



# National Judicial Opioid Task Force

## Treating Pregnant Women with Opioid Use Disorder

*This summary highlights the important evidence-based practices recommended in the Substance Abuse and Mental Health Services Administration's (SAMHSA) latest and most comprehensive guidance regarding pregnant women with opioid use disorders.*

In February 2018, SAMHSA released the new *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*<sup>1</sup> (<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>).

The *Clinical Guidance* provides reliable, useful and accurate information for professionals working to treat opioid dependent mothers and their children.

The guidance consists of 16 fact sheets on prenatal, infant, and maternal postnatal care that are directed at healthcare professionals. We believe the evidence-based practices found in SAMHSA's guidance can inform judges, court administrators, executive branch leaders, legislators, behavioral health treatment providers, community supervision agencies, medical experts, prescription drug monitoring program managers, regulatory agencies, child welfare representatives, among others. The fact that many non-medical professionals, including judges, can potentially affect treatment decisions for pregnant women with Opioid Use Disorder (OUD) can further exacerbate the care of women and their infants if

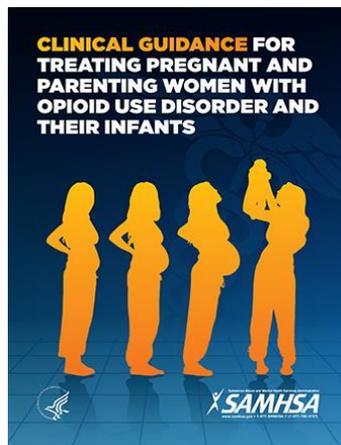
those non-medical professionals do not understand the best practices laid out in this guidance.

### Background

Treatment decisions for a mother and her fetus/infant are complex because they require balancing the needs of both patients (referred to as the maternal-fetal dyad or mother-infant dyad).<sup>2</sup> Effective interventions for OUD exist and include medication-assisted treatment (MAT). Healthy outcomes can occur for both the mother and the infant, but only when professionals can recognize and effectively treat OUD.

It is important to review the terms used in the guidelines. In clinical practice, prenatally substance-exposed infants are typically exposed to multiple substances (tobacco, alcohol, prescription medications, and illicit substances). Additionally, the research

publications relied on to support SAMHSA's guidance almost universally studied pregnant women with substance use disorders (SUDs), rather than OUD only. As such, the guidelines use the term neonatal abstinence syndrome (NAS) when referring to the withdrawal symptoms expressed by infants, as opposed to the more narrow term neonatal opioid withdrawal syndrome (NOWS).<sup>3</sup>



<sup>1</sup> Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 08-5054. Rockville, MD:

Substance Abuse and Mental Health Services Administration, 2018. Hereinafter *Clinical Guidance*.

<sup>2</sup> *Clinical Guidance*, Part A: Introduction.

<sup>3</sup> *Id.*

The overarching caveat for every best practice recommendation in the *Clinical Guidance* is that healthcare professionals need to make individualized treatment decisions because research findings can be difficult to apply clinically. Healthcare professionals must consider unique patient variables, the mother's preferences, the experience of the clinician, and resource availability.

## Initiating Prenatal Pharmacotherapy for Opioid Use Disorder

The importance of identifying OUD in pregnant women cannot be overstated. Pregnancy is a time of great potential for positive change. Once identified, pregnant and postpartum women with OUD should be encouraged to keep trying, through a combination of pharmacotherapy and behavioral interventions

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including trauma-informed care by a credentialed therapist, to reach the goal of ending substance use.<sup>4</sup> Immediate and simultaneous discontinuation of all substances may not be feasible or even safe, particularly during pregnancy because of the additional risk to the developing fetus, which may also be going through withdrawal unmonitored. It may lead to pre-term labor and premature birth. Babies born too early (especially before 32 weeks) have higher rates of death and disability.<sup>5</sup>

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<sup>4</sup> *Clinical Guidance*, Factsheet #1: Prenatal Screenings and Assessments.

<sup>5</sup> Preterm Labor and Birth Information from the American College of Obstetricians and Gynecologists (ACOG), available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm>.

Most significantly, immediate discontinuation of substances in women with substance use disorders are associated with extremely high risks of relapse and, for opioids, with an associated high risk of death. Because women with OUD are also at higher risk for HIV/AIDS and viral hepatitis infection than women who do not use substances, screening for these infections is critical.

The guidelines state that pregnant women with OUD should be offered pharmacotherapy with methadone or buprenorphine and evidence-based behavioral interventions including trauma-informed care.<sup>6</sup> Treatment without pharmacotherapy is complicated by poor fetal health, high rates of return to substance use, and significantly elevated risks of overdose. The guidelines state that there is insufficient information about the safety of extended-release injectable naltrexone during pregnancy and the effects of intrauterine exposure to this medication.

A woman receiving buprenorphine or methadone should be informed that the benefits of pharmacotherapy for OUD during pregnancy outweigh the risks of untreated OUD.<sup>7</sup> Healthcare professionals should also inform women that “methadone and buprenorphine are not associated with birth defects and have minimal long-term developmental impact on infants.”

Because the benefits of pharmacotherapy outweigh the risks of untreated OUD, starting a pregnant woman on methadone or buprenorphine can help the woman stop injecting drugs, a primary route of infectious complications.<sup>8</sup> By controlling the symptoms of OUD (e.g., withdrawal, cravings), the pregnant woman can stabilize, reengage in important obligations and activities in her life, and rebuild a supportive social environment for herself and her family which

<sup>6</sup> *Clinical Guidance*, Factsheet #2: Initiating Pharmacotherapy for Opioid Use Disorder.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

hopefully may lead to a healthy and meaningful life for the mother and her child.

Avoidance of NAS should not be the deciding factor in the initiation or dose of methadone or buprenorphine for OUD during pregnancy.<sup>9</sup> The dose of medication does not appear to impact the risk or severity of NAS. Therefore, the dose of medication should be titrated to control withdrawal, limit cravings, and prevent return to opioid use.

### Pharmacotherapy During Pregnancy

Pregnant women with OUD, with or without a history of pharmacotherapy for OUD, should be advised that medically supervised withdrawal from opioids is associated with high rates of return to substance use and is not recommended.<sup>10</sup> Therefore, pregnant women with OUD should not be encouraged to withdraw from pharmacotherapy during their pregnancy or after delivery. To help the developing fetus and her own health, pregnant women should be encouraged to give up or limit cigarettes, alcohol, and other drugs. She should be provided with tobacco use cessation treatment services and other SUD treatment services to accomplish this. After delivery, the mother should be counseled on birth control options, including offering family planning options to the significant other of the mother.

A pregnant woman may need periodic adjustments to the dose of her OUD treatment medication in response to the physiological changes of pregnancy (e.g., increased metabolism) to prevent reemergence of withdrawal symptoms.<sup>11</sup> Pregnant women need reassurance that the amount or dose of the medication used to treat her OUD is not associated with the degree of NAS the baby may experience.

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<sup>9</sup> *Id.*

<sup>10</sup> *Clinical Guidance*, Factsheet #3: Changing Pharmacotherapy During Pregnancy.

<sup>11</sup> *Clinical Guidance*, Factsheet #4: Managing Pharmacotherapy over the Course of Pregnancy.

<sup>12</sup> *Clinical Guidance*, Factsheet #5: Pregnant Women with Opioid Use Disorder and Comorbid Behavioral Health Disorders.

<sup>13</sup> Adverse Childhood Experiences. United States Department of Health and Human Services, Centers for Disease Control

and Prevention.  
<https://www.cdc.gov/violenceprevention/acestudy/index.html>

However, she must also be informed that tobacco use is associated with the degree of NAS the baby may experience.

### Mental Health Conditions and Polysubstance Use During Pregnancy

Depression and other psychiatric disorders are common among women with OUD.<sup>12</sup> Research has found that the majority of women entering treatment for OUD have a history of Adverse Childhood Experiences (ACEs).<sup>13</sup> This includes sexual assault, trauma, chronic neglect, both physical and emotional abuse, domestic violence and/or had caregivers or other household members with substance use disorders, mental health problems, or homes where there was divorce or separation of parents, or absent caregivers or other household due to incarceration.<sup>14</sup> Selecting the best pharmacotherapy management for pregnant women who have OUD and concurrent depression and/or anxiety is a complex decision.<sup>15</sup>

*“A pregnant woman may need periodic adjustments to the dose of her OUD treatment medication in response to the physiological changes of pregnancy (e.g., increased metabolism) to prevent reemergence of withdrawal symptoms.”<sup>11</sup>*

Some medications used to treat depression and anxiety may increase the severity of NAS. However, these risks “must be weighed against the risks of

and Prevention.

<https://www.cdc.gov/violenceprevention/acestudy/index.html>

<sup>14</sup> See the NJOTF’s resource, Juvenile Justice and Trauma, for more information on courtroom strategies that can reduce trauma.

<sup>15</sup> *Supra*, note 11.

untreated depression or anxiety, their contribution to the risk of return to substance use, and the risks of abrupt cessation of either type of medication.” Therefore, offering other non-medication-based trauma-informed evidence-based therapies is also critical.<sup>16</sup>

Pregnant women with OUD may also have other substance use disorders.<sup>17</sup> Because methadone and buprenorphine only treat OUD, pregnant women with other SUDs should receive additional behavioral interventions and supports to address these conditions. A tobacco use cessation program is one of the most important therapies to begin when a pregnant woman enters OUD treatment because smoking cigarettes is known to cause more severe NAS and has lasting developmental effects on the infant. The misuse of benzodiazepines (anti-anxiety medications) can also increase the severity of NAS, and maternal cannabis smoking is associated with low birthweight infants. While pregnant women with multiple SUDs may respond to outpatient treatment, they may benefit from a higher level of care, such as residential treatment, provided pharmacotherapy for OUD is not disrupted. There is limited but promising research supporting the role of peers in recovery themselves in assisting others with SUD. To ensure that a comprehensive plan of safe and effective care is developed, pregnant women with OUD should have access to a qualified assessor who also can conduct an ACEs survey.<sup>18</sup> The plan should delineate underlying health, emotional, and social problems; how each will be addressed; and who is responsible for addressing each and the minimal credentials of such providers.

## Labor and Delivery

Pregnant women with OUD taking methadone or buprenorphine should be informed of the possibility of NAS and counseled on its diagnosis, management, and

consequences.<sup>19</sup> Predicting the risk of NAS is difficult because several substances can influence the presentation of or lead to NAS, particularly nicotine and benzodiazepines. Reducing the dose of methadone or buprenorphine will not reduce NAS expression or severity and should be avoided. When planning for delivery, healthcare professionals should take time to explain the benefits of breastfeeding. Ideally, each new mother should have the option to receive a long-acting reversible contraceptive prior to leaving the hospital. Pregnant women with OUD need to be assured that they will receive adequate pain relief during labor and the postpartum period.<sup>20</sup> During labor and delivery, the mother should maintain her current dose of methadone or buprenorphine for OUD.

## Maternal Postnatal Care



In the immediate postpartum period, a mother taking methadone or buprenorphine for OUD may experience extreme drowsiness or somnolence.<sup>21</sup> Healthcare professionals should use signs of somnolence to guide their recommendations on reducing the postpartum dose of methadone or buprenorphine. Breastfeeding mothers taking either of these medications need to be especially careful to avoid alcohol or any sedating medications, especially benzodiazepines, as this combination is dangerous to them and their breastfed infants. Discontinuation of pharmacotherapy for OUD

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<sup>16</sup> <https://www.samhsa.gov/nctic/trauma-interventions>

<sup>17</sup> *Clinical Guidance*, Factsheet #6: Addressing Polysubstance Use During Pregnancy.

<sup>18</sup> <https://www.cdc.gov/violenceprevention/acestudy/about.html>

<sup>19</sup> *Clinical Guidance*, Factsheet #7: Planning Prior to Labor and Delivery.

<sup>20</sup> *Clinical Guidance*, Factsheet #8: Peripartum Pain Relief.

<sup>21</sup> *Clinical Guidance*, Factsheet #14: Adjusting Pharmacotherapy Dose Postpartum.

should generally be avoided in the immediate postpartum period.<sup>22</sup> Every effort should be made to avoid discontinuing pharmacotherapy for OUD at the request of the patient’s family, social service provider, parole or probation officer, or judge. Pharmacotherapy should be continued as long as needed, as determined by the mother and her healthcare provider. Any new mother with OUD should receive a trauma assessment before discharge from the hospital and again at the postpartum outpatient appointment. She should also be counseled regarding contraception and have immediate, easy access to her contraceptive of choice before discharge.

Return to substance use occurs among people with OUD.<sup>23</sup> When this happens, an appropriate response is a reassessment of the patient and adjustment of the treatment plan. If the mother is still breastfeeding, return-to-use may impact whether or not she should be advised to discontinue.

### Legal Consequences

Women who are pregnant and have OUD or another SUD can be fearful of the legal consequences they may face if they seek SUD treatment.<sup>24</sup> Policies on whether and when to assume custody of a newborn or older child whose mother has untreated OUD vary by state, county, and even hospital.<sup>25</sup> Justice system professionals and healthcare professionals need to be aware of the regulations in their region. All clinicians and staff members must understand their legal responsibility for reporting substance exposure or withdrawal of an infant and should be sensitive to the social and legal

consequences for the mother and infant of reporting such concerns to state and local authorities.

Because of the life-changing ramifications for the mother and infant, if there are positive test results for substance exposure, healthcare professionals need to confirm any positive test results to protect against a false positive.<sup>26</sup> Nonetheless, upon confirmation, notification of local or state child welfare agency is critical; a safety plan or family treatment plan needs to be implemented to assure a child develops healthy, socially and emotionally.<sup>27</sup>



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<sup>22</sup> *Clinical Guidance*, Factsheet #15: Maternal Discharge Planning.

<sup>23</sup> *Clinical Guidance*, Factsheet #16: Maternal Return to Substance Use.

<sup>24</sup> *Clinical Guidance*, Factsheet #9: Screening and Assessment for Neonatal Abstinence Syndrome.

<sup>25</sup> See Guttmacher Institute. State laws and policies: Substance use during pregnancy. (2017). Available at [http://www.guttmacher.org/statecenter/spibs/spib\\_SADP.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf).

<sup>26</sup> *Clinical Guidance*, Factsheet #9: Screening and Assessment for Neonatal Abstinence Syndrome.

<sup>27</sup> See *supra*, note 22 for information on the CARA amendments to CAPTA that require states to have “policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure.