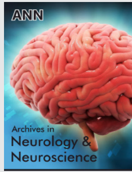

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Opinion Article

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A Call to Action: Person-Centered Care Aligned with Reproductive Justice for Incarcerated Pregnant People with Substance Use Disorders

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Abstract

Although research has proven that jails and prisons are ineffective in preventing or reducing substance use among pregnant people, the USA continues to rely heavily on the criminal legal system as its intervention. Pregnant people with an opioid use disorder are more likely to experience incarceration than pregnant people without an opioid use disorder. In some states, pregnant people are transported from jail to prison through the process of safekeeping in order to receive physical or mental health care that the jail does not provide, despite conviction status. When pregnant and postpartum safekeepers with an opioid use disorder experience incarceration, they face barriers related to continuity of physical and behavioral health care, have limited access to maternal-infant attaching opportunities at delivery, and are at risk for an opioid-related overdose upon release. This commentary describes clinical care challenges that impact the reproductive health needs of pregnant safekeepers with an opioid use disorder and offers solution-focused innovations to reduce harm. Such solutions include uninterrupted optimal dosing of medication and integrated prenatal clinics, specialized substance use disorder treatment, and opportunities to integrate lactation programs and perinatal dyadic-focused services.

Keywords: Pregnancy; Opioid use disorder; Person-centered care; Carceral settings; Jail; Prison; Breast feeding; Chest feeding

Introduction

While rates of incarceration for women reduced by nearly 30 percent during the COVID-19 pandemic [1,2], this drop is not a shift in the over-reliance on prisons or use of carceral systems to address substance use and misuse. For the past 40 years the USA criminal-legal system has incarcerated more women than ever before in its history [3]. Between 1980 and 2020 [4], women have been the fastest growing population in USA in carceral settings, primarily due to the ongoing criminalization of substance use and the non-evidence-based moral model of addiction treatment [5]. Recent studies indicate that around 3% of women admitted to jails and 4% of women admitted to prisons are also pregnant, and at least 900 people give birth in custody each year [6,7].

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Jails and prisons are the main institutions, excluding Immigration and Customs Enforcement detention centers, within the U.S criminal-legal system. In brief, jails are secure facilities that are typically operated by local governments and utilized to detain individuals who have been arrested and are awaiting trial or until they can afford bail. Conversely, prisons are usually operated by a state's department of corrections and house individuals upon conviction. Despite the purpose of jails (short-term and awaiting trial) and prison (long-term and sentenced), pregnant people who interface with the criminal legal system are more likely to experience both jail and prison, no matter their conviction status, through a process known as safekeeping [8,9]. Safekeeping originated during the reconstruction era in the U.S.A. as a form of discipline and enslavement of Black men and women throughout Southern states [8,9]. Today, safekeeping is a commonly used practice in which individuals experiencing mental health, medical complexities, and pregnancy are housed in state prisons to receive medical care that jails report not being able to provide. However, safekeeping for pregnant people with an opioid use disorder (OUD) can lead to adverse maternal-infant outcomes.

Discussion

Aligning Carceral Care and Reproductive Health for Safekeepers

In July 2022 the U.S. Department of Justice created the Reproductive Rights Task Force to protect reproductive rights and health for non-incarcerated people both federally and locally. Pregnant and postpartum people and safekeepers experiencing incarceration are often excluded from discussions about reproductive health and optimal healthcare. However, there are opportunities to expand the reproductive health worldview outlined by the task force by increasing compassionate care for incarcerated pregnant people and safekeepers through evidence-based practices. Increasing clinical services to increase reproductive health such as medication to treat opioid use disorder (MOUD), psychoeducation on maternal-infant attachment, and supportive transition plans can increase reproductive and maternal health outcomes. Therefore, this commentary describes clinical care challenges that impact the reproductive health needs of pregnant safekeepers with an OUD and offers solution-focused innovations that promote the advancement of reproductive and maternal health in carceral settings.

Medication to Treat Perinatal OUD during Safekeeping

The American College of Gynecology (ACOG) and the American Society of Addiction Medicine (ASAM) recommend that all pregnant people who meet the Diagnostic and Statistical Manual-5 (DSM-5) criteria for OUD be considered as possible candidates for MOUD. MOUD is a continuous treatment to address the chronic condition of OUD. Detoxification is not recommended as it is an acute care approach that has little efficacy in preventing a return to opioid use. During pregnancy, detoxification can create health risks for the fetus and the birthing person (SAMHSA, 2018).

Individualized treatment plans should highlight both pharmacologic and nonpharmacologic interventions. Although the gold standard is to combine both interventions, individuals with an OUD should not be denied access to their medication if they are unable to access behavioral health services. While methadone and buprenorphine are the leading pharmacologic interventions, the relative safety and efficacy of Naltrexone, an opioid antagonist that can treat both opioid and alcohol use disorders, is under current study for safety and efficacy during pregnancy (SAMHSA, 2018). Non-pharmacologic interventions that include contingency management, a community reinforcement approach, and cognitive behavioral therapy represent treatment options for any type of substance use disorder, especially those that do not have FDA-approved medications to treat them [10].

Pregnant and postpartum safekeepers experience unique challenges with accessing MOUD. Pregnant safekeepers with OUD are more likely to access MOUD than non-pregnant patients with OUD [8]. Immediately following delivery, postpartum people and safekeepers lose access to their MOUD. While some jails and prisons are hesitant to integrate SUD treatment into their settings, there are jails and prisons that are interested in supporting this effort. However, carceral settings also face systemic barriers to providing MOUD. To administer Methadone, a setting must meet state and federal regulations to operate as an Opioid Treatment Program (OTP), one of the most regulated clinics in the U.S. Likewise, an agency must employ a licensed provider who has received specialized training to be considered an Office-based Opioid Treatment (OBOT) program. These treatment modalities are not economically feasible without the support of community stakeholders, the state, or a source of external funding.

Demonstrated benefits of integrated perinatal and SUD care models include improvements in perinatal and parenting outcomes, [9–11] as well as in minimization of provider burnout [10]. In addition, while complex care navigation may be critical for all people affected by perinatal SUD [12], those experiencing incarceration are likely to demonstrate the highest need for care coordination.

Behavioral Health Services and Substance Use Treatment in Jails and Prisons

When perinatally incarcerated persons with SUDs fall under the care of safekeeping programs, the involuntary transfer between jail and prison may evoke fear, loss of connection to family and community, and isolation. Behavioral health providers with specialized training in addiction services and treatment management are essential when working with pregnant people and safekeepers with an OUD. Behavioral health providers specializing in addiction are equipped to facilitate evidence-based SUD services, such as individual counseling psychoeducation and trauma, maternal-infant SUD interventions, coping strategies to manage emotional and behavioral triggers, and comprehensive dyadic care coordination. However, given that jails and prisons do not typically dedicate resources to employ counselors with specialized addiction certification and licensures, the level and amount of SUD-inclusive and maternal-infant care coordination in carceral settings are unknown. While some states are implementing family drug treatment courts (courts with an SUD and maternal-child focus to reduce family separation

and access to treatment), these models are not universally accepted. For instance, in one Southeastern state with 100 counties, only eight counties offer family-specific drug treatment courts; family drug treatment courts are not to be confused with traditional drug courts. Decreasing and limited adequate safeguards to ensure continuity in obstetric care and SUD treatment in carceral settings pose deleterious outcomes [13], The consequences of limited care coordination for pregnant and postpartum people may be catastrophic for the pregnant individual and infant. Studies in non-pregnant populations have determined that risk of death due to overdose is particularly high post-release from jail or prison [14]. For pregnant and postpartum safekeepers with OUD, treatment during incarceration and during transitions to the community after release are paramount to preventing overdose deaths [15].

How to Provide Effective Physical and Mental Health Care in Jail and in Prison – Need for Integrated Care

Although the stated aim of incarceration during pregnancies affected by SUD is often improved access to high-quality prenatal care, including SUD care, studies of USA jails and prisons do not support that this care is universally available [1-4]. Even where prenatal care and SUD care are both available, the extent to which jail and prison facilities provide comprehensive, integrated models of perinatal SUD care is unknown.

To our knowledge, the integrated perinatal SUD clinic that serves pregnant and postpartum people sent through safekeeping into the NC state prison system is one of the first such clinics implemented in a carceral context [9]. Patients in the clinic receive comprehensive prenatal care, including referrals for appropriate ultrasonography and high-risk consultation where necessary, perinatal SUD counseling with a social work practitioner, as well as supplemental case management services related to SUD, and can access MOUD prescribed by their prenatal provider. The clinic collaborates with prison-based primary care and mental health providers as well as social work practitioners in a variety of prison-based roles to coordinate complex care needs. Through this service integration, the proportion of patients with OUD who receive MOUD substantially increased as did the ability to meet requests for residential treatment upon release [9,10].

Goals for the integrated perinatal SUD clinic in prison to increase patient support include adding a group childbirth education and birth support, providing in-person and telehealth lactation consultation, and providing seamless connections to pregnancy and postpartum care providers following release [11-15].

Continuity of integrated perinatal and SUD care postpartum is limited in many carceral settings. First, patients in our clinic and in many other settings have MOUD withdrawn postpartum despite medical recommendations against this practice [3,16]. Second, although experts in perinatal care increasingly view the postpartum period as lasting for a year or more after birth, the mechanics of the safekeeping policy and prioritization of family reunification mean that many patients only continue in our clinic for 1-6 weeks postpartum.

Supporting the Dignity and Rights of Reproductive People and their Infants Impacted by SUD and Incarceration

The USA is one of only four countries that permit state-sanctioned maternal-infant separation for pregnant people who have been convicted and are safekeepers [16]. There is no national policy regarding the placement of infants born in custody; therefore, separation practices vary considerably by state, type of correctional facility, and other situational factors of mothers and infants [5,16].

Separation negatively impacts neonatal health, maternal-infant attachment, postpartum psychosocial adjustment, and long-term family well-being. It also disrupts breastfeed initiation, an internationally recognized a reproductive right for childbearing people and their children [17,18].

Approximately 50-80% of neonates exposed prenatally to opioids will develop neonatal opioid withdrawal syndrome (NOWS). [19] Clinical recommendations from the American Association of Pediatrics state that infants with NOWS have improved clinical outcomes when their birthing parent is able to remain stabilized on MOUD, able to room-in as a dyad, and able to nurse their infant or express milk for them. [20–22] Nonpharmacologic interventions such as breast/chest feeding are critical to caregiver-child health immediately following delivery and across the life course, [23,24] and have been associated with a reduction in hospital stays (SAMHSA, 2018). For postpartum safekeepers who wish to breastfeed, donor human milk is an alternative recommendation for infants exposed to opioids during pregnancy who need supplementation or replacement feeding. [25] Postpartum bonding, attachment, and responsive caregiving are also enhanced when lactation services are accessible. [26,27] Breast/chest feeding and expressing milk are essential to the mothering experiences of women receiving and stabilized on MOUD who experience incarceration [28–30].

Solutions to Aligning Carceral Care and Reproductive Health for Safekeepers

A myriad of literature exists that examines the adverse outcomes of perinatal and maternal incarceration. However, the literature does not offer evidence-based strategies to ameliorate the associated harms for pregnant and parenting people and safekeepers experiencing incarceration with an OUD. The following section will focus on strategies that carceral settings can adopt to promote reproductive health and mitigate the harms of perinatal incarceration and safekeeping through partnerships with community providers.

Implement Integrated Prenatal Clinics in Jails and Prisons

We propose that carceral settings ensure that every person with a perinatal SUD has the human right to optimal care and humane conditions throughout pregnancy, intrapartum, and postpartum during incarceration. To achieve optimal care, we suggest that a greater effort be made to bring the patient voice into the decision-making process in treatment. Shared decision-making can occur when evidence-based screening tools such as the Subjective Opiate Withdrawal (SOW) are administered to the client

and their needs and preferences are honored in the development of their treatment plan. We suggest promoting continuity of MOUD throughout the perinatal period by adjusting medication treatment plans when appropriate. Further, we suggest promoting birthing plans that include pre-delivery cultural, community, and linguistic resources, and providing support to ensure that the pregnant person experiences bodily and medical autonomy and freedom during delivery.

Implement Behavioral Health Services and Substance Use Treatment in Jails and Prisons

We suggest that carceral settings employ behavioral health providers or specialized addiction providers to provide evidence-based treatment and program management to address perinatal and maternal substance use. Comprehensive SUD treatment before, during, and after incarceration is essential to maintaining long-term recovery, increasing maternal-infant connection, and reducing recidivism during the perinatal period. A pilot program conducted in the southeastern section of North Carolina that provided perinatal substance use counseling during incarceration and specialized gender-responsive reentry services had promising outcomes,30 including a reduction in recidivism, a reduction in opioid-related deaths and injuries upon release, and an increase in maternal-infant reunification post-incarceration. Other meaningful behavioral health supports include Family Drug Treatment Courts, specifically designed to promote maternal-child reunification and treatment over incarceration/separation, and recovery-supportive housing for the dyad.

Implement Integrated Prenatal SUD Clinics in Jails and Prisons

Comprehensive integrated prenatal SUD clinics offer the best chance for healthy outcomes for pregnant people who have been sentenced or convicted of a crime. For safekeepers who have been charged but not convicted of a crime, we suggest that these individuals should be released from custody and referred to community agencies to address their SUD. Enhanced pregnancy and postpartum support services and programs, including doulas with lived experiences and other resources upon release (housing, food, transportation), hold promise to prevent a return to substance use and promote healthy outcomes. Systemic interventions include state and federal funding to support local carceral settings to operate integrated prenatal SUD clinics, opioid treatment programs, and/or or office-based opioid treatment clinics. The goal of such proposed services is to increase access to medication to treat OUD continuously during pregnancy and for the duration of incarceration, with attention paid to a seamless connection to outside MOUD providers upon release.

Implement Policies and Programs that Support the Dignity and Rights of Reproductive People and their Infants Impacted by SUD and Incarceration

A systematic review examining lactation support for people experiencing incarceration advised that carceral settings should identify opportunities to support breast/chest feeding. [31] Postpartum bonding, attachment, and responsive caregiving are enhanced when breastfeeding is supported. [26,27] Interventions that reduce the stigma related to breast/chestfeeding and other lactation services for incarcerated people and safekeepers with a history of substance use can improve access to care and the quality of that care. [32] Culturally and linguistically effective childbirth education courses, doula services for birthing pregnant people experiencing incarceration, human milk pick-up/delivery programs, and implicit bias training for healthcare providers and child welfare workers are critical pathways through which to intervene. [33] Finally, carceral leaders should work alongside lactation consultants to develop programs and create policies to eliminate the structural barriers that impede access to quality lactation support. [31]

Conclusion

There are opportunities for carceral settings and community providers to work alongside each other to strengthen reproductive health in carceral settings in the present. Providing uninterrupted optimal dosing of medication, culturally and linguistically-informed behavioral healthcare, and perinatal dyadic-focused services are evidence-based interventions shown to reduce discrimination and improve outcomes for all pregnant people in carceral settings. We suggest that these are strategies prison and jail leadership can take to reduce harm and improve the health and well-being of pregnant and post-partum birthing people.

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Conflicts of Interest

The authors have no conflicts of interest to declare. All co-authors have seen and agree with the contents of the manuscript and there is no financial interest to report. We certify that the submission is original and is not under review at any other publication.

Declarations

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