Testimony of State Senator Lena C. Taylor
Senate Committee on Judiciary and Public Safety
October 19, 2017
Senate Bill 393

Good afternoon Chairman Wanggaard and fellow committee members. Thank you for the opportunity to speak with you today regarding SB 393.

I want to begin by thanking Jenissee Volpintesta for bringing this bill to our attention and her work on it. A few months ago, Jenissee shared the vision that women in labor should have the dignity and security to give birth without being shackled. Her work lead us to a similar bill that Minnesota passed unanimously in 2015 with the support of law enforcement and the Minnesota Department of Corrections.

I would also like to thank Milwaukee County Supervisor Sequanna Taylor for following our lead and introducing a shackling resolution at the county level. Her work, and the work of Milwaukee County Acting Sheriff Richard Schmidt, represented a needed partnership that helped reform Milwaukee County's shackling guidelines to conform to what we hope to do today with SB 393.

According to a story written in 2015 in the Guardian, the number of women who cycle through US jails is increasing by approximately 1.6% each year, to 109,100 in 2014, while the number of women in prisons has risen nearly tenfold in the past 40 years, to 111,300 in 2013. There is no current data on how many of these women are pregnant. However over the years, the Bureau of Justice Statistics has found that on average 3% of women in federal prisons and 4% of those in state prisons were pregnant upon arrival.

It's an alarming trend that has required that states rethink how we address the needs of pregnant women while incarcerated and protect the lives of the innocent children they carrying. States have begun to better understand the restrictions and confinement inherent in prisons and how they can make pregnancy and birthing traumatic. One such confinement technique has been under scrutiny for over 20 years. The practice of shackling pregnant inmates, whether through the use of ankle irons, handcuffs, or belly chains, during both the pregnancy and delivery process, has been under review. In fact by 2010, at least 10 states had passed anti-shackling legislation and today that number tops 26 legislative bodies that have looked at this issue and made the decision to do something.

Currently, in Wisconsin, there is no statutory guidance on how correctional facilities restrain pregnant women. This is out of step with correctional practices nationwide. Federal agencies such as the U.S. Marshal Service, Federal Bureau of Prisons, and Immigration and Customs Enforcement all have policies that restrict shackling pregnant individuals. In fact, a recent lawsuit alleges that at least 40 women in Wisconsin have been shackled while giving birth since 2011.

In one case, a woman was shackled and handcuffed during 21 hours of labor. In another instance, corrections officers overruled medical staffs' request to remove a patient's belly-chain—a device which ties a person's wrists to their waist and attaches iron shackles to their legs. As a result, hospital staff had

difficultly administering an epidural and providing necessary medical care. This lawsuit is just one of three shackling-related lawsuits Milwaukee County jails have faced in recent years.

This bill would restrict shackling of pregnant and postpartum women.

In addition, it would allow incarcerated women who are pregnant or have recently given birth, access to certain health and emotional services through something known as doula support. A doula is a trained professional who provides continuous physical, emotional and informational support, but not medical care, to a mother before, during, and shortly after childbirth. Choices in Childbirth, a maternal health advocacy organization, notes that doula services can reduce the need for caesarean births by 28 percent. Given that the additional cost to Medicaid for each caesarean birth is $4,459—generally 50 percent more expensive than vaginal births—the support from doula services, along with the mitigated harm from shackling, can provide significant cost savings.

Shackling women who are giving birth is cruel, dangerous, and rarely necessary. Through this bill, we have an ability to create better health outcomes for both the mother and child, while saving taxpayer dollars through reduced health care expenditures and reduced litigation costs. I encourage your support for SB 393 and thank you for your consideration of this bill.

Senator Lena C. Taylor
4th Senate District

Scott Walker
Governor

Jon E. Litscher
Secretary

State of Wisconsin
Department of Corrections

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January 11, 2017

Erica Gerrity, LICSW
Minnesota Prison Doula Project
330 Hubert H. Humphrey Center
301-19th Ave South
Minneapolis, MN 55455

Dear Ms. Gerrity,

As Deputy Warden at the Taycheedah Correctional Institution in Wisconsin, I would like to express our agency's full support for our collaboration with the Minnesota Prison Doula Project. As an agency, we are committed to implementing this model with pregnant women incarcerated at our facility and look forward to collaborating with you and your team.

Although pregnant women make up only a small part of our offender population, we recognize that they have unique health care needs that must be addressed during their incarcerations. Through group-based education and one-on-one support, the Minnesota Prison Doula Project provides evidence-based, gender-specific care for incarcerated pregnant women. We strongly believe that this is a program that pregnant women incarcerated in our facility would benefit from and look forward to implementing this model at Taycheedah.

Our agency commits to providing staff time to make referrals to your program, and space within the facility to conduct prenatal education groups and one-on-one meetings with clients. We look forward to collaborating with you and your colleagues.

Sincerely,

Jennifer McDermott
Deputy Warden

JMD:cs

Cc: File

Continuous labor support by a doula is "one of the most effective tools to improve labor and delivery outcomes."
American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine[4]

WHAT DOULAS DO

Doulas provide emotional, informational & physical support before, during & after birth for childbearing women and their partners

Doulas and family members work together as a support team.

Family members have long-term, close relationships with the mother-to-be.

Doulas are trained and experienced at providing labor and birth support.

INFORMATION

Prenatal & postpartum resources & referrals

Answering questions about labor and birth

EMOTIONAL SUPPORT

Relaxation techniques

Encouragement

Calm environment

COMMUNICATION

Foster positive communication with doctors, midwives & nurses

Support informed decision making

Help women advocate for themselves

HANDS ON SUPPORT

Walking & position changes

Massage

Hydrotherapy

Breastfeeding support

UNMET NEED[5]

Just **6%** of women had labor support from a doula in 2011-12

Of those who did not use a doula, more vulnerable women were more likely to have wanted doula support

Private Insurance 21%

Percent of women who wanted - but did not have - doula support

Latina 30%

White 22%

SPENDING

In 2013, hospitals billed

$126 billion[6]

for maternal & newborn care

is spent on childbirth care than any other type of hospital care[7]

Reducing spending on childbirth care by even a small percentage would have a big effect!

Maternal & newborn stays account for[8]

49% of Medicaid hospitalizations

34% of privately insured hospitalizations

1 in 3 births

is by cesarean[9]

56% more than in 1996

but this hasn't made moms or babies healthier![4]

Doulas lower spending by

Decreasing

- cesareans (an average of 28%)
- repeat cesareans
- epidurals
- complications
- chronic conditions

Increasing

- breastfeeding

Cesarean births cost

50% more

than vaginal births[10]

$9,537 more for private insurance

$4,459 more for Medicaid

(includes maternal and newborn care costs)

Decreasing cesareans

28% would save

$1.74 billion for private insurance

$659 million for Medicaid

each year

Lisa Subeck

STATE REPRESENTATIVE

To: Senate Committee on Judiciary and Public Safety
From: Representative Lisa Subeck
Date: October 19, 2017
Subject: Testimony in support of Senate Bill 393, relating to the treatment of a pregnant or postpartum person in prison and county jail.

Chairman Wanggaard and members of the Senate Committee on Judiciary and Public Safety:

Thank you for the opportunity to testify on Senate Bill 393, which would restrict shackling of pregnant women and provide needed resources for new moms who are incarcerated.

In Wisconsin, there is currently no statutory guidance on how prisons and jails can restrain pregnant women while federal facilities and 18 states have policies that prohibit or restrict shackling pregnant women. This undefined area in state law has led to some outrageous instances of pregnant women being shackled during childbirth.

Recently, there was a lawsuit in Wisconsin regarding 40 women that were allegedly shackled while giving birth. One woman claimed she was shackled and handcuffed during labor that lasted 21 hours. Another woman was giving birth while her wrists were handcuffed to her waist and connected to her legs. When medical staff asked the handcuffs and shackles be removed, the correctional officers present declined to do so, and the woman had to receive an epidural and give birth to her child all while completely handcuffed and shackled.

While these instances have been well documented and reported on due to the lawsuit, there are certainly many more instances not so well documented. Therefore, we do not know the full extent of imprisoned women being shackled while giving birth. Whatever the number of imprisoned women shackled during labor, we must put an end to this inhumane practice. No woman should be unnecessarily restrained during labor and childbirth, and no baby should be born to a mother in shackles.

SB 393 would create the much needed statutory guidance on when corrections officers may shackle pregnant women and limit the practice to only when absolutely necessary to preserve safety. The bill would also give incarcerated women access to much needed maternal support services including the ability to pump breast milk for their babies, helping get their children off to a healthy start. Finally, the bill would expand voluntary STI testing in correctional facilities, which will increase early detection and decrease the risk of transmission to a pregnant woman's child.

Thank you again for your time and your consideration of Senate Bill 393. I would be happy to answer any questions.

78TH ASSEMBLY DISTRICT

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My name is Laura Jacques and I am an assistant professor of obstetrics and gynecology at the University of Wisconsin, Madison. I have worked previously in the same capacity at the Medical College of Wisconsin, in Milwaukee.

I am testifying in support of senate bill 393, which relates to the treatment of pregnant and postpartum women in prison and county jail.

I am here today as it is my fervent belief that all women deserve appropriate, timely and respectful care during pregnancy and that these principals should not be forgone due to incarceration of the patient.

In my work at Froedtert hospital in Milwaukee, I had an interaction with the justice system that motivates my testimony today. A 16-year-old patient was brought in from the jail for a labor evaluation. In order to complete the examination, I needed to perform a pelvic exam. I entered the room and found the young woman shackled by one arm and one leg to the hospital gurney. Seeing that this young woman would be physically restrained during this sensitive exam left me profoundly uncomfortable. We are taught, and I now teach, students to perform pelvic exams in a way that is non-threatening, that gives the woman agency and respect. There is good reason for this practice. In its summary of studies reporting on over 4000 women, the

American College of Physicians reported that approximately 35 percent of patients may experience pain, discomfort, fear, embarrassment, or anxiety during a pelvic exam.[1]

I could not think of a way to complete a pelvic examination in accordance to these principals on a woman who is bound to the bed. I expressed my ethical reservations to the guards who accompanied her and was directed to contact their supervisor at the jail. I spoke with this person, and he informed me that as the patient was in jail for truancy, and was unlikely to be dangerous, that the guards could unshackle her during the examination. In order to do this, however, the hospital had to provide a security guard who would remain outside of the room during the exam as additional security in the event that she try to escape.

These requirements were met, the patient had her pelvic exam and was found to not be in labor. Had there not been enough hospital security available to accommodate this request, in order to care for my patient, I would have been forced to go against my training and teaching, treat a woman in a manner that I consider inhumane and due to the physical difficulty of performing a pelvic exam with one leg shackled, perform a suboptimal examination-which may have led to an inaccurate diagnosis. Disputing the need for restraint during the exam also took away my time from treating other patients and was a delay in delivery of care for this patient. It is for this reason, that I believe clear regulations need to be in place to prevent this event from happening in the future.

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[1] Qaseem A, Humphrey LL, Harris R, Starkey M, Denberg TD, Clinical Guidelines Committee of the American College of Physicians Ann Intern Med. 2014;161(1):67.

I am in support of bill 393, as it reinforces the American College of Obstetricians and Gynecologists in their position that "The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary".[2]

[2] Health care for pregnant and postpartum incarcerated women and adolescent females. Committee Opinion No. 511. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:1198–1202.

ACOG
THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS
WISCONSIN SECTION

Testimony in Support of Senate Bill 393
Public Hearing – Senate Committee on Judiciary and Public Safety
Provided by Dr. Kathy Hartke, MD
October 19, 2017

Thank you Chairman Wanggaard and members of the committee for holding a public hearing on Senate Bill 393. I am here today to testify in support of Senate Bill 393, and I want to thank Senator Lena Taylor for her work on this very important issue.

My name is Dr. Kathy Hartke and I live in Brookfield, Wisconsin. I am the Immediate Past Chair and the current Legislative Co-Chair of the WI Section of The American College of Obstetricians and Gynecologists (ACOG). I also currently serve as a Clinical Assistant Professor of Obstetrics and Gynecology at the Medical College of Wisconsin and most recently was on staff at Froedert Memorial Lutheran Hospital after 27 years in private practice in Waukesha County. I also served in the United States Air Force.

ACOG supports legislation to restrict shackling of and to ensure appropriate medical care is available to incarcerated women and adolescents during pregnancy and the postpartum period. In my 34 years of practice I have cared for a number of nonviolent pregnant women, brought to my office, a courtroom, or the hospital in shackles. Some have not been allowed prenatal care for long periods while in jail.

A pregnant woman and her fetus should have access to regular prenatal care. Medication Assisted Treatment (MAT) and behavioral therapy is the standard of care and must be offered if she suffers from the chronic medical disease of Substance Use Disorder (SUD). In addition to the above, the standard of care also includes screening and treatment for sexually transmitted infections (STIs) including HIV. She and her fetus need appropriate maternal nutrition and treatment for medical complications of pregnancy to achieve the best outcome for both.

Many mothers suffer from postpartum depression. Women who are incarcerated have a much higher rate of substance use disorder, mental health problems, trauma and postpartum depression. Screening must be allowed and treatment must be covered for best outcomes for the maternal-infant dyad.

Shackling is demeaning, rarely necessary and should not be routine in pregnancy, labor assessment, delivery, or postpartum. Pregnant women are more likely to experience balance problems and are at greater risk of falls. Shackling of pregnant women should not be the norm, rather only used in exceptional circumstances after the provider has considered the health effects of restraints.

Shackling in labor is dangerous to the mother and fetus. It prevents position changes and delays emergency cesarean delivery in cases of maternal hemorrhage, fetal bradycardia, umbilical cord prolapse and numerous other emergent situations.

To my knowledge, there have been no reported escape attempts among pregnant incarcerated women who were not shackled while in labor.

There MUST be provisions to allow medical personnel to have restraints removed immediately, and any time restraints are used, written documentation by corrections personnel should be required. Corrections personnel should be required to remain outside delivery and exam rooms for the privacy of the mother.

Senate Bill 393 also allows for "Doula" services, which ACOG supports for many reasons including childbirth education, emotional support, potential to reduce cesarean delivery and postpartum support. Doula services help to promote immediate maternal-infant bonding. And all mothers should be encouraged to breastfeed unless medically contraindicated. Infants with Neonatal Opioid Withdrawal Syndrome (NOWS) do much better when the mother provides human breast milk. These supports are not only good for mother and baby, but can also help to reduce costs in the long term.

As I wrap up, I would like to share a story about one of my patients to emphasize why changes to current practices in county jails are necessary.

My patient first learned of her pregnancy at 9 weeks gestation when she was arrested. She was brought to each obstetrical visit in shackles. Despite my calls to the Waukesha County Jail nurse and written medical orders for treatment of her heroin addiction, she was forced to endure acute and chronic withdrawal. Phone consults from two addictionologists recommended medication assisted treatment, which was denied by the jail.

My patient had a very high-risk pregnancy with twins, severe anemia, hypothyroidism, cervical insufficiency with history of two neonatal losses at 22 and 23 weeks, and psychiatric illness. She was denied medications for her psychiatric illness and iron for her anemia. She was forced to stay in the medical cell with 24-hour lights preventing her from sleeping and was given inadequate nutrition. At 23 weeks I ordered admission to the hospital where the jail attendant dropped her off at the front door of the hospital with no attendant.

There are other examples. No pregnant woman should be placed in solitary confinement as occurred in Taylor County in 2014. No woman should be denied transport to a hospital and be abandoned to labor alone, deliver with no birth attendant and watch her baby die which occurred in Milwaukee County Jail in 2016.

As of this year, 23 states have passed laws restricting restraints on incarcerated pregnant women. Senate Bill 393 is a step in the right direction and I urge you to pass this long overdue legislation.

Thank you for your time today and I'm happy to take any questions.

EVAN
GOYKE
STATE REPRESENTATIVE
18th ASSEMBLY DISTRICT

October 19th, 2017
Public Testimony of State Representative Evan Goyke
Re: Senate Bill 390

Good afternoon Chairman Wanggaard and committee members. Thank you for holding this public hearing and the opportunity to testify in support of this important piece of legislation.

Senate Bill 390 started four years ago as part of the 2013 Legislative Study Committee on Problem-Solving Courts, Alternatives, and Diversions. I was proud to serve as the Committee's vice-chair alongside former Representative Garey Bies.

The study committee was well represented by members of law enforcement, the legal system, and treatment courts.

Our task was to review the 50+ problem solving courts currently in operation in Wisconsin, the effect they have on recidivism, and the fiscal impact of these courts. Problem-solving courts include veteran's courts, drug and alcohol courts, mental health courts, and drunk driving courts. We reviewed the effectiveness of existing problem-solving courts in Wisconsin and their ability to reduce recidivism.

One of the products of that committee was 2015 Assembly Bill 51, which we have reintroduced as 2017 Assembly Bill 481/Senate Bill 390. Last session AB 51 passed the Assembly unanimously, but failed to pass the Senate.

SB 390 creates a grant-making program for problem solving courts within the Department of Children and Families. The form and function of this program is similar to the Treatment, Alternatives, and Diversion (TAD) program, which is limited to the adult criminal justice system and correctly administered by the Department of Justice.

SB 390 would create a program that would not apply to criminal behavior, but to child welfare actions under Chapter 48 and juvenile delinquency actions under Chapter 938. While in many ways these cases appear similar to adult criminal cases, they are not. Thus, the Department of Children and Families (DCF) should oversee the creation of the grant-making program because DCF is the primary state agency staffing and supporting these cases and courts.

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Grants under SB 390 would enable counties to establish and operate problem-solving courts beyond the adult criminal justice system. This recognizes the power and effectiveness of treatment and close court supervision to solve complex issues that trigger court intervention and evidence suggests that these courts may be as effective (or even more effective) as problem-solving courts in the adult criminal justice system.

There is no appropriation in SB 390. Any decision to appropriate additional funds to DCF for qualified problem solving courts is a future decision, but one only made possible first by establishing the Department's ability to make such a grant and establishing the appropriate, evidence-based criteria to warrant the State's investment.

Today you will hear from members of the Milwaukee County Family Drug Treatment Court. Milwaukee County has pioneered the use of a treatment court in the family court setting and today you will meet the Court Coordinator and a program graduate. These individuals will be able to provide first hand experiences on how a treatment court functions differently than a normal family court – and how the outcomes for families are improved.

All of us have seen our communities struggle with drug addiction. SB 390 empowers counties to develop evidence-based programs to better defeat addiction, get families sober, and keep families together. These treatment courts can save lives – and save money.

I am grateful to Representative Rodriguez, Representative Nygren and Senators Darling and Johnson for their support, as well as the support from the large number of co-authors from both chambers.

I welcome the opportunity to answer any questions I can.

To:	Members, Senate Committee on Judiciary and Public Safety
From:	Badger State Sheriffs' Association (BSSA)
	Wisconsin Sheriffs and Deputy Sheriffs Association (WS&DSA)
Date:	October 19, 2017
RE:	**Statement on Senate Bill 393 – For Information Only**

Badger State Sheriffs' Association and Wisconsin Sheriffs and Deputy Sheriffs Association want to make the committee aware that most Wisconsin Sheriffs' departments already have a restraint policy on pregnant and in-labor inmates in place.

Badger State Sheriffs' Association (BSSA) is a statewide organization representing all of Wisconsin's 72 Sheriffs and (WS&DSA) is a statewide organization representing over 1,000 members, including Sheriffs, Deputies, and jail officers. BSSA and WS&DSA have a joint legislative committee and work closely on public safety issues of concern to our members.

Currently, Sheriff's Offices and other law enforcement departments issue and implement jurisdictional-level policies, such as Use of Restraints policies. In fact, in 2015, the National Sheriffs' Association requested that all law enforcement agencies establish policies to ensure that pregnant inmates will not be inappropriately shacked.[1]

Most departments require policies for pregnant inmates based on nationally used best practices similar to the provisions in this bill. These best practices include provisions that restraints not be used on pregnant inmates unless the department makes an individualized determination that they are necessary for the safety of the inmate, unborn child, staff, or public. If restraints are used, they must be the least restrictive possible. Inmates in labor may only be restrained if there is a substantial flight risk and there is no objection from the medical care provider.

We appreciate the intent of this legislation, but lawmakers should be aware that these policies already exist and are being enforced across the state. Attached are a few examples of current policies.

Thank you for the opportunity to submit these comments.

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[1] https://www.sheriffs.org/sites/default/files/uploads/documents/GovAffairs/Resolution%202015%20-%204.pdf

OF THEIR CLOTHES REMOVED BY SELF OR JAIL STAFF.

IF AN INMATE IS SPRAYED WITH OLEORESIN CAPSICUM, HE/SHE WHENEVER APPROPRIATE WILL BE DE-CONTAMINATED, OR OFFERED DECONTAMINATION BEFORE BEING RESTRAINED IN THE VIOLENT PRISONER CHAIR OR BOARD.

523.5 RANGE OF MOTION

Inmates placed in restraints for longer than two hours should receive a range-of-motion procedure that will allow for the movement of the extremities. Range-of-motion exercise will consist of alternate movement of the extremities (i.e., right arm and left leg) for a minimum of 10 minutes every two hours.

523.6 FOOD AND HYDRATION

Inmates who are confined in restraints shall be given food and fluids. Provisions shall be made to accommodate any toileting needs at least once every two hours. Food shall be provided during normal meal periods. Hydration (water or juices) will be provided no less than once every two hours or when requested by the inmate.

Offering food and hydration to inmates will be documented to include the time, the name of the person offering the food or water/juices, and the inmate's response (receptive, rejected). Inmates shall be given the opportunity to clean themselves should they soil themselves or their clothing while they are in restraints.

523.7 AVAILABILITY OF CPR

Cardiopulmonary resuscitation equipment such as barrier masks shall be provided by the facility and located in proximity to the location where inmates in restraints are held.

523.8 RESTRAINED INMATE HOLDING

Restrained inmates should be protected from abuse by other inmates. Under no circumstances will restrained inmates be housed with inmates who are not in restraints. In most instances, restrained inmates are housed alone or in an area designated for restrained inmates.

523.9 PREGNANT INMATES

Restraints will not be used on inmates who are known to be pregnant unless based on an individualized determination that restraints are reasonably necessary for the legitimate safety and security needs of the inmate, the staff or the public. Should restraints be necessary, the restraints shall be the least restrictive available and the most reasonable under the circumstances.

Inmates who are known to be pregnant will not be handcuffed behind their backs or placed in waist restraints while being transported.

528.9.1 INMATES IN LABOR

No inmate who is in labor, delivering or recovering from a birth shall be restrained except when all of the following exist:

(a) There is a substantial flight risk or some other extraordinary medical or security circumstance that dictates restraints be used to ensure the safety and security of the inmate, the staff of this or the medical facility, other inmates or the public.

(b) A supervisor has made an individualized determination that such restraints are necessary to prevent escape or injury.

(c) There is no objection from the treating medical care provider.

(d) The restraints used are the least restrictive type and are used in the least restrictive manner.

The supervisor should, within 10 days, make written findings specifically describing the type of restraints used, the justification and the underlying extraordinary circumstances.

511.4 PREGNANT INMATES

Best Practice
MODIFIED
Updated: 07/18/2017 10:23am

Use of restraints Pregnant inmates in labor Restraints will not be used on inmates who are known to be pregnant unless based on an individualized determination that restraints are reasonably necessary for the legitimate safety and security needs of the inmate, the staff or the public. Should restraints be necessary, the restraints shall be the least restrictive available and the most reasonable under the circumstances.

511.4.1 INMATES IN LABOR

Best Practice
MODIFIED
Updated: 07/18/2017 10:23am

No inmate who is in labor, delivering or recovering from a birth shall be restrained except when all of the following exist:

a. There is a substantial flight risk or some other extraordinary medical or security circumstance that dictates restraints be used to ensure the safety and security of the inmate, the staff of this or the medical facility, other inmates or the public.
b. A supervisor has made an individualized determination that such restraints are necessary to prevent escape or injury.
c. There is no objection from the treating medical care provider.
d. The restraints used are the least restrictive type and are used in the least restrictive manner.