Ultimately, much of the deliberate indifference at the facility was attributable to insufficient staffing,¹⁰⁵ faulty internal procedures, and poor communication, all resulting in a denial or substantial delay in care for the inmates. Of these, the "grossly inadequate" administrative and record-keeping procedures encompassed the factor most glaringly responsible for the omissions indicating deliberate indifference.¹⁰⁶ Although "adequate medical care is often provided at Bedford Hills" and was certainly better than that reported in other cases, "[t]he result[ing] . . . denial of necessary medical care for substantial periods of time is the same. . . . If the result is the same, the Court perceives no legal significance to the difference in cause, except insofar as it affects the necessary remedy."¹⁰⁷

Following *Todaro*, suits specific to the circumstances of pregnant women were brought. *Archer v. Dutcher* concerned a woman who was pregnant at the time she was admitted to a county jail.¹⁰⁸ Ms. Archer had received care from medical staff, but she alleged "intentional efforts on the part of defendants to delay her access to medical care at a time when she was in extreme pain."¹⁰⁹ Although the parties did not agree on the plaintiff's health status and the timing of when emergency medical care was provided prior to her miscarriage—correctional authorities contended that her initial complaints did not concern her pregnancy, and the parties disagreed whether those problems commenced in early May or several days earlier—according to the court, "[t]hese assertions, however disputed, do raise material factual issues. After all, if the defendants did decide to delay emergency medical aid—even for

¹⁰²*Id.* at 1132.

¹⁰³*Id.* at 1131. Bedford Hills, discussed *infra*, today is recognized as a leading example of correctional care for pregnant inmates.

¹⁰⁴*Id.* at 1133.

¹⁰⁵Judge Ward did remark that he "was not unfavorably impressed with the individual members of the Bedford Hills medical staff. They appeared to be truly concerned with the well-being of the inmates they served." *Id.* at 1159–60.

¹⁰⁶*Id.* at 1160.

¹⁰⁷*Id.* Compare *Batton v. North Carolina*, 501 F.Supp. 1173 (E.D. N.C. 1980) (holding, *inter alia*, that no Eighth Amendment violations existed with regard to provision of medical care where plaintiffs were unable to demonstrate series of serious medical deprivations, rather than select and discrete incidents).

¹⁰⁸*Archer v. Dutcher*, 733 F.2d 14, 15 (2d Cir. 1984).

¹⁰⁹*Id.* at 16.

‘only’ five hours—in order to make Archer suffer, surely a claim would be stated under *Estelle*.”¹¹⁰

The circumstances of *Boswell v. Sherburne* present a particularly distressing example of deliberate indifference inflicted upon a pregnant woman in custody.¹¹¹ Ms. Boswell, while being admitted to the county jail informed the jailer processing her that she was experiencing a “problem pregnancy,” which in recent days had been marked by troubling symptoms.¹¹² Despite having this knowledge, as well as the telephone number of Ms. Boswell’s physician, jailers ignored glaring signs of trouble with regard to her pregnancy. This included persistent bleeding (and the passage of blood clots), cramping, and numerous requests for a doctor. The chief jailer at the facility, upon being informed of the trouble Ms. Boswell was experiencing, was apathetic to her situation. As the court noted, “[t]hey left Boswell, cramped and bleeding, to languish in her jail cell while they waited for someone to take Boswell off their hands.”¹¹³ Help, once provided by a local police officer who also worked as an EMT, came too late for Ms. Boswell and her infant: “As Boswell was being transferred by ambulance to the hospital, she began giving birth. Her baby, Joseph Boswell, was born at the hospital, where he died thirty-four minutes later.” The court of appeals, affirming the motion denying summary judgment by the district court, noted that Ms. Boswell had succeeded ‘in stat[ing] with particularity the circumstances under which [the defendants] violated Boswell’s clearly established right to medical care.’¹¹⁴

Pregnant women who have suffered ill treatment continue to bring viable cases, even after *Farmer v. Brennan* clarified the need to establish a defendant’s mental state with regard to deliberate indifference. *Coleman v. Rahija* involved a situation in which a woman’s history of troubled pregnancies—including premature deliveries and “precipitous labors lasting less than an hour”—was well-known to medical staff at the facility at which she was incarcerated.¹¹⁵ Despite this knowledge and the

¹¹⁰*Id.*

¹¹¹*Boswell v. Sherburne*, 849 F.2d 1117 (8th Cir. 1988). The plaintiff in this case was a pretrial detainee, incarcerated after having been arrested for driving under the influence. *Id.* at 1119-20. On the basis of Ms. Boswell’s status as a pretrial detainee, the defendants in the case attempted to evade liability by arguing that “their obligation to provide medical treatment to a pregnant pretrial detainee was not clearly established at the time this incident took place. . . .” *Id.* at 1120. The *Boswell* court disagreed.

¹¹²*Id.* at 1119. The facts described here are taken from the decision on pages 1119–20.

¹¹³*Id.* at 1123. This aspect of the court’s description of the circumstances leading to Ms. Boswell’s suit is the most alarming. In a footnote, the court records the teletype communication between Ms. Boswell’s jailers at Sherburne and another county that also had an outstanding warrant for her. The Sherburne officials wrote, “[s]he is 6 mo [sic] pregnant and is starting to bleed. What would you like done about your bail. [sic]We want her out of our facility as soon as possible. Any suggestions?” The response to this inquiry is unapologetically callous: “If she has the bail take it—if she doesn’t, release her from our charges, we’ll try for her later. We don’t want the medical bills either!!!!!!” *Id.* at 1120.

¹¹⁴*Id.* at 1122.

¹¹⁵*Coleman v. Rahija*, 114 F.3d 778, 781 (8th Cir. 1997). Facts described here are taken from the decision on pages 782–83.

difficulties Ms. Coleman experienced in the days prior to giving birth, on the evening when she went into labor, she was largely dismissed by the nurse on duty. The nurse failed to examine Ms. Coleman's initial concerns with any particularity, although she noted the possibility of Ms. Coleman being in early labor. Approximately four hours after seeking help from the nurse, arrangements were finally made to transport Ms. Coleman to the delivery facility. She was transported at 11:45 p.m. and after arriving at the hospital, she delivered a son at 12:20 a.m. Critical in finding that the nurse had exhibited deliberate indifference toward Ms. Coleman's "serious medical need" was knowledge concerning her obstetrical history, the nurse's notation concerning a possible early labor, and Ms. Coleman's unequivocal manifestation of symptoms of a preterm labor: "[f]rom this evidence, a trier of fact could have found that [the nurse] had actual knowledge of the risk of pre-term labor."¹¹⁶ As such, the court held that the nurse's delay in providing transport to Ms. Coleman constituted deliberate indifference.

The circumstances of *Doe v. Gustavus*¹¹⁷ bear some resemblance to those of Louwana Yeager, described in the Introduction of this article. Like Ms. Yeager, Ms. Doe gave birth alone. Ms. Doe's troubles began when she initially refused to have her labor induced. Once another appointment had been set, Ms. Doe was placed in "segregated confinement."¹¹⁸ A day later, Ms. Doe began to experience labor symptoms which were disregarded as evidence of "false labor." She received little care and only improper examination of her condition.¹¹⁹ Scarcely more than twenty-four hours after her difficulties began, Ms. Doe, upon feeling "some movement between her legs," delivered her child. Only then was she taken to a hospital. After her return, she was accused of "push[ing] that baby out on purpose, just to get out of segregation" and placed in a maximum security portion of the correctional facility, where the provision of items necessary to her recovery was long delayed.

Two things become clear in evaluating these cases. First, the distress pregnant women experienced, in addition to the anticipated rigors of pregnancy and childbirth, was unnecessary. Had personnel provided the attention and appropriate level of concern to these women, their crises may have been averted. Second, these cases demonstrate that courts have been and continue to be willing to enforce the rights of women, pregnant or otherwise, to adequate medical care.¹²⁰ This is true even in

¹¹⁶*Id.* at 786.

¹¹⁷*Doe v. Gustavus*, 294 F.Supp. 2d 1003 (2003). Facts described here are taken from the case on pages 1006–07.

¹¹⁸*Id.* at 1006. The justification for this was that "knowledge of an off-site appointment could pose a security risk." The court later noted that "putting a late term pregnant woman in seg[regation]" was something a jury could find to be deliberate indifference, "particularly when it is alleged, as here, that the defendants based their decisions on an animus against the plaintiff." *Id.* at 1010.

¹¹⁹*Id.* at 1009. Owing to her segregated confinement, she was "only examined . . . through the small tray slot in the cell door."

¹²⁰*Compare, e.g., Pohlman v. Stokes*, 687 F.Supp. 1179 (S.D. Ohio 1987) (holding that damage sustained to inmate's reproductive organs and rendering her unable to have children while performing surgery to address ectopic pregnancy did not constitute deliberate indifference); *Whiting v. Marathon Cty Sheriff's Dept*, 382 F.3d 700 (7th Cir. 2004) (finding

those cases, such as *Todaro* and *Archer*, where care is provided, but not in a manner sufficient to satisfy the requirements established by *Estelle*. This presents two distinct avenues for improving the quality of care for incarcerated pregnant women, as addressed below: attacking their treatment through continued litigation on behalf of pregnant women harmed by the deliberate indifference of correctional facility officials as well as proactively addressing the needs of these women by encouraging change at the legislative level.

IV. EFFECTING CONSTRUCTIVE CHANGE FOR PREGNANT INMATES

Since the 1980s, conditions have improved in some facilities that house incarcerated pregnant women. This change has come about in a variety of ways, most notably through litigation and legislation. This section reviews the use of 42 U.S.C. § 1983 in class action suits and provisions enacted by state legislatures that have improved conditions for pregnant women. It also provides examples of programs that have been implemented to help these women, both in correctional settings and as alternatives to incarceration.

Despite the change effected to date, many pregnant women are still incarcerated under conditions that constitute deliberate indifference to their medical needs.¹²¹ No

that jail officials' inadvertent permission of an encounter with the object of a no-contact order resulting in extreme stress and which may have led to inmate's premature delivery did not constitute deliberate indifference to an objectively serious risk of harm).

¹²¹ Although most of the discussion here has focused on women challenging their treatment under the Eighth Amendment or the Fourteenth Amendment's Due Process Clause, the rights of women inmates has also been challenged under the Equal Protection Clause. *See Holt, supra* note 50, at 533. These cases have addressed a variety of shortcomings in the programs and services provided to women inmates as compared to those provided to men, including health care ((*see, e.g.,* *Batton v. North Carolina*, 501 F.Supp. 1173 (E.D. N.C. 1980) (holding that contracting out medical services for women inmates, rather than providing hospital care as for men, did not result in a substantial disparity in provision of medical services)).

Invoking equality arguments should be done cautiously, however, when the result may be so-called gender neutrality, which often entails simply providing programming designed for men equally to both men and women instead of providing programming tailored to the unique experiences of women inmates. "Outwardly even-handed treatment produces inferior treatment for incarcerated women because the norm is still set by male administrators, working with male needs uppermost in mind," says Rafter. Rafter, *Equality or Difference, supra* note 2, at 10. Others note that the "emphasis on equality may in some cases push women's punishment even more toward the traditional incarceration model, rather than advancing the use of alternatives to incarceration for women (and men) for whom these alternatives are appropriate." *Developments in the Law—Alternative Sanctions for Female Offenders*, 111 HARV. L. REV. 1921, 1942 (1998) [hereinafter *Alternative Sanctions*].

In the context of medical treatment for women prisoners, gender-neutral policies "allow[] women's medical needs to go grossly unaddressed." Kendra Weatherhead, Note, *Cruel but not Unusual Punishment: The Failure to Provide Adequate Medical Treatment to Female Prisoners in the United States*, 13 HEALTH MATRIX 429, 454 (2003). In California, for example, the State Department of Corrections "continue[s] to employ medical protocols and allocate health care resources using a healthy, young male as its model prisoner" despite increases in the number of women inmates in its system. Amy Petre Hill, *Death through Administrative Indifference: The PLRA Allows Women to Die in California's Standard Prison Health Care System*, 13 HASTINGS WOMEN'S L. J. 223, 232 (2002). California has,

one strategy can work as a complete solution. Rather, broader strategies for achieving constructive change for these women may need to consider the use of litigation, legislation, and creative programs. Litigation can be an effective “stick” when the “carrot” of legislation fails to work or, where achieving change through litigation is unlikely: “litigation . . . is particularly effective at generating publicity and forcing correctional facilities to the bargaining table.”¹²² By examining strategies that have worked to help similar women, one hopes that such examples might encourage additional constructive change.

A. Class Action Litigation as a Tool for Improving Medical Treatment for Pregnant Inmates

Litigation under § 1983 has long been—and remains following the passage of the Prison Litigation Reform Act (PLRA) in 1996, discussed below—an important tool for seeking improvement in the quality of medical care provided to all women inmates.¹²³ “[L]itigation is often necessary to pressure officials to reform a prison or jail system that has been historically unresponsive, or under-responsive[,] to the needs of pregnant and postpartum prisoners,” says Barry.¹²⁴ These suits are often settled rather than being taken to trial, which can be time consuming, expensive, and a drain on scarce judicial resources. These factors were noted by the judge approving a settlement agreement in *Laube v. Campbell*, a class action brought on behalf of women prisoners in Alabama.¹²⁵ To resolve complex and multiple issues related to prison conditions through trial often requires “an extensive and prolonged—not to mention contentious—trial to resolve them.”¹²⁶ In *Laube*, the judge estimated that a trial would have caused litigation costs to double and delayed an improvement in the conditions at the facilities concerned. Furthermore, he wrote that “the court cannot overlook the millions in tax dollars that will be saved by avoiding litigation—money that can, of course, now be spent directly on redressing

however, developed some innovative programs for pregnant and parenting women as described *infra*.

¹²²Stefanie Fleischer Seldin, *A Strategy for Advocacy on Behalf of Women Offenders*, 5 COLUM. J. GENDER & L. 1, 21, 31 (1995). Seldin focused on litigation related to the Fourteenth Amendment. Additionally, Seldin focuses on use of community programs; however, because alternatives to incarceration may not be appropriate to all pregnant inmates and is not applicable to the situations of pretrial detainees, this article also addresses programs developed for those pregnant women who are incarcerated.

¹²³See Holt, *supra* note 50, at 530. Although this portion of my article focuses on class action suits, it should be reiterated that individuals often use § 1983 actions to seek redress for injuries they suffer while incarcerated or in pretrial detention, as was true in the reported cases discussed *supra* to illustrate deliberate indifference.

¹²⁴Barry, *Pregnant Prisoners*, *supra* note 5, at 201.

¹²⁵*Laube v. Campbell*, 333 F.Supp.2d 1234, 1246 (M.D. Ala. 2004). The settlement reached is addressed in greater detail *infra*.

¹²⁶*Id.* For a comparison, however, see *Madrid v. Gomez*, 889 F.Supp. 1146 (N.D. Cal. 1995), a case that illustrates the bullet dodged in *Laube*. The bench trial in *Madrid* took approximately two months and involved fifty-seven lay witnesses, ten expert witnesses, and more than six thousand exhibits. *Id.* at 1156–57.

state prison conditions to the extent needed.”¹²⁷ Furthermore, settlements can be more effective than seeing such matters through the trial process because of the potential for “creative remedies” and relatively more expedient resolution.¹²⁸ “Although successful litigation of these cases through the trial phase would establish valuable precedents of eighth amendment violations in the pregnant prisoner context,” Barry concedes, doing so might not “lead to as many specific improvements in prison conditions. . . .”¹²⁹ Agreements, ultimately, result in “giv[ing] the plaintiffs more control in determining which improvements in prison conditions are most necessary.”¹³⁰

Actions brought have focused sometimes on the needs of all inmates and sometimes on the needs of pregnant inmates specifically; both can have the effect of prompting constructive change. Although some attorneys might resort to bringing “kitchen sink complaints” that seek to remedy myriad conditions in correctional facilities, this strategy is more appropriate for those ready to face “litigation that may continue for many years.”¹³¹ More rapid relief is usually obtained by bringing “numerous but narrowly defined and highly compelling class action suits.”¹³² Although the long-term benefits of litigation must always be qualified—as discussed below, some settlement agreements that result from litigation are not fully implemented, for example—in many instances, they have made a constructive difference for pregnant women in affected correctional facilities.

1. Notable Settlement Agreements Before the Prison Litigation Reform Act Passage and Their Efficacy

Litigation has been a primary means of attempting to improve conditions for pregnant women in correctional facilities. A California organization, Legal Services for Prisoners with Children, has been particularly skilled at bringing suits against correctional facilities that have resulted in settlement agreements. Inspired by an agreement achieved in a Connecticut suit brought on behalf of pregnant inmates,¹³³ LSPC brought a series of class action suits in the 1980s against California correctional facilities for both pregnant and postpartum prisoners.¹³⁴ The first suit, *Harris v. McCarthy*, achieved a comprehensive agreement that required, among other things, the hiring of an OB/GYN to provide treatment and supervise the care of pregnant prisoners, the adoption of policies for handling high-risk pregnancies and

¹²⁷*Id.* at 1247.

¹²⁸Barry, *Pregnant Prisoners*, *supra* note 5, at 202.

¹²⁹*Id.* at 202–03.

¹³⁰*Id.* at 203.

¹³¹*Id.* at 202. Such suits, she remarks, also “require large attorney teams and budgets.”

¹³²*Id.* Barry continues that “[u]nder this approach, the plaintiff class consists of prisoners with well-defined grievances within a single facility.” This approach was used by Legal Services for Prisoners with Children, discussed *infra*.

¹³³This suit, *West v. Manson*, challenged a number of practices with regard to pregnant women including the use of shackles on pregnant women and inadequate provision of nutrition and prenatal care. McGurrin, *supra* note 53, at 166.

¹³⁴Barry, *Pregnant Prisoners*, *supra* note 5, at 194.

emergencies occurring in pregnancy, and establish a specialized unit for pregnant women.¹³⁵ The agreement also called for overall increases in the number of medical staff and improvements in record keeping. Agreements to settle subsequent lawsuits sought improved access to prenatal care, care specific to the needs of women with substance abuse problems, guideline development for the care of pregnant prisoners, and so forth.¹³⁶

Of course, the effectiveness of settlement agreements or court supervision of facilities is sometimes dubious. The facility featured in Vaughn and Smith's study of penal harm is stark evidence of this. In addition to being accredited by the National Commission on Correctional Health Care, the facility had been operating under a consent decree for nearly twenty years at the time of their study—during which time “medical facilities were never in full compliance with the consent decree’s mandates.”¹³⁷ Among the incidents identified and substantiated by the researchers were those in which medical care had been used to “humiliate” prisoners or in which medical care had simply been withheld.¹³⁸ The implications for pregnant women at the facility were grave. For example, one woman with a history of troubled pregnancies and who, during her incarceration, was experiencing considerable difficulties, pleaded to see a physician only to be told by the jail’s medical staff that “they did not treat pregnant prisoners.”¹³⁹ Another woman, whose pregnancy was compounded by the existence of an undiagnosed gynecological illness, was also denied treatment (despite being seen by an OB-GYN) although she experienced persistent pain and abundant malodorous vaginal discharge.¹⁴⁰ As the reports of these women demonstrate, supervision may not guarantee that the quality of medical care will improve for pregnant inmates.

In addition to concerns about the efficacy of litigation and resulting settlements, some observers caution against immediate resort to litigation when other avenues for achieving change for pregnant inmates are available. “Advocates should realize that lobbying and creating community programs are options worth trying in addition to, or even instead of litigation,” says Seldin.¹⁴¹ None of this is to suggest that litigation

¹³⁵Barry et al., *Legal Issues*, *supra* note 7, at 159.

¹³⁶*Id.* at 160.

¹³⁷Vaughn & Smith, *supra* note 23, at 185–86. The accreditation had not been revoked despite this. *See also* Nelson v. Prison Health Services, 991 F.Supp. 1452 (M.D. Fla. 1997). This case concerns the facility studied by Vaughn and Smith, which had been operating under court supervision since 1975 but continued to experience persistent problems in its delivery of treatment and a disparity in care provided to women inmates. *See also* Hill, *supra* note 121, at 225–26 (describing failure of a settlement agreement to achieve improvements in two California correctional facilities for women).

¹³⁸Vaughn & Smith, *supra* note 23, at 192. The authors concede however, that despite corroborating the allegations of mistreatment at the facility, “potential for fabrication by prisoners render[ed] our conclusions tentative.” *Id.* at 219. They ultimately cast their findings of abuse as being “snapshots” of conditions at the facility, partial accounts indicating a “persistent pattern of medical ill-treatment . . . over the entire five-year period.” *Id.*

¹³⁹*Id.* at 199.

¹⁴⁰*Id.*

¹⁴¹Seldin, *supra* note 122, at 31.

and subsequent settlement agreements should be abandoned as a strategy for effecting change. To the contrary, “[w]ithout external supervision of correctional medical care, . . . ill-treatment . . . would be a far greater problem.”¹⁴² The point is rather that the agreements achieved through litigation must be regarded with cautious optimism.

2. The Prison Litigation Reform Act and Implications for Litigation by Pregnant Inmates

Fewer correctional facilities today are operating under some variety of court supervision. In 2000, fifty-nine facilities were being monitored for the “totality of conditions,” down from 149 in 1995; those facilities being monitored for the quality of their medical facilities specifically is also down to seventy-five in 2000 from 139.¹⁴³ Because the quality of conditions in correctional facilities has not experienced a revolutionary improvement, the decline in the number of facilities operating under court supervision is likely the result of the Prison Litigation Reform Act of 1996, which contributed to a reduction in the number of suits brought by prison inmates seeking to challenge the conditions of their incarceration.¹⁴⁴ Exemplifying this trend is the facility evaluated by Vaughn and Smith in their discussion of penal harm: the consent decree under which it operated “was terminated pursuant to the 1996 Prison Litigation Reform Act” despite the fact that this jail had never been in compliance with the decree and its inmates continued to experience dubious medical care.¹⁴⁵ In a study examining prisoner petitions filed in 2000, the PLRA appears to have been successful in reducing caseloads: “Between 1995 . . . and 2000, the number of civil rights petitions decreased from 41,679 to 25,504.”¹⁴⁶ The number of civil rights petitions filed per thousand inmates went from thirty-seven to nineteen.¹⁴⁷ While the problems of prisoner litigation—such as large numbers of usually unsuccessful cases which the PLRA sought, in part, to address—were evident, they have to be examined in the context in which most prisoners were litigating: as *pro se* litigants faced with a high persuasion burden.¹⁴⁸ As noted by Schlanger, “[a]ny reform effort . . . faced a very difficult challenge: how to limit the number of bad cases . . . while protecting and even strengthening both

¹⁴²Vaughn & Smith, *supra* note 23, at 218.

¹⁴³STEPHAN & KARBERG, *supra* note 9, at 9.

¹⁴⁴For a discussion of a better crafted congressional effort to curb prisoner litigation with the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA), see Susan H. Herman, *Slashing and Burning Prisoners' Rights: Congress and the Supreme Court in Dialogue*, 77 OR. L. REV. 1229, 1270–72 (1998). By comparison to the consideration that went into its predecessor legislation, Herman notes that “[t]he legislative process leading to the passage of the PLRA was characterized by haste and lack of any real debate.” *Id.* at 1276.

¹⁴⁵Vaughn & Smith, *supra* note 23, at 184 fn15.

¹⁴⁶JOHN SCALIA, U.S. DEPARTMENT OF JUSTICE, PRISONER PETITIONS FILED IN U.S. DISTRICT COURT, 2000, WITH TRENDS 1980–2000 1 (2002).

¹⁴⁷*Id.* The tastelessly titled Antiterrorism and Effective Death Penalty Act, a companion of the PLRA, has been less successful in achieving its goal of habeas reform. As noted in the same study, the rate of habeas petitions filed has increased from nineteen to twenty-three.

¹⁴⁸Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555, 1692 (2003).

litigation's already compromised compensation function and the positive effects of the litigation system on correctional practice."¹⁴⁹

The broader goals of the PLRA were reducing the cost of litigation and the "flood" of litigation,¹⁵⁰ especially of the frivolous sort.¹⁵¹ In 1995, prior to the passage of the PLRA "civil rights" petitions from inmates—a category that often includes suits challenging prison conditions—constituted thirteen percent of the civil cases in federal district courts.¹⁵² Although many of these cases are dismissed as frivolous, Judge Newman warned that among them were "a small number of serious matters that pose substantial issues."¹⁵³ Additionally, while the claims may be numerous, "prison cases do not consume nearly a proportionate share of the federal courts' time. . . . [P]risoner petitions rarely go to trial or even to hearings, and are generally screened and summarily dismissed at early stages of the proceedings."¹⁵⁴

The legislation creates several disincentives for bringing suits, as described by Herman's analysis of the PLRA, including paying filing fees and creating barriers to *in forma pauperis* filing. As noted by Ellen Barry, since the passage of PLRA "it has become substantially more difficult for women prisoners and their advocates to bring class action litigation."¹⁵⁵ Among the provisions that work a particular hardship against recently pregnant inmates is the requirement that inmates exhaust their administrative remedies before bringing suit. This is problematic where those

¹⁴⁹*Id.* at 1694.

¹⁵⁰Notions of a "flood of litigation" are somewhat misleading, when one accounts for the concurrent growth of inmate populations: "Between 1980 and 1995, the rate at which State inmates filed civil rights petitions was stable, averaging forty petitions per 1,000 inmates. The State prison population, by contrast, increased more than threefold from 305,458 during 1980 to 1,025,624 during 1995." SCALIA, *supra* note 146, at 3. In this context, the increased number of suits makes rational sense.

¹⁵¹"Frivolity," notes Herman, "is a self-fulfilling category. As the Supreme Court narrows the definition of rights and raises procedural hurdles for relief, prisoners are bound to lose more cases. . . . This result does not necessarily mean that the claims are unworthy, but only that they are unsuccessful." *Id.* at 1295–96. Interestingly, in a study of § 1983 litigation conducted in 1992, frivolousness as a rationale for dismissal was found only in nineteen percent of cases. ROGER A. HANSON & HENRY W.K. DALY, U.S. DEP'T OF JUSTICE, CHALLENGING THE CONDITIONS OF PRISONS AND JAILS: A REPORT ON SECTION 1983 LITIGATION 20 (1994). At any rate, the suits brought by pregnant women as individuals or in class actions, are improperly lumped in any category called "frivolous" given the gravity of the conditions they challenge.

¹⁵²Jon O. Newman, *Pro Se: Looking for Needles in Haystacks*, 62 BROOK. L. REV. 519, 519 (1996). Judge Newman's article exposes the true circumstances behind some of the infamous prisoner suits—such as the "chunky peanut butter" case—that inspired the PLRA. See also Herman, *supra* note 144, at 1296. Many of the cases brought by inmates are disregarded as being meaningless or trifling, particularly because when they settle, the settlements are for small amounts of money.

¹⁵³*Id.*

¹⁵⁴Herman, *supra* note 144, at 1295.

¹⁵⁵Barry, *Bad Medicine*, *supra* note 52, at 43. Certainly, if any matter were to encourage courts to review the "haystacks" of prisoner lawsuits for the "needles" of meritorious claims" it would be the circumstances of pregnant inmates. Newman, *supra* note 152, at 527.

procedures require a claim be filed within a short period time after the incident has occurred for women who have experienced a miscarriage, stillbirth, or the like; “[i]t seems particularly inhumane to expect a woman who has just lost a child to focus on something as mundane as filing an administrative appeal. . . .”¹⁵⁶ Furthermore, grievance procedures can be used in a calculating manner by corrections officials seeking to evade the scrutiny of federal courts. In California, for example,

[p]rison officials can keep . . . women inmates out of federal court indefinitely simply by choosing not to resolve appeals [brought pursuant to the state’s administrative relief process]. With seeming disregard for due process, the PLRA has inadvertently granted the California Department of Corrections the power to sentence non-violent female offenders to death by keeping their pleas for medical aid tied up in red tape until they die.¹⁵⁷

Another portion of the PLRA—18 U.S.C. § 3626—is pertinent to the relief potentially sought by inmates who are able to pass the other PLRA hurdles and “prevail[] despite the rigors of . . . federal law.”¹⁵⁸ Prospective relief under the act “must be narrowly drawn, extend no further than necessary to correct the violation of the Federal right, and [be] the least intrusive means necessary to correct the violation of the federal right.”¹⁵⁹

3. Settlement Agreements Post–Prison Litigation Reform Act: *Laube v. Campbell*

The settlement agreements reached in *Laube v. Campbell* were the result of a 2001 investigation into conditions at women’s prisons in Alabama and subsequent litigation which commenced in 2002.¹⁶⁰ Their initial claim in the § 1983 class action suit alleged that the state’s facilities for women prisoners were unsafe, had failed to provide for the basic needs of inmates, and that officials had been deliberately indifferent to these circumstances.¹⁶¹ After hearing evidence regarding a preliminary injunction and visiting two of the facilities himself, the judge observed that at one facility “unsafe conditions . . . are so severe and widespread today that they are essentially a timebomb ready to explode facility-wide at any unexpected moment in the near future.”¹⁶² The court rejected the initial attempt of officials to craft a plan

¹⁵⁶Barry, *Bad Medicine*, *supra* note 52, at 43. Barry recommends that the PLRA be amended to accommodate the experiences of pregnant prisoners, “waiv[ing] strict adherence to the administrative appeals provision of the Act in instances where a women prisoner has suffered a miscarriage, the death of a child, serious complications during pregnancy. . . .” *Id.*

¹⁵⁷Hill, *supra* note 121, at 227.

¹⁵⁸Herman, *supra* note 144, at 1286.

¹⁵⁹18 U.S.C. § 3626(a)(1)(A). The provision for preliminary injunctive relief under § 3626(2)—discussed at length in the *Laube* litigation *infra*—is very similar.

¹⁶⁰*Laube v. Haley*, 333 F.Supp.2d 1234, 1246 (M.D. Ala. 2004).

¹⁶¹*Laube v. Haley*, 234 F.Supp2d 1227, 1230 (M.D. Ala. 2002) (granting preliminary injunction at Tutwiler facility with regard to overcrowding and understaffing, but denying injunction for Mitchell and Birmingham facilities).

¹⁶²*Id.* at 1252.

for rectifying circumstances at the facilities.¹⁶³ While a subsequent plan was drafted, submitted, and evaluated through late February and early March, the preliminary injunction issued on December 2, 2002, expired per the requirements of § 3626(a)(2) of the PLRA.¹⁶⁴ This apparently caught all concerned by surprise, as action on the matter had proceeded without concern for or apparent knowledge of the March 2, 2003 expiration—plaintiffs responded to the defendants’ plan on March 3 and a hearing occurred on March 6.¹⁶⁵ It was only after the hearing that the court determined it needed to “research[] the limits” that the PLRA created for such injunctions.¹⁶⁶ Judge Thompson conceded in his ruling that “both the court and the parties will have to be more attentive to the PLRA’s requirements.”¹⁶⁷

All was not lost however. During a conference among the parties and the judge, the defendants “assured the court that they intended to go forward with their initial and supplemental remedial plans, regardless of the status of the preliminary injunction.”¹⁶⁸ In 2004, the parties met to discuss settlement and then commenced mediation (overseen by a federal magistrate judge).¹⁶⁹ In addition to adhering to the normal review requirements mandated by federal civil procedure rules, Judge Thompson was careful to ensure that aspects of the PLRA did not go ignored. He stated, “[a]lthough ‘private settlement agreements’ are not subject to the statute’s limitations, . . . the agreements in this case are subject to judicial enforcement and are thus within the scope of the statute.”¹⁷⁰ All parties acknowledged that the agreement “satisfi[es] the statute’s three-part ‘need-narrowness-intrusiveness’ requirements.”¹⁷¹ Judge Thompson also clarified that the healthcare monitor provision of the Medical Settlement Agreement did not implicate the PLRA’s provisions regarding Special Masters.¹⁷² After reviewing the agreements for fairness, adequacy, and reasonableness, Judge Thompson approved them, stating that they would “not make the Alabama Department of Corrections’ women[s]’ facilities

¹⁶³Laube v. Haley, 242 F.Supp.2d 1150 (M.D. Ala. 2003). The proposed plan was rejected because: (1) in requesting the court to restrain or prohibit the transfer of inmates to one of the facilities, the defendants sought something in violation of both a state-court order and the PLRA’s provisions limiting the power of single-judge courts; and (2) defendants’ admission that their proposed plan was hindered by insufficient funding. *Id.* at 1152.

¹⁶⁴Laube v. Campbell, 255 F.Supp.2d 1301, 1303 (M.D. Ala. 2003).

¹⁶⁵*Id.*

¹⁶⁶*Id.*

¹⁶⁷*Id.* at 1304.

¹⁶⁸*Id.* at 1303.

¹⁶⁹Laube v. Haley, 333 F.Supp.2d 1234, 1237 (M.D. Ala. 2004).

¹⁷⁰*Id.* at 1238.

¹⁷¹*Id.*

¹⁷²*Id.* at 1239–40. To accomplish this, Judge Thompson analogized the role of the healthcare monitor to that of a similar function in a Second Circuit case where the monitoring function was held to be dissimilar from that of a special master. *Id.*

comfortable or pleasant places, but . . . [would] afford class members the basic necessities mandated by the United States Constitution.”¹⁷³

The agreements reached—one addressing general conditions at the facilities¹⁷⁴ and one addressing provisions of medical care¹⁷⁵—were intended to improve the circumstances of all women incarcerated within the Alabama correctional system. However, the Medical Settlement Agreement made specific provision for the care of pregnant women. At intake, women would be screened for pregnancy and an obstetrical history would be taken.¹⁷⁶ This initial step ensures that pregnant women will be provided appropriate care immediately upon being received into the facility. Furthermore, as illustrated by *Coleman v. Rahija*, knowledge of a woman’s obstetrical history can be an indication that a current pregnancy may need to be monitored more closely.¹⁷⁷ The Agreement also makes a clear provision for the level of care pregnant inmates shall receive, appropriate diet, and how to address high-risk pregnancies:

Pregnant prisoners shall be monitored regularly by a medical doctor or physician assistant with obstetric specialty, in accordance with American College of Obstetrics and Gynecology (“ACOG”) guidelines for prenatal care. Pregnant women shall be provided an appropriate diet and supplemental vitamins, and given the opportunity to request and receive educational information regarding pregnancy. Gestational diabetics shall be treated according to ACOG guidelines. All high-risk pregnancies, as well as women near term, shall be closely monitored and treated. Upon return from the hospital post-delivery, women prisoners will be allowed appropriate bed rest and time for recovery.¹⁷⁸

Other provisions in both agreements will make distinct improvements for the care of pregnant women as well. The Medical Settlement Agreement requires counseling to be available to women “to address depression and to resolve issues associated with the victimization from sexual and physical abuse”¹⁷⁹ and the Conditions Settlement Agreement mandates “adequate and appropriate drug treatment programs.”¹⁸⁰ Both these aspects of the agreement address long-standing issues faced by women inmates. Furthermore, the Medical Services Agreement requires that help be provided to women who will need medical care after leaving prison, including

¹⁷³*Id.* at 1246.

¹⁷⁴*Id.* at 1248.

¹⁷⁵*Id.* at 1253.

¹⁷⁶*Id.* at 1255.

¹⁷⁷*Coleman v. Rahija*, 114 F.3d 778, 785 (1997) (in which plaintiff “presented evidence of her previous rapid labors and premature deliveries to establish a substantial risk of pre-term labor”).

¹⁷⁸*Laube*, 333 F. Supp.2d at 1258.

¹⁷⁹*Id.* at 1260.

¹⁸⁰*Id.* at 1250.

referral for further medical services and assistance in applying for Social Security benefits for eligible women.¹⁸¹

The agreements reached and approved in *Laube* demonstrate that litigation after the passage of the PLRA remains a viable option for pregnant women incarcerated under substandard conditions. It provides a blueprint for succeeding in a climate more hostile to prisoner litigation, including how to elude problematic aspects of the legislation. How this affects the actual conditions of women in the Alabama system, of course, remains to be seen; nevertheless, *Laube* sends a clear message that the needs of this population will not be ignored once the considerable hurdles of the PLRA's other modifications are cleared.

B. Proactive Change: Avoiding Litigation Through Legislative Action

The potential for the action of state legislatures to change conditions for pregnant women in any meaningful way is somewhat limited by the exigencies of election politics in an atmosphere that favors a "get tough on crime" philosophy. However, given that litigation is no guarantee for improvement and that the PLRA limits its use, clearly legislative action can only help these women. Furthermore, legislation can create an atmosphere for encouraging correctional facilities—by providing funding, indicating concern through hearings, and so forth—to take proactive steps to improve conditions for pregnant women.¹⁸² That is, corrections officials with limited resources and unlimited demands on those resources may respond favorably to signals from state legislators indicating support for improved care of pregnant inmates.¹⁸³ Action by state legislatures would probably save money drawn from state coffers to wage costly litigation battles by directly addressing problems that some corrections officials seem to favor managing in court. "[P]rison conditions cases sometimes border on collusion," notes one observer.¹⁸⁴ She continues

The prison-warden defendants would certainly prefer to run institutions that are not overcrowded, that have adequate ventilation, adequate nutrition, and enough security to prevent inmates from attacking one another. . . but they often lack adequate funding to do so, and so are delighted if a court requires the legislature to increase their budgets. . . . In the type of systemic challenge Congress addressed in [§ 3626 of the

¹⁸¹*Id.* at 1255.

¹⁸²See Barry, *Bad Medicine*, *supra* note 52, at 42 (discussing the effect of legislators in California).

¹⁸³*Id.* at 43. These officials are often caught in the unenviable position between the Scylla of limited funding and the Charybdis of prisoner civil rights litigation. While proactive development of programs might deter some litigation, some officials "have no idea how to remedy practices." Nicole Hahn Rafter, *Even in Prison, Women Are Second-Class Citizens*, 14 HUM. RTS. 28, 31 (1987) [hereinafter Rafter, *Second-Class Citizens*]. Doing so under the auspices of legislative approval might relieve some officials of the Catch-22 burden that these situations present.

¹⁸⁴Herman, *supra* note 144, at 1287.

PLRA], however, the defendants generally would be pleased to address prisoners' requests.¹⁸⁵

The efforts of the warden at the Tutwiler facility in the *Laube* legislation is an example of what the defendant Herman describes: "Warden Deese has made yearly budget requests, asking for more staff, more holding cells, and additional facilities; but her requests for more funds have been rejected. . ."¹⁸⁶ Finally, if legislatures, aware of the challenges faced by officials such as Deese, were more realistic about the requirements under which they are required to imprison people in the process of waging their "get tough on crime" campaigns—specifically that costs will include more than simply building more correctional facilities—they might head off some litigation or perhaps reconsider the wisdom of their policies.¹⁸⁷

In charting the direction of improving conditions for pregnant inmates, state legislatures can attack this problem indirectly, such as through adjustments to mandatory minimum sentencing legislation or approving funding for more programs that provide alternatives to incarceration, or directly through mandating appropriate treatment of pregnant inmates and pretrial detainees.¹⁸⁸ California's Family Foundations Program (FFP), for example, was established through legislation specifically for pregnant women and pregnant and parenting women who have histories of substance abuse.¹⁸⁹ This program is a sentencing alternative that provides substance abuse treatment as well as parenting programs.

¹⁸⁵*Id.* As far back as 1981, corrections officials quoted in a Supreme Court concurrence conceded that "judicial intervention has helped them to obtain support for needed reform." *Rhodes v. Chapman*, 452 U.S. 337, 360 (1981) (Brennan, J., concurring).

¹⁸⁶*Laube v. Haley*, 234 F.Supp.2d 1227, 1240 (M.D. Ala. 2002).

¹⁸⁷Fearn & Parker, *Health Care for Women Inmates*, *supra* note 23, at 18.

¹⁸⁸*See Seldin*, *supra* note 122, at 22–27. Seldin, however, in her advocacy proposal for women offenders, makes the suggestion that in promoting increasing respect for the rights of these women, their advocates should "promot[e] the 'woman as victim' stereotype," *Id.* at 4. Doing so, she argues, garners sympathy for these women which they would not otherwise receive and this image will contrast the other stereotype of these offenders as "vicious and subhuman." Seldin rationalizes this approach as the best means to achieve the end of bettering conditions for these women. "Reinforcing the gender stereotype is troubling," she concedes. "Yet, to empower offenders by portraying them as victims is a worthwhile tradeoff." *Id.* However, this suggestion is faulty, in part because "uncritical acceptance of victim rhetoric can derail political efforts to challenge oppression." Martha Minow, *Surviving Victim Talk*, 40 U.C.L.A. L. REV. 1411, 1413 (1993). Furthermore, a history of sexual and/or physical abuse has also condemned these women to disabling passivity, especially when such experiences can sometimes inspire women to take proactive steps to change their circumstances. *Id.*

¹⁸⁹CAL. PENAL CODE § 1174–1174.9 (Deering 2006). California's legislature also established a program for inmate mothers called the Community Prisoner Mother Program. CAL. PENAL CODE §§ 3410–24. The latter program is intended for parenting women who have already been sentenced to prison, but pregnant women may be eligible for participation. The programs have only limited availability—around seventy-one beds for the CPMP and seventy for the FFP—despite high demand for the services provided. For greater detail about each of these programs, see Kelly Parker & Noelle Fearn, *Mothers behind Bars: Challenges and Opportunities*, in CORRECTIONAL HEALTH CARE: A FOCUS ON PREVENTION (Rick Ruddell & Mark Tomita, eds.) (forthcoming).

States developing legislation to address the situations of pregnant inmates specifically have a variety of options to consider, including standards promulgated by groups such as ACOG and the American Correctional Association or standards required by corrections organizations that provide accreditation to correctional health care systems, such as the NCHCC.¹⁹⁰ Settlement agreements that have addressed the needs of pregnant women—either exclusively or within the context of larger agreements addressing health care for women inmates, as was the case in *Laube*—are also instructive, particularly for those legislatures seeking to avoid litigation.

Legislators can also look to the work of their peers in other states. Provisions for the care of pregnant inmates provide a spectrum of examples, from the somewhat minimalist approach of Indiana¹⁹¹ to the more detailed legislation of Florida.¹⁹² New York legislation makes ample provision for birth arrangements and care for the infant after its birth—which may be permitted within the facility itself for up to one year of age and sometimes up to eighteen months—or its placement.¹⁹³ Tennessee allows some pregnant inmates a furlough of up to six months “to permit the giving of birth and the ‘bonding’ between mother and child.”¹⁹⁴

C. Innovative Programs for Pregnant Inmates

Examples of successful programs for pregnant women involved in the criminal justice system are notable. These programs have helped women in correctional facilities themselves as well as those in programs in the community corrections setting.¹⁹⁵ In developing programs for these women, it is important to explore

¹⁹⁰Nebraska, in its Correctional Health Care Services Act, mandated both that protocols be developed for its correctional facilities that were in keeping with “a community standard of health care” and that its state correctional department to seek accreditation by the American Correctional Association for its medical program. NEB. REV. STAT. § 83-4, 160, 165 (LexisNexis 2006).

¹⁹¹IND. CODE § 11-10-3-3 (2004). The Indiana statute merely provides for “necessary prenatal and postnatal care” and allows for delivery outside the correctional facility “when possible.” Although its language is sparse and somewhat vague, some specific provision for the care of pregnant inmates is better than *no* specific provision.

¹⁹²FLA. STAT. ANN. § 944.24 (West 2006). In addition to providing the inmate with prenatal care, the Florida statute requires appropriate diet, clothing, and work assignments and transfer outside the facility to a hospital for pregnancies “beyond the scope and capabilities of the prison’s medical facilities.”

¹⁹³N.Y. CORRECT. LAW § 611 (McKinney 2006).

¹⁹⁴TENN. CODE ANN. § 41-21-227(h)(1) (West 2006). In turn, this lets the state off the hook with regard to payment for the delivery, as the corrections department “shall not be responsible for any expenses, medical or otherwise, incurred by the inmate while on furlough.”

¹⁹⁵Facilities housing such programs “provide a much more child-friendly setting and provide intense supervision for women. . . . [T]hese community corrections facilities harbor great potential as laboratories for innovation in the punishment and rehabilitation of female offenders.” *Alternative Sanctions*, *supra* note 121, at 1932.

alternatives to incarceration more fully with regard to pregnant women inmates, who are less likely to be violent.¹⁹⁶

In developing programs for pregnant women in either setting, some needs are universal, including improving prenatal education that includes explanations of the birthing process¹⁹⁷ and providing classes that teach parenting skills.¹⁹⁸ Furthermore, whether examining programs within correctional facilities or in community settings, it is also important to consider the larger challenges faced by pregnant women—particularly the difficulties they will face as mothers after being re-integrated into society. Thus, addressing the situations of pregnant women must also give consideration to housing needs as well as the necessity for education and vocational training.¹⁹⁹

1. Programs Serving Pregnant Inmates Within Correctional Facilities

Generally, for conditions for pregnant women to improve in correctional facilities the ideal would be the creation of national standards for their care.²⁰⁰ Short of that, increased numbers of facilities seeking accreditation would also facilitate constructive change.²⁰¹ Given that there is no shortage of standards to draw from, correctional facilities have the tools to develop internal policies of their own.²⁰² Officials ideally can exhibit an awareness of the needs of this population through policies that seek “to reduce stress, to decrease environmental restrictions, to promote a healthy lifestyle, and to develop decision-making and coping skills for resolving infant placement problems and assuming a maternal role after birth.”²⁰³ Specific provisions might include efforts to ameliorate the “physical problems” of pregnant inmates by providing a full-time doctor or nurse, providing special diets and appropriate work assignments, and providing “less crowded”

¹⁹⁶This recommendation is raised by many legal and social science scholars. See, e.g., Acoca & Raeder, *supra* note 36; *Alternative Sanctions*, *supra* note 121, at 1921; Ross & Lawrence, *supra* note 8, at 128; McHugh, *supra* note 47, at 259. Access for women to programs that provide alternatives to incarceration have sometimes been quite limited, especially in the area of drug treatment programs. *Alternative Sanctions*, *supra* note 121, at 1939. For drug-addicted pregnant women, these barriers are particularly daunting—some programs refuse to admit pregnant women. *Id.* at 1939–40.

¹⁹⁷Hufft et al., *supra* note 29, at 58.

¹⁹⁸Barry, *Bad Medicine*, *supra* note 52, at 43. An additional consideration for women inmates is an abolition of the use of restraints when transporting pregnant women to hospitals to give birth.

¹⁹⁹Shearer, *supra* note 36, at 47.

²⁰⁰See, e.g., Barry et al., *Legal Issues*, *supra* note 7, at 160 (arguing that “widespread change within the correctional system remains hampered by the lack of national standards specific to the needs of pregnant prisoners”).

²⁰¹However, as noted by the study by Vaughn and Smith, accreditation is not fail-safe itself. See Vaughn & Smith, *supra* note 23.

²⁰²See, e.g., McHugh, *supra* note 47, at 247–48 (citing standards developed in 1870 and 1931).

²⁰³Hufft et al., *supra* note 29, at 56.

accommodations.²⁰⁴ Additionally, in facilities where women are not permitted to keep their infants with them, some provision should be made for these women “to stay with their newborns for a minimum of seventy-two hours.”²⁰⁵ The Federal Bureau of Prisons (BOP) has developed a strategy for dealing with pregnant inmates in its Health Services Manual and through other policies.²⁰⁶ At intake, women are tested for pregnancy and those identified as pregnant are to be referred to a physician within fourteen days.²⁰⁷ Ideally, then, inmates are to receive appropriate “medical and social services related to . . . pregnancy, child placement, and abortion”²⁰⁸ and, once the birth approaches, medical officials arrange for the birth to take place “at a hospital outside the institution.”²⁰⁹

Developments at the Santa Rita County Jail in Alameda County, California, following the settlement of *Jones v. Dyer*, provide an example of the medical care that can be provided to incarcerated pregnant women.²¹⁰ The jail has a facility geared toward providing “comprehensive OB/GYN and prenatal services” for inmates in which staff are provided through a contractual arrangement.²¹¹ The OB/GYN services are provided “by a multidisciplinary medical team composed of a perinatal case manager, a nurse practitioner, a physician and a nursing staff.” Care for substance abuse is also provided. Women at the jail receive appropriate diets, prenatal care, and social services that “include information and assistance on adoption, resources and coping skills for single-parent mothers, options and skills for child care, and family planning.”²¹²

²⁰⁴Wooldredge & Masters, *supra* note 54, at 196–97. Separate living facilities for pregnant women is their specific recommendation; however, this seems improbable.

²⁰⁵Barry, *Bad Medicine*, *supra* note 52, at 43.

²⁰⁶HEALTH SERVICES MANUAL, BUREAU OF PRISONS (1996). Any recommendation of BOP policies and procedures must be read with a note of caution, as their practices may not reflect these written norms.

²⁰⁷*Id.* at XI-1–2.

²⁰⁸Bureau of Prisons, Policy Statement 6070.05, Birth Control, Pregnancy, Child Placement, and Abortion (1996).

²⁰⁹28 C.F.R. § 551.22(c) (2003). This rule became effective in 1999. 64 Fed. Reg. 9429 (Feb. 25, 1999).

²¹⁰Other notable programs within correctional facilities are those that incorporate nurseries, including the Children’s Center at New York’s Bedford Hills Correctional Facility and the Residential Parenting Program at the Washington Corrections Center for Women. See MERRY MORASH, ET AL., NATIONAL INSTITUTE OF JUSTICE, WOMEN OFFENDERS: PROGRAMMING NEEDS AND PROMISING APPROACHES 8 (1998); Noelle Fearn & Kelly Parker, *Washington State’s Residential Parenting Program: An Integrated Public Health, Education, and Social Service Resource for Pregnant Inmates and Prison Mothers*, 2 CAL. J. OF HEALTH PROMOTION 34 (2004). Maryland has also implemented a number of innovative programs that focus on the needs of all women inmates. See LaMont W. Flanagan, *Meeting the Special Needs of Females in Custody: Maryland’s Unique Approach*, 59 FED. PROBATION 49 (1995).

²¹¹Ross & Lawrence, *supra* note 8, at 126.

²¹²*Id.* at 128.

To make similar programs and policies more affordable to more facilities—especially important considering that few facilities are as large as that in Alameda County—Nicole Hahn Rafter recommends that “local, state, and federal prison systems . . . pool resources for dealing with women. . . . [C]ooperative measures would enable women’s institutions to specialize, providing prisoners with a greater range of programs.”²¹³

2. Programs Serving Pregnant Inmates Through Alternatives to Incarceration

Incarceration for certain women—particularly nonviolent offenders—has been deemed by some to be “unnecessary and counterproductive.”²¹⁴ In addition to not serving “relevant penological goals” for these offenders, incarceration is often “not cost-effective [and] . . . harmful to her children.”²¹⁵ Probation is one option to consider for these women.²¹⁶ However, programs that might be most effective for these women “are those sanctions that are adapted to their characteristic circumstances: nonviolent offenses, parenthood, drug use, and domestic violence.”²¹⁷ These alternatives address the “[o]vercrowding and overuse of women’s prisons . . . by planning creatively for reduced reliance on imprisonment for women.”²¹⁸

A Michigan program developed by social workers and corrections officials, the Women and Infants at Risk (WIAR) program, is illustrative of how such programs can help pregnant women offenders in a community corrections context. Admission to the program was limited to women who had histories of substance abuse and who had sentences of less than two years.²¹⁹ Once admitted to the program, women began receiving prenatal care and were given assistance in gaining access to social services, among other things.²²⁰ Women in the program gave birth at a local hospital where they could be assisted by a nurse midwife and a labor coach.²²¹ Other critical services

²¹³Rafter, *Second-Class Citizens*, *supra* note 183, at 31.

²¹⁴*Alternative Sanctions*, *supra* note 121, at 1929.

²¹⁵*Id.*

²¹⁶It should be noted that race plays an important role in determining how this sanction is meted out, one which appears inequitable. Whereas sixty-two percent of women afforded the privilege of probation were white in 1998, only thirty-eight percent of these were women of color. GREENFELD & SNELL, *supra* note 9, at 6.

²¹⁷*Alternative Sanctions*, *supra* note 121, at 1930. *See also* Seldin, *supra* note 122, at 23.

²¹⁸CHESNEY-LIND & PASKO, *supra* note 13, at 166. The authors also raise the possibility of a “moratorium” on the building of prisons for women, instead funneling those monies toward “services that would prevent women from resorting to crime.” *Id.*

²¹⁹Siefert & Pimlott, *supra* note 32, at 130. Other criteria for admission included no history of escape from correctional facilities, nonviolent offenses, no history of “criminal sexual misconduct,” pregnancies prior to the thirty-second week if no prenatal care had been provided (thirty-six weeks with prior care). *Id.*

²²⁰*Id.* at 131.

²²¹*Id.* Birth outcomes for women in the WIAR program were better than those documented in other studies. *Id.* at 132. However, the authors cautioned that the success was due to more than merely the program itself: “The selection criteria used for entry into the program may have favorably influenced birth outcomes among participants, although in

provided to WIAR participants included individual counseling, “didactic sessions for substance abuse” and Narcotics Anonymous meetings, and family and couples counseling.²²² Many of the services provided to the women in the program were coordinated through partnerships with local community service providers. Once women moved into the final phase of the program, they were assisted in making arrangements for life in the community, including “housing, aftercare services, medical care, and appropriate day care.”²²³

V. CONCLUSION

Pregnant women living in correctional facilities against which litigation has been successful have seen improvement in the conditions under which they live. However, successes seem to occur only within specific facilities and achieving change on a larger scale, such as through creation of national standards, remains elusive. Therefore, the progress of efforts to improve the conditions of pregnant women incarcerated in our nation’s jails and prisons can only be described as Sisyphean because the challenges which have long been complained of persist despite consistent efforts to improve them and where improved policies are developed, problems such as overcrowding roll back any positive developments. This remains true even in California, where despite litigation, seeking improvements for these inmates remains critical. In 1997, a woman incarcerated at the California Institute for Women²²⁴ faced labor largely alone, due to the refusal of the nurse—the sole medical staff member available that day—to assist her in the process, aside from strapping the inmate to a gurney and restraining her arms.²²⁵ Her infant was born unable to breathe. The nurse, handy with restraints but not with a breathing apparatus to help the infant, called paramedics, who transported him to a nearby hospital where he was declared brain dead.²²⁶ In addition to experiences such as this, several other challenges described by McHugh in 1980 are as-yet unaddressed in many facilities housing pregnant inmates. And as recently as 2004, an incarcerated woman could face a fate similar to that of Kimberly Grey, a former jail inmate who

practice a number of the participants who were screened initially and accepted into the program subsequently were found to fall into one or more high-risk categories.”

²²²*Id.*

²²³*Id.*

²²⁴This facility has been subject to considerable legal scrutiny. It was the object of a suit in 1985—*Harris v. McCarthy*—which led to a settlement agreement that specified several specific measures for caring for pregnant inmates. See Barry et al., *Legal Issues*, *supra* note 7, at 159. Another class-action lawsuit was brought against the facility in 1995 alleging poor medical care. As noted by Ellen Barry, despite achieving another settlement agreement in the 1995 litigation, any improvements achieved because of the agreement “were difficult and many problems remained at the close of the monitoring period.” By 2000, efforts to achieve anything further were abandoned. Barry, *Bad Medicine*, *supra* note 52, at 43. One possible explanation for the subsequent suit may be that the prison was required to report progress to attorneys only for eighteen months regarding actions taken to effectuate the settlement, reached in 1987. Barry, *Pregnant Prisoners*, *supra* note 5, at 197 (1989).

²²⁵Barry, *Bad Medicine*, *supra* note 52, at 40.

²²⁶*Id.*

brought suit “over the death of her baby, born over a cell toilet even though she complained of labor pains for nearly twelve hours.”²²⁷

Although litigation remains the primary means by which conditions are improved for these women, more attention should be devoted to creating legislative change and developing innovative programming. Many of the changes recommended for women inmates focus on alternatives that emphasize “address[ing] the problems of women on the economic and political margins rather than expensive and counterproductive penal policies.”²²⁸ The most significant agent responsible for this sort of policy shift comes from legislators who may not be up to the task: “the response to women’s offenses addresses human needs rather than short-sighted objectives of lawmakers who often cannot see beyond the next sound bite or election.”²²⁹ Persuaded by well-spoken advocates of these women, however, legislators might consider looking beyond their own self-interest to focus on women who society has largely left behind. Reforms must address both alternatives to incarceration as well as conditions in correctional facilities—this ensures that pretrial detainees and women for whom such alternatives are not appropriate are not forgotten. Federal change seems unlikely, in our current political climate, and thus state-by-state lobbying in legislatures bears the most possibility for change. With regard to programming, many examples exist which corrections officials can use as a starting point to craft solutions, both for pregnant jail and prison inmates.

The treatment of pregnant inmates deserves special attention because of the devastating—and sometimes fatal—outcomes that sometimes result from improper or insufficient care. For any woman, incarcerated or not, pregnancy is a difficult physical experience. For pregnant inmates these difficulties are aggravated by a number of factors that make their pregnancies high risk. The wellbeing of a woman’s baby is also contingent on the quality of care the mother receives and some of the problems experienced by these babies could be mitigated through proper treatment of the mother during her pregnancy. What is necessary for the proper care of these inmates is clear, encompassing not only appropriate prenatal diet and medical care, but also vigilance on the part of correctional personnel who are well aware of the fact that many of these pregnancies are high risk.

Notions about the Eighth Amendment standing for what Chief Justice Warren described as “evolving standards of decency that make the progress of a maturing society” have little meaning when pregnant women incarcerated in our nation’s prisons and jails still endure conditions similar to women prisoners in the eighteenth century. Those high aspirations remain unfulfilled for many women in these facilities. Neglecting these women hurts them, their infants, and the larger society. However, examples of change through litigation, legislation, and programs do help these women. These strategies can transform the promise of the Eighth Amendment and the Due Process Clause into a consideration for the “dignity of man” that

²²⁷*Inmate Sues over Death of Her Baby*, CHI. TRIB., Section 1 p.25 (Dec. 12, 2004). According to this news report, “Grey was leaking amniotic fluid, running a fever and had asked repeatedly to be taken to a hospital before the March 5 birth.” *Id.* The incident took place in Tampa, Florida.

²²⁸CHESNEY-LIND & PASKO, *supra* note 13, at 168.

²²⁹*Id.*

includes pregnant women rather than sacrificing them to unnecessarily harsh and inhumane conditions.