ACUTE CARE INFO BRIEF

Medications for OUD in Pregnancy and Postpartum

Significance

- **Rising crisis:** Opioid-related deaths in pregnant people rose from 2007-2021.[1] Accidental overdose is a leading cause of pregnancy-related death in WA.[2] Overdose risk is highest during the first year postpartum.[3]
- **Treatment gap:** Only 50% of pregnant people with OUD receive MOUD, the gold standard of care.[4] MOUD reduces the risk of death by at least 50%.[5]
- **Disparities:** Pregnant people of lower socioeconomic status, rurally located, and from minority racial/ethnic backgrounds receive MOUD at lower rates.[6,7]
- **Barriers to care:** Patient fear of incarceration/custody loss, concerns about fetal risks, lack of funds/daycare/transportation, social/partner pressure, internalized stigma/shame, provider stigma and lack of knowledge/experience.[8]

Evidence-based OUD treatment

Opioid agonist MOUD (methadone, buprenorphine) is the **gold standard** for OUD. In pregnancy, it improves the health of the dyad and is recommended by the American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, and the Society for Maternal-Fetal Medicine.[9]

NO MOUD: Maternal risks	MOUD: Maternal benefits
Decreased prenatal care, obstetric complications (fetal growth restriction, placental abruption, fetal death, preterm labor); increased exposure to STIs, violence; loss of child custody, incarceration	Improved nutrition, increased prenatal care engagement, reduced obstetric complications, reduced morbidity and mortality
NO MOUD: Neonatal risks	**MOUD: Neonatal benefits**
Preterm delivery, low birth weight, adulterant exposure, prolonged hospitalization	Improved health, breastfeeding encouraged. NOWS may occur but is treatable; no known long-term developmental risks.[3,9,10]

KEY TERMS:

OUD – Opioid Use Disorder

MOUD – Medications for Opioid Use Disorder

NOWS – Neonatal Opioid Withdrawal Syndrome

OTP – Opioid Treatment Program

RESOURCES:

Perinatal Psychiatry Consultation Line (Perinatal PCL) for provider consultation.

Eat, Sleep, Console:

- Admission Guidelines from the Washington State Hospital Association
- Sample hospital policy from Swedish Health Services

Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder

Parent-Child Assistance Program (PCAP) home visitation and case-management for pregnant/parenting patients with SUD

The First Clinic for patient legal support

- **Deliver compassionate, evidence-based OUD care** with MOUD for pregnant and postpartum patients to improve outcomes.[11]
- **Withdrawal is dangerous.** Severe opioid withdrawal causes fetal distress and requires urgent treatment. Withdrawal management from extra-medical opioids or MOUD carries high risk of return to substance use, overdose (loss of opioid tolerance), and obstetric complications.[9]
- **Offer MOUD initiation** using shared decision-making.

MEDICATION	KEY ADVANTAGES	KEY CHALLENGES
Methadone	No withdrawal needed to start; highest agonist effect	OTP-only for ongoing care, limited rural access; can be slow to titrate to therapeutic dose; BID dosing in pregnancy
Buprenorphine	Easiest access	Low dose up-titration is preferred to prevent withdrawal during initiation (done most effectively while inpatient)
Naltrexone	—	Not recommended for initiation in pregnancy due to withdrawal and overdose risk. Ok to continue if already stable.

- **Dose to symptom control (craving/withdrawal):** Higher doses of methadone are often needed in pregnancy. Higher doses do not worsen NOWS.[12]
- **Screen for other substance use:** Polysubstance use is common. Treat co-occurring substance use disorders simultaneously.
- **High risk of psychiatric morbidity/mortality:** Screen early and often for anxiety, depression and intimate partner violence in the peripartum period.[3,9]
- **Treat patient-reported symptoms:** Use clinical judgment and patient history to contextualize COWS. Treat withdrawal symptoms as long as it is safe to do so, even if COWS is confounded.

Pain management

- **Adequately manage pain throughout the perinatal period.**
- Opioid dependence results in higher tolerance and hyperalgesia.
- MOUD treats OUD, not pain. Patients on buprenorphine or methadone with acute pain may require additional opioids and at higher doses. If respiratory rate is normal, the dose is not too high.[11,13]

Postpartum considerations

- **Continue MOUD postpartum.** The first year carries increased stress, physical recovery, hormonal changes, and sleep deprivation; it is a high-risk period for return to substance use and overdose.[3,9]
- **Methadone dose reductions** should be symptom-based (sedation at peak), not routine.[9]
- **Encourage breastfeeding,** if stable. MOUD is safe, reduces NOWS severity, and facilitates bonding. Unregulated substance use may contraindicate breastfeeding.[12,15]

Neonatal opioid withdrawal syndrome (NOWS)

NOWS occurs from long-term exposure to opioids (including MOUD). Symptoms can occur within 24 hours to 5 days after birth. Incidence has increased 8-fold nationally. It is treated by facilitating the parent-infant bond and with pharmacologic measures, if needed.[12]

Dyad-centered care strategies

Environmental support	Parental involvement
• Dim lighting, reduced noise/stimulation • Consistent caregivers; cluster care • Private room when possible • Swaddling and positioning support	• Skin-to-skin contact: regulates physiology • Breastfeeding encouraged with MOUD: provides comfort, bonding, lessens NOWS symptoms • Rooming-in: increases breastfeeding, discharge to family; lower costs[6,7,12,14]

Eat, Sleep, Console method

Evidence-based and widely recognized by medical societies, including the National Perinatal Association and American Academy of Pediatrics. Reduces length of stay and reduces need for pharmacologic intervention.[15]

Eat	Can baby eat ≥1 oz/feed or breastfeed well?	Observe suck-swallow-breathe; note duration/distress
Sleep	Can baby sleep undisturbed ≥1 hour?	Evaluate between care periods; optimize environment first
Console	Can baby be consoled within 10 min?	Use escalating measures: swaddle → hold → rock → pacifier

If YES to all 3 → Continue supportive care. **If NO to any** → Optimize non-pharmacologic support, reassess in 2-4 hours. **If continued NO** → Consider pharmacologic intervention. See resources for more information on implementing Eat, Sleep, Console.

Pharmacologic intervention

- **First-line:** Morphine taper; use only when non-pharmacologic measures are insufficient.
- **Goal:** Shortest duration needed to maintain comfort and function.[16]

Key takeaways

1. **Compassion matters.** Nonjudgmental care encourages treatment engagement.
2. **Agonist MOUD is the gold standard.** Dose to symptom control.
3. **Encourage breastfeeding** if stable on MOUD.
4. **Keep dyad together** and use **Eat, Sleep, Console** to address NOWS.

REFERENCES:

1. Bruzelius E, Martins SS. US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020. JAMA. 2022;328(21):2159-2161. doi:10.1001/jama.2022.17045
2. Washington State Department of Health. Maternal Mortality Review Panel: Maternal Deaths 2021–2022. Publication No. 141-253. Washington State Department of Health; 2025.
3. Barber CM, Terplan M. Principles of care for pregnant and parenting people with substance use disorder: the obstetrician gynecologist perspective. Front Pediatr. 2023 May 24;11:1045745. doi: 10.3389/fped.2023.1045745. PMID: 37292372; PMCID: PMC10246753.
4. Harris M, Schiff DM, Saia K, Muftu S, Standish KR, Wachman EM. Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023). Breastfeed Med. 2023;18(10):715-733. doi:10.1089/bfm.2023.29256.abm
5. National Academies of Sciences, Engineering, and Medicine 2019. Medications for Opioid Use Disorder Save Lives. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310.
6. Kelley AT, Smid MC, Baylis JD, Charron E, Begaye LJ, Binns-Calvey A, Archer S, Weiner S, Pettey W, Cochran G. Treatment access for opioid use disorder in pregnancy among rural and American Indian communities. J Subst Abuse Treat. 2022 May;136:108685. doi: 10.1016/j.jsat.2021.108685. Epub 2021 Dec 13. PMID: 34953636.
7. Schiff DM, Nielsen T, Hoeppner BB, et al. Assessment of Racial and Ethnic Disparities in the Use of Medication to Treat Opioid Use Disorder Among Pregnant Women in Massachusetts. JAMA Netw Open. 2020;3(5):e205734. Published 2020 May 1. doi:10.1001/jamanetworkopen.2020.5734
8. Admass BA, Admassie BM, Chekol WB, et al. Barriers to opioid replacement therapy in pregnant women with opioid use disorder: a systematic review. Subst Abuse Treat Prev Policy. 2025;20(1):39. Published 2025 Oct 1. doi:10.1186/s13011-025-00675-5
9. Committee Opinion No. 711 Summary: Opioid Use and Opioid Use Disorder in Pregnancy. Obstet Gynecol. 2017;130(2):488-489. doi:10.1097/AOG.0000000000002229
10. Miller SC, Rosenthal RN, Levy S, et al. The ASAM Principles of Addiction Medicine. 7th ed. Lippincott Williams & Wilkins; 2024.
11. Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. SAMHSA; 2018.
12. Patrick SW, Barfield WD, Poindexter BB; COMMITTEE ON FETUS AND NEWBORN, COMMITTEE ON SUBSTANCE USE AND PREVENTION. Neonatal Opioid Withdrawal Syndrome. Pediatrics. 2020;146(5):e2020029074. doi:10.1542/peds.2020-029074
13. Lim G, Carvalho B, George RB, et al. Consensus Statement on Pain Management for Pregnant Patients with Opioid-Use Disorder from the Society for Obstetric Anesthesia and Perinatology, Society for Maternal-Fetal Medicine, and American Society of Regional Anesthesia and Pain Medicine. Anesth Analg. 2025;140(6):1318-1346. doi:10.1213/ANE.0000000000007237

REFERENCES (CON'T):

14. MacMillan KDL, Rendon CP, Verma K, Riblet N, Washer DB, Volpe Holmes A. Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome: A Systematic Review and Meta-analysis. JAMA Pediatr. 2018;172(4):345-351. doi:10.1001/jamapediatrics.2017.5195
15. Washington State Hospital Association. Eat, Sleep, Console Admission Guidelines. Accessed February 4, 2026. https://www.wsha.org/webfoo/wp-content/uploads/Eat.-Sleep-and-Console-Sample-Documents.pdf
16. Young LW, Ounpraseuth ST, Merhar SL, et al. Eat, Sleep, Console Approach or Usual Care for Neonatal Opioid Withdrawal. N Engl J Med. 2023;388(25):2326-2337. doi:10.1056/NEJMoa2214470