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EVIDENCE-BASED, WHOLE-PERSON CARE FOR PREGNANT PEOPLE WHO HAVE OPIOID USE DISORDER

Opioid use during pregnancy has risen significantly,¹ with data showing a 131-percent increase in opioid use–related diagnoses at delivery between 2010 and 2017.² Opioid use in pregnancy can lead to a range of significant health problems, including death, both in the pregnant person and their baby.^{3,4} Pregnant and postpartum people are at high risk for fatal opioid overdose. In fact, drug overdose mortality for this population increased approximately 81 percent from 2017 to 2020.⁵ Additionally, in a national sample,^{*} those who had a diagnosis of opioid use disorder (OUD)[†] at

Key Messages

- Buprenorphine **and** methadone can be safely used in pregnancy to treat OUD.
- Despite their safe use during pregnancy, changing methadone to buprenorphine or buprenorphine to naltrexone during pregnancy is not recommended. Transitioning from buprenorphine to methadone does not pose a risk of precipitated withdrawal. However, transitioning from either methadone to buprenorphine or from an agonist to an antagonist (naltrexone) does pose a risk and is not recommended.
- Medically supervised withdrawal from medications for OUD during pregnancy is not recommended, as it can cause harm to the pregnant person and their fetus.
- Breastfeeding while taking methadone or buprenorphine is recommended and beneficial for both parent and child.
- Pregnant people, particularly those of color, may face increased stigma and discrimination and potential child welfare involvement if they are taking medications for OUD. Also, long wait times for entry into OUD treatment, particularly in rural areas, can limit access, affect treatment rates, and potentially negatively affect the pregnant person and their baby. As a result, this population often has had less access to medications for OUD and shorter retention in care.
- There is a need for providers to prioritize health equity for underserved pregnant people with OUD who are in critical need of culturally responsive and empathetic care.
- Providers should consider the needs of the pregnant person using “whole patient” care. This includes assessing and planning for the treatment of co-occurring mental disorders in pregnant patients who have OUD.

^{*} Diagnosis of OUD based on the *International Classification of Disease*, Ninth Revision, Clinical Modification [ICD-9 CM]-coded diagnoses of opioid abuse or dependence.

[†] The authors of this study relied on deidentified administrative data and thus, were not able to confirm diagnoses and comorbidities or distinguish between women who had problematic prescription opioid or heroin use and those who were enrolled in opioid maintenance programs.

the time of delivery were found to be 4.6 times more likely to die during hospitalization, 3.5 times more likely to have a cardiac arrest, and twice as likely to have a premature birth, blood transfusion, stillbirth, cesarean section, and preeclampsia, compared with individuals without this diagnosis.^{6,7} Babies born to pregnant people who have OUD may face a range of health problems, including neonatal opioid withdrawal syndrome (NOWS). NOWS is a group of symptoms a baby may develop because of withdrawal from opioids. The number of babies born with NOWS has been steadily increasing. Between 2000 and 2016, the incidence of babies born with NOWS increased from 1.2 to 8.8 per 1,000 hospital births.⁸

Whereas many factors, including poverty, unequal access to health care, poor nutrition, stigma, and racism can significantly contribute to these health problems, the effective treatment of the pregnant person's OUD can improve outcomes for both the pregnant person and their baby. Effective medications exist to treat OUD during pregnancy, but rates of treatment remain low. Only 50 to 60 percent of pregnant people who have OUD take any medication for the treatment of the condition.⁹ This may be largely linked to the significant systemic barriers pregnant people face in seeking and receiving treatment for OUD,¹⁰ including stigma from the healthcare community and the limited number of providers available to treat OUD in pregnancy. Other barriers include a legal system that may penalize pregnant people who disclose their substance use to their provider when seeking help and the potential for child welfare system involvement, including removing a child from the home, if substance use or related treatment is identified during pregnancy.

With medication and support, recovery from OUD during pregnancy is possible. This Substance Abuse and Mental Health Services Administration (SAMHSA) *Advisory* outlines how healthcare providers (i.e., obstetrician-gynecologists [OB-GYNs], primary care physicians, nurse practitioners, certified midwives, specialists, and other professionals who treat pregnant people) can take an active role in supporting the health of pregnant people who have OUD, as well as their babies.

Providers have a unique opportunity to contribute to ending the opioid crisis by supporting a vulnerable population—pregnant people who use opioids. With the help of providers, more pregnant people can learn about their options for treatment and recovery from OUD, which will benefit their infants, families, and communities. Recovery from OUD can and does happen every day.

Providers Can Fill the Treatment Gap for Pregnant People With OUD

Pregnant people may face significant barriers to receiving treatment for OUD. The opioid epidemic has highlighted the systemic bias and discrimination that pregnant people who have OUD can face in their communities, and even within the healthcare system. Pregnant people who have substance use disorders (SUDs), particularly people of color, have historically had less access to treatment services and can face additional stigma from the healthcare system when they do seek care.¹¹ For example, some providers may believe that prescribing OUD medications is encouraging patients to “trade one drug for another.” Also, long wait times for entry into OUD treatment, particularly in rural areas, can limit access, affect treatment rates, and potentially negatively affect the pregnant person and their baby.^{12,13}

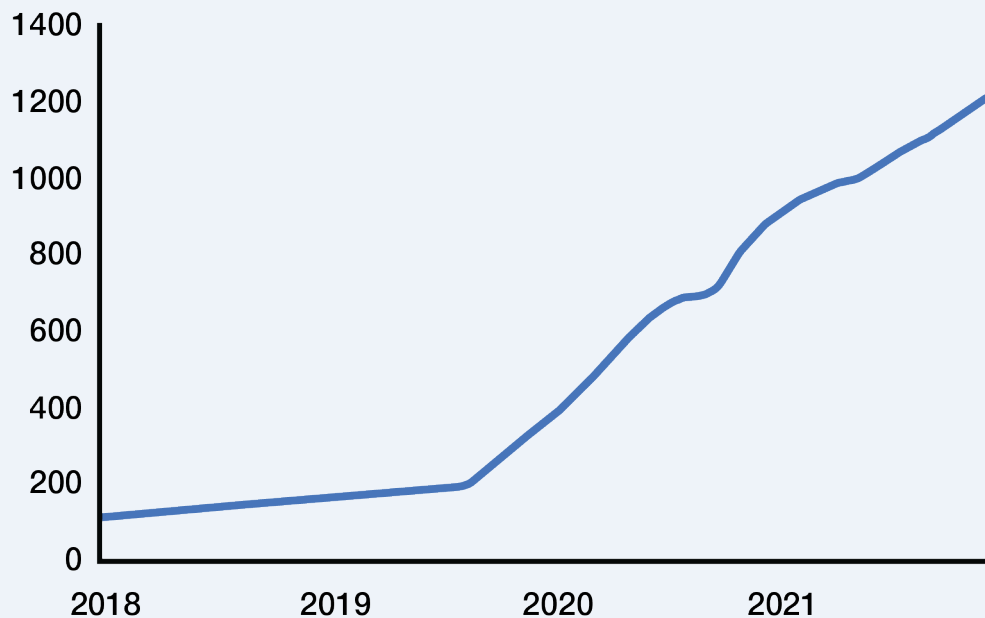
Furthermore, research reveals greater buprenorphine prescription rates for White individuals as compared with Black individuals.¹⁴ In one study, pregnant people of color were less likely to receive any medication to treat OUD.¹⁵ In another study, among individuals receiving buprenorphine treatment, people of color had higher rates of early discontinuation and decreasing adherence to treatment during pregnancy compared with White individuals.¹⁶ Additionally, pregnant people, particularly

people of color, who have problematic substance use may fear the consequences (e.g., child welfare involvement) of seeking care if their state requires mandatory reporting when substance use is identified.^{17,18} These fears drive many pregnant people who have OUD away from seeking the care they need.¹⁹

Among those living in rural areas, barriers to obtaining care for OUD are often even more significant, with data demonstrating differential access to medication and prescribers by neighborhood.²⁰ Pregnant people in rural areas who report OUD often have fewer options for treatment and less financial resources to pay for care or transportation. Pregnant people with OUD also may face stigma from their rural communities.²¹ This disparity is evidenced in one study that found that the rate of neonatal abstinence syndrome (NAS) grew in rural areas. NAS is a group of conditions a baby may develop as a result of withdrawal from substances. NAS is different from NOWS, a related term that refers to symptoms resulting from exposure to opioids specifically. In rural regions from 2004 through 2013, NAS was nearly double the rate in urban areas, a disparity that has grown over time.²² A lack of provider education and training related to OUD, along with few medical centers with resources to support perinatal addiction medicine, further contributes to the stigmatization and undertreatment of rural populations.^{23,24}

Compounding these treatment barriers is a shortage of practitioners authorized to prescribe medications for OUD. For example, between 2018 and 2021, the number of OB-GYNs and certified nurse midwives who received waivers allowing them to prescribe buprenorphine, while on the rise (see Exhibit 1), did not meet demand. In 2021, for example, 22,000 pregnant women ages 15–44 misused opioids in the past month, according to the National Survey on Drug Use and Health.²⁵

Exhibit 1. Changes in the Cumulative Number of Buprenorphine- Waivered Providers from 2018 to 2021 (OB-GYNs and Clinical Nurse Midwives)



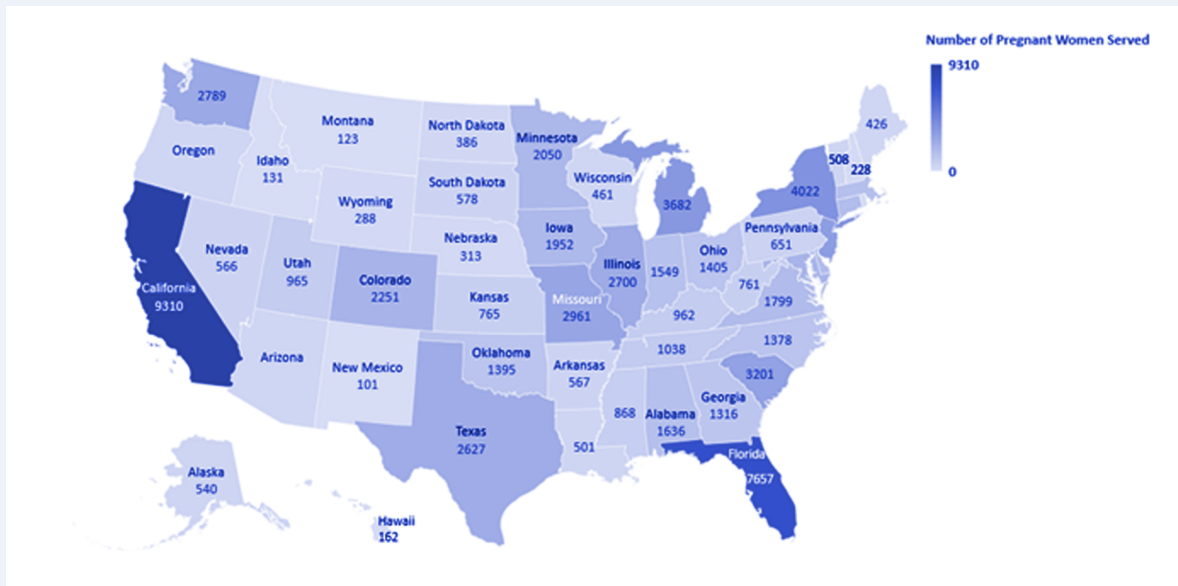
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, Buprenorphine Waiver Management System.

The Consolidated Appropriations Act, 2023 removes the requirement for a separate waiver to prescribe buprenorphine for the treatment of OUD, as had previously been required by the Drug Addiction Treatment Act of 2000. Though it is unclear how this statutory change to the waiver requirement will affect the treatment gap, it facilitates access to this lifesaving medication. (For more on how SAMHSA is actively addressing treatment and prevention needs for pregnant people, see Exhibit 2.)

The barriers to care for pregnant people who have OUD are significant. However, providers have an opportunity to help fill this treatment gap and offer support that can change the lives of this underserved population. As part of this work, providers should have knowledge about their state's rules and regulations around reporting requirements.

Exhibit 2. Pregnant People Served Through SAMHSA's Substance Use Prevention, Treatment, and Recovery Services Block Grant Program: 2018–2021

SAMHSA's Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) Program provides states with funding for substance use treatment, prevention, and recovery support services. Data from this program offers insight into the number of pregnant people receiving treatment for SUDs. SAMHSA is also providing grants to states to fund activities related to treatment for pregnant and postpartum people with SUD, including OUD. Between 2018 and 2021, the SUPTRS BG Program served 77,418 pregnant people. A majority of those served through the program during this period (more than 65 percent) were White. Between 2019 and 2021, the number of SUPTRS BG clients served decreased by approximately 8 percent, or 112,455 people. There was also a slight decrease in the number of people served in 2020 and 2021 (about 3 percent, or 41,657 people). Between 2018 and 2021, five states served most of the SUPTRS BG Program's pregnant clients (California, Florida, New York, Michigan, and New Jersey).



Source: SAMHSA. *The Web Block Grant Application System (WebBGAS)*.

Note: Due to a data validity issue, Arizona and Oregon were omitted from the number of persons served.

A Call to Action

Providers can contribute to ending the opioid crisis by providing compassionate care to pregnant people who have OUD. The first step is to gain knowledge on OUD during pregnancy and learn about the Food and Drug Administration (FDA)-approved medications available.

Compassionate care also includes practitioners who:

- **Provide universal prenatal SUD screening and assessment.** Providers treating pregnant people should offer universal, evidence-based screening to identify substance use. This screening should be conducted at the first prenatal visit.²⁶ Screening after the first visit can also include follow-up questions to encourage ongoing conversation about problematic substance use. The purpose of screening is to ensure that all pregnant people who have SUDs can engage in substance use treatment and optimize their medical and obstetric care. More information about screening for SUDs during prenatal care can be found in SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>).
- **Encourage and, if appropriate, prescribe pharmacological treatment for OUD during pregnancy.** Providers can help pregnant patients who have OUD by offering them information about FDA-approved medications and referring them to prescribing providers, as appropriate. Better yet, providers can themselves prescribe buprenorphine and treat the pregnant person's OUD. As mentioned, Section 1262 of the Consolidated Appropriations Act, 2023 removed the requirement for a separate waiver to prescribe buprenorphine for the treatment of OUD. Providers can learn more about the Consolidated Appropriations Act, 2023 at <https://www.congress.gov/bill/117th-congress/house-bill/2617/text>. More information about buprenorphine for the treatment of OUD can be found in SAMHSA's Treatment Improvement Protocol (TIP) 63, *Medications for Opioid Use Disorder* (<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002>).
- **Offer person-centered care and services.** All pregnant patients who have OUD should be offered person-centered, trauma-informed treatment and services developed in collaboration with their providers. Incorporating patients' concerns and preferences into shared decision making can improve patient engagement in treatment services.²⁷ To meet the needs of each individual patient, providers should consider modifying some elements of prenatal care. These include screening for, evaluating, and treating any mental health needs; testing for sexually transmitted infections (beyond screening for syphilis, which is mandated by many states); or offering additional ultrasound examinations to assess fetal weight.²⁸ SAMHSA's Person- and Family-centered Care and Peer Support webpage (<https://www.samhsa.gov/section-223/care-coordination/person-family-centered>) contains more information about person-centered care and support.
- **Connect pregnant people with life-saving medications that can stop an opioid overdose, and with other harm reduction-related services.** Opioid overdose rates are at an all-time high.²⁹ Providers should be aware of harm reduction strategies that can help pregnant people. This is particularly important if a pregnant person experiences an opioid overdose. Naloxone, a short-acting opioid antagonist, can rapidly reverse the effects of opioids if administered immediately. The American College of Obstetricians and Gynecologists (ACOG) states that although induced withdrawal may potentially contribute to fetal stress, naloxone should be used in pregnant people in the case of an opioid overdose.³⁰ SAMHSA provides more information about naloxone at <https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naloxone>. Providers should also be aware of local harm reduction organizations that can provide referrals to supportive services, including syringe services programs for the prevention

of bloodborne illness and soft-tissue infections that can spread to the heart. Harm reduction partnerships may also serve as a vehicle to refer people for pregnancy services, given that these organizations may be able to reach people not currently engaged with the healthcare system. The following Resource Alert contains links to additional information on harm reduction resources.

Screening and Assessment To Support the Treatment of OUD in Pregnant People

According to the Society for Maternal-Fetal Medicine (SMFM), ACOG, the American Society of Addiction Medicine (ASAM), and the U.S. Preventive Services Task Force, all pregnant people should be screened for substance use, starting at the first prenatal visit using a screening tool that is easily administered, acceptable to patients, and economical.^{31,32} Screening tools offer information that allows providers to engage in brief behavioral interventions with pregnant patients and obtain consent to communicate with current treating providers or make prompt referrals to SUD treatment programs—including opioid treatment programs (OTPs)—as appropriate. Universal screening also promotes health equity.

Some pregnant people may be hesitant to disclose information about their substance use, risk-taking behaviors or situations, and medications for treating OUD because they fear social and legal consequences, such as criminal justice involvement, restrictions of welfare benefits, and perceptions that they are unfit to be parents. Providers can reassure their pregnant patients that the goals of screening are to not only identify problematic substance use as a health condition, but also to encourage engagement in harm reduction behaviors and/or treatment and other services to achieve healthy outcomes for themselves and their babies. To provide comprehensive prenatal care, providers need to understand whether pregnant patients have a history of or are currently using prescribed, licit, or illicit substances as well as whether there are any high-risk behaviors or situations present (e.g., injection drug use, sexual risk-taking, human trafficking, or other behaviors). Providers should also be aware of the patient's use of medications to treat OUD to ensure that these medications are continued during pregnancy.

States have varying requirements when it comes to addressing substance use during pregnancy. Some states may require providers to report substance use during pregnancy to state agencies, whereas other states may offer priority access to treatment programs for pregnant people with OUD.³³

Resource Alert: Harm Reduction Services To Support Pregnant People With OUD

Several resources and toolkits are available that offer additional information about harm reduction strategies to support pregnant people with OUD:

- SAMHSA's Harm Reduction Webpage: <https://www.samhsa.gov/find-help/harm-reduction>
- National Harm Reduction Coalition, *Pregnancy and Substance Use: A Harm Reduction Toolkit*: <https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/>
- Academy of Perinatal Harm Reduction Website: <https://www.perinatalharmreduction.org/>
- University of North Carolina, Greensboro, *Reproductive Harm Reduction Toolkit*: <https://communityengagement.uncg.edu/reproductive-harm-reduction-toolkit-a-narrative-approach-to-reducing-stigma-and-improving-healthcare-and-social-services-for-people-who-use-drugs-pwud/>

Providers should become familiar with their state rules and seek advice regarding how they can best support their pregnant patients with OUD while protecting themselves and their patients.

Universal toxicology tests are not recommended because:³⁴

- They may not capture occasional use.
- They may fail to capture some substances.
- A positive result does not mean the person necessarily has an SUD.
- They may discourage pregnant people from seeking and engaging in regular prenatal care.

Instead, providers should consider using biological testing of urine or blood in distinct situations where objective findings are necessary, such as when changes in alertness or other physiological markers of intoxication lead a provider to suspect the pregnant person is using substances.³⁵ When deciding whether to conduct a biological test, providers should recognize that discrimination and stigma can lead to inequities³⁶ and approach the decision from an unbiased perspective.

Providers considering biological testing should:

- Discuss with the patient the purpose of the test; the benefits, risks, and alternatives; and the need for confirmatory testing when there is a positive result.
- Ensure that patients understand why the test is being done and how the results may be used as part of the provider's clinical decision making. This includes answering questions about how substance use can affect the pregnant person and the baby during and after pregnancy.
- Offer patients the opportunity to provide information about what they think might be detected as part of testing.
- Receive informed consent from patients (verbal consent is required, but written consent is ideal).

Providers can frame discussions about the need for toxicology screening by asking the pregnant person the following questions:

- What do you want to know about blood or urine tests used to screen for substance use as part of your prenatal care?
- What are your concerns about toxicology testing?
- If your toxicology screening returns a positive result that is confirmed with additional testing, would you like help to reduce your substance use or abstain from substances? How can I help you do this?

More information about universal screening of pregnant people for substance use, including screening tools, can be found in Fact Sheet #1 of SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>).

How Providers Can Support People Who Have OUD With Pregnancy Planning

Providers play a vital role in helping people who have OUD prepare for a safe and healthy pregnancy by offering information about how OUD can affect the baby, options for effective OUD treatment, and other steps to support a healthy pregnancy. Providers can help patients who are interested in becoming pregnant learn about:

- The benefits and risks of continuing pharmacotherapy to treat OUD during pregnancy and how medication dosing needs may change across the perinatal period.
- The need for ongoing prenatal care.
- The potential for the baby to develop NOWS, including how these conditions can be treated and managed.
- The need to address polysubstance use during pregnancy, in addition to OUD.
- Safe pain management options during and after pregnancy.
- Available recovery supports, including counseling and other services that may be helpful to address any housing or food-related needs.

More information about pregnancy planning for people with OUD can be found in SAMHSA's fact sheet *Pregnancy Planning for Women Being Treated for Opioid Use Disorder* (<https://store.samhsa.gov/product/pregnancy-planning-for-women-treated-for-opioid-use-disorder/SMA19-5094-FS>).

Initiating Pharmacotherapy for OUD

SAMHSA, SMFM, ACOG, ASAM, and the World Health Organization all state that buprenorphine and methadone, when taken as prescribed, are safe and effective for treating OUD during pregnancy.^{37,38,39} In addition to effectively treating OUD, these medications can reduce the risk of a recurrence, limit illicit substance-related effects on the developing fetus, and help prevent the separation of families.^{40,41} The use of medications for OUD in combination with prenatal care is associated with reduced risk of obstetric complications⁴² as well as positive outcomes for the baby, including increased birth weight and gestational age at delivery.⁴³

Pregnant people who have OUD should begin treatment as soon as possible to obtain the best outcomes for themselves and their baby. As soon as a pregnant person is diagnosed with OUD, providers should discuss the risks and benefits of medication and reinforce that medication is strongly recommended.

Key Differences Between Medications To Treat OUD During Pregnancy

Methadone has been prescribed to treat pregnant people since the 1970s and has demonstrated safety effectiveness in both reducing opioid use and maternal mortality and increasing engagement in prenatal care.⁴⁴ Buprenorphine has been more recently approved to treat OUD in pregnant people and has also been shown to be effective in reducing mortality and overdose deaths.⁴⁵ Both medications are safe and effective in treating OUD; however, there are key differences in terms of how they are dispensed and their effect on retention in care.⁴⁶

Although both methadone and buprenorphine may be dispensed in a hospital setting, buprenorphine can also be prescribed on an outpatient basis, via telehealth by practitioners with active Drug Enforcement Administration registration, at a medical clinic, or at an OTP. Methadone is dispensed at an OTP when used for OUD. OTPs may now also apply to operate mobile components, or mobile methadone vans, to dispense methadone. Providers should become familiar with relevant federal and state regulations that govern provision of these medications.

Patients who take buprenorphine appear to have higher dropout rates (i.e., stopping medication use) initially, compared with patients who take methadone.⁴⁷ This may be attributed to the requirement for moderate opioid withdrawal symptoms before initiation of buprenorphine. Tolerating moderate symptoms of withdrawal may be difficult for patients and may be a barrier to initiation of the medication.

Before initiating buprenorphine, pregnant patients should wait until they are experiencing moderate opioid withdrawal, typically between 12 and 16 hours after the last dose of a short-acting opioid (heroin, hydrocodone, oxycodone), 17–24 hours after intermediate-acting opioids (oxycodone), or 30–48 hours after methadone. Pregnant patients should wait at least 12 hours after their last dose of fentanyl before initiating buprenorphine, and more than 24 hours if they have taken fentanyl daily.^{48,49} Patients should be closely monitored during this period for symptoms and discomfort.⁵⁰

Providers should be aware that opioid withdrawal can negatively affect the health of the pregnant person and developing fetus. In the pregnant person and the fetus, withdrawal can cause an irregularly fast heart rate (tachycardia) as well as increased muscle activity and metabolism. High blood pressure and tachycardia can also reduce oxygen supply to the fetus. Severe withdrawal from opioids may also lead to preterm delivery.⁵¹ (Providers can learn more about effective initiation of buprenorphine in SAMHSA's *Buprenorphine Quick Start Guide*, located at <https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf>.)

Buprenorphine has fewer known drug interactions than methadone.⁵² Methadone has significant interactions with many other medications, including HIV medications.⁵³ Among people who take buprenorphine, infants have higher average gestational age at birth, head circumference, and average birth weight as compared with patients who take methadone.⁵⁴ Given that buprenorphine is a newer medication relative to methadone, however, there is less data about its long-term effects on the infant.⁵⁵ Studies of methadone use during pregnancy indicate no significant effect on cognitive development in children up to 5 years of age who were exposed in utero, as compared with similarly matched control groups.⁵⁶

Guidance for Providers About OUD Medication Use During Pregnancy

The benefits of medications for OUD are numerous and outweigh the risks of continued use of opioids during pregnancy. The use of medication to treat OUD during pregnancy supports the overall health of both parent and child. Alternatively, continued opioid use has been linked to maternal death, poor fetal growth, preterm birth, and long-term disabilities.⁵⁷ Providers should be aware of several key points about the use of these medications during pregnancy:

- **Medically supervised withdrawal is not recommended.** People who have OUD should not withdraw from pharmacotherapy during pregnancy or shortly thereafter.^{58,59,60} Medically supervised withdrawal from pharmacotherapy is associated with a high risk of return to opioid use, which can increase the risk for overdose, lead to obstetric complications, and create barriers to seeking prenatal care. If a pregnant person taking medications for OUD decides to undergo medically supervised withdrawal, it can be conducted if the benefits outweigh the risks. In this case, medically supervised withdrawal should occur in a controlled setting. Providers should tell the patient that discontinuing medications for OUD is associated with high rates of opioid use recurrence and poorer fetal health and is therefore not recommended.⁶¹

Resource Alert: Culturally Responsive Care and Use of Supportive Language

The National Institute on Drug Abuse offers information for providers on how to reduce stigma when discussing SUDs with pregnant people by using person-first language and avoiding certain terms (<https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-language-showing-compassion-care-women-infants-families-communities-impacted-substance-use-disorder>).

SAMHSA's TIP 59, *Improving Cultural Competence* (<https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>), includes information about offering culturally responsive services.

- **Increased or split dosing may be required, especially in the third trimester, for pregnant people being treated with medications for OUD.** Because of the metabolic changes that occur as a pregnancy progresses, the dosing of OUD medications may need to be adjusted, especially during the third trimester.⁶² A single daily dose of methadone or buprenorphine, for example, may not control withdrawal symptoms over a 24-hour period. In these cases, it may be appropriate to split doses. Split dosing can help manage the impact of metabolic changes on serum levels, particularly for women in the third trimester of pregnancy, and can also make medications for OUD more tolerable for pregnant people experiencing nausea.⁶³ This decision will need to be made on a case-by-case basis.
- **A comprehensive treatment plan that includes medications for OUD, counseling, mental health supports, wraparound services, and recovery supports may help address the multiple needs of the pregnant person.** The components of the treatment plan, in addition to medication to treat OUD, should be tailored to each patient's needs, and care should be integrated. These should also include additional consideration of the mental health needs of pregnant patients, particularly given that studies indicate that both mental health conditions and substance use are common in pregnancy.⁶⁴ To offer culturally responsive services, providers must understand the cultural context of the patients they serve. Providers should actively assess their own biases and work to increase their self-awareness through self-reflection practices. The following Resource Alert contains links to more information about the use of culturally responsive practices and compassionate language when caring for people with SUDs.

If providers are unable themselves to provide medications for OUD, they should refer patients for such treatment as indicated, including referral to OTPs within their community. A list of OTPs can be found at <http://dpt2.samhsa.gov/treatment/directory.aspx>. Patients should also be offered counseling and recovery support services, but making medications contingent upon participation in these services is not recommended.

Managing Pharmacotherapy Over the Course of Pregnancy

The use of pharmacotherapy should be tailored to the needs of the pregnant patient. Prior to initiating pharmacotherapy for OUD treatment, providers should discuss the process with their pregnant patients, including providing information about possible side effects; how they can take and store their medications, if applicable; and interactions with other medications they are taking. Providers can learn more about initiating and dosing of OUD medications in SAMHSA's TIP 63, *Medications for Opioid Use Disorder* (<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002>).

Medications for OUD Are Safe for Use While Breastfeeding

Breastfeeding is generally considered safe for new parents who are taking medications for OUD.^{65,66} Breastfeeding in people receiving treatment for OUD with either buprenorphine or methadone should be encouraged, unless the risks highly outweigh the benefits. For example, breastfeeding is not recommended if the person has untreated HIV infection, human T-cell lymphotropic virus type I or type II infection, or untreated brucellosis.⁶⁷ Although it is generally safe for people who have hepatitis to breastfeed, there is not enough data to support the safety of breastfeeding in people with hepatitis who have cracked or bleeding nipples. In this instance, people should stop breastfeeding temporarily until cracks in the nipples have healed and the nipples are no longer bleeding.⁶⁸

Certain substances such as opioids, cocaine, and phencyclidine can also affect a person's decision to breastfeed because of potential long-term consequences for the infant's neurobehavioral development. To reduce the effects of potential opioid withdrawal on the infant, people who have used opioids prenatally should initiate breastfeeding and practice exclusive breastfeeding.⁶⁹ Breastfeeding while taking medications for OUD can decrease the severity of NAS, length of stay of infants in the hospital, and need for medications to treat NAS.⁷⁰ Breastfeeding can help parents and babies bond and improve recovery from birthing.⁷¹

Providers should review recommendations about breastfeeding on an ongoing basis, recognizing that guidance about breastfeeding may change based on emerging evidence. When working with new parents who decide to breastfeed their infants, providers should present information and guidance in a supportive and trauma-informed manner that allows parents to advocate for their family's preferences and needs.

Changing Pharmacotherapy During Pregnancy

Changing medications for OUD (methadone to buprenorphine, or methadone or buprenorphine to naltrexone) during pregnancy is not recommended. Transitioning from buprenorphine to methadone (i.e., from a partial opioid agonist to a full opioid agonist) does not pose a risk of precipitated withdrawal.⁷² However, transitioning from either methadone to buprenorphine or from an agonist to an antagonist (naltrexone) does pose a risk and is not advised.⁷³ Some pregnant people may have concerns about the medication they are taking or want to change medications. These decisions warrant a prompt discussion with their provider. However, it is not advisable to transition from methadone-based treatment to buprenorphine or from methadone or buprenorphine to naltrexone, given the risk of withdrawal that may result.

Admission and Discharge Considerations

Inpatient labor and delivery teams have capacity to provide ongoing treatment, monitoring, and observation of the parent, as well as monitoring and initiation of interventions, as needed, for the newborn. Pregnant people taking buprenorphine or methadone, and who are in labor, should have their opioid agonist dose continued and they should receive additional pain relief. Epidural or spinal anesthesia should be offered, when appropriate, for management of pain in labor or for delivery. It is important to include treatment teams early, and to integrate them in treatment planning and patient-centered decision making. The pregnant person should be introduced to all team members and be provided with an opportunity to ask questions. The pregnant person should also be made aware that their infant may require a period of monitoring, to assess for NAS, and that this is to ensure the newborn's safety and wellbeing. Lactation consultants can also provide advice and support to those pregnant people who wish to consider breastfeeding.

It is important to initiate early discharge planning from the inpatient setting. Discharge plans should include follow-up with practitioners for the parent and newborn, assurance of continued access to medications for OUD, and the potential provision of a short-term supply of medications for OUD, as permitted by federal and state law, to ensure a safe bridge to outpatient services. Such decisions can be made in conjunction with inpatient addiction medicine teams, and/or outpatient addiction medicine specialists. Addiction medicine specialists can also advise on adjustments to the dosage of medications for OUD in the postpartum period.

Polysubstance Use Considerations

People who have OUD may have other substance use that needs treatment.⁷⁴ One study found that over 89 percent of people of reproductive age (18–44 years) who used illicit opioids also used at least one nonopioid substance, such as tobacco, alcohol, or cannabis.⁷⁵ Polysubstance use, or the use of more than one substance at the same time, among pregnant people is common and has increased significantly.⁷⁶ Polysubstance use (including opioid use) is significant, with amphetamine and tobacco use occurring most frequently.⁷⁷ Providers should screen pregnant patients for polysubstance use and, if identified, they should offer or connect those patients to treatment and recovery supports.

Providing Comprehensive Patient-Centered Care for Pregnant People Who Have OUD: Treating the “Whole Person”

Pregnant people who have OUD can benefit from comprehensive services to support them on their path to recovery. Providers play a vital role in ensuring that pregnant patients who have OUD are offered “whole person” care. This can include addressing concerns that pregnant patients may have about their safety at home or other health, financial, or housing needs. Pregnant patients who have OUD will also need special considerations related to labor and delivery, peripartum pain relief, and the treatment of co-occurring mental disorders. Providers should consider the following points when caring for pregnant patients who have OUD.

- **A safe living environment supports both a healthy pregnancy and recovery from OUD.** People who have OUD may be more likely to experience unsafe living conditions.⁷⁸ People with problematic substance use may be more likely to experience intimate partner violence.⁷⁹ Providers should discuss the importance of a safe home environment and its role in supporting healthy child development with patients. Referrals to programs that can help pregnant people access in-home services and resources can help. For example, pregnant patients may be eligible for visits from the federal Home Visiting program (<https://mchb.hrsa.gov/programs-impact/programs/home-visiting>) and other services through the Healthy Start program (<https://mchb.hrsa.gov/programs-impact/healthy-start>). These programs can provide services to at-risk parents with OUD and their children.
- **Recovery is a highly personal process that occurs via many pathways.** Each pregnant person who has OUD will have a different approach to achieving recovery. Providers should work with patients and their care team to determine what services are needed to support their growth in the four domains of recovery (health, home, purpose, and community),⁸⁰ including connecting patients to recovery support services. More information about recovery and recovery support can be found at <https://www.samhsa.gov/find-help/recovery>. To move toward recovery, patients can take steps to address the social determinants of health (SDOH) impacting their lives, or conditions that affect a range of health and quality-of-life outcomes.⁸¹ Providers should be able to recognize and understand not only the connection between SDOH and OUD, but also areas where patients

may need support. Providers should refer patients to case managers who can take active steps to address any SDOH-related needs. More information about SDOH can be found at <https://health.gov/healthypeople/priority-areas/social-determinants-health>.

- **Counseling can help pregnant people engage and remain in OUD treatment by enhancing their coping skills and preventing recurrence.** In addition to pharmacotherapy to treat OUD, counseling helps the pregnant person learn ways to make healthy choices, handle stress, and address mental problems, such as anxiety and depression. Providers can encourage pregnant patients who have OUD to engage in counseling to complement their medications, but not make access to medications contingent upon participation in counseling. Providers can help patients locate services using SAMHSA's behavioral health treatment services locator (<https://www.samhsa.gov/find-help/treatment>).
- **Peer workers, or nonclinical professionals with lived experience in behavior change and recovery from SUD, can support pregnant people who have OUD during their recovery journeys.** Peer workers support people in or seeking recovery from OUD by providing education about triggers that can lead to recurrence, advocating for people in recovery, sharing resources, teaching skill building, and mentoring. More information about peer workers can be found at <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>.
- **Pregnant people who have OUD need additional support in planning for labor and delivery.** Providers will need to discuss the possibility of the child being born with NOWS. Pregnant people who have OUD will need information about how to prepare for a NOWS diagnosis and its management, including nonpharmacological interventions to reduce symptoms, such as having the baby stay in the mother's room after delivery. Pregnant patients who have OUD should also receive education on early pediatric care after delivery and hospital discharge. Fact Sheet #7 in SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>) contains more information about planning for labor and delivery for pregnant patients who have OUD.
- **Pregnant people who have OUD need information about their options for pain relief during labor, delivery, and the postpartum period.** Providers should discuss options to address pain relief during the perinatal period and ensure that the care team is aware of the individual's OUD diagnosis and treatment plan. The pregnant person must be allowed to make informed choices about pain relief based on advice from practitioners who have knowledge of pain management. Fact Sheet #8 in SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>) contains more information about pain relief during labor and delivery.
- **Providers should assess and plan for the treatment of co-occurring mental disorders in pregnant patients who have OUD.** Peripartum behavioral health conditions, including depression, "baby blues," and postpartum depression are common. In fact, it is estimated that one in eight women who have recently given birth experience symptoms of postpartum depression.⁸² For pregnant people with OUD, the risk of serious co-occurring mental disorders is even higher, particularly during the year following childbirth, a period in which there is a higher potential for a return to use. Therefore, providers should screen patients for depression and other co-occurring mental disorders during pregnancy.⁸³ In addition, postpartum individuals who have OUD should be screened for co-occurring mental disorders before discharge from the hospital and again at the postpartum outpatient appointment.

- **Providers should help with planning for treatment of mental disorders if identified,** recognizing that having a child can result in stress and sleep deprivation, which may make the condition worse or trigger a substance use recurrence. Behavioral therapy and pharmacotherapy to address mental disorders during and after pregnancy are effective treatments (more information about these treatment options can be found at <https://www.nimh.nih.gov/health/publications/perinatal-depression>). Fact Sheet #15 in SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>) contains more information about how to manage co-occurring mental disorders in pregnant people who have OUD.
- **Providers should help connect pregnant people to the resources they need.** Providers may not be able to provide the wide range of services or necessary treatment to patients. In cases where the practitioner cannot provide effective OUD treatment directly, knowing where to refer pregnant people who screen positive for OUD for further treatment in their local area is essential.
- **Caring for pregnant people with OUD is empowering for the provider and patient.** Expanding skills and knowledge through learning about medications to treat OUD, prescribing OUD medications to pregnant patients with OUD, and engaging with other resources provide a practical way to help a growing number of individuals. In this way, providers can ensure that their patients receive essential care while also promoting equity and healthy outcomes for pregnant people and their infants.

Resource Alert: Opioid Use and OUD in Pregnancy

ACOG published a committee opinion about opioid use and OUD that includes information about the physiology and pharmacology of opioid use, the effects of opioid use on pregnancy and pregnancy outcomes, screening for opioid use and OUD in pregnancy (including screening tools), medications to treat OUD and medically supervised withdrawal, considerations across the peripartum period, NOWS and long-term infant outcomes, and the role of OB-GYNs and other obstetrical care providers in responsible opioid prescribing during pregnancy. The resource can be accessed at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy>.

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