

PLANNING PRIOR TO LABOR AND DELIVERY



CLINICAL SCENARIO

A pregnant woman with opioid use disorder (OUD) has questions about neonatal abstinence syndrome (NAS), support services, and postpartum planning.

CLINICAL ACTION STEPS

Patient Education on NAS

A pregnant woman with OUD should receive the same education and information that all pregnant patients receive (e.g., tour of labor and delivery suites, newborn nursery).

Healthcare professionals should inform the pregnant woman of the possibility of neonatal abstinence syndrome (NAS) and counsel her on its diagnosis, management, and consequences. The woman should also receive education on ways to optimize the well-being of the fetus such as tobacco cessation and early pediatric care after delivery and hospital discharge. Healthcare professionals should ensure that she is aware of nonpharmacological interventions that should be provided to her infant to reduce NAS symptoms, including rooming-in.

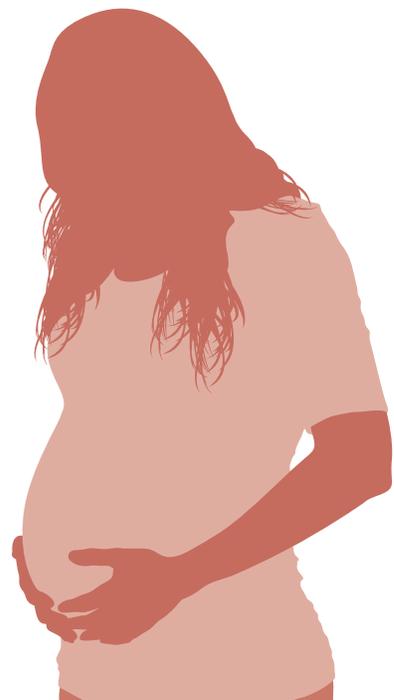
Caregivers of opioid-exposed infants should be informed that while the infant may carry a genetic risk for substance use disorder the fact of experiencing NAS as an infant does not increase the risk of developing a substance use disorder in life.

Healthy Home Environment

Caregivers should be informed about and supported in providing a stable, healthy home environment to enhance protective factors and reduce social risk factors that may impact the future risk for substance use disorder in the child.

Contraception

Women with OUD should be counseled about contraception and have immediate, easy access to the contraceptive of their choice after delivery.





Patient Education on NAS

- **Some infants exposed to methadone or buprenorphine in utero experience opioid withdrawal after birth.**

NAS is a treatable condition, but caregivers and healthcare professionals need to be alert to signs of NAS in the infants of women with OUD so that therapy can begin as necessary. Infant withdrawal usually begins a few days after the baby is born but may begin as late as 2 to 4 weeks after birth. All caregivers should know what symptoms indicate the onset of NAS and when to seek additional medical care for the infant. Clear communication about NAS between the new mother and pediatricians, neonatologists, or family practice doctors, in addition to support from OB/GYNs, midwives, and nurse practitioners, is critical.

Predicting the risk of NAS for infants of mothers with OUD is difficult, because several substances in addition to opioid exposure can influence the presentation of NAS, such as smoking tobacco (Jones et al., 2013a) and using other substances (Patrick et al., 2015). Infant-related variables can affect the infant's NAS course, such as genetics, gender, and gestational age (Wachman et al., 2013, 2015). NAS is an expected and treatable outcome of opioid agonist or partial agonist pharmacotherapy to treat OUD during pregnancy. Recent studies have shown NAS associated with pharmacotherapy is not worse than that experienced after untreated heroin use (Buckley, Razaghi, & Haber, 2013). Being treated with an opioid agonist such as buprenorphine or methadone, by itself, is not a basis for determining parental fitness or child safety.

A woman may want to change or reduce her medication in hopes of reducing the chance or severity of NAS in her infant. Randomized trials of the medications have found no relationship between methadone or buprenorphine dose and outcomes such as NAS peak score; total morphine needed to treat NAS; neonatal hospital stay duration; number of days that pharmacotherapy was given for NAS; estimated gestational age at delivery; Apgar score at 5 minutes; and neonatal head circumference, length, and weight at birth (Jones, Jansson, O'Grady, & Kaltenbach, 2013b; Jones et al., 2013b; 2014; Lund et al., 2013). In a meta-analysis, Cleary et al. (2010) and Patrick et al. (2015) found the severity of NAS was unrelated to methadone dose. The practice of minimizing or even reducing maternal opioid agonist medication to protect the fetus is unnecessary and should be avoided.

When discussing options to maximize the health of the pregnant woman and infant, remind the pregnant woman that she CAN take several steps to protect her health and the fetus:

- She can enroll in a tobacco cessation program, and participate in treatment programs for comorbid alcohol, other substance use disorders as needed.
- She can maintain a healthy weight and take prenatal vitamins as prescribed.
- She can learn how NAS is diagnosed and treated.
- She can learn which nonpharmacological interventions can reduce the incidence and severity of NAS.
- She can inform and prepare herself for breastfeeding.
- She can enroll in parenting classes recommended by her prenatal healthcare professional.

FACTSHEETS TO REVIEW

Reducing the dose of pharmacotherapy will not reduce NAS expression or severity.

No relationship was found between either methadone or buprenorphine dose and significant infant outcomes, including NAS expression or severity. The dose of pharmacotherapy should be optimized to suppress withdrawal, minimize cravings and prevent a return to substance use. **Factsheet #2 Initiating Pharmacotherapy For Opioid Use Disorder and Factsheet #10: Management of Neonatal Abstinence Syndrome, Exhibit FS #10.2**, lists factors that influence NAS expression, severity, and pharmacological and nonpharmacological treatment options.

- **When planning for delivery, healthcare professionals should take time to talk about the benefits of breastfeeding.**

Breastfeeding has positive physical and behavioral health results for mother and baby. When appropriate, any amount of breastfeeding, however brief, can decrease NAS severity, reduce the infant’s need for pharmacological treatment, and decrease the length of pharmacological therapy and hospitalization (Abdel-Latif et al., 2006; Bagley, Wachman, Holland, & Brogly, 2014; Jansson et al., 2008a, 2008b; Reece-Stremtan, Marinelli, & Academy of Breastfeeding Medicine, 2015; Ruwanpathirana et al., 2015). Introduce the concept of breastfeeding in the last trimester and assure the mother that a team will be available at the hospital to facilitate her breastfeeding, including a lactation consultant. However, not all women with SUD are appropriate candidates for breastfeeding.

Planning for labor and delivery should include inviting members of the collaborative team to meet with the pregnant woman before delivery. Many clinics have a pediatrician/neonatologist on staff to discuss what to expect after birth. This consultation builds trust between the pregnant woman and her care team. This is an opportune time to introduce the pregnant woman to a lactation consultant if one is available. Teaching the mother how to score NAS in her infant and to participate in the NAS scoring is also beneficial. **Factsheet #11: Breastfeeding Considerations for Infants at Risk for Neonatal Abstinence Syndrome** provides a discussion on when to breastfeed and when not to breastfeed.

Healthy Home Environment

- *Women may be eligible for visits from the **Federal Home Visiting Program**, funded by the **Administration for Children & Families’ (ACF’s) Early Head Start (EHS) programs** and **Health Resources and Services Administration’s (HRSA’s) Healthy Start program**, a network of more than 100 grantees nationwide. Each member program focuses on providing services to families in the nation’s poorest neighborhoods. These services attempt to reduce infant mortality, advocate for an end to health disparities, engage fathers, and encourage preconception health.*

Discharge plans should be compatible with and support the plan of safe care for mother and infant; this includes addressing potential maternal comorbid medical or mental disorders. See Factsheet #15: Maternal Discharge Planning, for a more extensive discussion about implementing a plan of safe care.

Contraception

- **Preventing unintended pregnancies and planning for future pregnancies is critical.** Healthcare professionals should offer all women, including those with OUD, non-coercive contraceptive counseling and discuss different forms of birth control and the effectiveness of each method before they are discharged from the hospital. Whether a woman is on pharmacotherapy for OUD or continues to misuse opioids, a conversation about the importance of contraception is critical. Women of reproductive age who have OUD experience a high rate of unintended pregnancy (Heil et al., 2011). One study found that only about half of the women with current opioid use were using contraception; the majority of women were not using long-acting reversible contraception (LARC) options, such as implants or intrauterine devices (IUDs) (Terplan, Hand, Hutchinson, Salisbury-Afshar, & Heil, 2015).

Ideally, each new mother should have the option to receive a long-acting reversible contraceptive prior to leaving the hospital. At a minimum, women should receive non-coercive contraceptive counseling and the option to leave the hospital with a prescription for contraception, contraceptive supplies, or a contraception plan (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

The American College of Obstetricians and Gynecologists (ACOG), 2017) and the American College of Nurse-Midwives and other nurse professional societies **recommend** offering immediate postpartum LARC to reduce unintended or short-interval pregnancy (Committee on Healthcare for Underserved Women, American Society of Addiction Medicine, & ACOG, 2017). LARC can consist of IUDs or implants. Although there is a higher chance of expulsion

with the immediate placement of an IUD after delivery, a risk-benefit analysis concluded that, because many women do not attend their 6-week postpartum visit (at which time a LARC is often provided), insertion while still at the hospital after delivery is an excellent time to implant the device. Concerns with **Medicaid** reimbursement are an issue, but many states are now providing policy statements on reimbursement at time of insertion.

Healthcare professionals can encourage women already in treatment to consider planning their next pregnancy with the healthcare team to make sure they are on safe medications, their treatment status is stable, and they are ready for the stresses of motherhood on top of treatment or recovery.

Other Evidence/Considerations

- **In some communities, programs to support women with OUD offer services for mothers who are in recovery.** Examples of relevant programs within medication-assisted treatment services include peer support, medication education, family support and education for childrearing, escape from interpersonal violence, and stable housing. The support and practical help these programs provide can make a difference in the day-to-day life of a mother and her infant. Healthcare professionals might check with local child protection services or opioid treatment programs (OTPs) to determine whether such programs are available in their area. OTPs can be located through SAMHSA's Opioid Treatment Program Directory [Opioid Treatment Program Directory](#).
- **People who are in recovery from SUD or who live with behavioral health disorders often find support, encouragement, and community in consumer-/patient-led organizations.** These organizations, which are generally set up and run by volunteers, can provide a supportive environment that helps some people maintain recovery. Women on pharmacotherapy for OUD are encouraged to seek out programs where pharmacotherapy is accepted as complementary to traditional 12-step treatment programs and is supportive of using pharmacotherapy. Peer counselors or recovery coaches can help those who are new to recovery avoid triggers that can lead to return to substance use. Coaches can provide practical support such as transportation to and from meetings and show new parents how to securely store all medications, including pharmacotherapeutics for OUD, so that children cannot get into them.



WEB RESOURCES ON THIS TOPIC

Breastfeeding

Academy of Breastfeeding Medicine Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, 2009, Revised 2015

This protocol provides evidence-based guidelines for the evaluation and management of women with SUDs who are considering breastfeeding. It includes information on methadone and buprenorphine.

Baby Friendly Hospital Initiative-USA

This global initiative was launched by the World Health Organization and the United Nations Children's Fund in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother-infant bonding.

Breastfeeding Initiatives: Family Resources

This American Academy of Pediatrics (AAP) webpage lists breastfeeding resources for families; some resources are in Spanish.

Childbirth, Breastfeeding, and Infant Care: Methadone and Buprenorphine

This brochure urges pregnant women who use heroin or abuse opioid prescriptions to seek medication-assisted treatment with methadone or buprenorphine. It discusses how methadone therapy works and women's issues such as breastfeeding, opioid withdrawal, birth control, and child protection services.

Drug Entry Into Human Milk

This InfantRisk Center webpage describes in detail the mechanisms of drug entry into human milk and provides general rules on breastfeeding.

Drugs and Lactation Database (LactMed)

This National Library of Medicine searchable database provides information on medications and other chemicals to which breastfeeding mothers may be exposed.

Medications and Breastfeeding: Tips for Giving Accurate Information to Mothers

This two-page AAP document discusses clinical points to consider when prescribing medications to breastfeeding mothers.

Policy Statement: Breastfeeding and the Use of Human Milk

This AAP-updated policy statement reviews the benefits of breastfeeding for the mother and child.

When Should a Mother Avoid Breastfeeding?

This Centers for Disease Control and Prevention webpage provides links to information about illnesses and conditions that contraindicate breastfeeding.

Home Visiting and Peer Support Services

Alcoholics Anonymous (AA)

AA has traditionally emphasized recovery without medication. A person receiving recovery support from AA may need to attend a variety of meetings to find one that recognizes the role of pharmacotherapy in recovery.

Core Competencies for Peer Workers in Behavioral Health Services

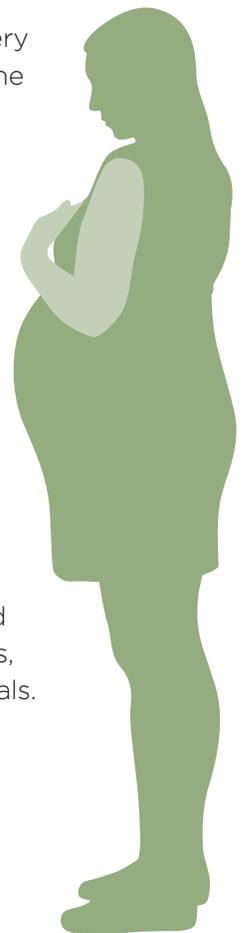
On this webpage, SAMHSA defines peer workers and recovery and lists several categories of core competencies for peer workers.

Early Head Start Programs

Early Head Start EHS programs administered by HHS's Administration for Children and Families serve infants and toddlers younger than under the age of 3, and pregnant women. These EHS programs provide intensive comprehensive child development and family support services to low-income infants and toddlers and their families, and to pregnant women and their families.

Federal Home Visiting Program

This webpage provides background about the HRSA and ACF program, its structure, and its mission and services, which involve evidence-based, voluntary home visiting programs, where families receive help from health, social service, and child development professionals.



Healthy Beginnings

This program meets the U.S. Department of Health and Human Services criterion for an effective childhood home visiting service delivery model. In this model, nurse home visitors provide education on infant nutrition, family nutrition, and physical activity and address family members' concerns. Nurse visitors typically made 8 visits from a prenatal visit through age 24 months.

Healthy Start

This webpage describes the HRSA Healthy Start program and links to a technical assistance center with more information on program approaches and grantees. The program provides depression screening, healthcare services, care coordination, public health services such as immunization and health education, and training for community health workers and care coordinators.

Narcotics Anonymous (NA)

NA has traditionally emphasized recovery without medication. A person receiving recovery support from NA may need to attend a variety of meetings to find one that recognizes the role of pharmacotherapy in recovery.

National Alliance for Medication Assisted Recovery

This organization is led by people in recovery and supports all pathways to recovery, including medication. Recovery Community Centers offer peer support and opportunities to socialize with others in recovery.

General Resources

Opioid Treatment Program Directory

The dropdown menu on this SAMHSA website links users to information on the availability of OTPs in the United States and its territories.

Strong Start for Mothers and Newborns Initiative

This joint effort by the Centers for Medicare & Medicaid Services, HRSA, and ACF aims to reduce preterm births and improve outcomes for newborns and pregnant women.





PERIPARTUM PAIN RELIEF

CLINICAL SCENARIO

A pregnant woman with opioid use disorder (OUD), in treatment or not, needs pain relief during her labor, delivery, and postpartum period.

CLINICAL ACTION STEPS

Pain Management Options

A pregnant woman will naturally be nervous about how her pain will be controlled during labor and delivery. When a woman is already using pharmacotherapy for OUD or has not started therapy and is misusing opioids, her options for pain control should include epidural/spinal anesthesia and short-acting opioid analgesics.

Differentiating OUD Pharmacotherapy and Pain Management During Delivery or Postpartum

A woman's existing opioid agonist dose should not be expected to provide adequate pain relief either intrapartum or postpartum. Do not attempt to increase the woman's prescribed dose of buprenorphine or methadone for short-term intrapartum or postpartum pain control.

Contraindicated Medications

Do NOT administer butorphanol, nalbuphine, or pentazocine to a pregnant woman with OUD, whether she is on pharmacotherapy for OUD or not. These medications have partial antagonist properties and will precipitate acute opioid withdrawal.



SUPPORTING EVIDENCE AND CLINICAL CONSIDERATIONS

Pain Management Options

- **Pregnant women with OUD need to be assured that they will receive adequate pain relief during labor and the postpartum period.** Healthcare professionals will need to inform the pregnant woman of her labor and delivery pain treatment options, talk with her healthcare professional, and consider arranging for her to meet with the anesthesiologist before she goes into labor.

Patients with long-term opioid use are at risk for hyperalgesia and may derive insufficient pain relief from standard therapeutic doses of a nonsteroidal analgesic (NSAID), acetaminophen, or short-acting opioid analgesic (Savage, 1996). During labor and delivery, they are likely to require higher doses of opioid agonist medication than women who have not experienced long-term opioid use (Alford, Compton, & Samet, 2006; Meyer, Paranya, Norris, & Howard, 2010; Meyer, Wagner, Benvenuto, Plante, & Howard, 2007). If a woman needs higher doses of NSAIDs, acetaminophen, or short-acting opioid analgesics for adequate intrapartum pain relief, this need may continue into the initial postpartum period regardless of the method of delivery.

Providing pain relief to women receiving methadone or buprenorphine, whether via epidural and/or short-acting opioids, is essential (Jones, Johnson, & Milio, 2006; Jones et al., 2008, 2009). Morphine sulfate, fentanyl, or hydromorphone (Dilaudid®) are reasonable options for acute pain management during labor and delivery for patients with OUD. These medications need to be responsibly prescribed following Centers for Disease Control and Prevention guidelines that, if opioids must be prescribed for acute pain, the effective dose should be used for 3 or fewer days and rarely more than 7 days (Dowell et al., 2016).

Any antepartum discussion or guidance regarding pain relief during labor, delivery, and postpartum should be documented in the antepartum or intrapartum record and accessible to all members of the treating team. Documenting recommendations for pain relief in the patient's record so that they are available to the treatment team during labor and delivery, as well as postpartum, is a simple way to improve communication among the team members. For example, the healthcare professional responsible for prescribing opioid agonist therapy can provide instruction to the team regarding the management of the pharmacotherapy for OUD and guidance for acute pain management to support the treating team in achieving adequate pain control.

Opioid Agonist Therapy for OUD Cannot Provide Pain Management During Delivery or Postpartum

- **During labor and delivery, the mother should be maintained on her current dose of opioid agonist therapy for OUD.**

The daily pharmacotherapy dose should be considered the new mother's baseline. The daily dose of methadone or buprenorphine should not be expected to provide analgesia, and neither the dose nor the schedule should be altered to relieve pain (Committee on Healthcare for Underserved Women, American Society of Addiction Medicine, & American College of Obstetricians and Gynecologists, 2012, 2017; Meyer et al., 2007).

Pregnant women on pharmacotherapy do NOT need to be transitioned from their maintenance medication before a planned cesarean section (Jones et al., 2006). Labor and operative pain can be managed while pharmacotherapy is still being administered (Jones, et al., 2009).

Contraindicated Medications

- **Certain analgesics should NEVER be given to women with OUD.** Practitioners must not prescribe opioid analgesics with antagonist properties (e.g., nalbuphine, butorphanol) to women receiving opioid agonists (e.g., methadone, buprenorphine) or with an OUD, because of the likelihood of precipitating acute withdrawal (Cassidy & Cyna, 2004; Jones et al., 2014; Savage, 1996).



WEB RESOURCES ON THIS TOPIC

FDA Drug Safety Communication: FDA Has Reviewed Possible Risks of Pain Medicine Use During Pregnancy

This Food and Drug Administration 2015 communication discusses its review of published research studies on the use of pain medicines during pregnancy. It does not make any recommendations, because of limitations FDA found in the studies. The communication urges pregnant women to discuss their medications with their healthcare professionals before taking them.

