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Implementation of Family Planning and Contraception for Female Inmates in Vermont

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Abstract

Background and Objective(s): Unplanned pregnancies are disproportionately high among female inmates, and incarceration provides a unique opportunity for care may be otherwise difficult to obtain, including reproductive health and family planning services, specifically the provision of contraception. It is known that women are 14 times more likely to initiate contraception if education and services are provided within the prison (Clarke et al., 2006b). Despite decades of research identifying the unmet need, very few prisons around the country provide any sort of sexual health or family planning care to prisoners (Braithwaite, Treadwell, & Arriola, 2008).

Methods: This project involves the creation of new program and implementation of a new model of care within the existing health care structure at Vermont's sole women's prison, Chittenden Regional Correctional Facility (CRCF). First, determination of the most appropriate model of care; second, building a curriculum based on existing evidence-based practice guidelines; and third, implementation of the program using a one-year pilot program. Quality metrics, as yet undetermined and beyond the scope of this project, will need to be monitored throughout the year by the research and quality team within the prison to measure impact of the new program.

Results: Partnership with the Vermont Department of Justice, Department of Corrections, Centurion Health, and Planned Parenthood was necessary for completion of the project. A one-year pilot program begins June 2017, including

group and individual education sessions and coordination with staff to expand family planning services within the existing health care clinic, as well as a referral system for care outside of the scope of the clinic.

Implications: Despite decades of research demonstrating the need and female inmates desire to obtain contraception before discharge from prison, multiple barriers to accessing care still exist, making reproductive services limited in U.S. women's prisons. The pilot program will serve as a model for other prisons, and quality measures throughout the year will be vital in demonstrating the success of the program. Extreme attention to ethics and adaptations appropriate to working with a vulnerable population of imprisoned women were central to the completion of this project.

Introduction

Prisons have historically been a challenging setting for health care delivery. Despite the landmark 1976 Supreme Court case, Estelle v. Gamble, establishing that the adequate provision of health care for prisoners was a constitutional and legal right under the Eighth Amendment's prohibition of cruel and unusual punishment (Legal Information Institute, 2015), providing health care to incarcerated individuals, particularly women, continues to prove challenging and poses many unique challenges (Kouyoumdjian et al., 2015). These challenges include complex medical problems and multiple comorbidities, higher rates of mental health disorders including substance abuse, complex social situations and lack of access to resources, and specific risks from living in prison including communicable disease and violence including sexual assault (Van den Bergh, Gatherer, Fraser, & Moller, 2011). Incarcerated women often come from economically, educationally, socially, and emotionally disadvantaged environments, often with a undetected health issues and multiple unmet needs, including reproductive health needs (American Congress of Obstetrics and Gynecology [ACOG], 2012).

Women currently represent 15% of incarcerated individuals. Overall, the rate of incarceration in the United States is increasing disproportionately faster for women, and women now represent the fastest growing population in prisons,

particularly women of color and women in poverty (Vera Institute of Justice and The Safety and Justice Challenge, 2016). In addition to increasing numbers of women in prison, recidivism is common among prisoners, with 67.8% of prisoners rearrested within 3 years of release, and 76.5% within five years (National Institute of Justice, 2014). Research has demonstrated that providing adequate health care in prison is associated with improved public safety, lower reincarceration rates and less recitivism (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005). With the vast majority of incarcerated women being of reproductive-age, they require gender-specific health and care needs including gynecologic and reproductive services, including the provision of contraception (Braithwaite, Treadwell, & Arriola, 2008).

The paucity of access to contraceptive care for incarcerated women, which has historically been considered non-essential care for women while in prison, has been identified as a significant unmet public health issue. Eighty four percent of incarcerated women have had an unplanned pregnancy before or during incarceration, compared to the national average of 45% of women (Guttmacher Institute, 2016). Female inmates have had six pregnancies on average, and two deliveries (Clarke et al., 2006a). 72% of women are not consistently using any form of contraception, and 85% of women report they planned to be sexually active and thus at risk for pregnancy immediately upon release (Clarke et al., 2006a). Despite only 9% of incarcerated women expressing the desire for a pregnancy, 44% of women released from prison are pregnant within the year (Clarke et al., 2010). Studies demonstrate that between 60% to 77% of inmates would like information and access to contraception, and would accept access if offered (LaRochelle, 2014;

Clarke et al., 2006b). Women are over 14 times more likely to initiate birth control when offered during their incarceration (Clarke et al., 2006b). High recidivism rates, coupled with lack of reproductive services and access to contraception, results in 50% of women becoming pregnant between incarcerations (Clarke et al., 2010). This demonstrates the need for education and contraception initiation before release from prison.

It is estimated that between six to 10% of women in prison are pregnant during their incarceration (Clarke, Phipps, Tong, Rose, & Gold, 2010). Many women learn they are pregnant upon intake into the prison system. In addition to the lack of contraception, research has demonstrated that women with unplanned or undesired pregnancies are not fully counseled on their pregnancy options including parenting, adoption, and termination services, despite recommendations by the National Commission on Correctional Health Care (NCCHC) that unbiased counseling about all pregnancy options be a routine part of intake and care for those women who are pregnant upon entry to prison (Kasdan, 2009). Women should be offered all of their pregnancy options and referral to abortion services should be provided when desired.

Incarcerated individuals are not eligible for private insurance plans or public government insurance such as Medicaid to cover the cost of health services obtained while in prison; care is financed through state Departments of Corrections (DOC) using taxpayer dollars. In 2010, the most recent year for which data on prison spending is available, prison health care costs totaled $7.7 billion, or 20% of total U.S. prison expenditures (Pew Charitable Trust, 2014). Following an incarceration,

most inmates are enrolled in Medicaid prior to discharge or are released uninsured. Due to the unique financial policies and constraints, payment for services rendered remains one of the primary challenges in the prison setting. Contraception and family planning is not considered an essential health benefit for women while they are incarcerated and thus state DOCs and taxpayers are hesitant to pay for the cost.

There is significant evidence that covering the cost of contraception increases the uptake and use. The Affordable Care Act (ACA), as of 2012, requires that insurance, both public and private, provide contraception as a part of preventative care services without cost-sharing (ObamaCare, 2016). Since the implementation of the contraceptive provision, it is estimated that 55 million women are currently accessing contraception without out-of-pocket expense, and that the percent of women paying out-of-pocket for their contraceptives declined rapidly from 20.9% in 2012 to 3.6% in 2014 (Sobel, Beamesderfer, & Salganicoff, 2016). Interest and uptake of long-acting reversible contraceptive methods (LARC) have been increasing since the ACA required access without cost sharing, which made it possible for women to obtain these highly-effective, long-acting methods that were previously cost prohibitive. The U.S. still lags behind other developed countries in terms of LARC access, contributing to our staggering unplanned pregnancy rate. LARC uptake in teenagers remains under five percent in the U.S., likely contributing to a teenage pregnancy rate that is over seven times higher than in developed countries where LARC options have been available without cost for decades (Fox & Barfield, 2016).

Currently, taxpayers finance all health care services provided to inmates during their incarceration. Average incarceration times for women in Vermont range from 10 to 20 days, during which time prisoners are not eligible for either privately or publically funded insurance coverage (Vermont DOJ, personal interview, October 4, 2016). Upon release, research demonstrates that job acquisition is incredibly difficult for a multitude of reasons, leading to unemployment rates of between 60% and 75% for former prisoners at one year after release (National Institute of Justice, 2013). Insurance coverage is often tied to employment, thus the high unemployment rates combined with challenging social and financial situations post-incarceration often results in a lack of health care coverage and an inability to obtain health services once they are returned to the community. Therefore, incarceration has been identified as an ideal yet often overlooked time for education and provision of contraceptive and reproductive services before release.

Methods

This project seeks to improve access to reproductive and family planning, accessible education about contraceptive options, and improvement of availability of contraceptive choice within the prison setting. In the state of Vermont a private, for-profit organization, Centurion Health, contracts with the state of Vermont Department of Justice (DOJ) and Vermont DOC to provide full-scope care to prisoners during their incarceration. At this time, CRCF, located in South Burlington, Vermont, is the sole female prison in the state. The average census ranges from 150 to 180 inmates (Vermont Department of Justice, personal interview, October 4,

2016). Despite national standards and recommendations, family planning and contraceptive care is not part of routine prison health care in the vast majority of prison settings across the country, including CRCF.

Incorporation of counseling, including family planning, contraception options, sexually transmitted infection prevention, safe sex practices, and avoidance of unplanned pregnancies was the cornerstone of this project. Buy-in from all stakeholders was necessary for success and short- and long-term viability, including health care staff at CRCF (clinicians, nurses, social workers, educators, medical director, and administrative staff), the Vermont DOJ and DOC, Vermont Department of Health, and partnership with an outside organization, Planned Parenthood of Northern New England (PPNNE).

Due to limited literature and prior research of implementation of contraception in the prison setting and scarce examples to model this project on, multiple avenues for best implementation needed to be explored. This included determination of best funding sources, including possible grant options, a legal precedent route such as the passing of a bill through the Vermont legislature, and taking into account of limited resources and knowledge within the existing CRCF health care clinic. After exploration with all stakeholders, a one-year pilot program contract between CRCF and PPNNE (local experts in clinical and educational content) was deemed the most viable and efficient option for implementation.

Current evidence-based practice in reproductive health will be used as the template for implementation of care. There is a plethora of literature and research on best practices for the provision of family planning services, with the need to be

adaptive in order to implement in a unique environment with a vulnerable population, such as the prison system. A PPNNE employee, specifically hired and trained to work within the prison system as an Education Coordinator, was hired to provide education services in the form of voluntary twice weekly classes for inmates at CRCF and individual information sessions as desired. These education classes will consist of the current evidence-based guidelines and recommendations around contraception and family planning services. The Education Coordinator will assist existing prison health care staff on how to incorporate reproductive planning and provision of contraception services to CRCF staff onsite, as well as facilitate referral services as needed for care outside of the prison health care system.

Ongoing assessment of quality and outcome of the project will be necessary following implementation, which is planned for May 2017. The Education Coordinator will work closely with the Vermont DOC and Centurion research and quality staff in order to determine best quality metrics and measures that will be used to assess the program. These quality metrics, both qualitative such as a survey post-education class, and quantitative, such as the rate of contraception initiation in prison, can then be used to improve delivery of care and services.

Ethical considerations and the concepts of reproductive justice are at the forefront of this project. Incarcerated individuals are part of a vulnerable population, making the principals of ethical, just, and fair delivery of care as well as maintaining prisoner autonomy and ensuring informed consent, are paramount in the provision of any health services. Female inmates are a vulnerable population at risk of coercion, both real and perceived. It was critical to remain sensitive to the

potential pressure these women may feel to use birth control in this unique environment. There are historical and recent examples of prisoners feeling pressure to undergo treatment, such as the forced sterilization of female inmates in the state of California, as recently as 2013. Reproductive justice is the human right to maintain bodily autonomy, have children, not have children, and parent the children we do have in a safe and sustainable community (SisterSong, 2016). Reproductive justice is founded on the concepts of choice and access, recognizing that the most vulnerable populations need to be able to access the resources and full human rights to live self-determined lives without fear, discrimination, or retaliation.

Results

This project underwent many revisions throughout the process. Due to the nature of creating a previously non-existent program with few models to draw from, it was necessary to explore all possible options and work with stakeholders to determine the most appropriate, cost-effective model that would fit the care needs and budget for Vermont, and will be successful and continue past the first pilot year.

Timeline of Project

Month/Year	**Intervention**	**Outcome**
September 2015- November 2015	Interviews with Centurion health care staff, needs assessment, discussion of	Many possible road-blocks to success, challenges with financial

	possible routes	viability, staff hesitant to participate
January 2016-February 2016	Meeting with Vermont legislative representatives to explore legislative mandate and drafting of bill	Would likely take years to draft bill and pass through Vermont House and Senate
March 2016	Possible partnership with PPNNE determined	Initial meeting with director of the Program to Reduce Unintended Pregnancy
April 2016-May 2016	Initial meeting with Vermont DOJ and DOC to help guide the process, provide input and insight into the prison health care system	Initial interest, but more research and evidence needed to get stakeholders onboard with plan
May 2016-June 2016	Follow up meetings with DOJ, DOC, and Centurion staff including presentation of evidence and research	Increased interest, widely varied among staff, but overall promising

July 2016	Definitive confirmation from all stakeholders to move forward with project	Exploration of scope of project and gathering of materials for initial contract negotiations
August 2016-October 2016	Initial contract drafted detaining partnership between PPNNE and CRCF, multiple contract negotiations including financial reimbursement	Multiple drafts needed before final contract including many meetings between PPNNE, CRCF, and DOC
November 2016	General election held, Donald Trump elected president with new budget and state allocations damaging previous revenue sources	Funding losses to DOJ, DOC and public health programs necessitates new contract
December 2016-January 2017	Renegotiation of contract with significant overhaul of scope of project including downsizing hours	Reduction in scope of project, reduced to 1-year pilot with possibility of expansion dependent on success
January 2017	Final contract signed for	Began job search for

	1-year pilot program for PPNNE employee to provide services within CRCF	Education Coordinator
February 2017-March 2017	Interviews and hiring process for Education Coordinator role	Candidate hiring and initial orientation to PPNNE
Anticipated May 2017	Orientation of Education Coordinator to the role including training with materials, research, best practice, ethics	Access to prison, orientation to the prison system, and continued training
Anticipated June 2017	Official start of family planning services, reproductive education, contraceptive counseling at CRCF	Consistent learning and modification in order to make project successful including exploration of expansion

Discussion

This project sought to bring reproductive and family planning and contraceptive care to the female inmates in the state of Vermont. Policies that enable correctional facilities to provide comprehensive family planning – including reproductive goals, contraceptive counseling, and method provision – promote

equitable access to critical health services and provides services to an at-risk group that otherwise has limited ability to obtain such services.

Key aspects included collaboration with multiple stakeholders including Centurion and CRCF staff, Vermont Department of Corrections, and PPNNE. This project highlights the need to be dynamic and adaptive to the environment to successfully implement a policy and practice that is sustainable for the future. In a political climate that is undergoing change, it was necessary to adapt to the unforeseen limitations and make changes, which included scaling back of the project to due funding cuts to the Vermont DOC, and a reduction in financial support necessary for implementation. Instead of completely abandoning the project, it was modified to fit the scale of the available resources. When working with multiple organizations, it is imperative that garnering the support of stakeholders and key leaders early in the process using provision of evidence and scientific research, leading to greater long-term success.

The benefits of this project are largely unknown at this time, and will unfold as the project continues in the future as the project fully implements and continues. Quality measures and continuous quality improvement is planned, in partnership with PPNNE and Centurion, throughout the one-year pilot program. Understanding successes and setbacks and demonstrating measurable outcomes will be necessary to provide evidence of the impact of the program and secure funding the future.

Based on existing evidence and research, if a reduction of unplanned pregnancies is demonstrated by implementation of reproductive health education and improved access to and use of contraception, there are multiple benefits to

individuals and families, communities, and the population at large. For individual women, there is a plethora of well-documented negative effects of unplanned pregnancies on maternal and infant health, mental health, education level achieved, and socioeconomic status (Gipson, Koenig, & Hindin, 2008; Guttmacher Institute, 2016). These negative effects are shared with women experiencing incarceration, thus resulting in compounding health effects.

In the U.S., the direct medical costs of unintended pregnancies totaled over $5 billion in 2002; direct medical cost savings due to contraceptive use was $19 billion (Trussel, 2007). Lowering the incidence of intended pregnancies is correlated with far-reaching public health benefits, including elevated economic growth, socioeconomic development, and reduction in burden in medical costs and government spending through assistance programs (Yazdkhasti, Pourreza, Pirak, & Abdi, 2015). Measurement of the economic benefits to the communities and state of Vermont are beyond the scope of this project, however, it will be possible for Centurion to measure their health care spending on contraception versus cost of prenatal care and delivery.

Due to the nature of a one-year pilot project, there are significant limitations of this project, largely related to the current lack of research and data on the impact of the project, which is in the process of implementation. Data collection is planned throughout the year, in partnership with Centurion's quality improvement staff and PPNNE. Other challenges of implementation of new program include possible resistance from current Centurion staff who provide health care, which currently does not include contraceptive provision. The project may result in an increased

burden on staff time and will require training. Shifting the culture to include family planning and contraception as a routine part of health care within the prison may take time to be fully accepted and implemented by staff. Resistance to obtaining reproductive health services by the female inmates due to fear, resistance to compromised fertility, and skepticism of authority has been voiced by staff as a possible barrier that will need to be monitored. The ethical principals of reproductive justice, informed consent, and freedom of choice are critical in provision of care.

Funding for implementation of the education program has shifted throughout the project. Initially, funding was through the Vermont Women's Health Initiative, which extended participation in the Vermont Blueprint to women's health specialty providers, with funding through Vermont Medicaid and Agency of Human Services. However, due to the political climate, the recent U.S. election, and reallocation of available funds, funding of the education program, including the Education Coordinator role, is now directly through the Vermont DOC.

If there are demonstrated and measurable benefits of the one-year pilot program, future expansion of services may be possible. This may include offering full-scope contraceptive choice within the prison health care clinic including LARC insertions on-site. There are limited prisons throughout the U.S. currently providing family planning services, therefore this project may serve as a model for other prisons to implement family planning services.

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