Insights in Practice

international lactation consultant association®

Journal of Human Lactation
2017, Vol. 33(4) 672–676

DOI: 10.1177/0890334417726057
journals.sagepub.com/home/jhl
SAGE

Breastfeeding Support for Criminalized Women in Canada

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Keywords
breastfeeding barriers, breastfeeding experience, breastfeeding support, maternal health, mother–infant dyad

Background

Women are the fastest growing population in Canadian prisons and most women in prison are mothers (Pate, 2017). There is increasing critical press attention to pregnancy while imprisoned (Dimmick & Armstrong, 2013; Foote, 2017) and scholarship on the benefits of prison nurseries (Abbott, 2016; Fritz & Whiteacre, 2016; Goshin, Byrne, & Hennigar, 2014). Several federal prisons in Canada have active Mother-Child Programs through which children up to age 7 years may live with their mothers in custody (Correctional Service Canada, 2016). Yet, there is almost no research and little practical scholarship on breastfeeding support for criminalized women. This article provides insight into practice for breastfeeding support for criminalized women based on experiences from a service program in Nova Scotia (NS), Canada, and offers strategies for practitioners to better meet the needs of the criminalized breastfeeding population.

Women's Wellness Within

Following the much-publicized birth of Gionni Garlow at the Ottawa Carleton Detention Centre to first-time mother Julie Bilotta in 2012, several doulas, nurses, midwives, and social workers in Halifax, NS, created Women's Wellness Within (WWW), an organization serving criminalized women as a platform for advocacy and direct service to criminalized women in NS, Canada. The first task of this group was to extend the services of an existing volunteer doula program for single, newcomer, low-income, and teen mothers to include women incarcerated at the provincial jail.

As of 2017, WWW services include (a) one-on-one doula support at the provincial jail and the federal prison; (b) parenting counseling; (c) referrals to external providers including public health, community clinics, and midwifery care; (d) infant-feeding information and support; and (e) support for women recently released to the community. Although volunteer doula programs for incarcerated women exist in several American states (Schlafer, Hellerstedt, Secor-Turner, Gerrity, & Baker, 2014), our community-based program is unique in Canada.

Ms. Bilotta's experience exemplifies the need for specific breastfeeding support for criminalized women. On September 29, 2012, Ms. Bilotta, 8 months pregnant and on remand at the Ottawa Carleton Detention Centre, began labor. She was sent to solitary confinement for crying out in pain, pleading for help for an entire day. She received nursing attention only when her son's legs were visible through her vulva. He was in critical condition following his footling breech birth in the cell. Despite emergency surgery following delivery, Ms. Bilotta was sent back to the remand center 3 days after surgery, with no visitation with her son for 3 weeks. Ms. Bilotta did not trust correctional staff to transport her milk to her son in hospital. She describes being shamed by a guard and a nurse for not making the effort to breastfeed (J. Bilotta, personal communication, February 12, 2017). The infant Gionni experienced persistent respiratory problems and died in his bed when he was 13 months old. The civil suit related to his death and Ms. Bilotta's treatment by the detention center is ongoing (*Bilotta v. Her Majesty the Queen in Right of Ontario et al*., 2014). Since its founding, WWW has supported criminalized women to receive prompt breastfeeding instruction, to stay with their infants during neonatal intensive care unit hospitalizations, to have access to pumping and milk storage equipment, and to manage lactation after infant death.

Criminalized Women

Criminalized women are disproportionately subject to histories of physical, sexual, and emotional abuse (Pate, 2017). Breastfeeding can be triggering and retraumatizing for victims of sexual abuse (Elfgen, Hagenbuch, Gorres, Block, & Leeners, 2017). These triggers are amplified in the context of confinement, shackling, isolation, and surveillance. The

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Date submitted: February 17, 2017; Date accepted: July 21, 2017.

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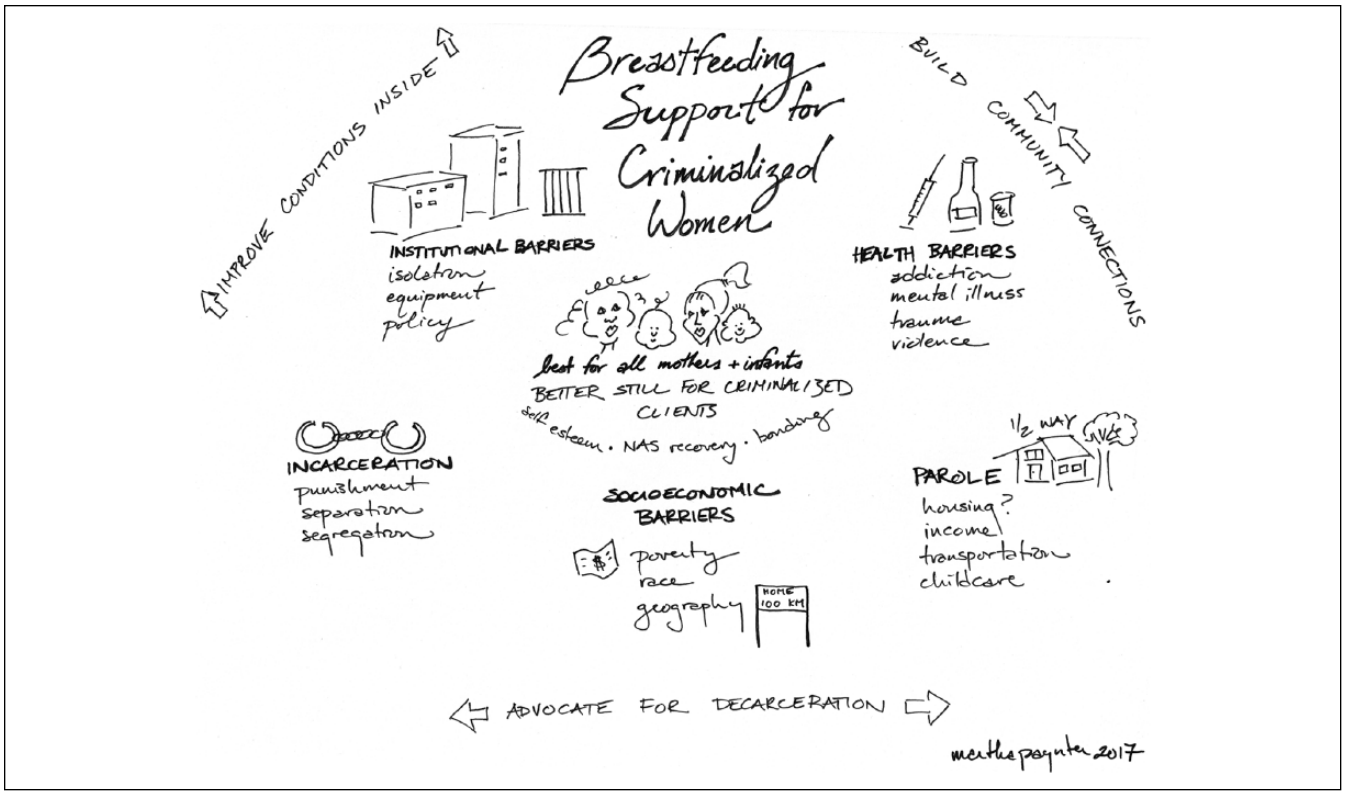

Office of the Correctional Investigator (OIC, 2013) reported that use of force against and segregation of female inmates are increasing.

Minority and Indigenous populations have lower breastfeeding rates than White women (Jones, Power, Queenan, & Schulkin, 2015; Moffitt & Dickinson, 2017). There is a disproportionate population of African-Nova Scotian and Indigenous women in corrections in NS (Luck, 2016). Thirty-sex percent of women in federal prison are Indigenous (OIC, 2016). Given the disproportionate incarceration of Indigenous and African-Nova Scotian women, breastfeeding support for these populations must also be culturally relevant.

Although pregnant inmates may express the intention to breastfeed and a belief that it will enhance their self-worth (Huang, Atlas, & Parvez, 2012), criminalized women face extensive socioeconomic barriers to breastfeeding. They are likely to mother alone and lack family support (Pate, 2017). In a large U.S. study, Dumont et al. (2014) found that mothers who reported that they or their spouse had been incarcerated in the year prior to delivering had lower incomes and lower education and were less likely to be married, to have planned the pregnancy, to have received prenatal care in the first trimester, and to have any history of breastfeeding.

More than half of women in Canadian federal prison report a mental health need (OIC, 2016). Past mental illness is a significant factor in the development of peripartum depression (O'Hara & Wisner, 2014). Figueiredo, Canário, and Field (2014) found that prenatal depression may negatively impact breastfeeding and that breastfeeding may reduce symptoms of depression.

Correctional Contexts

In NS, there is one provincial jail and one federal prison for women. Sixty-eight percent of inmates in NS are on remand—they are incarcerated while presumed innocent and awaiting trial (Woodbury, 2017). This is the highest rate of remand in Canada. The federal prison in NS holds women from across Atlantic Canada and, due to distance, visitors can be infrequent. The prison has about 90 beds. Applicants to the Mother-Child Program must qualify for the minimum-security unit. All prison staff are employees of the Correctional Service of Canada. In the provincial jail, which has about 45 beds, the provincial health authority provides healthcare services, whereas correctional services are under the jurisdiction of the Department of Justice. From our experience, offering perinatal support to women inside requires navigation of these departments.

Criminalized women are highly transient. Remand periods vary. Jail sentences are for no longer than 2 years less a day; federal prison sentences are for 2 years or more, although some may qualify for parole after serving one-third of their sentence. Reaching these clients, developing trusting relationships, and

remaining connected is a great challenge for all supportive programming, including breastfeeding support.

Prenatal Education and Care

Incarcerated women in NS have no access to prenatal education, including information on breastfeeding. In 2014, NS Public Health replaced universal prenatal classes with an online program called Welcome to Parenting. Incarcerated women in both provincial jail and federal prison in NS are denied Internet use.

Communication and Staff Turnover

Turnover and bureaucracy in corrections staff challenge provision of client support. There are no provisions in the Nova Scotia Correctional Services Act (Province of Nova Scotia, 2005) specific to pregnancy or breastfeeding. The bulk of WWW volunteer time is devoted to advocacy and to efforts to communicate with staff.

To improve continuity of perinatal care and breastfeeding support, in 2015, Women's Wellness Within advocated for midwives to have clearance to care for clients at the provincial jail. There are conflicting responses as to whether women currently have access to midwifery services while incarcerated. As a result, women inside do not have access to the same breastfeeding care as women outside.

Neonatal Abstinence Syndrome and Human Milk

Criminalized women face high rates of addiction (Farrell-MacDonald, MacSwain, Cheverie, Tiesmaki, & Fischer, 2014), and their infants are likely to experience neonatal abstinence syndrome (NAS). In response to evidence of effectiveness, the tertiary maternity care center in Halifax, NS, recently instituted provisions such that, whenever possible, infants with NAS room-in with their mother (Bagley, Wachman, Holland, & Brogly, 2014). Prior to this change, most infants were treated in the neonatal intensive care unit and incarcerated women stayed in hospital only at the discretion of correctional staff. The hospital adopted a rooming-in policy in which mothers are considered the "therapy" required for infant recovery: To heal, infants must be with their mothers 24 hours a day, 7 days a week. This policy change has enormous potential to support breastfeeding success, bonding, and maternal well-being for incarcerated women.

Breastfeeding reduces NAS severity, the need for and length of pharmacological intervention, and hospital length of stay and delays NAS onset (Bagley et al., 2014). Trace amounts of methadone in human milk may mediate NAS. Skin-to-skin contact while breastfeeding and the dietetic quality of human milk may also relieve NAS symptoms (Welle-Strand et al., 2013).

Pumping

Criminalized women may recognize that it is ideal to put the child to the breast to fully benefit from breastfeeding, especially for the infant with NAS, but are uncomfortable with the physical act. This is not uncommon among clients who have experienced sexual trauma. The provincial jail does not support women interested in pumping. The federal prison will rent hospital-grade pumps; however, women require instruction on operation, cleaning, and safe milk handling and storage. One of our program clients said that her pump went missing from her cell. When it was found, the client felt that she had lost her supply, and she stopped pumping. When paroled, she spent over $100 per month for hypoallergenic formula. The health and economic consequences of formula feeding for criminalized women are severe.

Parole

Despite growing use of the Mother-Child Program, there is only one halfway house in NS that will accept a mother with one child, once she is paroled. Many parolees are required to spend several months in a halfway house before applying for full parole. If that single bed for a mother is already taken, if the mother has more than one child with her in the Mother-Child Program, or if there is a person already at the halfway house in question who is incompatible with the newly paroled mother or with children, she cannot bring her child with her. Due to the lack of housing for parolees, an infant may be successfully and exclusively breastfed in prison and then suddenly lose access to her or his mother, once she is paroled. WWW had a client in this situation with a 2-month-old, exclusively breastfed infant. The infant was sent to live with the woman's spouse in another area of the province. The mother was connected to our program, WWW, in hopes that we could locate a free electric breast pump for her to use. It is not Correctional Service of Canada's responsibility to provide parolees with breast pumps. Parolees have almost no income; renting a pump on their own is prohibitively expensive and the economic consequences of formula feeding are particularly severe in these circumstances.

Women face threats to sustaining breastfeeding and to maintaining custody when they are paroled or released. One woman who had breastfed her infant in prison struggled to make necessary arrangements for life on parole. She was from another province, had no Internet access, and had limited access to a phone. She was required to attend weekly programs on the outside, and the infant was not allowed to be present—she had to find childcare. NS Community Services apprehended the infant. WWW members assisted with finding her primary care services, babysitting, legal support, parenting counseling, navigation of social services, and in kind supports and she regained custody.

Recommendations

Based on our work supporting criminalized women to breastfeed, we offer these recommendations:

1. Create opportunities and materials to educate lawyers, police, parole officers, corrections staff, and most important, criminalized women about breastfeeding.
2. Advocate for incarcerated women to have access to the same breastfeeding support people and resources as exist on the outside. Inside, mothers may also need personal mini fridges and hospital-grade pumps. Be conscious of the disproportionate criminalization and incarceration of Indigenous and racialized women and inquire as to culturally appropriate supports for breastfeeding.
3. Seek consent when you offer support. Be conscious of the likelihood of trauma and violence in their lives and how exposure and touching of breasts can be retraumatizing.
4. Plan for the possibility of separation of mother from infant. Teach hand expression and use of a pump.
5. As with all nursing care, begin with discharge in mind. Life outside can be more difficult for clients due to poverty and lack of services and housing options. Beyond the mechanics of breastfeeding, clients need help navigating social and clinical supports.
6. Work in a team. Share strategies and information about policy changes and new developments. Be careful not to burn out.
7. Congratulate the women who make breastfeeding work despite the odds.

Limitations

This discussion is based on the observations of community volunteers working with a small group of criminalized women in the perinatal period. This article does not stem from an experimental study.

Conclusion

Breastfeeding, child bearing, and parenting can be transformative to a person's self-worth. Providing human milk to their infants can be an opportunity for criminalized women to redirect lives dominated by childhood trauma, victimization, and addiction. It can be an experience that rehabilitates (Huang et al., 2012).

To support breastfeeding among criminalized women, it is critical to understand the context they experience inside and outside of correctional facilities, the limits to their access to resources and information, the likelihood of systematic infant–mother separation, and the community resources that can be pieced together to offer comprehensive breastfeeding support. The critical work of one-on-one support must be buttressed with advocacy not only to improve the conditions of confinement but to create alternatives to incarceration that better support the mother–infant dyad and the breastfeeding relationship.

Acknowledgments

The author would like to express gratitude to people working to advance the health of criminalized women and their children.

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