Tip Sheet #2

Buprenorphine and Methadone Help Support Recovery for Pregnant and Birthing People. Naltrexone is Being Studied

Audience for the Tip Sheet: Physicians, nurses, pharmacists, lactation consultants, social workers, behavioral health providers, social workers, psychologists, counselors, child protective services workers, peer support specialists, recovery coaches, policy makers, law enforcement, judges, attorneys and court staff.

The major organizations[1-11] that provide evidence-based guidance on the treatment of opioid use disorders (OUD) and pregnancy endorse that both methadone and buprenorphine are effective for alleviating withdrawal, reducing cravings, and blocking the effects of other opioids. Additionally, both are relatively safe and effective during the perinatal period for the birthing parent and child. At this time, more data are needed before naltrexone can be recommended for OUD treatment during the perinatal period.

- Based on research, the risks of continuing to have an untreated opioid use disorder during pregnancy greatly outweighs the minimal risks involved in using methadone or buprenorphine. There are two main types of buprenorphine, buprenorphine alone and buprenorphine+naloxone (naloxone is added to reduce potential misuse by injection). While buprenorphine alone has been more studied, available data show that buprenorphine+naloxone is as safe as buprenorphine alone. Canadian guidance recommends buprenorphine+naloxone use in perinatal patients11.
- To support the wholistic care and outcomes for the birthing person-child dyad, pregnant and post-pregnant people should be offered behavioral therapy and case management/care coordination in concert with their prenatal healthcare provider.
- Child welfare should not see the taking of medications for OUD as prescribed as a reason to consider removing a child from a parent's care.

Selecting a medication and dosing regimen needs to be patient-centered

- If a pregnant person is already stable on methadone or buprenorphine of any form and becomes pregnant, guidance recommends the person to stay on the same medication.
- There is no "best" dose of either medication in pregnancy. Every pregnant person should take the dose of methadone or buprenorphine that is right for the individual. The "right" dose will prevent withdrawal symptoms without sedation and will depend on how the person's body processes the medication.
- The dose of either methadone or buprenorphine often needs to increase with pregnancy – some people report feeling better when they split their total dose into half or even fourths.

- The dose does not seem to determine how intense the withdrawal of the baby will be. Thus, providing the "right" dose to the pregnant person then helps promote healthy outcomes for the dyad.
- The dose of medication may remain the same or may decrease after delivery particularly if the dose causes sedation. Good communication between the patient and prescribing provider is needed.

Aspects for a patient-centered delivery and post-partum plan

- Birthing people should visit the hospital/birth center or talk to the home birth specialist and share birth plan requests. This should include a discussion about pain management, OUD medication management before and after birth, and how babies are evaluated and supported if they have withdrawal symptoms.
- Birthing people should identify and meet with the pediatric or family medicine provider before delivery to discuss ways to care for the baby.
- Birthing people should talk to their healthcare providers about the child protection laws in their state so they can be aware of the protocol for possible drug testing of the birthing person or child and how the results are reported.
- Birthing people taking methadone or buprenorphine are usually encouraged to breast/chest feed. Only very small amounts of methadone or buprenorphine are received by the baby in breast milk. However, the act of breast/chest feeding may help lessen baby's withdrawal symptoms.
- The weeks and months after the baby is born can be a stressful time for birthing people in recovery. They should be encouraged to continue counseling, use parenting support programs and discuss decisions about their medication with their health care provider.

RESOURCES

1. https://pcssnow.org/resource/asam-brochures-pregnancy-labor-delivery-postpartum-women-methadone-buprenorphine/
2. https://store.samhsa.gov/product/Opioid-Use-Disorder-and-Pregnancy/SMA18-5071FS1
3. https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf
4. https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf
5. https://www.who.int/publications/i/item/9789241548731
6. https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf
7. https://www.asam.org/Quality-Science/covid-19-coronavirus/treating-pregnant-people-with-oud
8. https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline
9. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
10. https://www.cdc.gov/pregnancy/opioids/treatment.html
11. https://www.bccsu.ca/wp-content/uploads/2018/06/OUD-Pregnancy.pdf