The Journal of Forensic Psychiatry & Psychology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rjfp20

A rapid evidence review of clinical risk factors for poor perinatal mental health in women's prisons in England

Christy Pitfield, Joanna Binley, Shilpa Soni, Caroline Pontvert & Matthew Callender

To cite this article: Christy Pitfield, Joanna Binley, Shilpa Soni, Caroline Pontvert & Matthew Callender (2023): A rapid evidence review of clinical risk factors for poor perinatal mental health in women's prisons in England, The Journal of Forensic Psychiatry & Psychology, DOI: 10.1080/14789949.2023.2212657

To link to this article: https://doi.org/10.1080/14789949.2023.2212657

Published online: 24 May 2023.

THE JOURNAL OF FORENSIC PSYCHIATRY & PSYCHOLOGY
https://doi.org/10.1080/14789949.2023.2212657

A rapid evidence review of clinical risk factors for poor perinatal mental health in women's prisons in England

Christy Pitfield[a], Joanna Binley[b], Shilpa Soni[c], Caroline Pontvert[a] and Matthew Callender[b]

[a]Perinatal Mental Health, Health & Justice Directorate, Central and North West London NHS Foundation Trust CNWL, London, UK; [b]Institute for Public Safety, Crime and Justice, University of Northampton, Northampton, London, UK; [c]Department of Clinical, Educational and Health Psychology, University College London, London, UK

ABSTRACT

Pregnancy and the first year after childbirth are a high-risk period of a woman's life, and research shows that women in prison are at heightened risk for poor mental health, self-harm, and suicide. Whilst there has been a recent focus on studies into the health care for women in prison, research looking into the specific risk factors for poor perinatal mental health in women's prisons is sparse, with the majority having been conducted within a US context that will have different provisions available and population need. This rapid evidence review explored academic literature published to identify clinical risk factors of poor perinatal mental health for women in prison in England. Following the initial search, 21 documents were identified which were then thematically analysed, resulting in the identification of 72 clinical risk factors. Meta-themes identified included 'individual', 'relationships', 'prison context', 'provision', and 'processes'. The recognition and mitigation of identified clinical risk factors is critical to ensuring quality care for women in prison and reduction of poor perinatal mental health.

ARTICLE HISTORY Received 20 December 2022; Accepted 7 May 2023

KEYWORDS Perinatal mental health; pregnancy; prison; women; health

Introduction

In recent years, there has been increased interest in the health needs of women in prison (Bard et al., 2016). It is well documented that women in prison have multiple and complex needs and have higher rates of mental health, physical health and substance misuse difficulties, compared with women in the community (Abbott, 2021; Woodall et al.,

CONTACT Christy Pitfield Christypitfield@nhs.net Perinatal Mental Health, Health & Justice Directorate Central and North West London NHS Foundation Trust CNWL LondonUK

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

2021). Women make up a small proportion of the English prison population, occupying approximately of 5% of prison places (Ministry of Justice, 2022). The number of pregnant women in prison is estimated to be approximately 5% of the total female population in prison (Ministry of Justice, 2020).

It is recognised that there are gendered differences in offending, with women committing fewer and less serious crimes than men, with women more likely to be charged with non-violent offences (Rennison, 2009). However, females are often imprisoned in prison environments designed for males that lack a gender-sensitive understanding (Bartlett & Hollins, 2018). Women in custody have a five times higher risk of developing mental disorder than the general female population (78% compared to 15%; Plugge et al., 2006). Research suggests that over half the female prison population have a serious mental illness (SMI): almost half (47%) suffer from a major depressive disorder, 6% a psychotic disorder, and 3% have a diagnosis of schizophrenia (Offender Health Research Network, 2009; Tyler et al., 2019).

Women often come from backgrounds of poverty, homelessness, poor education, and unemployment. The Prison Reform Trust (2019) reported that 53% of women in prison had experienced emotional, physical, or sexual abuse as a child and 49% reported being victims of domestic violence at some point in adulthood. Research has indicated that irrespective of having experienced past trauma, women experience entering prison, and the environment itself as traumatic (Kelman et al., 2022). Women typically experience the system as neglectful, hostile, and chaotic (Douglas, Plugge & Fitzpatrick, 2009) and feel powerless in response to having little autonomy or control, all of which can reinforce themes of previous trauma (Crewe et al., 2022) and lead to psychological distress (Anderson et al., 2020). For many women, entering custody means separation from their children, and this has been found to be one of the most distressing and traumatic aspects of their prison experience (Celinska & Siegel, 2010). It is frequently recognised that a custodial sentence impacts a woman and her children, who experience the negative impact of being separated from their primary care giver (L. Baldwin, 2018).

Within the cohort of women in prison, there will be women who are pregnant, or have recently given birth. Women in prison are already a high-risk group, and many of their experiences (domestic violence, childhood sexual abuse, and a history of mental health difficulties) are risk factors for a decline in mental health during the perinatal period (Choi & Sikkema, 2016; Souch et al., 2022; Ward, 2020). Perinatal Mental Health refers to a woman's mental health during pregnancy and the first year after birth (England, N. H. S., Improvement, N. H. S., & National Collaborating Centre for Mental Health, 2018). This includes pre-existing, stable mental health conditions at risk of destabilisation during this period, mental health conditions

manifesting during pregnancy or the postnatal period, and conditions exacerbated during pregnancy or postnatal period.

Pregnancy and the first year after childbirth are a high-risk period of a woman's life. Women experience marked physiological and psychological changes and therefore this is a period of increased vulnerability in regard to a woman's physical and mental health outcomes. For example, in community samples, 20% of women will experience a perinatal mental health difficulty during this period (Howard & Khalifeh, 2020) and suicide is the leading direct (pregnancy-related) cause of death within a year after birth (UK, 2021). Other areas of known risk in this period are domestic violence, with over a third of women in community samples reporting violence starting or worsening during pregnancy (Howard et al., 2013). It is well documented that the wellbeing of the mother is crucial to the development of her child's emotional wellbeing, physical health, and resilience and that this influences their long-term health and social outcomes. The first '1001 critical days', spanning pregnancy and the first 2 years of a child's life, is considered a crucial period for infant health outcomes, and there is increased investment from the UK government, to provide timely support and interventions to families in this period (Government, 2021).

As expected, available literature has indeed shown that mental health problems occur at a high rate in women in prison during the perinatal period (R. Dolan, 2018) and that they are at risk of experiencing one or more mental health problems during this period (A. Baldwin et al., 2020; Bard et al., 2016; Birmingham et al., 2006; Edge, 2006; Foley & Papadopoulos, 2013; Gregoire et al., 2010; Kelsey et al., 2017; Paynter et al., 2019; Powell et al., 2017; R. Dolan et al., 2019; R. Dolan, 2018). Women in prison are already at elevated risk of suicide when compared to women in the community and completed suicide is the leading direct cause of maternal death in the UK (UK, 2021). However, research looking into the specific risk factors for poor perinatal mental health in women's prisons is sparse, with the majority having been conducted within a US context that will have different provisions available and population needs.

Aims

This scoping review aims to:

(1) synthesise the existing UK based research on clinical risks, defined as factors that relate to mental health decline, self-harm and suicidality, to women's mental health in prisons.
(2) investigate the extent, range, and nature of research in this area.
(3) highlight gaps in the evidence base where further research is required.

Design

The structure of this review was based on Powell et al. (2017) Rapid Evidence Assessment, due to the Rapid Evidence Assessment's utility at gaining a comprehensive overview of available evidence on a topic within a limited timeframe. The Rapid Evidence Assessment remains 'rigorous and explicit in method' but allows for limits around the extent of the search – something crucial for this paper due to time constraints and limited resources within the research team. The Rapid Evidence Assessment allowed the identification of a range of appropriate papers, for which we then used Braun and Clarke's Thematic Analysis (Braun & Clarke, 2006) to identify clinical risk factors from the papers.

Search method

To identify potentially relevant documents, the first 200 hits from the following databases were searched from the year 2000 onwards: PubMed, Science Direct, PsychNet, Web of Science. The following keywords were used in the four chosen databases: (pregnant OR perinatal OR prenatal OR postnatal OR antenatal OR mother) AND (prison OR "criminal justice system") AND (baby OR infant).

Inclusion criteria

To be included in the review, papers needed to include data or reflections about women in the perinatal period within prisons in England. The perinatal period was defined as being either pregnant or within the first 2 years postpartum. Literature was included if it was written between the years 2000 and 2022 and in English. Papers were excluded if they did not fit into the conceptual framework of the study (i.e. not related to the mental health of women in English prisons during the perinatal period). Review papers were also excluded, as most include studies based on non-England contexts that would limit the generalisability. Non-published and thus non-peer reviewed papers were excluded.

Selection of sources of evidence

Two independent researchers screened all titles and abstracts and obtained any potential includable records in full. Papers were included if they discussed the mental health or the psychological wellbeing of women in the perinatal period in prison (including experiences, prevalence, and risk factors). Literature was excluded if it discussed motherhood outside of the first 2 year postpartum. There were no restrictions by

study design; we included case studies, empirical studies, and intervention evaluations.

Data charting process

Clinical risk was defined as factors that relate to mental health decline, deliberate self-harm, and suicidality. Both researchers reviewed the included papers to identify and chart risk factors and themes. Data extraction included the names of the authors, year of publication, aims/purpose, study population, and sample size (if applicable), methods, risks, and key findings.

Data analysis

All articles were reviewed in full, and any identified clinical risks were coded. The analysis was based upon Braun and Clarke's (2006) framework for thematic analysis, in that articles were read and re-read to become intimately familiar with the data (Step 1: Familiarisation); articles were coded in relation to any identified clinical risks (Step 2: Identifying initial codes); individual codes were collapsed into organising categories of similar underlying concept (Step 3: Generating themes); generated themes were reviewed, considering the relations between coded data and the entire dataset (Step 4: Reviewing potential themes); and then themes were defined (Step 5: Defining and naming themes).

Procedure

See Figure 1 for details.

Results

Based on the search outlined above, 21 documents were identified as meeting the criteria for inclusion in the review. These documents were subjected to thematic analysis to identify clinical risks, where a total of 72 clinical risks were identified. Clinical risks were organised into five meta-themes: Individual; Relationships; Prison Context; Provision; and Processes (Figure 2).

Individual

The first meta-theme was individual, comprising two sub-themes relating to clinical risks associated with the individual. In total, 18 clinical risks were identified within this meta-theme.

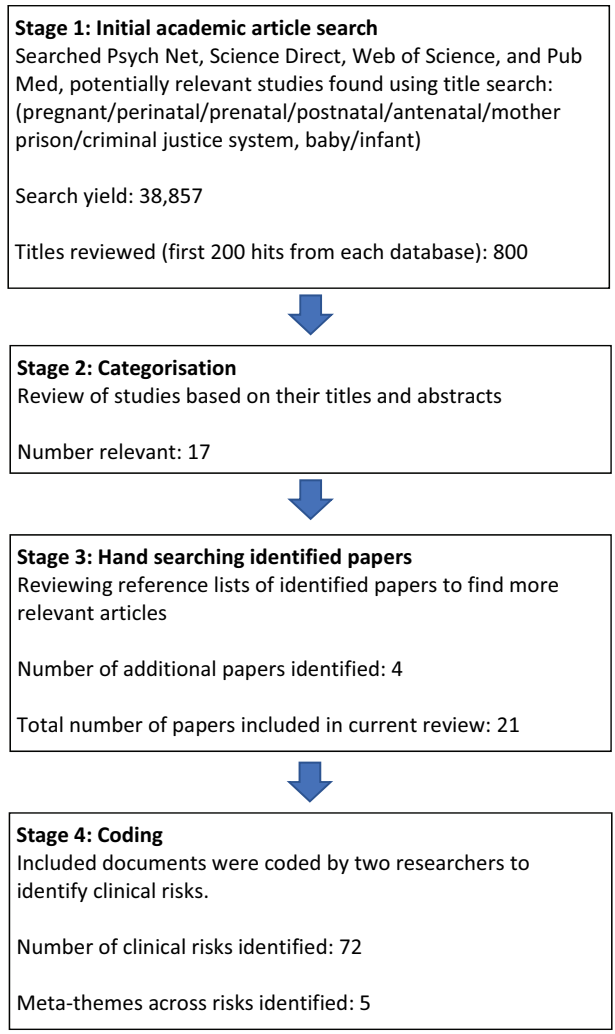

Figure 1. Flowchart showing search and analysis stages.

Women's Biography

For the theme of 'women's biography', nine clinical risk factors were identified from the papers included in the review. Papers consistently identified factors related to the women's history and personal circumstances that are known risk factors for poor mental health in the perinatal period, including (1) unemployment (Gregoire et al., 2010; R. Dolan, 2016), (2) a history of mental health difficulties (R. Dolan, 2016), experience of (3) domestic violence, (4) substance misuse, (5) homelessness, and (6) poverty (Brandon et al., 2008, Sleed et al., 2013). All increase the women's vulnerability of developing a perinatal mental health difficulty. Factors relating to the pregnancy that

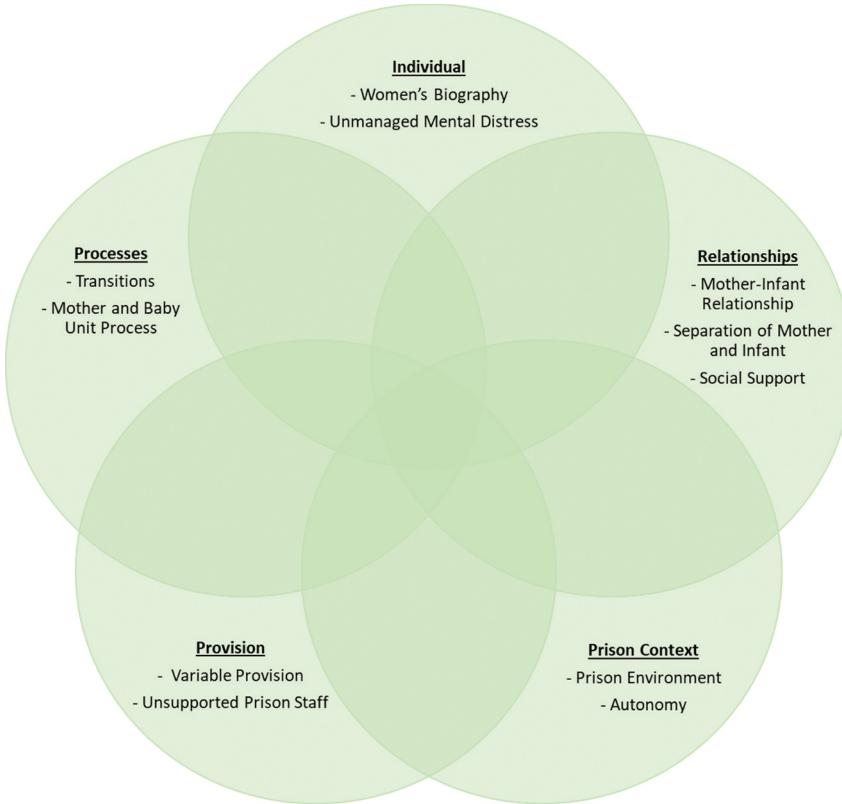

Figure 2. Thematic Analysis Findings.

could further predispose women to perinatal mental health difficulties include the (7) pregnancy being unplanned (Birmingham et al., 2004), being a (8) lone parent (Gregoire et al., 2010), and (9) poor maternal physical health (Price, 2005).

Unmanaged Mental Distress

Nine clinical risk factors from the review produced the theme 'Unmanaged mental distress'. There was recognition that the perinatal period is a time of heightened emotional distress, some of which increased in response to the journey of being a mother in prison. This included feelings of (1) guilt, anxiety, and shame (Powell et al., 2020) as well as (2) anger and hostility, which can become entrenched and infant-directed without intervention (Baradon et al., 2008; Sleed et al., 2013). There was a reference to women likely to be separated from their children (3) using strategies to suppress and block their emotions, such as using substances and rejecting their children

completely to help them cope with their distress around the impending separation (L. Abbott et al., 2020). Women separated from their children are a cohort already identified as having more severe and complex mental health difficulties and who are at an increased risk of self-harm and suicide (Gregoire et al., 2010).

There was an identified risk that (4) women do not always disclose mental health and trauma history, including experiences of childhood abuse, rape, and domestic violence (Gregoire et al., 2010; R. Dolan et al., 2019), all of which are (5) experiences of trauma that increase a woman's distress and risk of developing perinatal mental health difficulties. Sometimes, women may be less honest about the severity of their mental health issues for (6) fear of repercussions on childcare arrangements (R. Dolan et al., 2019), meaning their distress cannot be addressed. Several papers commented that (7) poor screening and delays to accessing of mental health care was of concern (Gregoire et al., 2010) and there was often (8) absence of specific pathways for recognition, detection, and treatment of a woman's mental health in prison (Birmingham et al., 2006; Gregoire et al., 2010). Once identified, there was (9) limited access to treatment for mental health problems (Birmingham et al., 2004; Windham Stewart, 2016).

Relationships

The second meta-theme was relationships, comprising three sub-themes relating to the relationships women have with others. In total, 17 clinical risks were identified within this meta-theme.

Mother-infant relationship

Six clinical risk factors made up the theme 'the mother-infant relationship'. The papers commented on areas that could be interpreted as being risks to bonding and attachment difficulties. Part of this is linked to the women's own history, current mental health difficulties, confidence as a mother and perpetuated by lack of access to appropriate support. There was recognition that women themselves had (1) insecure attachments, which are risk factors of intergenerational trauma (Baradon & Target, 2010) and (2) increased pressure on the mother as caregiver (Windham Stewart, 2016). For women in a prison Mother & Baby Unit (MBU), (3) the intensity of the relationship between mother and baby may heighten the less adaptive characteristics of their relationship, including parentification of the child, and spousal-like representation of the mother–baby relationship. Sleed et al. (2013) commented that baby could function as a source of comfort and emotion regulation to their mothers, a role reversal that is a key risk factor for the development of disorganised attachment relationships.

In terms of bonding, it was deemed that there was (4) little parenting support, including (5) for breastfeeding, that addresses the psychological and emotional difficulties that can accompany bonding and parenting in prison (Price, 2005). Women (6) anticipating a separation from their baby or feared this, were hypothesised to be less engaged with their baby and more likely to withdraw, impacting on maternal sensitivity and reflective functioning (Powell et al., 2017, 2020; Sleed et al., 2013).

Separation of mother and infant

Six clinical risk factors were identified from the review and grouped into the theme 'Separation of mother and infant'. Separation from their baby was identified consistently as leading to a decline in mental health, impacting on a woman throughout her pregnancy in anticipation of this, and following being together on a prison MBU. Women may (1) become less engaged with their infants, which in turn impacts their sensitivity, parenting skills, and bond (Sleed et al., 2013). Women separated from their babies are also at (2) higher risk of self-harm, suicide, reoffending, substance misuse, and further trauma (Baradon et al., 2008; Powell et al., 2017, 2020; R. M. Dolan et al., 2013), which may relate to (3) the guilt, anger, and shame they experienced (Baradon et al., 2008; Powell et al., 2020; Sleed et al., 2013).

Separations in prison directly after birth can be (4) poorly planned and so women are less able to prepare for them adequately (Powell et al., 2020; Sleed et al., 2013), this risk factor is further intensified by (5) poor continuity of care when mothers return to the mainstream prison following separation (Powell et al., 2020). Women who are separated from their babies are more likely to (6) have complex mental health problems, which suggests women who might only successfully parent with support, may not be given the opportunity (Gregoire et al., 2010).

Social support

The theme of 'social support' encompassed five clinical risk factors found from the papers reviewed. The lack of social support is frequently cited as a difficulty for many women. Due to the (1) smaller number of women's prisons, friends, and family may have long distances to travel and may result in seeing prisoners less frequently (L. Abbott, 2021; Marshall, 2010; Sleed et al., 2013; Windham Stewart, 2016). Separation from family may contribute towards (2) family breakdown, which can be an added stressor and risk factor for mental decline for women in this period (L. Abbott, 2021; R. Dolan, 2016; Windham Stewart, 2016).

It was highlighted that (3) professional and healthcare support was notably decreased post birth, particularly if a mother was separated from her child, when she may be the most vulnerable and need it the most (Powell et al., 2020; R. Dolan et al., 2019). One paper identified that few women received

breastfeeding support, which impacts bonding with the baby and the perinatal mental health of the mother (Price, 2005). Whilst another found women on the MBU could experience isolation, boredom, loneliness, and experience exclusion at being a new mother on an MBU (Baradon et al., 2008).

Prison staff can be seen as (4) unsupportive, where there were some reports of feeling bullied by staff who were untrained about mental health presentations or warning signs and generally unaware of the needs of perinatal women and how to provide emotional support to them (Powell et al., 2020; Sleed et al., 2013). Prison officers may also (5) lack an understanding of the impact on a mother of being separated from their child, and this may perpetuate the distress and impact of separation (Powell et al., 2020).

Prison context

The third meta-theme was 'prison context', comprising two sub-themes relating to the influence of the prison environment. In total, 14 clinical risks were identified within this meta-theme.

Prison environment

Nine clinical risk factors were found within the review papers, which the researchers grouped together into the theme 'Environmental conditions'. Several studies referenced (1) the stress of being in the prison environment as contributing to mental health difficulties. This stress is often related to (2) feelings of uncertainty, particularly around admission onto the MBU or care arrangements of their child, which can precipitate feelings of anxiety and despair (L. Abbott et al., 2020). Furthermore, (3) women experienced stress surrounding feeling watched during the birthing process and (4) feeling under pressure from staff (L. Abbott, 2014). These conditions can impact individuals' wellbeing and lay the foundations for or trigger a mental health decline, particularly in the psychologically and physiologically vulnerable perinatal period.

For many women in prison, a sensation of feeling unsafe may be a traumatising or re-traumatising experience. For example, (5) having difficulties with or feeling vulnerable around other prisoners (Windham Stewart, 2016), and (6) actual/perceived punitive treatment by prison staff (Abbott et al., 2020; Sleed et al., 2013) can reproduce conditions that many women in prison have experienced in an abusive past. Indeed, prison environments are noted to (7) lack a trauma-informed perspective (Sleed et al., 2013) and Price (2005) references their tendency to (8) prioritise security and control over women's health. An example of this is (9) lack of access to confidential space to access health-care appointments (Powell et al., 2020).

Autonomy

Five clinical risk factors made up the theme 'Autonomy'. Lack of autonomy was a recurrent theme leading to distress in women in prison. Women often have (1) little choice regarding midwifery care and (2) birth planning and prison security measures mean (3) privacy is often limited, leading to feelings of shame and experiencing a loss of dignity (L. Abbott et al., 2020; Price, 2005). This can also lead to women feeling they are not believed about concerns or queries they may have as prison staff can (4) invalidate women's concerns about their own bodies during the perinatal period (L. Abbott et al., 2020). Women often have very (5) little choice about their babies' futures, including caregivers, impacting their identity as a mother (L. Abbott et al., 2020; L. Abbott, 2021; Sleed et al., 2013).

Provision

The fourth meta-theme was 'provision', comprising two sub-themes relating to the provision of health-care services for perinatal women in prison. In total, 10 clinical risks were identified within this meta-theme.

Variable provision

Six clinical risk factors were identified which referenced variable provision of perinatal health care from the papers included in the review. Another aspect that emerged was the variability of care between different prisons. This can be a contributing factor for perinatal mental health problems due to the inequality of care provisions across the country. This also relates to the finding that, despite being entitled to as much, (1) pregnant women in prison may not receive the same quality of care as those in the community (Gregoire et al., 2010). For example, women in prison (2) do not always receive 24-hr access to midwifery services or (3) antenatal classes/written information at the same standard as those outside prison (Price, 2005).

The care of women during the perinatal period is often managed between a number of agencies and professionals. This care was often characterised by (4) inconsistencies in provision, (5) unclear responsibilities by professionals and (6) poor information sharing (Powell et al., 2020; Thomson, Mortimer, Baybutt & Whittaker, 2022). This can lead to poor health care being provided (Powell et al., 2020; Price, 2005), perpetuating perinatal mental distress.

Unsupported prison staff

Four clinical risk factors created the theme 'unsupported prison staff'. The papers recognised the immense challenge of prison officers offering care to women without (1) adequate training (Powell et al., 2020) and (2) emotional support themselves following being part of mother-infant separations that can be distressing and runs the risk of vicarious

trauma (Powell et al., 2020). This impacts on their capacity to detect women's mental health difficulties but also (3) repeated poor interactions with staff mean women may not (4) feel able to trust and share their distress (Powell et al., 2020; Sleed et al., 2013; Windham Stewart, 2016).

Processes

The fifth and final meta-theme was 'processes', comprising two sub-themes relating to procedures and processes concerning being in a prison environment. In total, 13 clinical risks were identified within this meta-theme.

Transitions

Seven clinical risk factors made up the theme 'transitions'. Factors that could also be a risk factor for triggering mental health decline involve those around key periods of change, including (1) entries into prison, such as unexpectedly receiving a custodial sentence when care arrangements for their baby have not been made and (2) sudden transfers to other prisons or changes in key staff could also act as a precipitating factor for mental health problems (Windham Stewart, 2016). The (3) transition to the MBU may also be a vulnerable time for a woman's mental health. Similarly, a woman's continuity of care may falter on their (4) return back to the mainstream prison post-separation (Powell et al., 2020).

Transitions (5) back into the community were also identified as a risk factor for poor perinatal mental health. There may be inadequate continuity of care as women may not be (6) appropriately referred to perinatal mental health services in the community (Gregoire et al., 2022). In some cases, it may be difficult to (7) trace their location to alert local health services of their needs (Gregoire et al., 2022; Price, 2005), resulting in disrupted mental health treatment and a decline in support.

Mother and Baby Unit (MBU) process

Six clinical risk factors were grouped into the theme 'Mother and Baby Unit (MBU) process' from the papers. The (1) process of applying, gaining admission, and moving onto the MBU is a significant period of change and uncertainty in a prisoner's life, which may contribute towards a sense of instability, anxiety, or hopelessness. The uncertainty of this leading to stress and anxiety during an already vulnerable time. Some studies identified that (2) not all women were adequately informed about the existence of the MBU or the process of application (R. Dolan, 2016; Price, 2005; Thomson et al., 2022). Women have (3) frequently reported that processes and decisions related to admission were slow, leading them to experience long periods of anxiety.

This can be impactful to a woman's mental health, as not only does it mean that she may have less access to greater liberties and professional support, but she may also be separated from her child, which has been repeatedly documented to have adverse effects on perinatal mental health outcomes. Thus, it has been repeatedly found that MBU places may be underused in some prisons, where (4) eligible women are not applying, which increases the possibility of a separation from their baby and increases the risk of a perinatal mental health problem (R. Dolan, 2016). This was found to be especially true for (5) women serving shorter sentences and those on remand, who were less likely to apply for a space on the MBU. The (6) variety of practice and admission procedures also increased uncertainty between prisons (R. Dolan et al., 2019).

Discussion

The population of women in the perinatal period within English prisons is a small number, within an already minority group. There is therefore a risk of their needs being overlooked and their specificities unknown. This paper has synthesised identified clinical risks within five domains relating to the *individual*, the *relationships* the individual has, the *prison context* where the individual is situated, the *provisions* of health-care available to the individual and the *processes* that shape the care of the individual in the prison setting. Across these domains, within the identified literature, 72 clinical risks were identified related to processes and organisational decisions that are distressing to already mentally vulnerable women because of their personal socio-economical situations and history of trauma, with little specialist and trauma informed care and support to manage this distress. It is paramount that these clinical risks are identified and mitigated in practice to prevent perinatal mental health decline. In so doing, the individuals mental health and quality of life will be improved, the infant's developmental, health and social outcomes will be enhanced, and the risk of intergenerational transmission of trauma will be reduced. There is a small proportion of research that has suggested that the prison environment has the potential to be a window of opportunity to improve perinatal outcomes (Bard et al., 2016). Although somewhat dated, a systematic review of largely US-based studies on pregnant prisoners found that imprisoned women had physically healthier pregnancies (higher birthweights and fewer pre-term births), than similarly disadvantaged populations (in terms of their socio-economic factors), in the community (Knight & Plugge, 2005). Possible benefits that prison can provide include the provision of consistent food and shelter, mental health treatment with likely shorter waiting times than in the community, a potentially moderated environment regarding the use of drugs and alcohol, protection against abusive partners, and access to antenatal care (Bard et al., 2016). In

addition, there are six MBUs in England which enable mothers to stay with their babies for up to 18 months. Research suggests and research suggests mothers and babies can thrive in this environment (Mulligan, 2019; Sikand, 2015) and infants in this environment can succeed in forming secure attachments to their mother (Edge, 2006). MBUs provide several protective features for both maternal mental health and infant development and represent an environment where mothers can, in a secure and supportive manner, experience motherhood, something that appears to motivate change for their child's benefit, (Chambers, 2009; Goshin et al., 2014; Rahimipour Anaraki & Boostani, 2014). Whilst the studies included in this review indicate the positive impact of MBUs, in November 2022 a review by the Chief Social Worker for Children and Families was published which has particular relevance to women who make applications to these (Trowler, 2022). This report reviewed social workers decision-making between 2017 and 2021 and outlined that there were cases where the decision to reject an MBU application was not deemed reasonable. Concerningly, there was found to be a lack of social worker involvement in cases that went onto be rejected. There was recognition that the MBU application process lacked scrutiny and that women were not routinely supported through this often anxiety provoking and distressing process. This indicates further work is required to ensure that all women are subject to a fair, equal, and supportive process when applying for an MBU placement.

There is a lack of existing literature on the experiences and outcomes of perinatal women in prison, and future research in England should aim to fill this literature gap in order to explore the clinical risk factors for this group and potential policies that could be implemented to mitigate these risks. Longitudinal studies can be helpful, particularly as it is important to understand the efficacy of any mental health interventions with a view of its long-term impact. For example, it would be useful to consider whether mental health interventions during pregnancy improved wellbeing both during and after pregnancy, and whether they had an influence on the relationship between mother and baby. Initial research in this area has demonstrated promising results. For instance, Bard et al.'s paper (Bard et al., 2016) highlighted that prison interventions must focus not only on quality care during the antenatal period and supportive MBU stays for the mother and child but also on coordinated care when women are released from prison. This 'wrap-around' care was associated with reductions in recidivism rates over a 10-year period post-release.

However, there are methodological barriers to research on this topic, especially so when combined with the complex and regimented nature of the prison environment, which is already understood to create obstacles when conducting research (Bard et al., 2016; Bretherton, 2010). Indeed, the high turnover of staff, short sentences, and the prioritisation of security act as

methodological issues (Price, 2005). Furthermore, the most mentally unwell, distressed women, as a result of child separation or perinatal ill health, may not want to participate in research, which could result in limited or unrepresentative samples when exploring this cohort (Gregoire et al., 2010). Similarly, some women choose not to reveal their status as mothers to the relevant authorities and make their own informal childcare arrangements (O'Keefe & Dixon, 2015), resulting in difficulty truly capturing women's voices when experiencing perinatal care in prison (North, 2004; Sikand, 2015).

There also remains an absence of centrally collected routine data about pregnancies and births in prison in a standardised manner (Galloway et al., 2014). This results in challenges holding people to account when things 'go wrong', collecting these data would indicate a real interest in the welfare of perinatal women in prison and represent crucial movements forward in this field (Albertson et al., 2012; Galloway et al., 2014; Abbott, 2018; North, 2004; Dolan et al., 2019; Dolan, 2016). Whilst we must hold onto the risks identified, and continue to understand, mitigate, and research these, we hope that with increased focus and investment in rigorous research this area, women under our care will have improved perinatal mental health outcomes.

Limitations

A key limitation of this rapid evidence review is that it does not include a full systematic review of the literature. Due to time constraints, the researchers searched the first 200 hits in each of the four databases, which could have resulted in peer reviewed – evidence being missed. Researchers also made the decision to omit grey literature and non-published papers from the review. Themes within the grey literature include the impact of early experiences of trauma being experienced through the prison environment, such as loss of control and power, little privacy, and a feeling of vulnerability (L. Abbott & Delap, 2016; O'Keefe & Dixon, 2015). Other literature reinforced the importance of transitions and timely decisions being made about placements on MBU's (North, 2004; Sikand, 2015) and the impact of this on bonding with her baby (Kennedy et al., 2016). Whilst these themes are echoed in the findings of this review, there is a quality issue in that grey literature by definition is not peer- reviewed.

Whilst several risks were identified in the papers reviewed, the separation of these into discrete themes is unlikely to reflect the complex relationships between these observed in clinical practice. Further research should not only investigate the risk factors identified in more detail but seek to explore the relationships between these risk factors, as well as the extent to which they influence each other. For example, the risk factors identified under 'unmanaged mental distress' are likely to be predisposed by women's history of trauma and disruptive attachment relationships in her own life, perpetuated

by the prison environment, lack of social support and lack of autonomy. This calls for a more nuanced and holistic approach to how women are assessed within the prison environment, to develop a more targeted and cohesive plan of support for women to achieve the best possible outcomes. Nevertheless, this paper represents the first known review that has specifically focused on the identification and synthesis of the individual risk factors to perinatal mental health for women in prison in the UK. In so doing, future research can now be directed into both the identified gaps within the evidence base as well as an interrogation of how the identified risk factors intersect and interact.

Implications

Due to the scarcity of research on this topic, much of the evidence included predates current policies and Prison Service Instructions (PSI) which dictate perinatal care in prisons. Therefore, many of the clinical risk factors identified in the papers predate the new policies and PSIs may now be invalid. We, therefore, recommend a formal review of the PSI in relation to the clinical risk factors identified. Alongside this, further research into the specificities of the mental health and distress of women in the perinatal period and their outcomes are required. Detailed analysis of this would enable greater understanding of their needs for treatment and prison-specific adaptations that can be made.

The current review indicates several important practical implications to be embedded across the female prison estate. We often accept the notion that women in prison should be given *'equivalent care'* to those in the community, however the number of risk factors identified in this population, including those specific to the setting, indicates that *'equivalent care'* for perinatal mental health, and distress should be a minimum requirement. The expectation should be *equitable* care, which takes into account the added risks, adversities, and complexities of women within prison settings. A preventative model should be adopted, health services should ensure there is a lower threshold to access support and treatment and that this should be delivered by specialist perinatal mental health services. Clinicians need to work with women during transitions, including separations from children, and ensure women have choice and autonomy over their care and treatment, in line with a trauma-informed approach (Sweeney et al., 2016). The development of treatment interventions in the prison setting require further research and evaluation.

Whilst there is a wish to develop trauma-informed care in women's prisons, there is a need to understand the very specific and ongoing trauma that a woman may be experiencing during the perinatal period. They may be pregnant, have recently given birth, and have been separated, often due to care proceedings. A core part of perinatal mental health service delivery in

prisons should be offering training in trauma informed care and perinatal mental health. Skilling up prison officers to build trusting relationships, validate distress, and identify the presence of red flags indicating perinatal mental health concerns is essential to ensure women are correctly directed to appropriate services. The emotive nature of this work cannot be underestimated, and it is likely at times to generate strong reactions in professionals working with these women and their babies. Professionals may have strong views about the women's situation of being in prison, yet also powerless to change these circumstances. Any trauma-informed approach must acknowledge that staff may also have histories of trauma and can be deeply impacted by the trauma of others they support. The availability of regular reflective practice and case consultation for all professionals is considered imperative to an approach that aims to work at multiple systems, each of whom may have a different core task in supporting mothers in prison. Finally, effective communication and joint working between all agencies is central to good clinical care and risk management in the perinatal period.

Conclusions

Overall, the range and scope of research on perinatal mental health in prisons in England is limited, which has significant implications for practice and achieving a high quality of care for women and their babies. There are recognised gaps in the evidence base as well as limitations to the studies identified, which calls for further research to address these omissions. Several prospective lines of enquiry are outlined in this paper, and it is hoped that this rapid evidence review will act as a catalyst for research to improve women's perinatal mental health as well as a reference point against which policy can evolve to mitigate the risks identified herein.

Acknowledgements

None

Disclosure statement

No potential conflict of interest was reported by the authors.

References

Abbott, L. (2014). The pregnant woman in prison. *The Howard Journal of Criminal Justice*.

Abbott, L. (Ed.). (2021). *Complex social issues and the perinatal woman*. Springer International Publishing.

Abbott, L. J. (2018). *The incarcerated pregnancy: an ethnographic study of perinatal women in English prisons*. Unpublished PhD thesis

Abbott, L., & Delap, N. (2016). Holding the baby: Responsibility for addressing the needs of offending pregnant women and new mothers should be shared across the system. *The Howard League for Penal Reform Early Career Academics Network Bulletin*, *31*, 34–40 .

Abbott, L., Scott, T., Thomas, H., & Weston, K. (2020). Pregnancy and childbirth in English prisons: Institutional ignominy and the pains of imprisonment. *Sociology of Health & Illness*, *42*(3), 660–675. https://doi.org/10.1111/1467-9566.13052

Albertson, K., O'Keeffe, C., Lessing-Turner, G., Burke, C., & Renfrew, M. J. (2012). Tackling health inequalities through developing evidence-based policy and practice with childbearing women in prison: A consultation.

Anderson, J. D., Pitner, R. O., & Wooten, N. R. (2020). A gender-specific model of trauma and victimisation in incarcerated women. *Journal of Human Behavior in the Social Environment*, *30*(2), 191–212. https://doi.org/10.1080/10911359.2019.1673272

Baldwin, L. (2018). Motherhood disrupted: Reflections of post-prison mothers. *Emotion, Space and Society*, *26*, 49–56. https://doi.org/10.1016/j.emospa.2017.02.002

Baldwin, A., Sobolewska, A., & Capper, T. (2020). Pregnant in prison: An integrative literature review. *Women & Birth*, *33*(1), 41–50. https://doi.org/10.1016/j.wombi.2018.12.004

Baradon, T., Fonagy, P., Bland, K., Lénárd, K., & Sleed, M. (2008). New beginnings –an experience-based programme addressing the attachment relationship between mothers and their babies in prisons. *Journal of Child Psychotherapy*, *34*(2), 240–258. https://doi.org/10.1080/00754170802208065

Baradon, T., & Target, M. (2010). Mothers and babies in prison: A psychoanalytic approach supporting attachment. In *Off the couch* (pp. 82–97). Routledge.

Bard, E., Knight, M., & Plugge, E. (2016). Perinatal health care services for imprisoned pregnant women and associated outcomes: A systematic review. *BMC Pregnancy and Childbirth*, *16*(1), 1–19. https://doi.org/10.1186/s12884-016-1080-z

Bartlett, A., & Hollins, S. (2018). Challenges and mental health needs of women in prison. *British Journal of Psychiatry*, *212*(3), 134–136. https://doi.org/10.1192/bjp.2017.42

Birmingham, L., Coulson, D., Mullee, M., Kamal, M., & Gregoire, A. (2006). The mental health of women in prison mother and baby units. *The Journal of Forensic Psychiatry & Psychology*, *17*(3), 393–404. https://doi.org/10.1080/14789940600738442

Birmingham, L., Gregoire, A., Kamal, M., Mullee, M., & Coulson, D. (2004). Psychiatric morbidity and mental health treatment needs among women in prison mother and baby units. *Advances in Psychiatric Treatment*, *9*(3), 191–201. https://doi.org/10.1192/apt.9.3.191

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bretherton, I. (2010). Parental incarceration: The challenges for attachment researchers. *Attachment & Human Development*, *12*(4), 417–428. https://doi.org/10.1080/14616730903417136

Celinska, K., & Siegel, J. A. (2010). Mothers in trouble: Coping with actual or pending separation from children due to incarceration. *The Prison Journal*, *90*(4), 447–474. https://doi.org/10.1177/0032885510382218

Chambers, A. N. (2009). Impact of forced separation policy on incarcerated postpartum mothers. *Policy, Politics, & Nursing Practice*, *10*(3), 204–211. https://doi.org/10.1177/1527154409351592

Choi, K. W., & Sikkema, K. J. (2016). Childhood maltreatment and perinatal mood and anxiety disorders: A systematic review. *Trauma, Violence, & Abuse*, *17*(5), 427–453. https://doi.org/10.1177/1524838015584369

Crewe, B., Schliehe, A., & Przybylska, D. A. (2022). 'It causes a lot of problems': Relational ambiguities and dynamics between prisoners and staff in a women's prison. *European Journal of Criminology*, 147737082211408. https://doi.org/10.1177/14773708221140870

Dolan, R. (2016). Pregnant women, mothers, mother and baby units and mental health in prison. *PsyPag Quarterly*, *100*(100), 32–35. https://doi.org/10.53841/bpspag.2016.1.100.32

Dolan, R. (2018). *Pregnant Women in Prison: Mental Health, Admission to Prison Mother and Baby Units and Initial Outcomes for Mother and Child* (Doctoral dissertation, University of Manchester).

Dolan, R. M., Birmingham, L., Mullee, M., & Gregoire, A. (2013). The mental health of imprisoned mothers of young children: A follow-up study. *Journal of Forensic Psychiatry & Psychology*, *24*(4), 421–439. https://doi.org/10.1080/14789949.2013.818161

Dolan, R., Hann, M., Edge, D., & Shaw, J. (2019). Pregnancy in prison, mental health and admission to prison mother and baby units. *The Journal of Forensic Psychiatry & Psychology*, *30*(3), 448–466. https://doi.org/10.1080/14789949.2019.1586978

Douglas, N., Plugge, E., & Fitzpatrick, R. (2009). The impact of imprisonment on health: What do women prisoners say? *Journal of Epidemiology & Community Health*, *63*(9), 749–754. https://doi.org/10.1136/jech.2008.080713

Edge, D. (2006). Perinatal healthcare in prison: A scoping review of policy and provision. *University of Manchester*.

England, N. H. S., Improvement, N. H. S., & National Collaborating Centre for Mental Health. (2018). *The perinatal mental health care pathways*. NHS England.

Foley, L., & Papadopoulos, I. (2013). Perinatal mental health services for black and ethnic minority women in prison. *British Journal of Midwifery*, *21*(8), 553–562. https://doi.org/10.12968/bjom.2013.21.8.553

Galloway, S., Haynes, A., & Cuthbert, C. (2014). *An unfair sentence. All babies count: Spotlight on the criminal justice system*. NSPCC and Barnardos.

Goshin, L. S., Byrne, M. W., & Henninger, A. M. (2014). Recidivism after release from a prison nursery program. *Public Health Nursing*, *31*(2), 109–117. https://doi.org/10.1111/phn.12072

Government, H. M. (2021). *The best start for life: A vision for the 1,001 critical days*. *The Early Years Healthy Development Review Report*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf

Gregoire, A., Dolan, R., Birmingham, L., Mullee, M., & Coulson, D. (2010). The mental health and treatment needs of imprisoned mothers of young children. *The Journal of Forensic Psychiatry & Psychology*, *21*(3), 378–392. https://doi.org/10.1080/14789940903294317

Howard, L. M., & Khalifeh, H. (2020). Perinatal mental health: A review of progress and challenges. *World Psychiatry*, *19*(3), 313–327. https://doi.org/10.1002/wps.20769

Howard, L. M., Oram, S., Galley, H., Trevillion, K., Feder, G., & Tsai, A. C. (2013). Domestic violence and perinatal mental disorders: A systematic review and meta-analysis. *PLoS Medicine*, *10*(5), e1001452. https://doi.org/10.1371/journal.pmed.1001452

Kelman, J., Gribble, R., Harvey, J., Palmer, L., & MacManus, D. (2022). How does a history of trauma affect the experience of imprisonment for individuals in women's prisons: A qualitative exploration. *Women & Criminal Justice*, 1–21. https://doi.org/10.1080/08974454.2022.2071376

Kelsey, C. M., Medel, N., Mullins, C., Dallaire, D., & Forestell, C. (2017). An examination of care practices of pregnant women incarcerated in jail facilities in the United States. *Maternal and Child Health Journal*, *21*(6), 1260–1266. https://doi.org/10.1007/s10995-016-2224-5

Kennedy, A., Marshall, D., Parkinson, D., Delap, N., & Abbott, A. (2016). Birth Charter for women in prison in England and Wales, Birth Companions.

Knight, M., & Plugge, E. (2005). The outcomes of pregnancy among imprisoned women: A systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*, *112*(11), 1467–1474. https://doi.org/10.1111/j.1471-0528.2005.00749.x

Marshall, D. (2010). Birth companions: Working with women in prison giving birth. *British Journal of Midwifery*, *18*(4), 225–228. https://doi.org/10.12968/bjom.2010.18.4.47372

MBRRACE-UK. (2021). *Saving lives, improving mothers' care*. https://www.npeu.ox.ac.uk/mbrrace-uk/reports

Ministry of Justice. (2020). *Review of operational policy on pregnancy, mother and baby units and maternal separation*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/905559/summary-report-of-review-of-policy-on-mbu.pdf

Ministry of Justice. (2022). Population bulletin: weekly 09 December 2022, Prison population figures: 2022. https://www.gov.uk/government/publications/prison-population-figures-2022

Mulligan, C. (2019). Staying together: Mothers and babies in prison. *British Journal of Midwifery*, *27*(7), 436–441. https://doi.org/10.12968/bjom.2019.27.7.436

North, J. (2004) 'Getting it right? Services for pregnant women, new mothers, and babies in prison' the maternity alliance.

Offender Health Research Network. (2009). *A national evaluation of prison mental health in-reach services*. University of Manchester.

O'Keefe, C., & Dixon, L. (2015). Enhancing care for childbearing women and their babies in prison. *Project Report. Sheffield, Sheffield Hallam University*. https://app.pelorous.com/media_manager/public/287/FINAL%20MBU%20report%207th%20December%202015.pdf

Paynter, M. J., Drake, E. K., Cassidy, C., & Snelgrove-clarke, E. (2019). Maternal health outcomes for incarcerated women: A scoping review. *Journal of Clinical Nursing*, *28*(11–12), 2046–2060. https://doi.org/10.1111/jocn.14837

Plugge, E., Douglas, N., & Fitzpatrick, R. (2006). The health of women in prison study findings. *Department of Public Health University of Oxford*.

Powell, C., Ciclitira, K., & Marzano, L. (2020). Overwhelmed and powerless: Staff perspectives on mother– infant separations in English prisons. *Journal of Criminal Psychology*, *10*(4), 311–328. https://doi.org/10.1108/JCP-04-2020-0017

Powell, C., Marzano, L., & Ciclitira, K. (2017). Mother–infant separations in prison. A systematic attachment-focused policy review. *The Journal of Forensic Psychiatry & Psychology*, *28*(2), 274–289. https://doi.org/10.1080/14789949.2016.1204465

Price, S. (2005). Maternity services for women in prison: A descriptive study. *British Journal of Midwifery*, *13*(6), 362–368. https://doi.org/10.12968/bjom.2005.13.6.18354

Prison Reform Trust. (2019). Bromley Briefings Prison Factfile: Winter 2019. http://www.prisonreformtrust.org.uk/portals/0/documents/bromley%20briefings/old%20editions/Winter%202019%20Factfile%20web.pdf

Rahimipour Anaraki, N., & Boostani, D. (2014). Mother–child interaction: A qualitative investigation of imprisoned mothers. *Quality & Quantity*, *48*(5), 2447–2461. https://doi.org/10.1007/s11135-013-9900-y

Rennison, M. C. (2009). A new look at the gender gap in offending. *Women & Criminal Justice*, *19*(3), 171–190. https://doi.org/10.1080/08974450903001461

Sikand, M. (2015). *Lost spaces: Is the current procedure for women prisoners to gain a place in a prison mother and baby unit fair and accessible?*. The Griffins Society.

Sleed, M., Baradon, T., & Fonagy, P. (2013). New beginnings for mothers and babies in prison: A cluster randomized controlled trial. *Attachment & Human Development*, *15*(4), 349–367. https://doi.org/10.1080/14616734.2013.782651

Souch, A. J., Jones, I. R., Shelton, K. H., & Waters, C. S. (2022). Maternal childhood maltreatment and perinatal outcomes: A systematic review. *Journal of Affective Disorders*, *302*, 139–159. https://doi.org/10.1016/j.jad.2022.01.062

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal*, *21*(3), 174–192. https://doi.org/10.1108/MHRJ-01-2015-0006

Thomson, G., Mortimer, R., Baybutt, M., & Whittaker, K. (2022). Evaluation of birth companions perinatal and peer support provision in two prison settings in England: A mixed-methods study. *International Journal of Prisoner Health*. https://doi.org/10.1108/IJPH-09-2021-0099

Trowler, I. (2022). Applications to mother and baby units in prison: How decisions are made and the role of social work: A case review of social work decision making (2017-2021). https://dera.ioe.ac.uk/39570/1/Applications_to_mother_and_baby_units_in_prison_-how_decisions_are_made_and_the_role_of_social_work.pdf

Tyler, N., Miles, H. L., Karadag, B., & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: Prevalence, comorbidity, and gender differences. *Social Psychiatry & Psychiatric Epidemiology*, *54*(9), 1143–1152. https://doi.org/10.1007/s00127-019-01690-1

Ward, L. G. (2020). Trauma-informed perinatal healthcare for survivors of sexual violence. *The Journal of Perinatal & Neonatal Nursing*, *34*(3), 199. https://doi.org/10.1097/JPN.0000000000000501

Windham Stewart, P. (2016). Creating mother and baby therapy groups in prison: Emotional valuation. *Psychoanalytic Psychotherapy*, *30*(2), 152–163. https://doi.org/10.1080/02668734.2016.1167769

Woodall, J., Freeman, C., & Warwick-Booth, L. (2021). Health-promoting prisons in the female estate: An analysis of prison inspection data. *BMC Public Health*, *21*(1), 1–8. https://doi.org/10.1186/s12889-021-11621-y