

ADJUSTING PHARMACOTHERAPY DOSE POSTPARTUM



CLINICAL SCENARIO

A new mother with opioid use disorder (OUD) is interested in changing her pharmacotherapy.

CLINICAL ACTION STEPS

Dose Adjustment Due to Oversedation

In the immediate postpartum period, complaints of drowsiness and somnolence (a strong desire for sleep, or sleeping for unusually long periods) should prompt evaluation of the new mother's dose of agonist therapy. A dose effective in pregnancy may be too high during the postpartum period. The patient may present with these complaints while still in the hospital or shortly after discharge.

Pharmacotherapy Changes

Struggling with cravings even without a return to substance use may prompt a new mother to ask about changing her medication. Cravings alone do not justify changing to a different pharmacotherapy for OUD. The effectiveness of the patient's pharmacotherapy dose should be evaluated, and the dose possibly adjusted. Cravings can occur even when OUD is well managed. Patients who report cravings during the postpartum period should receive additional behavioral interventions to address new or aggravated stressors.

Consideration may be given to a new mother's request to change the form of pharmacotherapy for OUD based on her preference and on health or social considerations after delivery. The reasons for and risks and benefits of such a change should be thoroughly discussed with other treating healthcare professionals, with the patient's permission, before the decision is made.



SUPPORTING EVIDENCE AND CLINICAL CONSIDERATIONS

Dose Adjustment Due to Oversedation

- **If a new mother is exhibiting signs of oversedation and is breastfeeding, the healthcare professional should assess both the mother and the infant.** Because of the variability in dosing amounts before delivery, healthcare professionals are advised to use signs of somnolence to guide their recommendations on tapering the postpartum dose for new mothers using either methadone or buprenorphine (Jones et al., 2008a, 2008b). The mother could be drowsy because she has a demanding newborn who does not sleep or eat well. Thus, dose changes need to be individualized, and uniform dose changes postpartum cannot be made. Evidence supporting the need to lower methadone or buprenorphine doses after delivery is mixed (Bastian et al., 2016; Bogen et al., 2013; Jones et al., 2008a; Pace, Kaminetzky, Winter, & Walley, 2014).



After delivery, a new mother's body will go through multiple physiological changes; her previously effective dose pharmacotherapy for OUD may, therefore, need to be adjusted. When oversedation is reported or observed, pharmacotherapy dosages can be titrated as indicated (Bogen et al., 2013; Committee on Healthcare for Underserved Women, American Society of Addiction Medicine, & American College of Obstetricians and Gynecologists, 2012, 2017; Jones et al., 2008a; Pace et al., 2014).

Mothers being treated with opioid agonists need to be especially careful to avoid alcohol or any sedating medications, especially benzodiazepines. Between 2000 and 2010, the number of substance use treatment admissions involving a benzodiazepine and narcotic pain reliever combination increased from 5,032 to 33,701 (Wyatt, 2015). Many more people have begun using these medications without prescriptions, and this combination is especially dangerous to breastfed infants.

Pharmacotherapy Changes

- **A mother who wants to change pharmacotherapy for OUD should first consider the risks and benefits with her clinician.**

When a new mother who is currently stable on methadone or buprenorphine requests a switch to naltrexone, begin a conversation about the risks of changing a medication, including the potential for destabilization and return to substance use. The risk of return to substance use is high in this case, and the woman should be advised that the change should not be made without a compelling reason. A new mother who is not stable on her current medication may need to have behavioral health and support services added to her care plan, and healthcare professionals can consider making dose adjustments to her postpartum care plan to address cravings or withdrawal signs (Bogen et al., 2013; Jones, 2008a; Pace et al., 2014).

Naltrexone may be the best pharmacotherapy for some women. Because no systematic research exists on the safety of naltrexone exposure via breast milk, the healthcare professional and the mother should carefully discuss the risks and benefits of continued breastfeeding. Every effort should be made to avoid premature discontinuation of agonist therapy given the overall benefits of breastfeeding to both mother and child in appropriate dyads. Nevertheless, the result of the discussion may be a decision to begin formula-feeding the infant. In general, unless safety is a concern, discontinuing one pharmacotherapy to start another should be avoided until breastfeeding is naturally concluded.

- **Some mothers will want to taper off their pharmacotherapy during the period they are breastfeeding.** Some women will attempt to taper off pharmacotherapy while breastfeeding and

Watch for signs of oversedation. The mother and family members should be informed of what to watch for and instructed to contact the healthcare professionals if signs or symptoms of oversedation appear. The healthcare professional should schedule a follow-up visit with the mother as early as possible after discharge.

Healthcare professionals must be keenly aware of the dangers of mixing opioid agonists and benzodiazepines for both the mother and infant.

Given the lack of research on the safety of naltrexone for breastfeeding infants, the decision to use naltrexone during breastfeeding should be undertaken only after an individual risk-benefit analysis.



FACTSHEET TO REVIEW

Factsheet #3: Changing Pharmacotherapy During Pregnancy includes more information about the risks associated with changing pharmacotherapy.

be faced with deciding whether to resume pharmacotherapy because of a return to substance use or a risk of returning to use. The mother can be reassured that the amount of prescribed pharmacotherapy to which the baby is exposed via breast milk is extremely small, while the risk of harm to the infant from her return to substance use is much greater.

Healthcare professionals should make every effort to avoid premature discontinuation of pharmacotherapy for OUD in light of the overall benefits of breastfeeding to both mother and child. Discontinuation of pharmacotherapy should, at the very least, be delayed until after the infant is consistently sleeping through the night and has completed breastfeeding. The longer the patient continues on OUD pharmacotherapy, the lower her risk of return to substance use when she eventually chooses to taper.

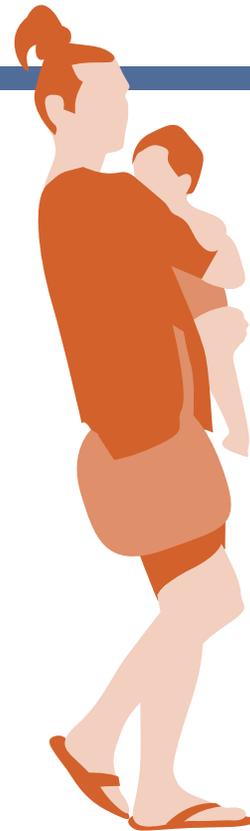
- **Transitioning medications can be challenging because of cost, availability, and preauthorization requirements.** Sometimes the logistics, reimbursement, or regulatory issues accompanying a change in pharmacotherapy for OUD can be daunting. The costs of medications may become an issue, regardless of the patient's insurance payer; securing the required insurance prior authorization can be challenging and time consuming. If the patient opts to switch medications, all documentation needs to be completed and the preauthorization received before the change is made to avoid gaps in treatment (Krans & Patrick, 2016).



WEB RESOURCES ON THIS TOPIC

National Center on Substance Abuse and Child Welfare (NCSACW) Webinar Series on Opioid Use Disorders and Treatment

Several NCSACW-sponsored webinars are specific to treatment of pregnant women with OUD or are focused on infants and children prenatally exposed to opioids.



MATERNAL DISCHARGE PLANNING



CLINICAL SCENARIO

A new mother with opioid use disorder (OUD) is ready for discharge after delivery.

CLINICAL ACTION STEPS

Comorbid Mental Disorders

Any new mother with OUD should be screened for comorbid mental disorders before discharge from the hospital and again at the postpartum outpatient appointment.

Discontinuation of Pharmacotherapy

Discontinuation of pharmacotherapy for OUD should generally be avoided in the immediate postpartum period but may be considered later if the mother is stable and the mother and child are well bonded and have a safe, stable social environment and home.

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 for OUD should be discontinued only when in the best interest of the mother and infant.

Contraception

A woman with OUD, whether she is receiving pharmacotherapy or not, should be counseled regarding contraception and have immediate, easy access to her contraceptive of choice before her discharge.



SUPPORTING EVIDENCE AND CLINICAL CONSIDERATIONS

Comorbid Mental Disorders

- **The discharge plan 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.** The plan of safe care should be made for the mother and the infant that includes addressing potential maternal comorbid medical or mental disorders. The plan of safe care should address any existing maternal comorbid medical or psychiatric condition and recognize that the physiologic change after delivery, stress and sleep deprivation the new mother experiences may exacerbate these conditions or trigger a return to some form of substance use. The discharge plan should include strategies for the new mother to get immediate and nonjudgmental assistance if she feels she is or may become unstable.

- **People who are in recovery from a substance use disorder (SUD) or who live with behavioral health disorders often find support, encouragement, and community in consumer-/patient-led organizations.** Peer counselors or recovery coaches assist people seeking recovery from SUDs by supporting them and helping them avoid triggers that can lead to return to substance use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Coaches can provide transportation to and from meetings and show parents how to securely store all medications, including pharmacotherapy for OUD, so that young children cannot get into them. SAMHSA has compiled a list of core competencies that healthcare professionals should expect from peer support staff (SAMHSA, 2015). The effectiveness of peer support has not been extensively evaluated, and such evaluations are even rarer for programs involving pregnant women with SUDs (Barlow et al., 2015; Sanders, Trinh, Sherman, & Banks, 1998).

The relapse rate for women with SUD increases for women after delivery (Helmbrecht & Thiagarajah, 2008) and can be impacted by issues such as postpartum/maternal depression and the stress of parenting.

Healthcare professionals should consider providing the mother with support services for longer than the traditional 6-week postpartum period.

Discontinuation of Pharmacotherapy

- **Explain the importance of not abruptly discontinuing pharmacotherapy.** Sometimes people feel that they no longer need pharmacotherapy for OUD and would like to stop taking these medications. Plans to stop taking a medication should be made by the mother in conjunction with her treatment team. Pharmacotherapy with methadone or buprenorphine must be tapered gradually to prevent withdrawal. A safety plan for the mother and family needs to be in place before the tapering starts in order to know what to do if she relapses to opioid use. Discontinuation of pharmacotherapy should, at the very least, be delayed until after the infant is consistently sleeping through the night and has completed breastfeeding. The longer the patient continues on OUD pharmacotherapy, the lower her risk of return to substance use when she eventually chooses to taper.

FACTSHEET TO REVIEW

See also **Factsheet #14: Adjusting Pharmacotherapy Dose Postpartum** and **FS #16 Maternal Return to Substance Use** for additional information on adjusting medications and support postpartum.

Reducing the pharmacotherapy dosage can be considered if the mother chooses when she is living in a safe and stable environment (Jones et al., 2014). The best time to begin initiating discontinuation of medication-assisted treatment is *after* the infant is consistently sleeping through the night, has completed breastfeeding, and the dyad has multiple indicators of life stability (Jones et al., 2014).

People can safely continue pharmacotherapy for OUD for as long as they need it. For some, this may be months or a year; for others, it may be a lifetime.

Contraception

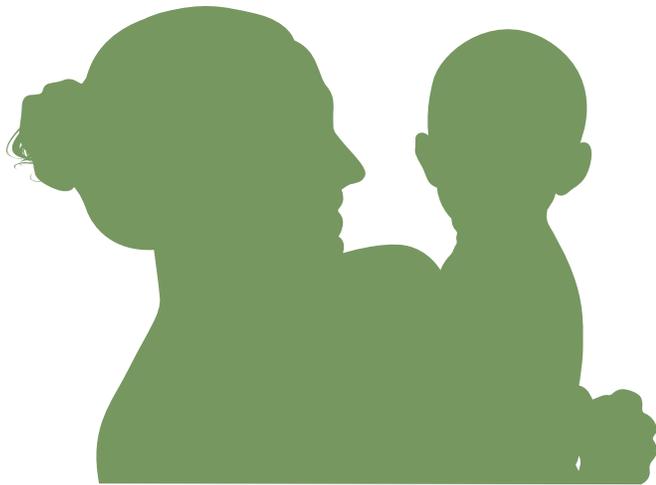
- **Preventing unintended pregnancies and planning for future pregnancies are critical.** Healthcare professionals should offer all women, including those with OUD, non-coercive contraceptive counseling and discuss different forms of birth control and the effectiveness of each method before they are 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 approximately half of women with a history of current opioid use were using contraception; the majority were not using long-acting reversible contraception (LARC), such as implants or intrauterine devices (IUDs) (Terplan, Hand, Hutchinson, Salisbury-Afshar, & Heil, 2015).

The American College of Obstetricians and Gynecologists (Committee on Healthcare for Underserved Women, American Society of Addiction Medicine, & American College of Obstetricians and Gynecologists [ACOG], 2012, 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. 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

- **Give referrals to services that provide perinatal and infant healthcare to increase access to quality care, promote healthy development, and reduce the risk of infant or maternal morbidity and mortality.** Support for the new mother is important to facilitate her bonding with the infant. The Health Resources and Services Administration (HRSA) **Federal Home Visiting Program** provides an array of services to vulnerable families through home visits, which may include assisting mothers with guidance on how best to breastfeed and care for their babies; helping parents understand child development milestones and behaviors; promoting parents' use of praise and other positive parenting techniques; and working with mothers to set goals for the future, continue their education, and find employment and childcare solutions.



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 (SAMHSA, 2014).

FACTSHEETS TO REVIEW

- **Factsheet #7: Planning Prior to Labor and Delivery** for topics to discuss with women during their pregnancy, including postpartum contraception plans
- **Factsheet #12: Infant Discharge Planning** for discussions of home visitation services and peer support services available to new mothers and caregivers
- **Factsheet #16: Maternal Return to Substance Use** for guidance on preventing return to substance use and supporting recovery



WEB RESOURCES ON THIS TOPIC

ACOG Immediate Postpartum Contraception Options

This ACOG website provides numerous policy documents and practice bulletins on the use of LARC immediately postpartum as well as material on access to contraception.

Current Understanding of the Interaction of Benzodiazepines and Buprenorphine

This Providers' Clinical Support System continuing medical education course reviews the dangers of combining benzodiazepines and buprenorphine.

Federal Home Visiting Program

This webpage provides background about the HRSA and Administration for Children & Families 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 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.

Resources for Consumers and Families

This joint SAMHSA-HRSA Center for Integrated Health Solutions webpage provides links to information to help families understand medication-assisted treatment and how it helps, as well as a guide for patients developed by the American Society of Addiction Medicine and essays collected by Faces and Voices of Recovery and the National Association of Medication Assisted Recovery.

MATERNAL RETURN TO SUBSTANCE USE



CLINICAL SCENARIO

A new mother returns to substance use, whether alcohol, benzodiazepines, cocaine, marijuana, methamphetamine, opioids, or tobacco

CLINICAL ACTION STEPS

Adjusting Pharmacotherapy Dose

A new mother who returns to substance use should be assessed for possible adjustment of the dose or schedule of her pharmacotherapy for opioid use disorder (OUD) and should receive more intensive behavioral interventions.

Changing or Resumption of Pharmacotherapy

If changing from one pharmacotherapy to another is necessary, healthcare professionals should carefully discuss with the new mother the risks of further destabilization in the context of active substance use. No change should be undertaken without her fully informed consent.

Breastfeeding in the Context of Return to Substance Use

A new mother who was previously stable on buprenorphine or methadone but has returned to opioid use should be assessed for dose adjustment, should receive additional behavioral interventions, and should be counseled on her lactation options.



SUPPORTING EVIDENCE AND CLINICAL CONSIDERATIONS

Adjusting Pharmacotherapy Dose

- **Return to substance use is a common occurrence among people with a substance use disorder (SUD).** Some people in recovery may never return to substance use; others may do so many times before establishing stable and lasting recovery. Given that returning to substance use is predictable and common, doing so should not be viewed as a setback or failure, but as an indication of the need to reassess the patient and adjust the treatment plan. Such adjustments may include engaging community and behavioral supports. Many people find that, for lasting recovery, they need to control stress, avoid places and situations where they once used drugs (triggers), and even end relationships with people involved with drugs. When making these changes, people in recovery may find that peers—such as other mothers in recovery who experienced a pregnancy affected by OUD—can help them in a way that healthcare professionals cannot. Limited but promising research supports the role of peers who are in recovery from an SUD (Barlow et al., 2015; Sanders, Trinh, Sherman, & Banks, 1998).

- **A collaborative care model enables healthcare professionals to work across disciplines and specialties and to provide services as needed to reduce maternal stress and risk of return to substance use.** Using a collaborative care approach (McLafferty et al., 2016; Substance Abuse and Mental Health Services Administration [SAMHSA], 2016), prenatal healthcare professionals, pediatricians, and behavioral health treatment providers work together to provide behavioral health services to reduce maternal stress. Behavioral health services often focus on preventing a return to substance use, such as through teaching new mothers how to manage triggers and connecting these clients to peer recovery support groups and programs that help new parents. Ideally, these healthcare professionals should be co-located in the same building, if not integrated into a single program, to facilitate postnatal care. If this is not feasible, then providing referrals and regularly communicating with all the healthcare professionals involved in the case is recommended. Healthcare professionals are advised to review the 2016 SAMHSA report **A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers** for a more detailed description of this approach.

Privacy requirements are higher with issues of SUD than with other conditions, so it is especially important to obtain signed informed consent agreements tailored to SUD issues to facilitate sharing of information among healthcare professionals. It could be useful to complete a paper or electronic consent form such as those provided at <https://pcssmat.org/opioid-resources/clinical-tools/> to secure the sort of information releases that will be necessary to coordinate care among healthcare professionals who write pharmacotherapy prescriptions, those who may manage other behavioral health issue, and those providing prenatal care. Electronic systems for managing patient consent to share protected health information are also an option. One example is SAMHSA's **Consent2Share**.

Resumption of Pharmacotherapy

- **If pharmacotherapy is discontinued postpartum and the behavioral supports are insufficient to prevent or interrupt return to substance use, the option to resume pharmacotherapy should be considered.** A new mother should restart pharmacotherapy for OUD if behavioral supports are insufficient to prevent a return to substance use. Pharmacotherapy selection should be informed by what worked well in the past and whether the mother is breastfeeding.

A mother's preference for beginning antagonist therapy may be considered if she resumes pharmacotherapy in the postpartum period. However, only one case study has reported examining how much naltrexone is secreted into breast milk (Chan, Page-Sharp, Kristensen, O'Neil, & Ilett, 2004). In this case, only very low levels of the naltrexone metabolite were detected in the infant plasma (1.1 micro g/L), and the infant appeared to be healthy, was meeting developmental milestones on time, and showed no adverse effects.

FACTSHEETS TO REVIEW

- **Factsheet #6: Addressing Polysubstance Use During Pregnancy** for recommendations on how to treat a return to substance use in the prenatal period
- **Factsheet #14: Adjusting Pharmacotherapy Dose Postpartum** for information on adjusting current pharmacotherapy doses before considering changing pharmacotherapy

CONTENT TO REVIEW

This link provides treatment agreements and consent forms to promote collaborative care plans in a SUD treatment setting: <https://pcssmat.org/opioid-resources/clinical-tools/>. The two exceptions to the privacy rule affecting behavioral health care are:

- If it appears the woman may harm herself or others.
- If she has been ordered into treatment by the courts.

Breastfeeding in the Context of Return to Substance Use

- **If the new mother returns to substance use, healthcare team members will have to consider whether to discontinue breastfeeding based on their knowledge of the patient and her access to behavioral and recovery support services.** If there is a return to substance use, healthcare professionals are advised to review the American Academy of Pediatrics (AAP) [policy statement on breastfeeding](#) (Hudak, Tan, & AAP, 2012) and the Academy of Breastfeeding Medicine (ABM) [Clinical Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, Revised 2015](#) (Reece-Stremtan, Marinelli, & ABM, 2009, revised 2015).

It may not be necessary to stop breastfeeding after an isolated incident of substance use that is quickly under control. The World Health Organization's (WHO's) [Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy](#) suggest carefully reviewing the mother's situation before recommending discontinuation of breastfeeding (WHO, 2014).

FACTSHEET TO REVIEW

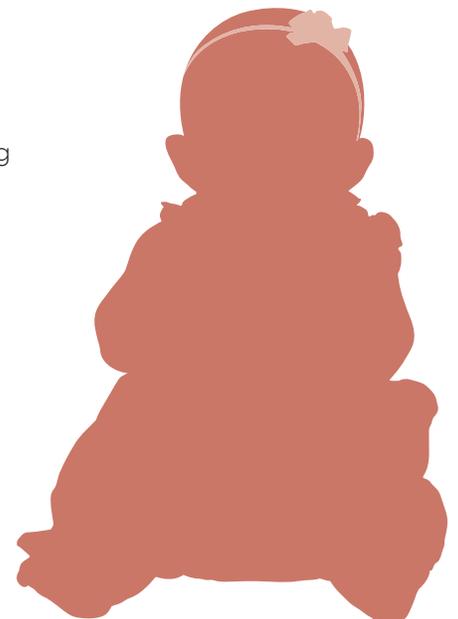
Factsheet #11: Breastfeeding Considerations for Infants at Risk for Neonatal Abstinence Syndrome for information on the benefits of breastfeeding if the mother is stable on medication-assisted treatment and when to bottle feed

Other Evidence/Considerations

- **There are many unknowns when assessing cannabis, alcohol, and tobacco use by pregnant women and new mothers.** Not enough data exist to determine the long-term consequences of cannabis exposure in infancy. The prevalence of past-month cannabis use increased from 2.37 percent in 2002 to 3.85 percent in 2015 (Brown et al., 2017). Although fetal exposure to cannabis, the illicit drug most commonly used by pregnant women, is not known to cause clinically important neonatal withdrawal signs, such exposure may have effects on long-term neurobehavioral outcomes (Campolongo, Trezza, Palmery, Trabace, & Cuomo, 2009). Maternal cannabis smoking has been found to be related to lower birth weight in offspring (Fergusson, Horwood, & Northstone, 2002; Gray et al., 2010; Gunn et al., 2016; National Academies of Sciences, Engineering, & Medicine, 2017).

Return to use of these substances by a mother while caring for her infant should prompt review of her treatment plan and consideration of adjusting medical, behavioral, and peer services to support discontinuation of these substances.

Until more is known about the long-term effects of exposure to these substances through breast milk or secondhand smoke, mothers should be counseled to avoid cannabis and tobacco smoke, as well as alcohol (Committee on Obstetric Practice, American College of Obstetricians and Gynecologists, 2017; National Academies of Science, Engineering, & Medicine, 2017; Reece-Stremtan et al., 2015; Volkow, Compton & Wargo, 2017; WHO, 2014).





WEB RESOURCES ON THIS TOPIC

ABM Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, 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.

Breastfeeding Initiatives: Family Resources

This AAP webpage lists breastfeeding resources for families; some resources are in Spanish.

A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers

This SAMHSA document provides information on the treatment of pregnant women with OUD, summarizes guidelines adopted by a variety of professional organizations, and presents a framework for organizing community efforts. It provides a coordinated, multisystem approach grounded in early identification and intervention to assist child welfare, medical, SUD treatment, and other systems in supporting families.

Drug Entry Into Human Milk

This InfantRisk Center webpage describes in detail the mechanisms of drug entry into human milk and provides some 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 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.

