MOMCARE

Maternal Opioid Use Disorder Management and CAre REsources in Custody

WHAT CUSTODY STAFF SHOULD KNOW: PREGNANT PATIENTS WITH OUD

This document provides vital information for custody officers on how to manage issues they may encounter with pregnant and postpartum patients with OUD in custody. We know custody officers are not medical personnel, but this content will help you know when to call medical or refer for a higher level of care, and what to do until they arrive.

How

- If you're an officer involved in intake for new detainees, use the **MOMCARE Initial Pregnancy & OUD Screening and Care at Jail Intake algorithm** for best practices. Alert medical staff to conduct a full evaluation and possible referral for a higher level of care if a pregnant patient reports or if you observe any of the following things:
  - **Urgent maternal warning signs** such as severe nausea/throwing up, a headache that won't go away, chest pain or trouble breathing, baby's movement decreasing or stopping, fever, and others you can find here.
  - **Signs of unwell** "unwell" means that someone has observed signs and symptoms that are obvious to a layperson that they are physically or psychologically sick, including signs of self-reported intoxication or substance withdrawal.
  - **Labor signs** such as abdominal pain/cramping, contractions that come and go, any amount of vaginal bleeding, or leaking fluid
- Know when to transport pregnant patients, including those with OUD, offsite for a higher level of care. See **MOMCARE When to Transport** for more details. Briefly, offsite transport is required for instances where qualified onsite medical is not available:
  - Urgent maternal warning signs, signs of being unwell, or labor
  - Pregnant patients starting MOUD/MAT
  - Pregnant patients going through withdrawal, including from alcohol or benzodiazepines
- In 42 states and DC, it is prohibited to use restraints (handcuffs, belly chains, ankle chains) on pregnant patients in custody who are in labor, even during transport offsite. Many states prohibit restraints at other points in pregnancy. Know your **state's law** and your jail's policy to keep pregnant patients safe and avoid litigation.
- Pregnant patients with OUD who decline MOUD/MAT and are undergoing medically supervised withdrawal should have continuous access to fluids like water or Gatorade.
- Do not house pregnant patients in isolation (including medical isolation), administrative segregation, or restrictive housing.
- Recognize that addiction is a condition with a biological basis, not a moral failing, and recovery is a long process. It does not mean that someone is not fit to be a mother.
  - Use non-judgmental, humanizing language when interacting with pregnant patients with OUD. This means using **non-stigmatizing language** and avoiding words like "addict/junkie/user" and "addicted baby/drug baby/born addicted to heroin."
  - See **MOMCARE Communicating with Patients** for more details.

Why

- Custody staff are usually the first point of contact if there is an issue or emergency. It's important to be aware of warning signs that can mean a dangerous pregnancy condition or that a pregnant patient is unwell, and signs of labor (both preterm and term labor) so you can respond timely and appropriately.
- The things you say are powerful and matter. How custody and medical staff interact with pregnant and postpartum patients can influence whether they seek prenatal care and treatment for OUD, and how they think about themselves. This has an impact on their babies too.
- You can have a positive impact on pregnant patients and their babies!

Keep In Mind

- In pregnancy, many things that appear to be minor signs or symptoms that you wouldn't worry much about for a non-pregnant patient may actually indicate a dangerous issue with the pregnant patient or their fetus. Take medical-related complaints from pregnant patients seriously. They are time-sensitive.
- Symptoms of opioid withdrawal can sometimes look the same as symptoms of pregnancy—nausea, vomiting, abdominal pain, for instance. Custody officers aren't trained to know the difference, so have a low threshold for referring patients for a higher level of care.
- Using restraints in pregnancy and ignoring labor and other serious pregnancy symptoms in jail can lead to lawsuits.

FREQUENTLY ASKED QUESTIONS

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What should custody officers performing jail intake know regarding pregnancy and opioid use?

- Use the MOMCARE Initial Pregnancy & OUD Screening and Care at Jail Intake algorithm for best practices in screening for pregnancy and opioid use at jail intake.
- Sometimes people do not know they are pregnant when they get to jail. Therefore, we recommend offering a urine pregnancy test on every female (or trans-male) younger than 55 years old.
- Pregnant patients who use drugs may be hesitant to share their substance use with jail staff due to fears or consequences like having their baby taken away, added jail time, or being judged. Therefore, we recommend screening for drug use using a standardized questionnaire.
    - National guidelines recommend that you should NOT do a urine drug test on pregnant individuals because it can be inaccurate, take time, and delay someone getting timely care.
    - However, we know that some jails still prefer to require a urine drug test. If your jail does this, we recommend (and some states require this by law) getting informed consent from the patient. Here is some sample language that informs them of why you are doing it and what will happen with the results.

What should custody officers do if a pregnant patient is complaining of abdominal/pelvic pain or vaginal bleeding?

- Alert medical immediately for proper evaluation if a pregnant patient reports or you observe:
    - Urgent maternal warning signs– such as a headache that won't go away, chest pain or trouble breathing, severe nausea/throwing up, baby's movement stopping, fever.
    - Signs of unwell– "unwell" means that someone has observed signs and symptoms that are obvious to a layperson that they are physically or psychologically sick, including signs of self-reported intoxication or substance withdrawal.
    - Labor signs- such as abdominal pain/cramping, contractions that come and go, any amount of vaginal bleeding or leaking fluid.
- Abdominal/pelvic pain or discomfort in pregnancy can be an emergency. So can vaginal bleeding, even if it is not heavy.
- Take medical-related complaints from pregnant patients seriously and call for help—custody officers are not expected to make medical diagnoses!
    - In the first trimester, severe abdominal/pelvic pain or bleeding can be a sign of a miscarriage, an ectopic pregnancy, or a pregnancy in the tubes, which is a life-threatening condition.
    - Abdominal/pelvic pain, even mild cramping, might be a sign of preterm (less than 37 weeks) or term labor.
        - If the patient is preterm (less than 37 weeks pregnant) and reports cramping, new back pain that comes and goes, or contractions, have them time them. If they are less than 10 minutes apart, they should be evaluated by medical personnel. If they are more than 10 minutes apart, they should rest for an hour, drink cold water, and see if they go away, If not, they should be evaluated by medical personnel.
        - If the patient is term (more than 37 weeks pregnant) and reports cramping new back pain that comes and goes, or contractions that are less than 10 minutes apart, they should be evaluated by medical personnel—especially if they have had babies before (these labors go faster!).
    - For any amount of bleeding, notify medical personnel.

What do custody staff need to know about accompanying pregnant patients to offsite medical appointments and childbirth hospital stays?

- When a pregnant, birthing, or postpartum patient is undergoing a vaginal exam or is actively giving birth, a male custody officer cannot be present. Doing so would violate PREA Standard § 115.15, which restricts staff of the opposite gender from viewing an incarcerated person's genitals.
- In general, it is best practice to have the officer, whether male or female, stationed outside the patient's hospital room to allow for privacy during the very sensitive and emotional process of childbirth.
- If a patient is undergoing a cesarean section, the officer should be stationed outside of the operating room, not inside, to reduce the risk of surgical infection.

FREQUENTLY ASKED QUESTIONS

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Should MOUD/MAT be withheld if a pregnant patient is caught diverting or has any other behavioral infractions in custody?

- **No. MOUD treatment should not be terminated for any reason other than if the treatment is harming the patient.** It is important to understand reasons why some people in a MOUD program in jail might divert because diversion is usually a symptom of something else going on.
    - Saving dose– Occasionally, people may divert to save a large enough dose to feel euphoria. More commonly, patients might divert their medication so they can split their dose to take some during the assigned dose time and some later if they feel they are having withdrawal symptoms before their next MOUD dose. Adjusting their dose can often address this.
    - Coercion by another incarcerated individual- Someone receiving MOUD may be bullied by another incarcerated individual to divert and give them their dose, sometimes for a high or because they have opioid cravings—and would benefit from medically authorized MOUD.

- **See MOMCARE Preventing and Managing Diversion for more details.**

What are some best practices for interacting with incarcerated pregnant and postpartum patients with OUD?

- How you interact with pregnant and postpartum patients influences how they seek care or ask for help and how they think about themselves. The things you say are impactful and matter.
- Research demonstrates that when jail staff use judgmental or stigmatizing language toward pregnant patients with OUD, they are less likely to get prenatal care or substance use treatment, which can lead to overdose.
- Communication with patients should be person-centered, meaning that they are first viewed as a person rather than their circumstances or experiences.
- Jail staff should refrain from casting judgment, whether verbal or nonverbal, on pregnant and postpartum patients with OUD in custody. See MOMCARE Communicating with Patients for more details.

What other things are important to know about pregnant patients in custody?

- **Access to fluids**– Hydration is very important in pregnancy. Dehydration can lead to contractions, low blood pressure, and other conditions. All pregnant patients, especially those with OUD, should have continuous access to fluids. Allowing access to ice makes them more likely to drink the water.
- **Restrictive housing/isolation**– No pregnant patients should be put in isolation. Isolation increases the likelihood of psychological distress, may limit access to emergency medical care, is not good for maternal health, and national guidelines recommend against it during pregnancy.
- **Bottom bunk assignments**– All pregnant patients in custody should be assigned to a bottom bunk to reduce the risk of harm to the patient and the baby if they fall out of bed.
- **Work assignments**– Some pregnant patients may need a light work assignment, especially as the pregnancy progresses. Others may not be able to work at all. Consult with medical.
- **Breastfeeding**– Postpartum individuals in custody who are breastfeeding should have time, privacy, and equipment to pump milk every 3-4 hours.

RESOURCES

- MOMCARE Initial Pregnancy & OUD Screening and Care at Jake Intake algorithm
- Urgent Maternal Warning Signs
- State laws on use of restraints in pregnancy
- MOMCARE Labor Signs
- BJA Guidelines for Managing Substance Withdrawal in Jails
- PREA Standard § 115.15 (d) Limits to cross-gender viewing and searches
- Position Statement on Solitary Confinement,