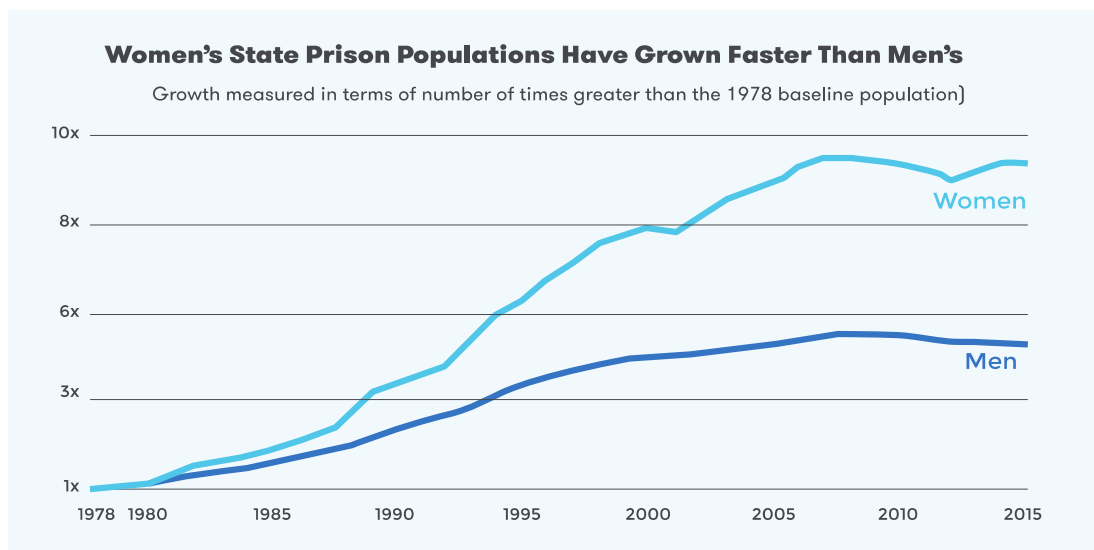




Integrating Obstetrical and Substance Use Disorder Treatment for Pregnant and Postpartum People in Prisons

By Hendrée Jones, Essence Hairston, James F. Alexander, Elton Amos, and Andrea Knittel

In recent decades, the number of U.S. women who are incarcerated rose a **startling 742 percent**, from 13,258 in 1980 to 111,616 by 2016. The proportion of women in prison for drug-related convictions **has also increased**, from 12 percent in 1986 to 26 percent in 2018. The **majority of women** in prisons are in their childbearing years; more than 80 percent have been pregnant and two-thirds are primary caregivers to children. This means, of course, that some women will be incarcerated while pregnant or after giving birth. While such data are difficult to obtain, pregnant women are **estimated** to represent 3.8 percent of newly admitted women in prison and 0.6 percent to 4 percent of all women in prison.



Source: Prison Policy Initiative, available at https://www.prisonpolicy.org/reports/women_overtime.html.

The number of pregnant women with opioid use disorder (OUD) has also been increasing in U.S. prisons and jails; as of 2016–17, **one-quarter of pregnant women in prisons had OUD**. There have also been **increases in referrals from prisons and jails** for treatment of pregnant women for prescription opioid abuse.

TAKEAWAYS

There has been a startling rise in the rate and number of women incarcerated overall and during pregnancy in the past decade.

Pregnant people who use substances face significant challenges accessing care; these challenges are exacerbated for those in jails and prisons

One FORE grantee is strengthening treatment and recovery supports for pregnant and postpartum women in prison by integrating obstetrical services and substance use disorder treatment and providing transitions to care after their release.

Pregnant and postpartum people who have OUD or other substance use disorder (SUDs) are at particular risk in prison. As with other people with SUDs, their incarceration can result in unsupervised or minimally supervised substance withdrawal and interruption or delays of medications for opioid use disorder (MOUD) and other treatment. During pregnancy, opioid withdrawal [can complicate or increase risks](#) to the embryo/fetus and birthing parent. People who are incarcerated during their pregnancy or the postpartum period may also have inadequate prenatal or other medical care, difficulty accessing nutritious foods, and experience high levels of anxiety and depression. And many women in prison have experienced traumatic events and may be retraumatized from physical searches, solitary confinement, or other negative experiences.

The [collateral consequences](#) of incarceration may also include harm to the parent–child relationship, harm to children, loss of housing, loss of employment and future job prospects, and increased reliance on friends and family members for childcare and other resources.

Both jails and prisons are required to provide health care to incarcerated persons, although compliance with published standards is voluntary, including for prenatal care. And while pregnancy and the postpartum period are key opportunities to engage people in addiction treatment, many prisons do not leverage them. Below, we profile a pilot effort, supported by FORE, to bring integrated prenatal care and substance use disorder treatment to women in a North Carolina prison. The [estimated proportion](#) of pregnant women imprisoned in North Carolina with OUD has increased steadily from 53 percent in 2016 to 62 percent in 2019

Criminalizing Substance Use During Pregnancy

Some state and local policies criminalize substance use by pregnant people. One study [documented](#) that between 1973 and 2005 there were 413 arrests, detentions, forced medical interventions, and separations of newborns among birthing parents, with the majority (84%) of cases involving substance use during pregnancy. Given the difficulty of identifying instances of legal intervention, the researchers speculated that thousands of cases may have been missed.

Pregnant people of color are at particular risk. While people of color use illicit substances at approximately the same rate as white people, Black and non-Hispanic Black people are [10 times more likely](#) to be imprisoned for drug offenses. Among a [sample of more than 160 prosecutions](#) across multiple states, 75 percent were brought against women of color, although women of color represent only 25 percent of the U.S. female population.

Many women who end up in prison have experienced poverty and trauma. For example, nearly all women enrolled during 2019–20 in the University of North Carolina’s Horizons program (UNC Horizons)—which provides treatment for pregnant and parenting women with substance use disorder—had been arrested at least once and more than half had been incarcerated. The majority report having experienced physical or sexual abuse and/or domestic violence, as well as homelessness and chronic health conditions.

Moving Pregnant People from Jails to Prisons for Prenatal Care

Some states routinely transfer pregnant people from jails into prisons because their jails do not offer prenatal care, a process known in North Carolina as “safekeeping.” (Jails are short-term facilities; people in jail may not yet be sentenced or may be convicted of misdemeanors and sentenced to less than one year.

By contrast, prisons are long-term facilities for people who typically have been convicted of felonies and received sentences of longer than a year.)

In North Carolina in 2016–18, [the majority](#) (62%) of pregnant people with opioid use disorder in one prison were there for “safekeeping.” Most were jailed because they were unable to afford bail and probation fees and were sent to prison not because they were convicted of a crime but because they were pregnant. These transfers may be performed without notification, leaving loved ones and attorneys unaware.

CHARACTERISTICS OF WOMEN TREATED AT UNC HORIZONS, A SUD TREATMENT PROGRAM FOR PREGNANT AND POSTPARTUM WOMEN

- Age: 19 to 42 years, with an average age of 31 years
- Race: white 79%; Black 19%; Native American 1%; self-identified “other” 1%
- Less than a high school education: 28%
- Substance use disorders: opioid use disorder (includes heroin) 55%; cocaine use disorder 22%, stimulant use disorder (amphetamines or methamphetamines) 12%; alcohol use disorder 5%; smoke tobacco 84%
- Pregnant at intake: 50%
- One or more child less than 18 years of age: 82%
- Child Protective Services involvement at intake: 45%
- Families of origin with substance use problems: 87%
- Homeless at some point in their lives: 66%
- Arrested at least once: 90%
- Convicted of at least one offense: 70%
- Incarcerated at least once: 57%
- Past mental health treatment for something other than SUD: 86%

Integrating Obstetrical Services and Substance Use Disorder Treatment for Pregnant People in Prison

With support from FORE, the UNC Horizons program, part of the School of Medicine’s Department of Obstetrics and Gynecology in Chapel Hill, North Carolina, launched Jenna’s Project in 2020. Named after a former patient who died from an opioid overdose shortly after being released from prison—an [all-too-common](#) occurrence—Jenna’s Project seeks to keep women connected to treatment as they leave prison while helping them reunite with their children and otherwise rebuild their lives.

In January 2021, Jenna's Project expanded to offer services to pregnant women while they are still in the North Carolina Correctional Institute for Women (NCCIW), a prison in Raleigh. Nearly all pregnant women in NCCIW have a SUD and more than half are in treatment for OUD. Jenna's Project services are offered to all prenatal clinic patients.

NCCIW's prenatal clinic typically offers pregnancy care through on-site clinic visits, coordinated referrals for subspecialty needs, and MOUD education and treatment until the end of pregnancy. There are psychiatric and other mental health professionals, case managers, and social workers. Jenna's Project enabled the prison to expand these services by adapting UNC [Horizon's model](#) of integrated obstetrical and SUD care. A behavioral health team from Horizons now works alongside the NCCIW clinic staff to address the intersectionality of substance use, pregnancy, trauma, and incarceration. The team provides the following services:

- Comprehensive clinical assessments of substance use disorder
- Development of drug treatment plans and goals and documentation of progress
- Use of screening tools to assess for perinatal mood disorders
- Sharing of clinical documentation and progress reports with other clinicians to promote coordinated care
- Education on topics including MOUD and dual diagnoses of mental health conditions and SUD.

Counseling for each pregnant woman is offered as often as once a week and customized based on their needs. It may focus on healing from addiction and trauma; identifying coping skills to manage emotional and behavioral symptoms; strengthening self-esteem; improving interpersonal skills, emotional regulation, mindfulness, and distress tolerance; use of motivational interviewing; cognitive-behavioral techniques; and solution-focused skills. The behavioral health staff help pregnant women navigate their early recovery during incarceration and help them sustain these efforts after their release by coordinating between staff at the prison, county jails, and treatment providers. They also help people find housing, jobs, or other resources.

The prenatal SUD clinic has had promising results since January 2021. Among the 39 individuals who have thus far received services, all returned for counseling (they are given the option not to take part in therapy and instead just receive MOUD and prenatal care). Of the 22 individuals who have returned to the community, all received post-release services. Follow-up is planned for six months after their release.

Policy Implications

The following policy changes are needed to improve supports for incarcerated pregnant or postpartum people and, in the long term, help them find SUD treatment and recovery supports, rather than criminalizing them for substance use.

Strengthen data collection to quantify the number of pregnant people in jails and prisons and monitor their pregnancy and other health outcomes. Such data are not widely or uniformly collected, nor analyzed in a way that reveals how the intersections of race, pregnancy, substance use, and incarceration affect people's lives and health. For example, collecting data on maternal, infant, and child outcomes for those in jails and prisons and comparing such outcomes to the general population would inform future interventions and policies.

Refine and implement national standards for perinatal and substance use disorder treatment in jails and prisons. All birthing people should be able to have a respectful, safe childbirth and postpartum period, including making decisions about breastfeeding and parent-infant bonding in the context of the safety needs of jail and prison facilities.

MOUD must be provided according to the published guidance by the [Substance Abuse and Mental Health Services Administration](#) and the [American Academy of Addiction Medicine](#). For example, withdrawing MOUD in the immediate postpartum period runs counter to the scientific evidence and community standard of care. This practice is common in jails and prisons, however, as Elton Amos, M.D. M.P.H., NCCIW's medical director says, "public safety in the healthiest way is the priority for corrections. We endeavor to meet [scientific standards] in a way that does not violate our charge as correctional health officers."

The American College of Obstetrics and Gynecology provides guidance on the context in which perinatal substance use disorder treatment should be provided in prison and jail facilities; their standards make clear that pregnant women should never be placed in solitary confinement or shackled during childbirth. Of note, many states including North Carolina have made and are making important strides forward. Amos notes that North Carolina is currently engaged in certifying its facilities with the standardizing agencies.

Ensure pregnant women and new mothers have uninterrupted health coverage when they leave prison, for example by automatically enrolling them in Medicaid. States could also take advantage of a new option in the American Rescue Plan to extend Medicaid coverage to low-income people for a full year after giving birth. In states that did not expand Medicaid eligibility to low-income, non-childbearing adults, many women lose coverage 60 days after giving birth.

Develop and implement SUD treatment programs that meet the needs of Black and Brown birthing people. As described in a prior [FORE issue brief](#), patients of color with OUD are more likely than white patients to receive methadone than buprenorphine for MOUD. Methadone is prescribed through highly regulated opioid treatment programs that tend to place high demands on patients, including requiring daily visits to obtain medication and frequent drug screening. Such programs typically do not offer care for other health conditions, nor do they provide transportation or childcare to help make services accessible.

Develop and implement culturally responsive birth practices in jails and prisons. Given that pregnant people are often transported from jails to prison during pregnancy, it is vital to expand ways to promote emotional support and autonomy at the time of delivery. Individuals who deliver while incarcerated are denied familial and partner support and separated from their newborns after delivery. Having birth and postpartum doulas whom the pregnant person could meet and establish rapport with during the prenatal period—and who are knowledgeable of the intersectionality of substance use during pregnancy, trauma, and incarceration—could reduce pregnant people's feelings of isolation, potentially improve delivery outcomes, and increase parent-baby connectedness after release.

AUTHORS

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We are committed to convening and supporting partners advancing patient-centered, innovative, evidence-based solutions to make the greatest impact on the crisis.

