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# “Is that a policy thing or is that a guard thing?”: A qualitative study of providers’ experiences supporting pregnant individuals incarcerated in Ontario, Canada

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## Abstract

**Background** Incarcerated pregnant individuals face barriers to perinatal care and health disparities when compared to the general population. Social and healthcare providers serving incarcerated pregnant clients are uniquely positioned to identify systemic barriers which hinder clients’ access to care and service delivery. This study explores the experiences of providers and the systemic challenges they encounter while delivering perinatal health and social services to individuals incarcerated in Ontario, Canada.

**Methods** We conducted a qualitative study using a descriptive design. We administered virtual, semi-structured interviews with social service and healthcare providers. Participants were recruited through purposeful and snowball sampling based on their experience delivering services to at least one individual who was pregnant while incarcerated in Ontario, Canada. All interviews were conducted individually to facilitate discussions and ensure confidentiality. We employed thematic analysis to identify and develop themes and subthemes.

**Results** Twenty-three participants (15 social service providers and eight healthcare providers) were interviewed. Participants explained how overlapping systems shaped their ability to deliver care, which we conceptualized as the carceral perinatal care system, composed of carceral, clinical, and community subsystems. Through thematic analysis, we also identified five themes, visually depicted as three concentric circles to reflect providers’ layered and compounding experiences. The outermost circle, divided into three segments, represents the main challenges providers encountered when delivering perinatal care: (1) *operating within a fragmented system*, (2) *knowing too little*, and (3) *witnessing dehumanization*. These challenges contribute to the middle circle theme of (4) *feeling powerless*, which culminates in the centre circle theme of (5) *enduring occupational stress*.

**Conclusion** Participants provided insights about the challenges involved in delivering perinatal care to incarcerated individuals. This study underscores the multifaceted, systemic barriers providers encounter, enhancing our understanding of the complexities surrounding perinatal care in carceral settings. The knowledge generated forms a foundation for developing policies, guidelines, and training resources tailored to the carceral context. Such

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interventions may strengthen providers' capacity to deliver equitable care, improving perinatal experiences and health outcomes of pregnant individuals and their infants. Future research should explore perinatal care from incarcerated individuals' perspectives to inform evidence-based solutions and guide comprehensive reforms.

**Keywords** Health services for prisoners, Incarceration, Perinatal care, Pregnancy, Healthcare provider, Social worker, Occupational health, Policy, Ontario

## Background

Pregnancy during incarceration presents unique challenges, as incarcerated individuals face substantial barriers to perinatal care. Studies conducted in Ontario, Canada, reveal stark disparities between incarcerated pregnant individuals and the general population. For example, incarcerated individuals are less likely to receive recommended prenatal care, such as first-trimester ultrasounds and antenatal appointments, reflecting inequities in access [1]. Furthermore, incarcerated individuals have poorer perinatal outcomes, including higher rates of preterm birth, low birth weight, and neonatal intensive care unit admissions [2]. Qualitative research has also highlighted incarcerated women's unmet reproductive health needs, restricted access to adequate care, and their expressed desire for improved reproductive health services, emphasizing systemic inadequacies within provincial carceral facilities [3]. Addressing these gaps requires an understanding of both the needs of incarcerated individuals and the challenges faced by social and healthcare providers who deliver perinatal care. However, there is a paucity of research examining providers' perspectives about systemic barriers to service delivery.

Systems thinking helps us understand how different entities are connected within a broader system. Its purpose is to deepen understanding of a system as a cohesive whole, including its components, their interactions, and relationships across different levels [4]. Every system inherently consists of smaller, self-contained systems, referred to as subsystems. A subsystem operates independently while contributing to the larger system's overall function (Young, 1964, as cited in Kramer & de Smit, 1977) [5]. Systems thinking provided the theoretical framework underpinning data collection and analysis, focusing on how subsystems operated independently and interacted within a larger system spanning institutions and services.

Within carceral facilities, incarcerated individuals access services delivered by facility employees, including physicians, nurses, and social workers. The Ministry of the Solicitor General oversees care within provincially managed facilities [6] while Correctional Service Canada manages services in federal institutions [7]. However, incarcerated individuals may also access public healthcare and social services external to the carceral facility, and under the purview of the Ontario Ministry of Health [8]. For example, they may receive permission to

visit their existing community-based midwife or obstetrician for prenatal care and they receive childbirth care and related social services at hospitals. In preparation for release from a carceral facility, pregnant individuals may also access other social services external to the facility, available through the Ontario Ministry of Children, Community and Social Services (e.g.: housing, financial assistance) and a range of community-based agencies (e.g.: shelters, parenting support programs). Since individuals may enter and be released from carceral institutions multiple times during a pregnancy, collaboration between healthcare and social service providers both internal and external to the carceral facility is essential for the delivery of continuous, comprehensive perinatal care [9, 10].

Social and healthcare providers delivering perinatal care to incarcerated clients must navigate this multifaceted system which presents significant challenges to service delivery. The division of perinatal services across health, social and carceral systems, and at the community, provincial and federal levels, leads to inefficiencies and inconsistencies, making it difficult to ensure continuity of care [11, 12]. Power dynamics, along with differing priorities between care providers, who prioritize patient care, and correctional employees, who prioritize institutional safety, impede care delivery [13, 14]. Gaps in knowledge of policies and regulations related to the perinatal care of incarcerated individuals also creates challenges for providers [15–17]. To deliver comprehensive perinatal care, providers must have some knowledge of the inner workings of these complex systems.

To improve perinatal care, it is important to examine providers' perspectives on how systemic barriers affect service delivery. Providers have valuable knowledge of the challenges their clients face when attempting to access comprehensive care. Social and healthcare providers serving incarcerated pregnant clients are uniquely positioned to identify systemic barriers which hinder access to care and service delivery. This study explores the experiences of providers and the systemic challenges they encounter while delivering perinatal health and social services to individuals incarcerated during pregnancy.

## Terminology

In this article, gender-inclusive terminology is employed recognizing pregnancy is not exclusive to individuals who identify as women; however, the term "women"

is retained when referencing published data utilizing this language. This article does not examine social, and healthcare services provided to transgender individuals within incarcerated settings. As it pertains to providers, the pronoun “she” is used when they identified as women.

## Methods

We used a qualitative descriptive design [18]. This qualitative research is part of a larger case study project exploring care delivery to pregnant individuals incarcerated in Ontario, Canada.

### Participant recruitment

Participants were recruited using purposeful and snowball sampling strategies. The principal investigator (XB) used emails and telephone calls to contact various provincial and national nursing, midwifery, social work, and medical organizations and associations. Some organizations shared recruitment information with their members via email distribution lists. XB also posted recruitment notices on social media. One community-based midwifery practice provided recruitment support by sharing information about the study with members of their network. Recruitment of participants continued until the data set was deemed to provide meaningful insight which helped answer the research question [19, 20].

**Table 1** Examples of interview guide questions

Topic	Questions
Work experiences	Tell me about an experience you had working with an individual who was incarcerated and pregnant, <ul style="list-style-type: none"> <li>• when the care experience went well?</li> <li>• when the care experience was difficult or did not go well?</li> </ul>
Management and organization	What type of support did you receive from your institution regarding provision of services to individuals who were incarcerated while pregnant?
Access to care	What measures are in place to ensure people who are incarcerated while pregnant receive access to social services and healthcare services? Are there barriers that prevent individuals who are incarcerated while pregnant from accessing reproductive healthcare services? If so, how do you think these barriers could be addressed? How do you balance following your professional standards, the guidelines that you receive from the correctional facility, and the security concerns of the facility with providing individualized care to someone who's incarcerated while pregnant?
Provision of care	Who are the service providers you collaborate with to ensure the well-being of pregnant individuals who are incarcerated? Which policies, guidelines, other documents or training do you refer to when it comes to the care of people who are incarcerated while pregnant?

### Eligibility criteria

Eligibility criteria included having at least one experience, acquired between January 2012 and July 2024, providing health care or social services to an individual who was incarcerated in Ontario during pregnancy, labour, or birth. There were no restrictions related to the setting (ex: community, hospital, correctional facility, etc.) in which the experience was acquired. Participants were eligible if they could understand and communicate orally in either English or French.

### Interview guide

The interview guide (Supplemental file) was informed by the American College of Obstetricians and Gynecologists' Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals [21], the Guidelines for the Implementation of Mother-Child Units in Canadian Correctional Facilities [22] and the Quality of Care for Maternal and Newborn Health: A Monitoring Framework for Network Countries [23]. These three documents were selected since they respectively provide guidelines related to healthcare for individuals who are incarcerated while pregnant, best practices for mother-infant support while incarcerated, and elements related to monitoring maternal and newborn health. Before beginning data collection, XB piloted the interview guide with two researchers with expertise in the areas of the lived experiences of incarcerated mothers and mothering while living in homeless shelters. Minor modifications were made to the interview guide based on their feedback and XB's observations. Examples of interview questions are provided in Table 1.

### Data collection

Data were collected between October 2023 and July 2024. Twenty-three individual, semi-structured interviews were conducted by XB, who has experience in qualitative data collection and analysis. The interviews lasted between 27 and 125 min, with a median duration of 69 min. Prior to each interview, XB emailed participants to confirm the agreed-upon date and time, attaching the consent form and interview guide for their review. Informed verbal consent to participate was obtained from each participant before beginning the interviews. Interviews were digitally recorded using either Microsoft Teams or Zoom. Upon completion of each interview, XB downloaded a Word version of the application-generated interview transcript and modified it to ensure it was a verbatim representation of the interview. Concurrently, each transcript was anonymized and assigned a unique participant identifier. Pseudonyms were also used to refer to locations, organizations, facilities, institutions, clients and providers. Completed transcripts were stored on the university password protected server. Only XB and

WP had access to the transcripts. Transcripts were not returned to participants for review or comments.

### Data analysis

We used Braun and Clarke's [20] reflexive thematic analysis framework to guide our analysis of the data. This framework provides an approach to systematically identify, organize and interpret the information shared through participants' narratives. Braun and Clarke [20] present a six-step, iterative process in thematic analysis, which includes: familiarizing oneself with the data, generating initial codes, identifying themes, reviewing themes, naming and defining themes, and producing a comprehensive report explaining links between themes. We used NVivo 14 to facilitate data management, coding of the verbatim interview transcriptions, and extraction of relevant quotes. XB coded all transcripts, and WP coded a subset of these transcripts. XB and WP met weekly to discuss and identify codes, themes, sub-themes and relationships between the themes. Meetings were then held with all authors (XB, WP, AFP, LM, AM) to validate the themes. LM and AM are both midwives

who have experience working with incarcerated pregnant clients, and AFP is a law professor with research expertise in the areas of informed consent and reproductive health. WP is a registered nurse with research expertise in maternal-newborn health and the health care experiences of marginalized pregnant and postpartum women.

### Ethical considerations

The study was approved by the University of Ottawa Research Ethics Board (H-01-23-8376). Each participant provided their verbal consent to participate in the study before beginning the interview. Participants were reassured their participation was voluntary, they were not obligated to answer any question, and they could end the interview at any time. Interviews were conducted virtually, allowing participants to select a private and comfortable interview location. Participants received \$25 (CAD) compensation in the form of either an Interac e-Transfer, a gift card, or a donation to a charity of their choosing. Two participants declined to accept the compensation.

### Findings

#### Participants

The sample was comprised of 23 participants who had at least one experience working with an individual who was pregnant while incarcerated in correctional facilities located in Ontario, Canada. Participants acquired their relevant experience through clinical facilities ( $n=9$ ), various community organizations ( $n=6$ ), correctional facilities ( $n=3$ ), an open custody facility ( $n=1$ ), an independent and non-partisan office ( $n=1$ ), a health authority ( $n=1$ ) or more than one of the settings listed ( $n=2$ ). Participants' clients served sentences in the province of Ontario across 11 correctional facilities, one group home and one house arrest.

Participants' education ranged from a high school diploma to PhD. Participants' self-identified gender, racial/ethnic background, levels of education, and years of experience working with pregnant and incarcerated individuals are summarized in Table 2. Jurisdiction responsible for the clients' sentences and participants' professional role/title while working with pregnant and incarcerated clients are included in Table 3.

#### Providers experiences of care provision

The purpose of the study was to explore providers' experience of care provision when working with individuals who were incarcerated while pregnant. Using thematic analysis, we identified five themes: (1) Operating within a fragmented system, (2) Knowing too little, (3) Witnessing dehumanization, (4) Feeling powerless, and (5) Enduring occupational stress. These themes and their corresponding subthemes are provided in Table 4. In the following paragraphs, we describe each theme and subtheme,

**Table 2** Social service and healthcare providers' characteristics

Participant characteristics	Number of participants (N=23) n (%)
<b>Gender</b>	
Female	21 (91.3%)
Male	2 (8.7%)
<b>Race/Ethnicity</b>	
Black	1 (4.3%)
Caribbean	1 (4.3%)
Caucasian	15 (65.2)
Indigenous	1 (4.3%)
Middle Eastern	1 (4.3%)
Multiracial	3 (13%)
Southeast Asian	1 (4.3%)
<b>Highest level of education</b>	
High school	2 (8.7%)
Bachelor's degree	7 (30.4%)
Master's degree	9 (39.1)
Postgraduate certificate	1 (4.3%)
Juris Doctor	1 (4.3%)
Doctor of Medicine	2 (8.7%)
Doctor of Medicine/PhD	1 (4.3)
<b>Years working with incarcerated and pregnant clients</b>	
< 1	3 (13%)
1–5	7 (30.4%)
6–10	7 (30.4%)
11–15	4 (17.4%)
16–20	1 (4.3%)
> 20	1 (4.3%)

**Table 3** Jurisdiction of clients' sentences and participants' professional roles/titles when caring for incarcerated pregnant individuals

Jurisdiction of clients' sentences	Number of Participants (N=23)
Participants' professional role/title	
<b>Federal</b>	
Education Coordinator, Intern	1
Midwife	2
<b>Provincial</b>	
Behavioural therapist & Child and youth worker	1
Court support worker	1
Doula	1
Manager, Social work	1
Registered nurse	2
Outreach coordinator	1
Program caseworker	1
Program coordinator, Midwife	1
Senior investigator	1
Social worker	7
Physician	3

**Table 4** Themes and subthemes identified in interviews with providers caring for incarcerated pregnant individuals

Themes	Sub-themes
1. Operating within a fragmented system	<ul style="list-style-type: none"> <li>• Disconnected service delivery</li> <li>• Lack of communication</li> <li>• Ambiguity in follow-up care</li> </ul>
2. Knowing too little	<ul style="list-style-type: none"> <li>• Absence of training</li> <li>• Partial view of the whole story</li> <li>• Do they still have rights?</li> </ul>
3. Witnessing dehumanization	<ul style="list-style-type: none"> <li>• Stigmatization</li> <li>• Cultural disallowance</li> <li>• Displaced agency</li> <li>• Erosion of confidentiality</li> </ul>
4. Feeling powerless	<ul style="list-style-type: none"> <li>• Restricted access to clients</li> <li>• Acquiescing to power dynamics</li> <li>• Perceived outsider identity</li> </ul>
5. Enduring occupational stress	<ul style="list-style-type: none"> <li>• Confronting ethical paradoxes</li> <li>• Burnout</li> <li>• Staffing limitations</li> </ul>

supported by verbatim quotes from the interviews. The relationship between themes is visually summarized in Fig. 1.

### The carceral perinatal care system and its subsystems

During the interviews, providers discussed the impacts of various systems on their ability to deliver care. Through data analysis we identified and defined a larger system within which providers deliver care, which we termed the *carceral perinatal care system*, and its three subsystems: *carceral*, *clinical*, and *community*. In this study, we define the *carceral system* as the network of interconnected

elements which define criminal offences, enforce punishment, and regulate the incarceration process, including but not limited to electronic systems, documentation, professionals working within the system, and the legal framework. The *clinical system* refers to the network of elements involved in the examination, diagnosis, and treatment of patients, as well as health promotion and related health services. It also includes electronic systems, documentation, and care professionals. We define the *community system* as a network of elements which provide incarcerated and formerly incarcerated individuals with formal and informal supports, excluding those provided by the carceral or clinical systems. Formal supports refer to services offered by compensated professionals, while informal supports include uncompensated resources provided by family, friends, or community members. These may encompass emotional and financial support, as well as material assistance such as housing, employment, food, and transportation. The interactions between these systems introduce challenges for service delivery and continuity of care, as described in this article.

### Theme 1: operating within a fragmented system

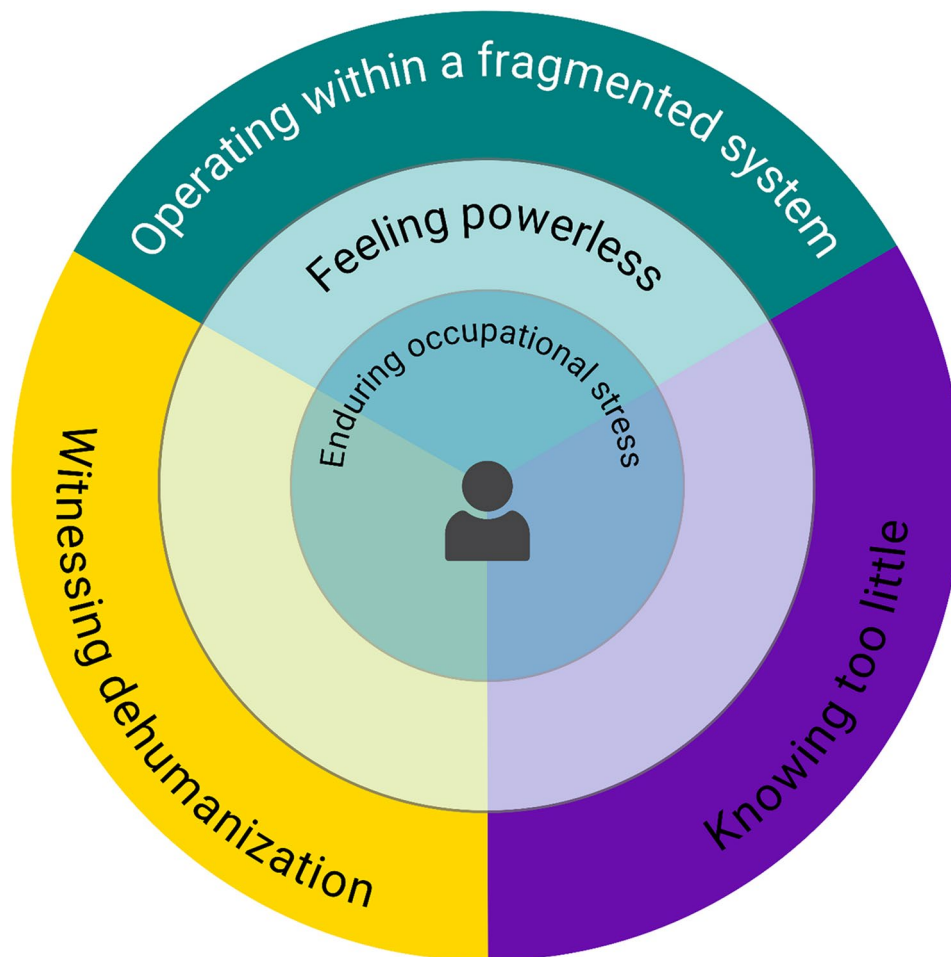
The *carceral perinatal care system* within which perinatal healthcare and social service providers work includes three subsystems: *carceral*, *clinical* and *community*. This multifaceted context introduces complexities when providing care to clients. Participants describe a disconnect between the subsystems, resulting in clients' care needs remaining unmet. These challenges are illustrated by the subthemes: disconnected service delivery, lack of communication and ambiguity in follow-up care.

#### Disconnected service delivery

A community-based midwife described how pregnancy-related incarceration can create inconsistencies in treatment plans. She explained how prescriptions written for a client by external providers must be reviewed and rewritten by the carceral facility's physician. In their experience, this may lead to the prescription being completely ignored by the internal healthcare team:

"[...] when someone is in the [correctional] institution, all you can do is send a script, they [the healthcare team in the correctional facility] have to send their own script internally to make that happen. So even if I was like, 'It's my professional and my... within my scope to increase her [medication]', it wouldn't have mattered. It still has to be internal." (SP22).

In the following example, an external physician illustrates the challenge of providing prenatal care to incarcerated individuals stemming from uncertainty regarding available services for these clients:



**Fig. 1** Understanding Providers' Experiences. Depiction of thematic findings of providers' experiences when working with individuals pregnant and incarcerated in facilities located in Ontario, Canada. Three segments of the larger outer circle represent *operating within a fragmented system*, *witnessing dehumanization* and *knowing too little*. The medium translucent circle symbolizes a sense of *powerlessness* felt by providers, while the smaller translucent circle highlights *occupational stress*. The figure at the core symbolizes the providers at the heart of these experiences. (Image created with BioRender.com)

*"I'm just thinking about all the things I do for all my other [clients] in my practice, and it's... I mean, to be honest it's not discussed because I don't know what is possible. But that would be helpful, I think from a kind of education point of view, and even just to sort of contextualize some of the recommendations that I'm giving or have a deeper sense of kind of the... I guess bigger framework within which the prenatal care is happening." (SP23).*

Although there may be external healthcare and social services involved in the care of pregnant incarcerated individuals, external providers described feeling disconnected from the internal providers, negatively impacting care provision.

#### **Lack of communication**

Clear and effective communication among all stakeholders is essential when delivering client care across multiple providers and systems. However, participants in our

study reported poor communication as a significant barrier to care provision.

Multiple providers recounted being unaware their clients had been moved from one location to another. For example, a court support worker recounted a situation where her client was relocated without notification:

*"I showed up to the jail to see her. And they're like, 'Ohh yeah. She's not here' like 'I have... what?'" 'Well, she's an overflow.' I'm like, 'What does that mean?' 'Well, she's in one of the various facilities.' I'm like 'You need to find her, and you need to tell me where she is.'" (SP07).*

These instances often resulted in delayed care since appointments then required rescheduling. Similarly, a physician described a communication breakdown, which resulted in the client missing some appointments and receiving duplicate services:

*"I'm supposed to see a pregnant-incarcerated patient tomorrow. She had a clinic appointment, and an ultrasound booked with me last week. She didn't attend either*

of them. When we phoned the prison to say, 'What happened?', we were told that we 'hadn't informed the right people' of her appointments. But we've been speaking with the medical staff who seem totally on board with this plan. I'm not sure how we could have handled that differently. I thought we had communicated the appointments. Then we learned that in addition, she had an anatomy ultrasound scheduled [elsewhere] in the community. So, there was almost duplication of services." (SP21).

Several providers explained the importance of timely access to prenatal care for completing tests limited to specific stages of pregnancy, which are routinely conducted in hospital or in the community and are not available within carceral facilities. A physician working in a carceral facility provided examples of these tests and the importance of timeliness, stating: "[...] prenatal screening, you know screening for genetic syndromes or screening for infections, you know, some things are most appropriately done at a specific point in the pregnancy [...]" (SP01). She continued, "... if you have to go for [...] screening for gestational diabetes, they do that in the hospital [or in the community] not in custody." (SP01).

In addition to missed or delayed care, providers described how poor communication among stakeholders hindered their ability to deliver client-centred care. Effective communication between social service providers, healthcare professionals and carceral staff remained essential for developing treatment plans, scheduling appointments, arranging transportation to and from medical facilities, and preparing clients for release from the carceral facility. However, participants repeatedly described instances of missed, absent or unclear communication. A hospital-based social worker described the lack of communication from correctional staff as a barrier to comprehensive care provision:

"I've never had the jail social worker, nurse or psychiatrist call me directly and say, 'Hey, [social worker's name], you know we have consent. We need to plan for this mom. These are the concerns. These are the issues. How can we work together for... having a good plan for this mom?' It never happened, right?" (SP02).

These examples underscore how insufficient communication leads to significant barriers to interprofessional collaboration and to the timely delivery of appropriate care. Such challenges extend beyond immediate care provision, influencing follow-up care and creating further ambiguity in the continuity of care.

### **Ambiguity in follow-up care**

Several participants described the challenges encountered when planning ongoing services for incarcerated pregnant clients. Primarily, the uncertainty of clients' length of stay in correctional facilities complicates the preparation and execution of transition plans.

An external hospital-based physician recounted her experience with a client who did not receive services in a timely manner and miscarried a multifetal pregnancy. The physician raised concerns regarding whether the client received any follow-up care:

"Even after she lost those babies, I'm not aware of her receiving any support medically beyond that point. And so yeah, it's a, it's a huge ethical dilemma. These people are so vulnerable and probably deserve the most care, and yet they get the least." (SP21).

A correctional facility-based social worker shared the uncertainty she encountered when preparing services for individuals who were incarcerated and pregnant:

"I know there was always a level of panic when I got a pregnant inmate because I wanted to make sure I got as much info as possible and started the process, but I didn't always get that information right away or if they were bailed or released before I could get everything, then I was left with an impartial process as well. So, if that person came back, which unfortunately sometimes happens with recidivism and people pulling bail and all that stuff, you could end up with someone back on your caseload, and then you could pick up where you left off. But that was always one of the pieces that made that difficult because you didn't know how long that person would be with you." (SP12).

The complex needs of incarcerated pregnant individuals present challenges, requiring providers to navigate multiple systems – carceral, clinical and community. Participants described their experiences as *operating within a fragmented system*. The disconnect between the systems, combined with the lack of communication and ambiguity regarding clients' length of stay within the carceral system, disrupts clients' access to care. This results in providers feeling powerless and increases their level of stress when caring for incarcerated pregnant individuals.

### **Theme 2: knowing too little**

In their interviews, providers described challenges working with limited information stemming from insufficient training, a lack of knowledge about clients' social and medical histories, and uncertainty about clients' rights. The challenges posed by these knowledge gaps are captured by the three following subthemes: absence of training, partial view of the whole story, and 'do they still have rights?'

#### **Absence of training**

Participants identified significant deficiencies in training and difficulties accessing information related to processes within correctional facilities.

For example, a midwife described the lack of guidance provided when she arrived at the correctional facility to work with a client:

*"[...] there wasn't really like any orientation to the facility or like 'Here's what to do. And here's the expectations.' It was just like 'Throw all your stuff in a locker. Here's your [panic] button. Go see your clients.' There wasn't any conversation about like what to do if I needed the institution's physician to do something for my client. So it was, like we kind of winged it and thankfully it worked out." (SP19).*

A physician described a similar lack of instruction and access to the correctional facility's relevant policies:

*"[...] healthcare providers, so physicians in particular, aren't employees of [the correctional facility], like, they're not part of, the... you know, the public service. So, they wouldn't be included in the formal training, and you don't get like a binder of policies and procedures. There's some place on [the correctional facility's internal] website that maybe you could go that we don't have access to." (SP01).*

A hospital nurse highlighted how knowledge of the correctional facility's policies would be beneficial for providers working outside of the facility, particularly when clients are handcuffed and/or accompanied by correctional officers (guards). During her interview, she posed several questions surrounding guards' constant presence in the client's hospital room during labour and birth, highlighting her lack of knowledge and access to facility policies and procedures:

*"I mean, it would be nice to have a better understanding about what the expectations of the guards are, you know, like, do they have to be present? Like I would love to know what their facility policies are around that. Do they have to be present? How... what is the definition of present? Is it outside the room? Is it in the room? Is it behind a curtain? It would be nice to know about, you know, do the handcuffs need to... have to stay on? You know, is that a policy thing or is that a guard thing? Just having a better understanding about the facility's policy, I think." (SP17).*

The same nurse continues, identifying the need for the hospital to have policies related to the care of patients who are incarcerated:

*"And having perhaps more support from management in regards to, like, maybe increasing [nurse] staffing so that if safety is a concern with the patient, we could have two nurses that go in and care for this patient together and, um... something like that, like some kind of a protocol or any kind of resource in terms of like that kind of care." (SP17).*

In our sample, three participants employed within correctional facilities under the jurisdiction of the Ministry of the Solicitor General reported an absence of training specific to their roles. All three social workers highlighted this gap, with one offering the following insight regarding training related to individuals who are incarcerated, including those who are incarcerated and pregnant: *"[...] when you become a correction social worker, you are thrown in. Good luck." (SP12).*

Deficiencies in training and regulatory knowledge create challenges for providers working with individuals who are incarcerated while pregnant. The absence of formal guidance forces providers to independently familiarize themselves with the facility's regulations and policies. This gap burdens providers already operating in a demanding environment.

### **Partial view of the whole story**

Participants highlighted the challenge of *knowing too little* about their clients, a barrier they attributed to the pervasive distrust incarcerated individuals harbour toward 'the system'. This mistrust, directed at both individuals and institutional processes, often manifests as limited communication with providers. These communication gaps significantly limit providers' capacity to deliver appropriate, individualized care for their clients.

For example, a correctional social worker described instances when clients deliberately withheld their pregnancy from correctional staff, resulting in delays receiving timely care:

*"There's some, there's some women, who maybe they've had a number of children, or they work as sex workers, and they're just scared to tell staff [correctional officers or facility health staff] that they're pregnant. I don't think the pregnancy, I could be wrong on this, but we have had times where inmates have come through [the correctional facility] and they weren't caught - in the sense that no one knew they were pregnant until they said, 'I'm pregnant.'" (SP12).*

A hospital-based social worker explained how, in the absence of a trusting provider-client relationship, clients do not share their 'whole story', hindering social workers' ability to effectively advocate on their behalf. This social worker began by providing an example of her role: *"Sometimes we push [advocate] with [other] service providers or ask for flexibility from the system to accommodate women we work with [...]" (SP02).* She continued describing her experience working with incarcerated clients who distrust the system, stating:

*"[...] but we don't know the whole story. So, we advocate without knowing the whole story. So, I find that it's really difficult sometimes for me to be a good advocate and have good, constructive conversations with women when I only know bits and pieces of their story. So... I go with what they wanna share with me and I go with what I feel would be the most human thing to do in this case for the best outcome for mom and baby umm...so I find that sometimes I'm flying blind." (SP02).*

In the following quote, a physician provides an example of the challenges they can face when trying to establish a therapeutic relationship with incarcerated clients. In this situation, the client refused a procedure which could have helped identify complications with her pregnancy:

*"I made efforts to speak to her, to try to have a conversation, and she did not engage. We [medical staff] asked for permission to perform the ultrasound, and we got a nod [from the patient] to go ahead with that. But almost as soon as we put the probe on her abdomen, she withdrew that consent and asked us to stop. There, at that point, she indicated that she wanted to return to her correctional facility with no further interaction. And so, we were not able to provide care to her that day. And she came back in [the medical facility] within the week and having lost all [number of babies] of the [multifetal pregnancy]." (SP21).*

These accounts illustrate challenges related to working with clients where a therapeutic relationship has not been established. Pregnant individuals who are incarcerated may hesitate to share information with providers committed to supporting them and delivering trauma-informed care. *Knowing too little* about the client restricts providers' ability to assess, collaboratively plan and implement effective, personalized care.

#### **Do they still have rights?**

Participants admitted *knowing too little* about the rights of incarcerated pregnant clients. Their questions about clients' rights often emerged when providers spoke of their experiences with having correctional officers present in clients' hospital rooms. In their interviews, providers questioned the appropriateness of guards being present during medical consultations, exams or procedures.

A hospital-based social worker described feeling unprepared when she first began working with clients who were pregnant and incarcerated. She wondered *"[...] how do you talk to the patient? There's guards present... And staff coming up to you, 'Like what's going on? There's guards. How do we do this?'" (SP14).* One nurse asked, *"[...] do they still have the right to privacy?" (SP04).* This nurse also expressed not knowing if incarcerated pregnant clients have the right to autonomy in decision-making:

*"Do they still have the right to make decisions about their care, their medical care? Like, do they? Do they? You know, like clarification around all that or because sometimes it feels like they do, but it's limited - or they don't." (SP04).*

Several providers expressed concerns about correctional officers' practice of restraining pregnant clients with handcuffs and/or shackles. As illustrated by the following quote, providers' misunderstanding of incarcerated, pregnant clients' rights can prevent them from challenging this practice:

*"[...] if I need to do a vaginal exam or even an ultrasound - to have somebody shackled to the bed is challenging for sure. It is something that we have to work around. As I understand, there's not a whole lot of ability to, um,*

*sort of change the regulations under which that person is able to be seen." (SP21).*

A nurse recounted an instance when a client did not have control over her body during childbirth. While in the hospital, the client remained handcuffed, which impeded the birthing process. The nurse explained how the correctional officer refused to remove the cuffs:

*"I have cared for a patient... who, the biggest thing that I can think of is like the shackles and being handcuffed to the bed. I remember a situation with another patient who had handcuffs and they, the guards, would not take those off during pushing, so it made pushing difficult." (SP17).*

*Knowing too little* can potentially leave clients vulnerable to unjust treatment. This dynamic facilitates the tolerance and the perpetuation of the dehumanization of incarcerated pregnant individuals. Providers' knowledge (or lack thereof) regarding their clients' rights may contribute to their feelings of powerlessness.

#### **Theme 3: witnessing dehumanization**

Dehumanization is the process of stripping uniquely human qualities from an individual to justify their mistreatment [24]. Participants discussed regularly witnessing the poor treatment of incarcerated pregnant individuals. Their observations of the dehumanization of their clients are reflected by three subthemes: stigmatization, cultural disallowance and displaced agency.

##### **Stigmatization**

During the interviews, several participants spoke about stigmatization associated with pregnancy and incarceration. This stigma influenced correctional staff's perceptions, sometimes leading them to dismiss medical situations as inconsequential. One social worker recounted the negative attitudes expressed by correctional facility staff, highlighting how these preconceived notions undermined the recognition of legitimate health-care needs:

*"Sometimes we do get negative attitudes from specifically correctional officers and nurses about the women who end up in jail, who are pregnant, particularly, you know, there's judgment about it. Like all the women that we've seen in jail while pregnant it's not their first pregnancy, and there's judgment about, you know, not using protection, about having other kids possibly in Children's Aid's care, about being... about not being responsible, you know, judgments about like being pregnant and still using substances which, you know, might have been the case for some of them." (SP06).*

One midwife recalled the stigma expressed by correctional officers, implying the client was unworthy of care due to the choices which led to their imprisonment:

*"[...] she was very heavily demonized. Like it was like, 'Well, do you know how dangerous this person is? Do*

you?.. We would go in to try to have, like, an assessment with the client or have a conversation with the client. There's always a guard present, which we are used to, but essentially there was, the conversation was always like 'You need to know how dangerous these people are.' and like 'This person that you're caring for, and you wanna show compassion to, that is a dangerous person who's done some really terrible things.' And I feel like, as a care provider, I don't need to know what someone has done. I need to know what someone needs from me. I need to know how to care for them. (SP22).

Participants recalled the attitudes of other providers and correctional employees as detrimental to the overall care of the client, systematically reinforcing the oppression of individuals incarcerated and experiencing pregnancy.

### Cultural disallowance

Cultural disallowance results from certain populations' cultural expressions, practices and beliefs being incompatible with the culture, practices or beliefs of the environment in which they find themselves. During the interviews, participants provided examples of cultural disallowance they had witnessed while working within correctional facilities.

A social worker who was familiar with Indigenous practices and cultures described the challenges she encountered when working with Indigenous clients. She explained how correctional facility regulations hindered her ability to support Indigenous clients in practising their cultural beliefs and traditions:

*"Like you're not allowed to bring in tobacco ties into a correctional centre, which is usually on a drum. So Indigenous people or First Nations people do hand drumming and the hand drumming is made with deer skin and or deer hide and you put tobacco ties on the side that it's [the drum] tied up with and you have to take off those tobacco ties prior to bringing them [the drums] into uh, like a correctional centre. And I did not know that because tobacco is considered one of the First Nations peoples' sacred medicines. So, there's four medicines that are considered sacred for First Nations people, and having the tobacco tie attached to the drum is considered sacred and removing that like that takes away some of the medicine of the drum." (SP10).*

Another social worker based in the correctional facility described an instance in which a pregnant client refused to be strip searched due to her religious and cultural beliefs. The social worker understood the reasons behind the client's refusal. The social worker then proceeded to successfully advocate on her client's behalf:

*"There was one time in particular I worked with a [ethnic background] client and anytime anyone's coming in [the correctional facility] they have to do the squat cough.*

*So, you're stripped naked, and you have to squat and cough to make sure you're not hiding anything in any orifices. That person didn't want to do it, but it was because of their religion. So, there was a time where I had to intervene pretty severely with the officers and just be like, 'Can we redo this?' like because I didn't want her to get a misconduct, because I knew it was religious. And so, I went to the sergeant, and I said 'Please don't give them a misconduct like, this is religious. This is cultural. They just can't be naked in front of men. So, can we, can we just arrange that all women and no men are coming down the hallway until this is process is done? It's awful enough on its own.' And they did. They did do that, so I was able to kind of mitigate that a bit. (SP12)*

This example demonstrates how, in some cases, those conducting strip searches do not intuitively consider the cultural or religious implications of these searches.

A court support worker discussed the challenges she encountered when attempting to access timely interpreting services for her Deaf client:

*"So in order for me to communicate with her, I need two interpreters - I need a ASL (American Sign Language) interpreter, so the American Sign Language to translate my English to sign and then I need a Deaf interpreter because Deaf sign is completely different than American Sign. The jail refused to let three of us be there [in a room] in order to communicate with her. Like refused. Would not let us. It's like, it was just the epitome of incompetence, of understanding like she doesn't understand the English language at all, like none of it. And so, the jail kept saying that I can write English, and she'll get it because she can read. She actually can't read because she doesn't speak English. She speaks Deaf sign and so it was... we actually had to wait 'till she got remanded to court to tell the judge that 'I need I need you to give us like special permission to the jail demanding that we're allowed in, the three of us.' " (SP07).*

These examples illustrate how rigidly enforced regulations disregard clients' religious, cultural and linguistic differences. Participants described witnessing the dehumanization of their incarcerated pregnant clients resulting from cultural disallowance. These practices dismiss clients' unique needs and prevent them from accessing individualized care and services.

### Displaced agency

Displaced agency refers the denial of an individual's autonomy over decisions affecting their lives. Many providers raised concerns about the practice of withholding information from clients regarding their off-site medical appointments.

A hospital nurse shared her experience with a client who was pregnant with multiples and for whom a caesarean section (C-section) had been scheduled. However,

the date of the surgery was withheld from the client due to concerns within the correctional system about clients becoming flight risks. The nurse explained how removing the client's agency over her care, and bringing her to the scheduled caesarean surgery without notice increased the client's level of stress:

*"[...] a patient who was having [multifetal delivery] and had to have a C-section, and they're not allowed to know their appointments, and when they're coming to the hospital. So, she wasn't allowed to have her C-section date. So, she wasn't...aware that she was, when she was coming to hospital that she was having her caesarean section. And I just... struggle with that... that they don't even know and that that's happening. And so obviously there was a lot of distress on her part... and... it was very yeah, that was just a very difficult situation. I think we ended up bumping her C-section so that she had some time to process what was happening and moved it to later in the day." (SP04).*

A doula described clients' experiences of displaced agency, providing multiple examples:

*"You don't get told when your appointments are you just get taken. Just because transporting you from the jail, they say is a flight risk, so they [correctional officers] just literally come [and say] 'Oh you, we're taking you to the doctor', they don't ever tell you when it's gonna happen. You're not allowed to have anyone at your birth. Sometimes, a lot of the times actually, you're shackled to the bed like one leg or something, and then if you're, you know, if you're staying after the birth of the baby, like incarcerated, usually you don't get a lot of time with your baby, and they bring you right back to the jail. So yeah, to actually fully support people while they're pregnant and incarcerated... when it comes to like appointments and you know, just they kind of just bring you and they don't really say much. So, it's hard to support someone incarcerated the same as I would support somebody who's outside. It's like almost impossible." (SP18).*

The structure of the carceral system, appearing to hold greater authority, deceptively shifts decision-making power over an individual's body and care to carceral system employees who may lack the qualifications to address clients' needs. This displacement of agency from incarcerated pregnant individuals to carceral system agents causes significant physical, emotional, and psychological distress for both clients and providers.

#### **Erosion of confidentiality**

Erosion of confidentiality refers to breaches or perceived breaches in the protection of clients' personal and medical information, whether through sharing sensitive details without consent, lack of private spaces for discussions, or inadequate safeguards within a given setting, which can lead clients to lose confidence in the providers and subsequently, withhold important information related to

their care. Providers highlighted the constant presence of correctional officers during care provision as a factor contributing to the erosion of confidentiality. A hospital labour and delivery nurse expressed her concerns about the presence of correctional officers in the hospital room, inferring clients were more likely to withhold important details about their medical history or other relevant information due to the officers' presence:

*"Building a rapport with a patient is tricky when you have people [guards] supervising patients. They're not always open to being entirely truthful or very open about their history or their thoughts and feelings, what they want, what they need kind of thing, so that that was definitely a challenge." (SP17).*

An obstetrician/gynecologist working in a hospital setting conducted a medical assessment of a client who was accompanied by two correctional officers. The physician described how the officers' presence appeared to interfere with the appointment, limiting the amount of information she could gather about the client's pregnancy:

*"She was handcuffed to the ultrasound bed, and she was [Indigenous] in background, and she was carrying a [multifetal] pregnancy while incarcerated. And the goal of that appointment was to do an ultrasound to assess fetal well-being. And the whole environment in the room was, I think, the word 'antagonistic' comes to mind. Clearly, the interaction between the guards and the patient was very sort of tenuous and stressed I would say. And on coming into the room, the patient did not make eye contact with me at all." (SP21).*

According to participants, the erosion of confidentiality is a frequent issue for people who are incarcerated and pregnant. Correctional officers regularly gain unauthorized access to sensitive client information, violating privacy rights. Participants are unaware of any formal documentation outlining confidentiality protocols regarding correctional officers' access to clients' care information.

*Witnessing the dehumanization* of clients leaves providers struggling to uphold their professional standards. As care providers navigate these moral and emotional challenges, it may hinder their capacity to provide compassionate care. The emotional toll of witnessing client's suffering, compounded by the constraints of fragmented systems, further contributes to job-related stress. Providers may also feel powerless if they are unable to address the inequities faced by their clients.

#### **Theme 4: feeling powerless**

Providers' dedication to serve and to advocate for their clients was not always compatible with the culture upheld by correctional facility employees, the structure of the facilities, nor the constraints imposed by institutional policies. Providers shared their experiences of

feeling powerless when working with pregnant, incarcerated individuals, as reflected by the three subthemes: restricted access to clients, acquiescing to power dynamics, and perceived outsider identity.

### Restricted access to clients

Correctional facilities are designed to restrict movement both in and out of the facility, while also limiting access to those experiencing incarceration. The infrastructure and inherent culture of these facilities, as well as certain staff members, create barriers to care provision by limiting service providers' access to their clients. For example, a social worker described an instance when she was unable to see her pregnant, incarcerated client in the correctional facility. The social worker had travelled over two hours one way, arriving at the correctional facility, only to learn she would not be able to speak with her client:

*"[...] they [correctional officers] said the client's behaviour was not appropriate and it wasn't a good time for me to see them. And I was like, OK, but like, it's a... it's probably like a two or three hour drive from [Name of City] to [Name of Township] and like, like it's a lot of effort that I put in to see the client and like they should just let me see them even though they had like a bad day or they had a meltdown or something like that happened." (SP10).*

Lockdowns restrict the movement of correctional staff, incarcerated individuals and others within a correctional facility. In Ontario, lockdowns are supposed to be implemented in response to medical quarantines, or serious safety or security concerns [25]. During lockdowns, which can last several days, incarcerated individuals remain in their cells for extended periods, and are denied access to recreational time, work, visits (including from providers), or telephone systems [25]. Research participants described how lockdowns frequently impacted their ability to deliver services. A social worker stated: *"[...] if I need to see someone for something, if there's a lockdown, doesn't matter. You're not going in there" (SP12).* An education coordinator described days without lockdowns, when she had access to her client, as particularly beneficial: *"[...] the days like when I could get in when there wasn't a lockdown, those were some really fruitful conversations." (SP16).*

Physical barriers also restrict providers' access to their clients. A program caseworker recalled attempting to support a client through their cell, and described the challenges this situation posed:

*"I've also had times where I've had to meet with pregnant clients, like through the hatch of their cell, so not being able to pull them into a professional visitation room, but actually having to talk with them through their cell, which is... it's a struggle to provide care and support to someone that way, like it's the most, I think, dehumanizing*

*way to provide support to someone through their cell." (SP09).*

Providers recounted experiencing a sense of powerlessness when access to their clients was restricted. These limitations impede care delivery to individuals incarcerated while pregnant and underscore the broader implications of power dynamics within the context of care provision.

### Acquiescing to power dynamics

Fear of losing access to their clients made providers vigilant when engaging with individuals they perceived as more powerful than themselves. In navigating precarious situations, they prioritized their clients' need for support, aware a misstep could result in loss of access or exclusion from the facility.

A court support worker expressed a fear of losing access to her client if she was not cautious during her interactions with correctional officers within the facility:

*"And one of the officers, this is with the client that had the miscarriage, I see that she's in a cell by herself. I don't know that that's the solitary confinement. And his response is, 'Well, she's fucked and needs to be alone, and we don't understand her 'cause she's a moron.' I'm like... I need to be able to see my client. This is the first time I'm allowed in here and I have my interpreters. I'm not gonna say anything because I know, and I've watched other workers say things and then not be allowed in 'Oh we're too busy', 'Oh, there's a lockdown', 'Oh, there was a riot', 'Oh, your client is in solitary confinement cause they like did something' and it just like, just the level of... like added... stumbling blocks or barriers created by the people that are... like it's almost like they believe that they are better than the people who are incarcerated." (SP07).*

A program caseworker employed by the correctional institution discussed the power dynamics between the correctional officers and other employees, like herself, within the correctional facility. She expressed concern about the imbalance of power which disproportionately favoured the correctional officers:

*"I find there's a huge power imbalance to be honest, between not only like the correctional officers and the [incarcerated] women, but as I've mentioned, the correctional officers and other support staff within the institution, and like it's, it's their way or the highway most of the time." (SP09).*

Acquiescing to power dynamic is therefore a strategy used by providers to maintain access to their clients. This approach reflects the complexities providers face when prioritizing their clients' care while navigating hierarchical systems within the constraints of the correctional environment.

### Perceived outsider identity

Power structures within the correctional facilities cause providers to feel as though they are outsiders in the spaces where they are meant to deliver services. Participants described an exclusionary environment stemming from hierarchal dynamics between correctional staff and external providers, where correctional staff projected an air of authority. Providers described feeling marginalized by correctional employees, which further hindered their ability to fully integrate into the correctional environment and provide services as they saw appropriate. One participant noted:

*"[...] it seemed like when it... when it came to like inmates with physical health concerns or pregnancies, the jail kind of wanted to take care of that on their own terms and they... there's a lot of reluctance to even have our service in the jail because we're an outside service, right? They're not really kind of... prison staff aren't really often excited to have outsiders come in to work in the jail. And so, for us, you know our, our, our main role was to stay in our lane and to focus on mental health and to ask the questions that we were there to ask and provide consultation and you know, not get too involved in decision making." (SP06).*

Similarly, a midwife described feeling like an outsider while working with the healthcare team at the correctional facility:

*"[...] when you're walking into that institution, you are a visitor. You're a guest and that your access could easily be restricted because if you don't fall in line, you will not be, you know, granted the same level of access. And that's very clear. So, you know, if I walk in there and I am not mindful of, like, my demeanour and my attitude the way I interact with the healthcare team, like, of course, like as a professional, you always have to conduct yourself in a professional manner. But I was always aware that you know, this is not a place you can easily challenge people's assumptions and norms. This is not a place where you know... this is a place where I could potentially walk in and never have, never be granted the opportunity to come back again." (SP22).*

This perceived outsider identity affected providers' professional autonomy and impeded their ability to effectively advocate for clients.

The *feeling of powerlessness* experienced by providers was demonstrated through the quotes within this theme. The *feeling of powerlessness* was also reflected in examples provided through the themes of operating within fragmented systems, knowing too little and witnessing dehumanization. All the themes described thus far negatively impact providers. The accumulation of the previously described factors contributes to providers enduring occupational stress, affecting providers' health and their ability to support their clients.

### Theme 5: enduring occupational stress

Providing social services and health care to clients can be physically and emotionally demanding. The pressures are further compounded when working in an oppressive environment. Participants shared their experience of enduring occupational stressors while working in correctional facilities or with clients requiring perinatal care during incarceration. Their accounts were categorized under the three following subthemes: confronting ethical paradoxes, burnout and staffing limitations.

#### Confronting ethical paradoxes

Working within correctional systems compels providers to continually question their positions on issues related justice, the treatment of others, and their roles as advocates. Providers working with individuals incarcerated during pregnancy must reflect on the wider implications of incarceration, including its impact on human rights and dignity. During the interviews, providers discussed encountering ethical dilemmas and experiencing moral distress, leading them to question which rights should be forfeited during incarceration and whether their work environment aligns with their professional values.

For example, an external nurse expressed experiencing moral distress when her client was seated in a large hospital waiting room, as opposed to a private area, alongside other patients while wearing a correctional uniform, shackles, and accompanied by guards:

*"I'm worried for them and their dignity and I get told that they lost, you know, they lost their rights when they got arrested. So that they don't, yeah, they don't have that right anymore, which I just... I... I struggle with that. Like dignity's a human right. So, I just, but like, what rights did they lose, right? Like so, just understanding, you know, I don't work in that realm where people have lost their rights." (SP04).*

One participant, a social worker, reflected on her struggle with the disconnect between working in the correctional system and adhering to her professional code of ethics:

*"I mean working in the jail system really is an ethical dilemma in and of itself, because you're in a different environment and that environment overrides my code of ethics. So that's tough. And there's moral burnout when you're dealing with that." (SP12).*

Several participants described correctional facilities as harsh and emotionally taxing work environments. The dissonance between professional codes of ethics and the realities of the correctional work environment can contribute to emotional exhaustion and burnout among providers.

### Burnout

Working in correctional facilities and delivering services to clients facing intersecting challenges can overwhelm providers and result in fatigue. During several interviews, participants reflected on their experiences of burnout, either in terms of experiencing the phenomenon themselves or observing it among their colleagues.

Some participants expressed concerns regarding the apprehension of newborns in the context of clients who were incarcerated and had given birth. The social worker questioned the necessity of these apprehensions and articulated how these concerns contributed to an emotional burden, one she accepted as part of her experience as a social service provider working within a correctional system:

*"[...] maybe in the future it would be nice if they could find a way to keep babies together with mom. Like, do they have to be apprehended? [long pause] I don't know these are questions I... I'd asked quite a lot, but again, it's one of those things that goes with the burnout, right, because it's like you're looking at a system that's way bigger than yourself and it often falls on deaf ears when you ask questions." (SP12).*

Another participant stated the correctional facility environment was a critical factor contributing to both the departure of well-trained employees and the burnout of those who remained in their roles:

*"I think also part of the problem is that the best-trained people in the prison system don't really want to stay there for very long because it's a difficult environment to work in, and so people work there for short period of time, especially social workers or nurses, and then they move on to a better paid job. And you know, the people who do end up staying end up burning out or have kind of power and control issues themselves, and or might have kind of negative attitudes towards the people that they're supposed to serve in the jail. And so that also impacts the kind of care and treatment people get in custody." (SP06).*

Providers experiencing or observing burnout in their colleagues may choose to take short-term or long-term leaves of absence from their job or even leave their positions altogether. Employers may struggle to find suitable replacements willing to work within the correctional system, furthering human resource challenges.

### Staffing limitations

Limited human resources, particularly as it pertains to correctional officers, was a recurring topic throughout the interviews. According to participants, staffing limitations affected every setting in which services were provided, whether it was correctional facilities, hospitals, or communities.

A physician described her experience requesting a patient be brought from the correctional facility to a

hospital for urgent medical care, and the resistance of correctional officers to comply due to staff shortages:

*"And I've often had pushback like, 'Are you sure? Can we wait a little longer? Do we really need to take that patient to the emerg [emergency department] tonight? Can we wait 'till tomorrow because we're short-staffed?' Like all those kinds of things which you know, I think is really problematic." (SP01).*

The requirement for correctional officers to accompany the pregnant patient to the hospital during labour and birth reduces the number of officers available at the correctional facility. A nurse who worked in a hospital explained how these shortages impacted the patient's care in hospital. Due to the shortage of correctional officers, hospital staff faced pressure from correctional officers to discharge the patient earlier than deemed appropriate:

*"Another thing that's difficult is um... when a mum has to be returned back to the correctional facility instead of staying here [in the hospital] with her baby, and so they're separated prematurely, and that's usually because of lack of staffing, because it takes two guards, two guards to be in the hospital at all times and that takes the guards out of the correctional facility. And so, they don't, they often want the patient to be discharged as soon as possible, but that means that they lose out on the care, the time that they could spend with their baby, and I find that very difficult." (SP04).*

While discussing her exit from her position within the correctional facility, a social worker explained how staffing issues affected the provision of care for incarcerated individuals who were pregnant or had recently given birth:

*"I think everything comes down to staffing. Staffing in the community and staffing within the institutions. When I left, we [the correctional facility] were critically short on our nursing staff. And you know, the loudest squeaky wheel is gonna be what's getting that attention. And sometimes that's not gonna be this young mom, because something else is going on - when we're having multiple overdoses or we're having multiple other issues within the institution. And then the same thing with the staffing shortages with correctional officers. You know, we need the correctional officers we need... if that individual is remanded, we need three people for them to go to a doctor's appointment; two correctional officers and a driver." (SP15).*

A midwife who provided care within a correctional facility described being unable to see her client due to a shortage of correctional officers at the time of her visit:

*"The other thing that's really clear and apparent is that they're very short-staffed and there's a lot of turnover. So, you know, there'll be times while going to see someone they're like 'Sorry, we don't have anybody for you. We can't, an officer can't be here. We don't have anyone who's*

able to accompany you to go see the client' and it just feels unreasonable that that would be the case... But you know, it definitely has an impact on the care that incarcerated individuals receive." (SP22).

Participants' accounts identify the shortage of correctional officers as a barrier to clients' accessing care within correctional facilities, clinical facilities and within the community. These examples illustrate how human resource challenges impact the care experiences and treatment of individuals incarcerated during pregnancy.

## Discussion

We explored the experiences of healthcare and social service providers working with incarcerated pregnant individuals. The resulting themes are represented by three concentric circles, which illustrate providers' experiences as a layered accumulation of impact, compounded progressively from the outermost ring to the centre (Fig. 1). The outer ring is divided into three segments, representing the three peripheral themes – the main challenges providers encountered when attempting to provide perinatal care to their incarcerated clients: *operating within a fragmented system*, *knowing too little*, and *witnessing dehumanization*. These challenges contribute to providers' feelings of powerlessness, represented by the next circle. This feeling of powerlessness persists and is further compounded by the demands of working in a carceral environment, escalating to the central theme of *enduring occupational stress*. Some providers described factors which directly contributed to this stress – experiences of moral distress, burnout, and carceral staffing limitations. Others highlighted how operating within a fragmented system, witnessing dehumanization or knowing too little, created a sense of powerlessness, ultimately culminating into *enduring occupational stress*. Finally, at the heart of the thematic circle lies the provider, illustrating their experience of the cumulative strain and burden in delivering care within a carceral setting.

Our findings suggest providers experience challenges fulfilling their care roles when navigating the fragmented *carceral perinatal care system* which includes *carceral*, *clinical* and *community* subsystems. These challenges impact providers' ability to deliver personalized care to clients. These findings underscore the need for systemic interventions to address factors affecting providers' capacity to deliver care to incarcerated pregnant individuals.

### Providers' experiences

Several cross-cutting threads became evident in the findings, each influencing providers' experiences delivering services to incarcerated pregnant individuals. These threads were salient throughout the themes, underscoring their importance and warranting focused discussion.

They highlight underlying structural and systemic factors affecting service provision within the *carceral perinatal care system*. The following discussion is structured to examine four cross-cutting issues related to providers' experiences: occupational stress, systemic structure, institutional culture, and limited knowledge.

### Occupational stress

Providers interviewed for this study frequently described challenges encountered while delivering healthcare or social services to incarcerated pregnant individuals. The repetition and intensity of these challenges led to expressions of powerlessness regarding their ability to fulfill professional duties.

Findings from study underscore the significant challenges experienced by health and social service providers when supporting incarcerated pregnant individuals. Participants consistently discussed the emotional and cognitive burden associated with navigating the carceral system, maintaining professionalism and advocating for their clients. This burden frequently entailed compromising personal values, questioning carceral practices, and confronting misalignments between their professional codes of ethics and the practices of carceral institutions. Managing moral distress, ethical dilemmas, and demanding workloads further intensified their occupational stress. Existing research on the mental health of correctional officers has recorded similar findings [26–31]. One study briefly discussed nurses' emotional discomfort when witnessing the separation of incarcerated individuals from their newborns [32] while another study underscored the emotional toll experienced by birth supporters of incarcerated individuals [33]. However, we were unable to locate studies focused on addressing emotional experiences of physicians, social service providers, midwives, or doulas when working with incarcerated pregnant individuals. Therefore, this study contributes to the existing literature by demonstrating how providers from a range of disciplines endure negative emotional and psychological effects when delivering services to incarcerated pregnant clients.

### Systemic structure

Providers identified challenges they experienced when delivering services within the *carceral perinatal care system*. The lack of coordination between the subsystems impedes access to care for individuals incarcerated during pregnancy and exacerbates barriers to continuity of care when clients transition between systems. Participants identified difficulties attempting to provide seamless care, a finding which aligns with previous research examining the experiences of physicians who have worked with incarcerated individuals [11, 12]. Douglas et al. [11] reported surgical trainees encountering

challenges in prescribing all necessary medications for incarcerated patients. Similarly, Jennings et al. [12] described patients encountering barriers in accessing prescribed medications when transitioning between carceral facilities and the community. Jennings et al. [12] also described disruptions in the provider-client relationship during transitions between carceral facilities and the community, identifying these disruptions as hindering continuity of care. Providers working within Ontario's fragmented system expressed concerns about their clients' wellbeing as they navigated these subsystems. Across all work settings — whether carceral, hospital, or community-based — providers expressed concern about the availability and continuity of care after their clients' discharge. This study adds the perspectives of social workers, nurses, midwives and doulas to existing literature about the challenges experienced by providers who care for individuals who are incarcerated while pregnant. Further research is needed to understand the implications of fragmented systems on both incarcerated pregnant individuals and the providers who work with them. Approaches to inter-institutional collaboration should also be explored to enhance the delivery of care for incarcerated pregnant individuals.

#### ***Institutional culture***

Carceral institutions differ significantly from other working environments because of the populations they serve. Participants in this study consistently described the culture of the carceral facilities as one which prioritizes safety and security over clients' well-being. This emphasis on security often leads to power imbalances affecting providers' ability to fully engage with their clients. Providers explained how employees of carceral facilities, particularly correctional officers, held far-reaching power which significantly influences incarcerated pregnant individuals' access to care. Providers reported feeling powerless within the hierarchical structure of the carceral system, where the power imbalances favour correctional officers. Concerned about being denied access to their clients, providers were vigilant during interactions with correctional officers, as any misstep could result in restricted or prohibited entry to the facility. To maintain access to their clients, providers often acquiesced to these power dynamics. These dynamics demonstrate the challenges providers encounter when attempting to deliver client-focused care within the rigid, security-focused culture of carceral institutions. Prior studies have examined power dynamics between care providers and correctional officers. Jenkins et al. [13, 14] examined the lived experiences of nurses and law enforcement officers in hospital settings, highlighting challenges stemming from power dynamics and conflicting priorities in the care of incarcerated individuals. These findings align with those of

our study. However, our research brings forth insights into provider-correctional officer dynamics and the strategies providers employ to maintain access to their pregnant clients in carceral settings. Future research should investigate the implications of provider-officer power dynamics on care delivery and identify strategies to mitigate these challenges.

#### ***Limited knowledge***

In this study, participants were either self-employed, employed by institutions external to correctional facilities, or employed directly by carceral facilities. Employment arrangements varied within provider types, with individuals affiliated with hospitals, community-based organizations, or carceral institutions. Social workers consistently reported a lack of specialized training in providing care to both incarcerated and pregnant individuals. In contrast, physicians, midwives, nurses and the doula in our study cited training in pregnancy and childbirth, as well as their previous experiences with pregnant patients, as the foundation of their knowledge for providing care to incarcerated pregnant clients. A lack of knowledge regarding policies on the use of restraints, clients' rights, medical decision-making authority, and privacy was identified as a concern by most participants, regardless of their professional expertise. These findings align with previous studies, highlighting nurses' and physicians' limited knowledge of regulations and policies regarding the use of shackles when providing perinatal care to incarcerated clients, and knowledge deficits regarding who holds decision-making authority for incarcerated patients - prison employees or others [15–17]. Furthermore, privacy breaches have been reported in other research, such as hospital staff discussing medical information with correctional officers overseeing hospitalized male incarcerated patients [34] or the presence of correctional officers or law enforcement during appointments [11, 16]. Our findings suggest specialized training related to the care of incarcerated pregnant individuals should be offered to social service providers. Additionally, all providers should receive training related to the use of restraints, clients' rights, medical decision-making authority, and privacy, in the context of perinatal care for incarcerated individuals. Correctional policies and operations manuals used in carceral settings are recognized as relevant and important resources for identifying the standard of care in these facilities [35]. Per *Carr v. Canada* [36], the absence of detailed policies and procedures in a prison environment may constitute a breach of duty of care. Future research should investigate gaps in training, policies and procedures used by providers serving incarcerated pregnant individuals and examine how these elements, or lack thereof, influence care delivery and patient outcomes.

### Strengths and limitations

To the best of our knowledge, this is the first study to explore the experiences of providers across various disciplines working with incarcerated pregnant individuals in Ontario. This study contributes valuable insights by identifying gaps in the literature and emphasizing the importance of addressing occupational stress within the carceral context. A key strength of this research lies in its unique approach, which examines the perspectives of both providers who work within and outside of the carceral system. This dual perspective reflects the reality of the complex network of individuals involved in the provision of care, offering a comprehensive understanding of the various roles and challenges faced by those responsible for supporting incarcerated pregnant individuals. By gathering insights from both internal and external providers, this research offers a comprehensive view of the care delivery process, enhancing the overall findings and contributing valuable perspectives to the field.

The small number of healthcare providers including midwives ( $n=3$ ), physicians ( $n=3$ ), and nurses ( $n=2$ ) is a limitation of this study. Most of the participants ( $n=12$ ) held social work degrees. Therefore, the findings may disproportionately reflect the perspectives of social workers compared to other types of providers. Furthermore, those who agreed to participate in this study may have had a heightened interest in the study topic of health and well-being of individuals who are incarcerated while pregnant. For these reasons, and due to the qualitative study design, these findings cannot be generalized to all providers in Ontario who work with incarcerated pregnant individuals. Furthermore, the findings of this study are not generalizable to other carceral contexts or settings, as legal, health, and social systems outside Ontario may differ in their structure and processes.

This study focused on the experiences of providers and did not include the perspectives of incarcerated pregnant individuals or correctional officers, which represents a limitation. Incorporating the perspectives of these groups would provide a more comprehensive understanding of the barriers to care and service delivery for incarcerated individuals. Therefore, future research should explore the experiences of incarcerated pregnant individuals and correctional officers.

### Conclusion

Our research explored social service and healthcare professionals' experiences of care provision to clients who were pregnant and incarcerated in Ontario, Canada. Consistent with a systems thinking approach, the findings highlight how dynamic interactions across institutions and services shaped providers' experiences delivering care to incarcerated pregnant individuals. Findings suggest providers working with individuals who

are incarcerated and pregnant experience emotional and psychological distress stemming from numerous challenges. Notably, the carceral system prioritizes safety and security, while the clinical and community systems prioritize client-centred health and advocacy. This divergence at the intersection of these subsystems creates barriers to care delivery, hindering access for incarcerated pregnant individuals. This study highlights how power dynamics between social service providers, healthcare professionals, and correctional officers across systems create barriers to the care delivery and service accessibility for individuals incarcerated while pregnant.

The mental health consequences of working in the carceral context requires targeted interventions. Efforts must be made to address providers' knowledge gaps concerning carceral operations, their own rights and those of their clients. Additionally, providers must have access to mental health resources and supports, equipping them with the tools required to manage the stressors of their demanding roles and work environment. Prioritizing providers' mental health could reduce provider burnout and employee turnover, facilitating continuity of care, while cultivating sustainable therapeutic relationships with clients. These measures would support providers' well-being and improve access to care for individuals who are incarcerated while pregnant.

### Abbreviations

CAD	Canadian
C-section	Caesarean section

### Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12884-025-07696-9>.

Supplementary Material 1

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### Author contributions

XB, WP conceived the study. XB, WP, AM, and LM contributed to participant recruitment. XB conducted and transcribed interviews. XB and WP coded and analyzed data. XB, WP and AFP interpreted data. AM and LM validated data interpretation. XB wrote the first draft of the manuscript. XB, WP, AFP, AM and LM revised manuscript. All authors have read and approved the content of the manuscript.

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### Data availability

The datasets generated and/or analyzed during the current study are not publicly available due to the sensitive nature of the data from providers and

information about individuals who were incarcerated while pregnant but are available from the corresponding author on reasonable request.

## Declarations

### Ethics approval and consent to participate

The study was approved by the University of Ottawa Research Ethics Board (REB) under Ethics File Number: H-01-23-8376. Participants received an electronic copy of the consent form when the interview was scheduled. Virtual interviews were conducted. Informed verbal consent was obtained from all participants before the onset of each interview. This study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki.

### Consent for publication

Not applicable.

### Competing interests

The authors declare no competing interests.

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