HHS Public Access

Author manuscript

*SSM Qual Res Health*. Author manuscript; available in PMC 2025 January 02.

Published in final edited form as:

*SSM Qual Res Health*. 2024 December ; 6: . doi:10.1016/j.ssmqr.2024.100453.

# "They talked to me like I was dirt under their feet:" Treatment and withdrawal experiences of incarcerated pregnant people with opioid use disorder in four U.S. states

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## Abstract

**Background:** Many pregnant individuals with opioid use disorder (OUD) spend time in jail, yet access to standard of care medications for OUD (MOUD) in jail is limited. Though qualitative studies of non-incarcerated pregnant and non-pregnant incarcerated individuals with OUD demonstrate complexities that must be considered in delivering effective care, studies with pregnant, incarcerated patients with OUD are lacking.

**Methods:** We conducted semi-structured qualitative interviews from October 2020–November 2021 with pregnant and postpartum people with OUD who were currently or previously in jail in Florida, Maryland, Ohio, and Virginia. Interview guides incorporated understandings of the power dynamics of incarceration and gendered expectations of motherhood. We analyzed transcripts using descriptive phenomenology to identify themes around experiences of treatment or withdrawal in jail and upon release.

**Results:** We interviewed 32 women, 23 pregnant and nine postpartum. Some received MOUD in jail and others endured withdrawal. All participants expressed concern for their babies. Five themes emerged: 1)lack of counseling or accurate information about MOUD in pregnancy;



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CRediT authorship contribution statement

**Carolyn Sufrin:** Writing – review & editing, Writing – original draft, Validation, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Tali Ziv:** Writing – review & editing, Writing – original draft, Formal analysis. **Lauren Dayton:** Writing – review & editing, Writing – original draft, Formal analysis. **Carl Latkin:** Writing – review & editing, Supervision, Methodology, Funding acquisition, Conceptualization. **Camille Kramer:** Writing – review & editing, Writing – original draft, Validation, Project administration, Investigation, Formal analysis, Data curation.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Carolyn Sufrin serves as a consultant to Advocates for Human Potential in disseminating the implementation recommendations for the Bureau of Justice Assistance document "Withdrawal Management Guidelines."

The other authors have no competing financial interests or personal relationships to disclose.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2024.100453.

2)absent, delayed, or coercive care in jail; 3)experiences of stigma and discrimination from staff and caregivers; 4)structural barriers to safe transitions and continuing MOUD; and 5)the destructive presence of child protective services for care continuity. These factors all influenced their ability to recover.

**Conclusions:** Jails must provide OUD care that is attentive to pregnancy physiology, pregnancy-stigma, reentry needs, and patients' fetal-newborn concerns. Tailoring care specific to pregnancy and postpartum context can improve recovery success, reduce overdose, and promote intergenerational equity.

## 1. Introduction

There are nearly 8000 annual admissions of pregnant people with opioid use disorder (OUD) to U.S. jails (Sufrin et al., 2020).[1] This phenomenon exists in the context of mass incarceration and the "war on drugs," where the U.S. utilizes incarceration as a means of racial, economic, and social control, characterized by a 525% rise in the number of women—disproportionatey Black—behind bars in the last 40 years (Alexander, 2010; Carson, 2022). Pregnant women who use substances, particularly Black women, have been particularly subject to criminalization instead of treatment that supports recovery and parenting (Goodwin, 2020). Overdose is a leading cause of maternal mortality (Trost et al., 2022). Incarceration during pregnancy increases the odds of postpartum overdose by 4 times (Nielsen et al., 2020) due in part to the lack of availability of medications for OUD (MOUD) during incarceration, which can decrease opioid tolerance and, in turn, can be associated with overdose risk if there is return to use (Merrall et al., 2010). Postpartum depression, for which incarcerated individuals are at higher risk, has also been associated with return to use, increasing the risk of overdose (Howland et al., 2021; Schiff et al., 2018). Jail thus presents an important moment to access lifesaving treatment for pregnant and postpartum people. Jails are generally short-stay facilities, with the majority of people incarcerated pre-trial or on violations of probation. People either go to prison to serve a longer sentence or, in most cases, return to their communities. Jails serve as important links in the continuum of care. Yet intersectional stigma and punitive approaches towards people who use substances in pregnancy, combined with a lack of standardization in jail facilities, makes MOUD access challenging. It is critical to understand the lived experience of pregnant people with OUD in jail to optimize care and advance equity.

MOUD with Food and Drug Administration (FDA)-approved methadone, a full opioid agonist, or buprenorphine, a partial agonist, and avoiding withdrawal is the established, evidence-based standard of care in pregnancy (ACOG, 2017). Treatment with MOUD has been shown to reduce the risk of fatal and non-fatal opioid overdose, including in the postpartum period (Larochelle et al., 2018; Schiff et al., 2018; Sordo et al., 2017). MOUD in pregnancy reduces recurrence risk and improves engagement in prenatal care and addiction treatment, overall improving maternal and fetal outcomes (ACOG, 2017). Without MOUD, pregnant and postpartum people with OUD in jail are forced to go through withdrawal, which is associated with a high risk of overdose upon release, in part due to decreased

[1]See Appendix for glossary of terms and abbreviations.

opioid tolerance during periods of non-use in custody and then return to use post-release (Binswanger et al., 2013; Merrall et al., 2010). Furthermore, lack of provision of MOUD for pregnant individuals in jail raises ethical and legal issues around forced withdrawal as punishment (Milloy & Wood, 2015). Yet there is a substantial unmet need for treatment for pregnant people in jail. A national survey of over 800 U.S. jails found that only one-third provided access to start MOUD while pregnant in custody (Sufrin et al., 2022). Even in jails that do provide MOUD in pregnancy, availability is often suboptimal (Benck et al., 2023; Sufrin et al., 2022).

Experiences of coercion, lack of autonomy, and stigma are common among people engaging in MOUD treatment. In an analysis of posts from pregnant women in an online forum, women described that stigma from family members, medical professionals, and society deterred them from disclosing OUD and getting on MOUD (Moore & Butzlaff, 2023). Qualitative studies with non-incarcerated pregnant patients have described their challenges in continuing MOUD if they felt pressured into treatment (Damon et al., 2017; Schiff et al., 2022). Another qualitative study among non-pregnant incarcerated people receiving MOUD reported that incarcerated people had MOUD preferences and valued autonomy, recommending that treatment in custody should be individualized through patient-centered counseling that promotes choice-making (Kaplowitz et al., 2021).

These qualitative studies demonstrate the nuances of receiving and trying to access MOUD over the course of a pregnancy and during incarceration. Yet research on direct experiences with MOUD among people who are both pregnant and incarcerated is lacking. It is essential to integrate their self-identified needs into practice with consideration for both mothers and babies in tandem. We conducted a qualitative study to explore the perspectives of people who were pregnant with OUD in jail.

## 2. Methods

### 2.1. Overall study design

We conducted semi-structured qualitative interviews from October 2020–November 2021 with a purposive sample of pregnant and postpartum people with OUD who were in jail while pregnant at 4 jails and 3 community opioid treatment providers (OTPs) across four states in the Eastern U.S.: Florida, Maryland, Ohio, and Virginia. Participants who were not incarcerated at the time of their interview reported on their experiences at non-study jails and may have reported on multiple experiences of jail incarceration while pregnant with OUD. All study jails provided MOUD in pregnancy; we could not verify the official MOUD pregnancy policies in jails that were not in our study.

### 2.2. Recruitment, participants, and study procedures

We identified study jails through responses to our national survey on pregnancy MOUD in jails (Sufrin et al., 2022). We had no geographic restrictions as we planned remote interviews. We located community OTPs through an internet search for programs that serve pregnant or postpartum people. Each site identified a non-custody staff person to serve as the liaison for recruitment efforts. Incarcerated participants had to be over 18 years old,

English-speaking, currently pregnant in jail, and using opioids in the three months prior to arrest. Community OTP participants were either currently or recently pregnant, and their experience of being pregnant while incarcerated and using opioids must have been within the last 2 years. We did not use DSM-V criteria for OUD, but rather applied broad criteria of self-reported opioid use during pregnancy, because we wanted to document the experiences of people who would benefit from treatment in jail. In this paper, we report this as OUD.

We contacted the site liaison weekly to inquire about new pregnant or postpartum admissions, and arranged a phone call with interested people to explain the study and assess eligibility. We conducted most interviews remotely via Zoom or telephone due to COVID-19, with some community OTP participant interviews being in-person. Participants were located in a private space to ensure confidentiality with jail staff. Interviews lasted 90 min and were audio-recorded, transcribed verbatim, and reviewed for accuracy. We used a HIPAA-compliant professional transcriptionist who has been approved by the Johns Hopkins IRB to transcribe all interviews. First names and agency names were included in the recordings and transcripts, but no individual identifiers were included. We stopped interviews once we reached thematic saturation.

Two female study team members interviewed all study participants. Our interactions with participants were for research purposes only and usually involved 2–3 touchpoints including the recruitment call, interview call, and a follow-up call for study remuneration. Both interviewers are extensively trained in qualitative research methods. Interviewer 1 (CS, principal investigator) has conducted research on reproductive healthcare for incarcerated pregnant people for over 15 years, and interviewer 2 (CK, senior research program manager) for nearly 5 years. During the recruitment and interview calls, we informed participants of the purpose of the study and our professional identities. Although CS is a medical doctor, she was explicit that she was not their doctor and could not give medical advice. We answered any further questions they had about the study or research team.

### 2.3. Interview guide

We developed the interview guide to explore how pregnant and postpartum people with OUD experienced addiction and pregnancy care while in and returning from jail, eliciting details about the clinical and social details of receiving MOUD or enduring withdrawal in custody. We asked open-ended questions about their experiences from intake, throughout the jail stay, and return to their community. We grounded the guide in theoretical and empirical foundations of the coercive, traumatizing, and stigmatizing nature of incarceration, especially for pregnant individuals and those who use drugs (Cavanagh et al., 2022). We understand these power dynamics and traumas within the broader context of reproductive justice, a framework developed by and centering Black women and others whose reproduction has been devalued (Ross & Solinger, 2017). We asked questions specifically around stigma to understand how participants thought about themselves, their pregnancies, and mothering. We gained input on the interview guide from two focus groups conducted with pregnant and postpartum people in the community with OUD and incarceration histories. Twelve participants joined the focus groups (7 in group 1 and 5 in group 2). They lasted approximately 90 min. We shared the purpose of the meeting and our

intended goal for the study before reviewing the interview guide. We asked them about the tone and framing of questions, what terminology is best to use, and how to approach difficult topics like trauma and child welfare. We then used their feedback to revise the interview guide before starting interviews. Focus groups participant provided consent to be in the study and were paid for their participation.

### 2.4. Data analysis

We applied thematic analysis based on descriptive phenomenology (Sundler et al., 2019). The codebook was developed iteratively over time. CS and CK developed an initial codebook based on *a priori* domains in the interview guide which was informed by prior research, theoretical foundations about the intersections of the criminal legal system, substance use, and pregnancy through the lenses of coercion, stigma, and differential valuing of people's reproductive worth; our team's deep knowledge of carceral health care delivery mechanisms; and focus groups with pregnant people with OUD who were previsouly in jail. We then added additional inductive codes from emergent and recurrent themes in the interview content. CS, CK and TZ manually coded all transcripts and post-interview memos and met regularly to ensure concordance and make adjustments to the codebook as needed. All three coders met periodically to discusse shared conceptual understanding. We then identified emergent themes from the interview content within and between codes. Coders reflected on their positionalities during the coding process, as researchers who have not personally experienced incarceration or OUD, taking care to consider how this might influence interpretation and representation of others' lived experiences.

### 2.5. Ethical considerations and terminology

The Johns Hopkins School of Medicine Institutional Review Board approved this study, and we also obtained approval from all participating sites. Study procedures aimed to avoid coerced participation, including having a lag time between recruitment and interview calls. We compensated participants with a $30 gift card. For those incarcerated at the time of the interview, we arranged to send the gift card after release. We use pseudonyms to maintain confidentiality of study participants. Participant characteristics at the time of the interview are reported with each quote; when type of MOUD is included, it is for their MOUD at the time of interview, not necessarily in jail. In the results, we refer to "women" because all participants identified as women, but we acknowledge that some transgender men and non-binary individuals also have the capacity to become pregnant. Additionally, we use the word "baby" to refer to both an infant and fetus, because participants referred to their developing fetuses as "babies."

## 3. Results

We interviewed 32 women; at the time of the interview, 23 were pregnant, nine were postpartum, half were in jail, and half were in the community. See Table 1 for the number of participants enrolled at each study site. Ten discussed experiences of going through withdrawal in jail, and 25 described receiving MOUD in jail. The majority of participants (24/32) were white and had a high school degree/GED or some college/trade school. Most had been previously incarcerated (29/32), including 8 while pregnant; were unemployed

(25/32); and relied on public insurance (23/32). About two-thirds (21/32) had child welfare system involvement. Table 2 provides demographic, pregnancy, and incarceration characteristics. All participants were using opioids prior to their arrest while pregnant or were on MOUD. Some participants reported several experiences of being incarcerated while pregnant and using opioids. These experiences consisted of multiple jail stays within one pregnancy or across prior pregnancies.

Overwhelmingly, women described concern for their babies and that they wanted to be "clean." For most, clean meant not using illicit or unprescribed drugs as well as living a healthy stable life. Many viewed MOUD as a pathway on the recovery continuum to getting clean but eventually wanted to wean off. Within this overarching context, we identified five themes around how pregnant women with OUD experienced incarceration: 1) lack of counseling or accurate information about MOUD in pregnancy; 2) absent, delayed, or coercive care in jail; 3) experiences stigma and discrimination from staff and caregivers; 4) structural barriers to safe transitions and continuing MOUD; and 5) the destructive presence of CPS for care continuity.

### (1) Lack of counseling or accurate information about MOUD in pregnancy

Many participants described their desire to learn about treatment options for OUD, whether medication treatment was safe while pregnant, and about potential for neonatal opioid withdrawal syndrome (NOWS), yet many did not receive such counseling. This finding held for women in jails both with and without MOUD. Monique, for instance, who was pregnant and started buprenorphine at a study jail, explained "I mean I don't want her to have to go through withdrawal symptoms. … I've never had a baby on methadone, so I don't really know too much about how it affects the baby." While she was at a jail that had provided MOUD in pregnancy for years, she received no counseling on the effects of MOUD on her pregnancy or newborn. We interviewed Patricia, who was postpartum and on buprenorphine at an OTP, about her experiences in a non-study jail with no MOUD when she was three months pregnant. She described how even when she was able to see the jail physician about her withdrawal symptoms, she received no medications for symptoms, and no counseling about MOUD as an option:

> No, they didn't bring [MOUD] up - they didn't talk to me about any of it. They never brought up treatment. The only thing we talked about was when I told the doctor that I was getting high and I was trying to get into a program. He said, well, we don't offer none of that here. I can only give you Tylenol with codeine …. He never offered any kind of solution. Once he found out I was allergic to codeine, that was it.
>
> -Postpartum on buprenorphine in the community

In addition to lack of treatment, Patricia's medical visit was marked by inaccurate clinical information, as acetaminophen with codeine is not recommended, nor an FDA or Drug Enforcement Administration (DEA) approved use for managing withdrawal symptoms.

Specifically, participants expressed concern that jail physicians and nurses had little clinical knowledge about MOUD and withdrawal in pregnancy. Many participants felt this deficit

may have contributed to the lack of counseling, as Rachel, who was postpartum and on methadone in the community, described: “The doctors that I saw at the jail, I don’t–they didn’t really seem to have much knowledge on very much. They were always – he was always, like, looking up everything you asked about in a book or someplace.”

Despite these gaps from jail staff, various participants conveyed nuanced understandings of MOUD treatment in pregnancy from prior treatment experiences. For example, Phylicia, who was pregnant at a study jail, shared that when the jail staff started her on buprenorphine they were unaware that buprenorphine is most safely administered after the early signs of withdrawal to avoid precipitated withdrawal:

> I know that there’s like precipitated withdrawals and I know those are like really dangerous . … And but I kind of knew, in the back of my head – because like, if you still have opiates in your system, like you have chances of like kicking precipitated withdrawals in. … Because I’ve taken the medication before. But I was afraid that, if I had refused the medication, that, maybe, they wouldn’t give it to me like in the future. … So, naturally, I started going kind of into withdrawal. … And, when I tried to explain to them what was going on, they had no idea what it was. ….
>
> -Pregnant on buprenorphine in jail

Despite Phylicia’s accurate understanding of buprenorphine, she was dismissed by jail staff. It was clear to her that jail staff needed “a little bit more education when it comes to administering this medication.” Ashley, who was pregnant at a study jail, also described how she received no counseling on the effects of withdrawal and treatment on her baby, she was just told she needed to start buprenorphine: “The jail [doctor] didn’t really explain much to me, just basically that I needed to take the Subutex so I wouldn’t hurt the baby as I’m going through detox. And that’s pretty much it. And they didn’t really tell me more about it than that or what I would be going through down the road.”

For many participants, this lack of clinical knowledge caused mental distress and cultivated mistrust in care providers. For example, when jail clinicians started Ashley on buprenorphine, her dose was too slowly escalated from 2 mg to 4 mg over several days. As a result, she experienced significant withdrawal symptoms and worried about how this would impact the health of her baby:

> I mean it would definitely help, I mean just to know what I’m supposed to be going through and what I shouldn’t. Like, right now, I mean detoxing every day, is that hurting my baby still? Or am I just enough to where I should suffer the little children a little bit because I’m an addict, and that’s what they’re expecting? [laughs] You know what I mean? Like, I don’t know. So, maybe a little bit of paperwork on that wouldn’t have been a bad thing.
>
> -Pregnant on buprenorphine in jail

Ashley wondered whether the jail was intentionally punishing both her and her baby because of her substance use disorder.

This lack of counseling and clinical knowledge led women to develop personal treatment strategies largely founded on inaccurate information about MOUD and pregnancy. Denise, who was pregnant at a study jail, had been sent to the hospital to begin methadone treatment, where she received no counseling about MOUD's safety in pregnancy or NOWS. Without accurate information and a desire to protect her baby, she planned her own methadone taper despite the medication being essential to her recovery. "So, it's just like I said, I don't want the baby to have to suffer or go through any problems. So that's one reason why I wanted to taper down." Several participants incorrectly believed that breastfeeding while on MOUD was harmful to the baby. They either planned to come off MOUD before birth or formula feed, despite the established safety and benefits of breastfeeding while on MOUD.

### (2) Absent, delayed, and coercive care in jail

The majority of participants were using non-prescribed opioids regularly at the time of their arrest; consequently, individuals incarcerated in jail facilities without MOUD endured opioid withdrawal. Teresa put it in simple, harrowing terms: "You feel like you're going to die." She was pregnant and in jail at the time of her interview, and though she had been on methadone prior to her incarceration, it took several days for the jail to dose her which pushed her into withdrawal. Patricia, who was postpartum and on buprenorphine in the community at the time of her interview, described withdrawal in jail as "the worst thing I've ever been through in my life– and I have buried two of my children." The pain of withdrawal was compounded by distress about how the symptoms of withdrawal were affecting her baby: "This time when I was going through the withdrawals while being pregnant, I was just mainly concerned about losing my child."

Patricia received no withdrawal care or MOUD treatment for the six days she was pregnant in jail. As a result, upon jail release, she recalled: "I was still in so much pain that it was ridiculous. So naturally I went and got something." Concerned about the health of her baby, she immediately purchased street opioids, not to get high, but "only doing enough to—to make it so I could function so that the baby wouldn't feel any of it. … I was just trying to keep my kid ok." The absence of post-release care led her to develop her own treatment strategy, taking illicit opioids to avoid the harmful effects of withdrawal on her baby, but with its own harmful implications.

When care was present in jail, it was often seriously delayed. Whether experiencing withdrawal symptoms or awaiting MOUD treatment or prenatal care, participants shared that it often took days or even weeks to see a medical provider. One participant described being screened by a physician upon intake, yet receiving no care during the first few days as she went into withdrawal. She thought that because she was pregnant, "I would have been like a top priority to see the medical provider," but at the time of her interview, three weeks had passed and she still had not seen a provider.

Broken promises of prompt care exacerbated frustration at its delay. Emily described this neglect in unsettling terms:

> I couldn't eat or nothing. I was puking up stomach acid, couldn't keep water down or nothing. And they told me, like, I kept asking and beating on the door for, to get

> help, because my stomach was cramping. And I told them, and all they did, every time they'd come, was just take my blood pressure. And they're, like, 'You just have to wait on the doctor, wait on the doctor.' So, I just waited it out. And it took - it took about two days.
>
> -Postpartum on buprenorphine in the community

Denise, who was in jail at the time of the interview and had been taking methadone pre-incarceration, did not receive methadone until she was taken to hospital four days after her intake, "which I thought was extremely crazy because, you know, I was already through the worst of it, you know, by the time that I was given the option to finally get my methadone back." This delayed care not only forced Denise to endure withdrawal, but also made her consider discontinuing methadone treatment altogether. This delayed care contributed to feelings of mistrust, and later in the pregnancy when Denise experienced bleeding, she did not report it to the jail nurses because she did not trust that she would get appropriate care. Such deficiencies in care threaten these women's abilities to safely have children, invoking one of the core tenets of reproductive justice.

A few participants did report prompt transfer to a hospital after jail staff learned of their pregnancy and opioid dependence. However, these participants reported that they were not given a choice about which MOUD medication they were given or about initiating MOUD altogether. Alex explained that she did not want to be on MOUD during pregnancy, but was forced to take the medication in jail:

> I want to do what's right for the baby, but I, personally, didn't want to be on the medication. And I asked multiple times to be off of it. And they said that wasn't an option. I did not want to be on this medication long-term . … It was very black-and-white. If I stop taking the medication, I could lose the baby.
>
> -Pregnant on buprenorphine in the community

Faced with no "options," Kristen, who was postpartum and on buprenorphine in the community at the time of the interview, also described the coercive nature of the MOUD care she received. She felt that she was placed on too high of a methadone dose by the jail in pregnancy and was then forced to detox in jail postpartum.

> Because I really didn't have a choice in the matter. They automatically put me on methadone when they found out I was pregnant the previous time. And the way that the methadone clinic does it is: you go up five milligrams every time you dose, after you screen your drug screens, and they got me up to 150 mg, and that was a real, real high dose for me and my baby, and it honestly felt like a high. … And then, when my daughter came out, she withdrew really, really bad. And then when I came off of it, I ended up going back to jail, and I wasn't pregnant, and they detoxed me cold turkey off of it. It was - it was pretty bad. … There's no way I could've refused [methadone while pregnant].
>
> -Postpartum on buprenorphine in the community

Kristen felt disempowered, and then endured physical suffering from inappropriate detox postpartum and emotional suffering from her infant's withdrawal. Jail is an inherently

coercive place, and for Kristen and Alex, they felt that coercion through forced treatment; this also violated their right to bodily autonomy, a tenet of reproductive justice.

### (3) Experiences of stigma and discrimination from staff and caregivers

Nearly every participant reported feeling judged by jail staff, whether through subtle gestures, insulting side comments, or direct insults. Women felt that they were singled out by medical and custody personnel because they were pregnant, "inmates," and "addicts."

Patricia felt like the jail staff consistently stigmatized her because of the false assumption that she did not care about her baby, when her baby was actually her primary concern.

> And, like, the COs [custody officers] just - they just looked at me like I was the worst person in the world because I was using drugs while I was pregnant. … Every time they would bring meals in, they would be, like, hmm, she probably won't eat. She don't care about anything else. She don't cared about the baby when she was getting high. And I'm just, like, what? Why? Just every time they - every time a guard would come and they would see me, it was a smart comment. … I got these people looking at me like I didn't even try or, like, I didn't even care, and I'm sitting there already crying asking them what else can they do? We got to be able to do something. I don't want to lose my kid and all I get told is, well, you should have thought about that.
>
> -Postpartum on buprenorphine in the community

Patricia's desperation conveyed the deep mental distress participants experienced in jail as they tried to get help. Ashley, who was started on buprenorphine at a study jail, described discriminatory treatment from the sheriff who arrested her, which surprised her because she wondered how an elected official could make her "feel like shit" for being pregnant and using drugs.

Once on MOUD in jail, some participants described the experience of MOUD administration as uncomfortable or humiliating. If they had to be taken off-site for daily dosing, they expressed feelings of shame about being seen in public waiting rooms with handcuffs and armed officers, as Michelle shared:

> I mean it's humiliating because again you are in handcuffs and jail clothes. And it's obvious that you're in jail. And then people ask questions. You know I'm not very far along, so you can't tell that I'm pregnant. And, you know, they are wanting to know why they didn't get treatment while they were in jail. And just it's embarrassing.
>
> -Pregnant on methadone in jail

Even when the medications were administrated in jail, Beatrice, who was postpartum and on buprenorphine in the community, recalled feeling "uncomfortable" and "judged" getting her dose. The jail required that a nurse watch the buprenorphine film dissolve under her tongue. Although such procedures are common practice in jails – in an effort to avoid diversion – Beatrice nonetheless felt like "they all just watched me really weird."

Participants even reported being discriminated against for taking prescribed, often court-mandated MOUD while pregnant. Lynn, who was interviewed postpartum in the community, shared:

> But I think [Suboxone] just carries this negative stigma, and people are ashamed, especially when you're pregnant. That's supposed to be this—I don't want to say, "holy thing," but it's supposed to be pure when you're pregnant. … You're like, "Well, I couldn't have my baby sober. I must—there's something wrong with me."
>
> -Postpartum not on MOUD in the community

Lynn was sensitive to the socially constructed expectation of "purity" of pregnant people. She felt that, whether she was taking illicit drugs or MOUD, she would never fulfill this standard because she could not have her baby "sober."

Many participants felt judged by both medical and non-medical staff in jails and hospitals. Ashley described being judged by the jail nurse administering her MOUD: "She's like, 'you ever think about how you're hurting your baby?'" Nikki, who was pregnant and on buprenorphine at a study jail, described similar sentiments expressed by the hospital staff caring for her newborn daughter as she went through neonatal opioid withdrawal: "It made me feel like, 'Damn. You supposed to be somebody, you know, that don't supposed to judge, you know, that supposed to help us and help me,' or whatever. … I mean, I just felt ashamed."

Rachel described the paradox of being judged for MOUD treatment in a jail that mandated methadone treatment for pregnant people:

> If you come in there off the street and find out you're pregnant and you're on heroin, they force you to get on methadone, and then they judge you for being on methadone after they force you to get on it, so it's just – it's just frustrating because, yeah, I was on methadone to kind of help my son and stay off of heroin, and they still made you feel kind of like you're – a terrible person because your baby is going to withdraw off of methadone. ….
>
> -Postpartum on methadone in the community

Shame from this stigma along with mistrust of providers led women to avoid seeking treatment for their drug use altogether. Patricia described how discrimination from jail staff made her want to return to street-based drug use:

> They talked to me like I was dirt under their feet. And it really hurt; like, it was devastating. It makes - it literally makes you not even want to tell nobody that you're on drugs or you're pregnant. You just want to go out and do what you got to do because you know at least you're not being looked at like that. You're not being talked to like that.
>
> -Postpartum on buprenorphine in the community

Despite the prevalence of discriminatory treatment by jail staff, a few participants did identify positive associations with the care they received. Denise, who was pregnant and on methadone at a study jail, had been incarcerated four times prior to this current

incarceration, yet this was her first experience being pregnant in jail. At the time of the interview, she was receiving methadone. Compared to her experiences of incarceration while not pregnant, Denise believed that "They pay more attention, are more involved compared to when you're not pregnant. They treat you differently. I think they treat you better. And, you know, are more involved just because I am pregnant." Jail either devalued the person because she used during pregnancy and presumably harmed the baby or valued her more because her pregnancy warranted special treatment for the baby.

### (4) Structural barriers to safe transitions and continuing MOUD

Jails alone were not responsible for determining pregnant women's ability to access treatment. Several women were mandated by judges to be on MOUD, only to be sent to jails without treatment. Probation officers also often required women to be in treatment to avoid further incarceration. This fragmented system created mental distress and forced women to develop their own treatment plans while navigating institutional demands and the bureaucratic cracks between them.

Denise was on methadone in the community for over a year, before and during pregnancy. She had an outstanding warrant that she wanted to clear, and before turning herself in she called the jail to ask whether she could continue her medically prescribed methadone in jail, and they said "no." Because she knew she would not have access to methadone in jail, Denise switched from treatment to using heroin prior to turning herself in, since the withdrawal from heroin, she said, was quicker and easier than methadone.

Patricia's experience illustrates the complex predicaments created at the intersections between institutional and bureaucratic practice. The jail in which Patricia had been confined provided her with no MOUD, no reentry services, nor referrals for treatment in the community. She was released from jail at 1:30am and immediately used heroin. With the help of her brother, she soon got into a treatment program that started her on buprenorphine. When she returned to court, the judge mandated her to a residential treatment program. When Patricia located a program that accepted pregnant people and had an available bed, she learned that the program only accepted people directly from the county jail. Then to enter the program, the judge sent her back to jail, the same jail with no MOUD where she went through opioid withdrawal from her mandated buprenorphine.

The majority of participants reported being released from jail without referrals to treatment, information about community-based resources, or any basic plans for housing or medical insurance. Many participants attributed their relapse to this lack of reentry support from the jail. Bethany, who was at a study jail, for example, was on methadone while pregnant, but as soon as she delivered the baby, the jail tapered her off methadone. Without any linkage to community-based treatment resources, she was able to abstain from use for two days post-release and then relapsed. Monique, who was pregnant and on buprenorphine at a study jail, was in a similar situation, and described the acute withdrawal from MOUD compounded by reentering the community without any support in these terms: "It's kind of like I'm going to be broken down completely and just thrown out to the wolves." Once Bethany and Monique were no longer carrying their babies, the jail deemed these women

no longer worthy of MOUD treatment. This disruption to their recovery interfered with their abilities to parent their children in safety, a tenet of reproductive justice.

Some women did receive reentry support. Michelle was referred back to the community-based obstetrician who had prescribed her buprenorphine prior to her incarceration. This continuity made her feel supported both in and out of jail, given that she had a plan for community-based care.

Sometimes, institutional and bureaucratic barriers were mitigated by other actors. For example, Holly, who was pregnant and incarcerated in the same study jail as Michelle, was started on buprenorphine when the jail transported her to a local hospital. She reported feeling grateful that the hospital obstetrician had walked her through the steps to continue buprenorphine upon release since jail providers had given her no reentry support. Participants offered many suggestions for reentry services that the jails could provide including: assistance with Medicaid (re)enrollment; housing and transportation support; assistance with locating and contacting outpatient and inpatient addiction treatment facilities, and referrals to prenatal and infant care providers. Without this support, Monique framed the grim reality of life in the community in this way: “it’s definitely … cheaper to go buy drugs than it is to get treatment without insurance.” Study participants also made suggestions for reentry preparation. They wanted social workers who could connect them with services in the community and could begin this linkage while incarcerated.

### (5) The destructive presence of CPS for care continuity

Participants described the powerful presence that CPS (i.e. child welfare, Department of Social Services) had in navigating reentry from jail, barriers to care, and the cracks between the different institutions governing their lives. In certain states, CPS is required to investigate when a parent is on MOUD. Monique offered details about this process:

> I think it’s very strange that even when you’re on Suboxone, CPS will fully investigate and fully be involved in you and your kids’ life, even if it’s just Suboxone. That they do an in-depth research, I guess, into you. You have to see them every couple months and everything … I did deal with them for the first year and a half of my daughter’s life. And then with my son, I was investigated. And then I’m sure with this baby I’ll be investigated as well.
>
> -Pregnant on buprenorphine in jail

Monique was confused that she was doing the right thing by being on treatment yet was still subject to CPS’ control. Rachel, too, noted that the hospital was required to call CPS and initiate “in-depth research” when a mother was on MOUD, which she told us was a downside to taking methadone. Other participants like Cecile, a postpartum woman on naltrexone in the community, reported that when she was on methadone CPS workers wanted her to wean off the medication. This desire went directly against medical recommendations. The majority of these participants felt that CPS involvement in MOUD treatment, as one woman put it, “makes you feel like you did something wrong.”

Some women were deterred from seeking care for their substance use for fear of having CPS involved in their lives. Diana, who was pregnant and on methadone in the

community, wanted additional support while under CPS supervision yet feared the potential consequences: “If I ask for more help or whatever, they’re going to think that I’m way worse than what I am. I don’t want them to be like, ‘Well, if you’re doing so much better and you’re not getting high right now, why do you need this, why do you need that?’” This fear of CPS involvement made Phylicia hesitant to take methadone and be honest with her doctor:

> If I’m on this medication and I have my baby and I’m in the hospital and they – because they’ll do a drug analysis or take the baby’s hair or however they do that – am I going to get in any – like are they going to look at me and say, hey, because I’m on this medication for opioid use, are they going to – is DCF [Department of Child and Family] going to step in and say, "Hey, let me make a plan – case plan or something like that for you"? Because that was a huge concern of mine. … Because, you know, of course, like I don’t, you know, want to have the state involved in my child, you know, in the birth of my child.
>
> -Pregnant on buprenorphine in jail

Participants described child removals by CPS as horrible traumas, ones that often prompted relapse. Monique shared: “it’s going to make it even harder for them to stay clean. Because now they got clean in jail for this baby, and now they’ve had this baby, the baby’s gone. And it’s like their will to get clean and try and do something with their life is taken away.” Monique noted the counterproductive logic of child removals from a mother in recovery. CPS’s omnipresence for women like Monique, interfered with their reproductive justice right to parent in dignity and safety.

Yet not all participants’ interactions with CPS were negative. Michelle described the positive interactions she had with CPS and the support that her caseworker gave her:

> Actually, they’ve been really good. They – I’ve complied with everything that they’ve asked me to do up until, you know, I can’t really do anything right now. But I spoke with her last week about the treatment facility and she was onboard with me going there and getting a ride when I do go. It’s been pretty easy dealing with her, like I said, because I have no objection to what she wants me to do.
>
> -Pregnant on methadone in jail

Even as Michelle identified her CPS interactions as “easy,” she nonetheless felt that her ability to parent was beholden to CPS workers. While she was optimistic, this view on their control resonates with other women’s fears of the CPS’ control.

## 4. Discussion

While our findings resonate with several qualitative studies of non-incarcerated pregnant and postpartum individuals with OUD (Damon et al., 2017; Moore & Butzlaff, 2023; Schiff et al., 2022; Work et al., 2023), this study is the first to our knowledge that gives voice to the experience of being incarcerated and pregnant with an OUD. Participants described numerous instances of substandard and even dangerous care while incarcerated,

demonstrating that pregnant women with OUD in jail experience suffering that is unique to their status of simultaneously being pregnant, incarcerated, and using opioids.

A critical issue identified by this study is that MOUD is not accessible for many incarcerated pregnant individuals. This study highlighted that bureaucratic court and jail procedures directly interfered with patients' treatment needs— for example, not being allowed to continue their prescribed or court-mandated MOUD in jail. Their lived experiences of no or delayed MOUD and poor treatment align with our national survey of U.S. jails with respondents from 47 states in which we found that MOUD was not consistently available for pregnant patients (Sufrin et al., 2022). Findings from this national study identified that only 60% of jails continued a pregnant patient's pre-jail MOUD, and only 32% initiated MOUD in pregnancy. Most MOUD-providing jails in the survey discontinued MOUD postpartum—something our participants endured. The national survey identifed geographic variability within and between states, including in Florida, Virginia, Ohio, and Maryland, sites represented in the present analysis. Our qualitative findings here, along with our prior national survey results, refute a common misunderstanding that correctional facilities prioritize pregnant patients for MOUD treatment (Grella et al., 2023; Nunn et al., 2009).

Our study also highlights the high frequency of experiencing withdrawal while incarcerated and pregnant—even at jails that provided pregnancy MOUD, but imposed delays in dosing. Withdrawal caused intense physical symptoms and concern over fetal well-being. In our study, many women experienced the withdrawal as uniquely punitive because they were in jail. None of our participants who endured withdrawal in jail—which was often not medically supervised— reported adverse fetal outcomes from withdrawal; this aligns with findings from a systematic review of opioid detoxification during pregnancy that medically supervised withdrawal in pregnancy is itself not associated with fetal demise or preterm birth (Terplan et al., 2018). However, withdrawal is nonetheless extremely painful and can have other ramifications, such as high risk of return to use, as was noted in the systematic review. This return to use was the experience of some of our participants who were denied adequate treatment in custody.

Participants identified that when care was present, it was often coercive. Coercion can be counterproductive to treatment, as shown in a qualitative study of 39 people on methadone in a community program, which found that people who started treatment at vulnerable "crisis moments," including incarceration or pregnancy, were more likely to feel coerced to start methadone and less likely to continue (Damon et al., 2017). But in our study, women experienced synergistic pressure due to their pregnant status and the inherently coercive environment of incarceration; indeed, some felt pressured by jail staff to be on MOUD, fearing immediate punishment if they declined. What is different about our study is that coercion, lack of autonomy, and punishment are explicit dimensions of jail culture. Incarcerated participants have no options to seek care elsewhere, and have legitimate fears of being immediately punished if they do not comply. The coercion, whether forced withdrawal or forced MOUD in jail aggravated women's existential fears for their babies and their status as mothers. This resonates with Schiff et al.'s qualitative study with 26 non-incarcerated pregnant individuals with OUD (Schiff et al., 2022). Women described a lack of autonomy and a double-bind in decision-making around treatment: they felt pressured to be on MOUD

because of their concerns for fetal wellbeing, but also felt punished by the requirements of child protective services (CPS) (Schiff et al., 2022). Similarly, most of our participants experienced contradictions and pressure from looming CPS cases. The pervasive fear of CPS among pregnant patients using substances has been reported elsewhere (Work et al., 2023), but in our study these feelings were amplified by the overtly punititive status of the jail. Furthermore, while previous studies have documented the judgment of unworthy motherhood that pregnant people who use drugs face (Moore & Butzlaff, 2023; Work et al., 2023), our participants' experiences reflect additional vectors of stigma from the criminal legal system via custody officers, jail nurses, and municipal judges.

While our participants consistently prioritized their babies' wellbeing, they received little to no counseling about the effects of MOUD and withdrawal because jail providers had limited understanding of the different MOUDs in pregnancy, of neonatal opioid withdrawal syndrome (NOWS), and of breastfeeding. Without accurate information, some returned to use, similar to the women in the Schiff's study, who were more likely to discontinue MOUD if they did not receive adequate information about it, especially if they believed MOUD posed risks for their babies (Schiff et al., 2022). Whereas women in Schiff's study could in theory freely seek out information, in jail, women's access to information is entirely controlled by the institution, and they have no autonomy to seek information elsewhere. This gap in accurate and compassionate information in jail has negative impacts on treatment engagement for incarcerated pregnant people with OUD.

Participants' experiences varied within a single jail and between jails, suggesting a need for training and standardization. Standardization of care is especially difficult in local jails, which are under county jurisdiction with little oversight. Desipte the constitutional mandate to provide care, there is no federally required set of health care services that county jails must provide (Saloner et al., 2022; Winkelman et al., 2022). This gives tremendous discretionary power to individual jail leaders to decide what they will provide—and this can exclude MOUD, even in pregnancy. Additionally, the method of health service delivery varies from jail to jail. Some jails contract with private health care companies, others partner with academic institutions, and others have different arrangements with varying levels of capacity and resources in their surrounding communities.

Perhaps the most crosscutting interpretation of our study participants' experiences was that these systems consistently considered the mother and baby as separate beings, with distinct needs, who were separately deemed worthy or unworthy of care. Rather than considering mother and baby as a dyad, or a relational being whose needs and interests cannot be separated from one another, we found that systems of incarceration consistently split them apart, both while pregnant and postpartum. For example, policies that only provide pregnant people with MOUD yet discontinue care postpartum directly split mother and baby, such that care for the mother postpartum is no longer considered necessary for the health of her baby, despite the evidence-based increased risk of relapse (Schiff et al., 2018), which could impair her ability to care for her child. Additionally, the well-being of the baby is impacted by the carceral system that delays or denies care and does not provide accurate information to the pregnant person, all the while, in our study, dismissing participants' concerns about the wellbeing of their babies. These pregnancy-specific factors and the failures to address

them in jail can decrease pregnant patients' engagement with both addiction treatment and prenatal care which, in turn, impact babies' well-being (ACOG, 2017). Furthermore, these dismissals contribute to disrespectful maternity care which has been linked to maternal mortality (Mohamoud et al., 2023). These findings reflect the interconnectedness of the core tenets of reproductive justice, and the ways that OUD mistreatment in pregnancy in jail disrupts those tenets (Hayes et al., 2020).

Findings from this study offer concrete recommendations for improved treatment experiences and outcomes for pregnant and postpartum people with OUD, both for jails that already provide MOUD and those that do not. Participants' experiences highlighted the need for pregnancy-MOUD specific training for jail clinical and custody staff, to be able to provide information and counseling that is accurate and delivered with compassion. Participants wanted jail workers to understand that they were "human," that they suffered from a disease yet cared deeply for their babies' wellbeing. Training to reduce stigma and maternal mistreatment should emphasize OUD in pregnancy as a chronic medical condition that requires treatment rather than a personal failure. Clinical staff would benefit from education on the standard of care for MOUD treatment in pregnancy and postpartum; on how to counsel patients about NOWS expectations, and that breastfeeding while on MOUD is safe and recommended. Clinical jail staff also need to be trained in providing non-coercive MOUD care to pregnant people, treating withdrawal symptoms, and referrals for appropriate services. These carceral workers would benefit from understanding that MOUD is not only critical to the health of the mother but also to the baby and they cannot treat or harm one without treating or harming the other. There are several toolkits and position statements addressing either OUD care in carceral settings, pregnancy care in carceral settings, and OUD care in pregnancy published by national organizations (Bureau of Justice Assistance, 2023; National Commission on Correctional Health Care, 2021; ACOG, 2021; Substance Abuse and Mental Health Services Administration, 2018, 2019). However, integrated guidance for pregnant individuals with OUD in custody is lacking and study findings highlight that such tailored guidance is critically needed.

Policies and operations within jails should be structured in a way that expedites both screening for pregnancy and OUD and MOUD treatment either on or off-site. Given participants' vulnerability to relapse upon release, jails need to ensure MOUD treatment linkage in the community and release people at times that facilitate access to this treatment. This includes direct connection with MOUD providers in the community who treat pregnant patients, and for buprenorphine, releasing patients with a 2-week supply. Given the humiliation that some participants described in off-site MOUD treatment facilities, jails and OTPs should work together to enact humanizing practices for facilities that cannot establish on-site MOUD care. Examples would be using a separate entrance to an OTP to maintain privacy, and refrain from shackling pregnant people when taking them for MOUD dosing—often a violation of state law.

Several states have enacted legislation to require MOUD in jails or prisons, which is a political effort that should be scaled up nationally (Pivovarova et al., 2022). Additionally, the federal legislature should extend Medicaid coverage inside carceral facilities to fund MOUD provision and the infrastructure to ensure consistent linkages to community MOUD

providers upon release. While several states have applied for waivers for Medicaid to cover care in custody, few have been approved (Kaiser Family Foundation, 2024).

Our findings should be considered in light of several limitations. One is that we could not verify the official MOUD or pregnancy care policies in certain jail facilities, as some participants were interviewed in the community and described experiences in jails that were not in our study. These experiences convey what is happening in facilities regardless of their official protocols. There may have been potential challenges with participants remembering all the details of their jail stays, given the time between jail-based experiences and time since release. Some participants were recounting their experiences from incarcerations that took place up to two years prior to the interview. Jails that agreed to be recruitment sites may be providing better care, so we may have missed cases of even poorer treatment. There also may be jails not part of our study that provide robust and compassionate MOUD care to pregnant and postpartum individuals. Those facilities would be important to understand so they could serve as a template for other jails. Furthermore, most participants were white. Yet, the medical, legal, and cultural responses to the opioid crisis are highly racialized (Hansen et al., 2023), and thus our study could not adequately explore how racism might have inflected pregnant women's experiences in jail.

The trauma pregnant people with OUD endure in jail, with or without MOUD, signals the need for policy changes that reduce criminalization and increase investment in the medical, recovery, and structural supports they need in a more healing setting. While jails are constitutionally required to provide health care, and some states mandate MOUD in jail (Pivovarova et al., 2022; Rold, 2008), our study shows legal mandates are insufficient to ensure effective care. As more jails work to implement access to MOUD for all people in custody, they must also be attuned to the specific needs of pregnant and postpartum individuals. Establishing evidence-based, comprehensive, and compassionate care for pregnant people with OUD who are cycling through jails is an essential strategy to promote maternal health equity and to reduce opioid-related maternal mortality.

## Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

## Funding

This study was funded by grant NIDA-1K23DA045934-01 from the National Institute on Drug Abuse of the National Institutes of Health.

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**Table 1**

Number of participants enrolled at each study site.

| Study Site | Pregnant (N = 23) | Postpartum (N = 9) | Total (N = 32) |
|---|---|---|---|
| Jail 1 (Virginia) | 11 | 0 | 11 |
| Jail 2 (Florida) | 4 | 0 | 4 |
| Jail 3 (Florida) | 1 | 0 | 1 |
| Jail 4 (Virginia) | 0 | 0 | 0 |
| OTP 1 (Ohio) | 3 | 4 | 7 |
| OTP 2 (Maryland) | 2 | 3 | 5 |
| OTP 3 (Maryland) | 2 | 2 | 4 |

## Table 2

Participant characteristics.

| Characteristic | Interviewed in jail (N = 16) | Interviewed in community (N = 16)[a] | Total (N = 32) |
|---|---|---|---|
| Average age (years, range) | 30.1 (24–43) | 31.2 (24–38) | 30.6 (24–43) |
| Pregnancy status at interview | | | |
| Pregnant | 16 | 7 | 23 |
| Median gestational age (weeks, min, max) | 23 (8,33) | 32 (16,36) | 28 (8,36) |
| Postpartum | 0 | 9 | 9 |
| On MOUD in pregnancy in jail[b] | 15 | 10 | 25 |
| Experienced withdrawal in pregnancy in jail[b] | 4 | 6 | 10 |
| Previously incarcerated | 16 | 13 | 29 |
| Number of living children (median, min, max) | 2 (0,4) | 3 (0,6) | 2 (0,6) |
| Number with child welfare system involvement | 9 | 12 | 21 |
| Race and ethnicity (self-reported) | | | |
| Black, non-Hispanic | 2 | 1 | 3 |
| White, non-Hispanic | 11 | 13 | 24 |
| Bi/Multi-racial | 2 | 1 | 3 |
| Unknown race, Hispanic | 1 | 0 | 1 |
| Highest education level | | | |
| Primary school | 0 | 2 | 2 |
| Some high school | 3 | 0 | 3 |
| High school diploma/GED | 6 | 8 | 14 |
| Some college | 6 | 2 | 8 |
| Trade school | 0 | 2 | 2 |
| Unstable housing before arrest | 7 | 3 | 10 |
| Employment/source of income | | | |
| Employed | 3 | 1 | 4 |
| Unemployed | 11 | 14 | 25 |
| Sex work | 1 | 1 | 2 |
| Drug trade | 1 | 1 | 2 |
| Health insurance status when not in custody | | | |
| Public insurance | 12 | 11 | 23 |
| Private insurance | 1 | 2 | 3 |
| None | 3 | 1 | 4 |

[a]Missing data for the following characteristics for participants in the community: age (n = 1), location of pregnancy discovery (n = 1), previously incarcerated (n = 2), race (n = 1), highest education level (n = 1), housing status before arrest (n = 2), employment status (n = 1), health insurance status when not in custody (n = 2).

[b]Some participants experienced both MOUD and withdrawal within the same stay due to >48 h delay in getting medication.