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GUIDE

COMPREHENSIVE CARE OF PATIENTS WITH OPIOID USE DISORDER IN PREGNANCY

TABLE OF CONTENTS

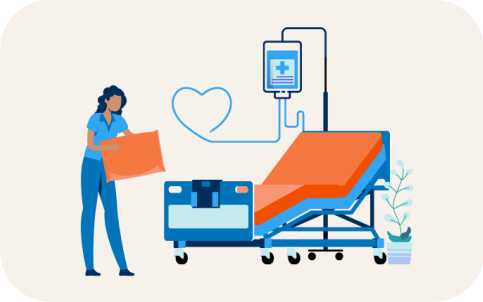
INTRODUCTION

Substance Use in Pregnancy

Opioid Use Disorder (OUD) in pregnancy is an increasingly urgent public health issue. In the U.S., the prevalence of OUD in pregnancy has doubled in the past decade.[1]

Overdose related to opioid and other substance use disorders (OUD/SUD) is the leading cause of pregnancy-associated mortality, accounting for nearly a third of pregnancy-associated deaths in Michigan.[2] Ongoing substance use in pregnancy is associated with adverse outcomes for both the birthing person and the baby. However, many of these outcomes can be mitigated through comprehensive, integrated care.[3] Addressing the crisis requires a comprehensive approach that includes preventions, improved access to evidence-based treatment, harm reduction strategies, and addressing the underlying factors contributing to substance use.

Using This Guide



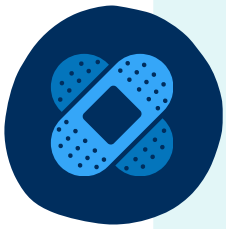
This guide is organized to provide a prenatal care roadmap for comprehensive care throughout pregnancy. We begin with principles for caring for birthing people with OUD/SUD, followed by methods of screening and diagnosing OUD/SUD and co-occurring mental health conditions. We then review modifications to routine prenatal care for birthing people with OUD/SUD, including counseling topics, medication management and additional services including antenatal testing and postpartum pain management.

This roadmap identifies additional services for birthing people with OUD/SUD that should be layered onto routine prenatal care delivery. We refer to excellent resources already compiled by local and national organizations on specific aspects of care. We hope this tool helps to bring these resources together in a single guide to help clinicians ensure pregnant patients with OUD/SUD receive the comprehensive care they need.

PRINCIPLES FOR CARING FOR BIRTHING PEOPLE WITH OUD/SUD

When providing care, these four principles honor each individual's unique experience and needs, building trust and reducing the risk of re-traumatization. By applying these principles, you can deliver more compassionate, person-centered care that leads to improved health outcomes.

WORDS MATTER



TRAUMA-INFORMED CARE

HARM REDUCTION

SOCIAL DRIVERS OF HEALTH

KEY POINT: Applying these principles in every patient interaction builds trust, improves equity, and fosters patient engagement in care.

WORDS MATTER

USE THIS:	AVOID THIS:
“PERSON WITH SUBSTANCE USE DISORDER”	**“SUBSTANCE ABUSER”**
	
• Humanized language • SUD as a chronic condition • Empathy and support	• Stigmatizing label • Negative self-perception • Reduced empathy

The language we use with patients matters!

- Using person-centered, gender-neutral language can lead to more welcoming discussions and patient interactions.
- Treatment is done WITH patients, not to them. This highlights shared decision-making in tailoring perinatal care.
- Recovery is a process, not a singular event.
- Acknowledge positive changes and small wins to help patients feel supported.

WORDS MATTER

INSTEAD OF:	TRY SAYING:
Addict/abuser	Person with SUD/person living with substance use disorder/person who uses drugs
Alcoholic	Person with alcohol use disorder/person living with alcohol use disorder
Clean/dirty urine (urine testing)	Urine negative for/positive for or substance not detected/detected
Clean (person)	Person in recovery from substance use/person in remission from substance use disorder or addiction
Criminal/felon/ ex-con	Person with justice involvement/person with criminal legal system involvement
Drug offender	Person arrested or prosecuted for substances
Fired/terminated	Guided to more appropriate treatment setting
Illicit	Criminalized
Medication assisted treatment (MAT)/opioid replacement therapy	Medications for opioid use disorder (MOUD)
Nonadherent/ noncompliant	Not using as prescribed
Relapse/slip	Resume use/restart use/recurrence of use
Strike/deviation	Concern
Drug abuse	Substance misuse
Reformed addict	Recovering patient

SHARED DECISION-MAKING LANGUAGE:

"The patient and I decided together that MOUD was right for them."

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TRAUMA-INFORMED CARE

- Trauma-informed care realizes that trauma is widespread: over 80% of patients with OUD/SUD report trauma.
- Recognize the signs and symptoms of trauma in each patient, noting they are highly specific to each person.
- Respond by fully integrating trauma-informed care into policy, procedure, and practice.
- Remember: patients may need time and relationship building before they are ready to share information.

Healthcare workers can experience trauma too! You can apply a trauma-informed approach to your team as well.

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TRAUMA-INFORMED CARE

AT A GLANCE:

TRAUMA IS COMMON

TRAUMA CHANGES TRUST AND WORLD VIEW

TRAUMA HAS LONG TERM IMPACTS ON PHYSICAL AND MENTAL HEALTH

THE IMPACT OF TRAUMA CAN HAVE MULTIGENERATIONAL EFFECTS

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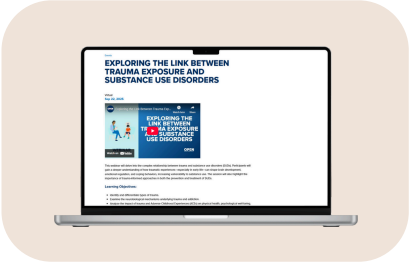

WEBINAR:
Exploring the Link Between Trauma Exposure and Substance Use Disorders

HARM REDUCTION

- Harm reduction meets people where they are, offering practical solutions to save lives and support safer choices.
- Harm reduction shifts the conversation from getting people to do the “right thing” to getting people to come back safely.
- Recovery is not all or nothing and harm reduction serves as a pillar of substance use treatment.
- Routine prenatal care, even in the context of continued substance use, offers benefit.

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SOCIAL DRIVERS OF HEALTH

- 80% of health outcomes are driven by non-medical factors, meaning what happens outside of clinical spaces has a greater effect than clinical care.
- Assessing for unmet needs allows for care teams to adjust plans to make care more accessible. For example, care teams can use virtual visits for patients with limited transportation access.

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THE INITIAL VISIT

Setting the Stage

Birthing people with OUD/SUD experience high rates of bias and stigma in medical care settings. Fear is the number one reason why this population doesn't seek care.[4,5] The initial visit is crucial for relationship building and getting patients to want to come back. Treating patients without judgement and celebrating their efforts to start care is crucial in creating a stigma-free environment. Using the four principles outlined in the previous section enhances the quality of person-centered care and is associated with improved patient health outcomes.

ROUTINE PRENATAL CARE CHECKLIST
INITIAL VISIT THROUGH 2ND TRIMESTER

- ☐ **Assess pregnancy symptoms**
- ☐ **Establish pregnancy dating**
- ☐ **Complete prenatal laboratory testing**
  - ☐ Consider urine drug testing with consent
- ☐ **Complete full patient medical history**
  - ☐ Assess substance use/substance use disorder history
  - ☐ Assess other substance use, including tobacco and cannabis
  - ☐ Review prior treatments and periods of recovery
  - ☐ Assess OUD/SUD related comorbidities (Hepatitis C, cardiac complications)
- ☐ **Complete pregnancy history**
  - ☐ Assess if other births were in the setting of OUD/SUD and treatments
  - ☐ Assess for birth/health care experiences, including trauma
  - ☐ Assess for prior pregnancy and birth complications including those related to OUD/SUD
  - ☐ Assess for prior peripartum pain management experiences
- ☐ **Complete full mental health history**
  - ☐ History of mental health diagnoses and prior treatments (medication, therapy, hospitalizations)
  - ☐ Mental Health Screenings
    - ☐ Depression/Anxiety (e.g., EPDS)
    - ☐ History of trauma/IPV (PSC-5)
- ☐ **Complete screening for unmet social needs**
  - ☐ Consider referrals to local organizations
  - ☐ Consider adjustments to make care more accessible (telemedicine, home monitoring)
- ☐ **Review MOUD treatment options**
  - ☐ Assess for dose adequacy/management of cravings

KEY POINT:

ACOG recommends universal drug screening for all patients.

Urine drug testing should never be done without the patient's permission.

KEY POINT:

More than 90% of individuals with OUD used more than 2 substances in the same year.

Polysubstance use may contribute to risk of overdose, traumatic injury, infectious disease, and mortality.[6]

KEY POINT:

80% of patients with OUD/SUD have concurrent Mental Health Conditions. Supporting mental health is crucial to supporting recovery!

COUNSELING: RISKS OF OUD IN PREGNANCY

- Ongoing substance use in pregnancy is associated with adverse effects for both the birthing person and the neonate, almost all of which can be mitigated through routine prenatal care and effective treatment for opioid and substance use disorder.

- Each substance has its own risks. Some risks include: fetal growth restriction, preterm labor, stillbirth, preeclampsia, and maternal overdose or death, structural anomalies (stimulants and alcohol), and abruption (cocaine).

- Medication for Opioid Use Disorder (MOUD) is the preferred treatment option during pregnancy, significantly reducing the risk of return to use and improving adherence to prenatal care. OUD/SUD is a chronic medical condition, and MOUD is an effective treatment option to support long-term recovery and maternal health.

- It is important to discuss with the patient that their medication needs may increase during pregnancy due to changes in the patient's metabolism.

- Dosing should be adjusted based on the patient’s symptoms, as the dose of MOUD does not correlate with the risk of Neonatal Opioid Withdrawal Syndrome (NOWS).

MEDICATIONS FOR OPIOUD USE DISORDER
MOUD OPTIONS

	METHADONE	BUPRENORPHINE	NALTREXONE
Medication	Agonist	Partial agonist (displaces opioids)	Antagonist (blocks the effects of opioids)
Forms	Tablet, liquid	Strip, film, tablet, injectables Combined buprenorphine and naloxone is preferred	Tablet, injectable
Risks	QT prolongation, drug interactions, overdose	Decreased overdose risk, precipitated withdrawal, dental caries	Precipitated withdrawal
Labor and Delivery Considerations	Continue; consider split dosing	Continue; consider split dosing	Discontinue 72 hours before labor or birth admission
Pregnancy Considerations	NOWS rates 60-80%	NOWS rates 20-40%	Less pregnancy specific data. NOWS rates 0% in one study

MEDICATION MANAGEMENT FOR OUD/SUD

FOR ALL PATIENTS **INCLUDING PATIENTS IN RECOVERY WITH ABSTINENCE**	• Shared decision-making • Discuss naloxone and provide prescription • Review safe storage and disposal of medications • Review desire for additional supports, including medication
PATIENT IN RECOVERY RECEIVING MOUD	• Review physiologic changes in pregnancy • Discuss potential dose increase to manage cravings or withdrawal symptoms
PATIENT IN ACTIVE USE	• Discuss options for management • Discuss harm reduction techniques

THIRD TRIMESTER

And Ongoing Care

Providing comprehensive, person-centered prenatal care is essential for supporting pregnant patients who use substances or are in recovery. This includes proactively managing common pregnancy discomforts, completing recommended third trimester evaluations, and preparing for individualized peripartum pain management.

Since unmanaged pain can increase the risk of return to use, prenatal care should emphasize early planning, shared decision-making, and access to both pharmacologic and non-pharmacologic options. Through thoughtful counseling, development of a personalized birth and postpartum plan, and education about newborn care—including Neonatal Opioid Withdrawal Syndrome—clinicians can help ensure safer, more informed, and more empowered experiences throughout pregnancy, labor, and the postpartum period.

ROUTINE PRENATAL CARE CHECKLIST
THROUGH 3RD TRIMESTER

- ☐ **Assess pregnancy symptoms**
  - ☐ Back pain
  - ☐ Pelvic pain
- ☐ **Complete third trimester laboratory testing**
  - ☐ CBC
  - ☐ Diabetes Screen
  - ☐ Repeat ID testing (HIV, Hep B, Hep C)
  - ☐ Repeat urine drug testing per shared decision-making plan
- ☐ **Preparation for birth/postpartum:**
  - ☐ Anesthesia consult
  - ☐ Develop and review birth plan
  - ☐ Discuss postpartum pain management
  - ☐ Discuss preparation for baby
  - ☐ Discuss contraception
- ☐ **Review MOUD treatment options**
  - ☐ Assess for dose adequacy/management of cravings
- ☐ **Antenatal testing**
  - ☐ Complete 3rd trimester growth ultrasound
  - ☐ Initiate antenatal testing
    - ☐ For patients with active substance use, twice weekly testing is
    - ☐ recommended
      For patients receiving MOUD, weekly testing is recommended

KEY POINT:

Unmanaged pain can be a risk factor for return to use. Explore options for managing discomforts of pregnancy like PT, support belts, Tylenol, and topical therapies.

KEY POINT:

There is no "one size fits all' approach to managing pain during pregnancy. An anesthesia consult can help prepare patients through pain management education and shared decision-making. Having a pain management plan on file before arriving at the hospital helps to avoid delays in pain management.

COUNSELING: DEVELOP A BIRTH PLAN

Develop a Birth Plan which includes strategies for managing pain:

- Review pain management expectations for labor and postpartum.
- Complete birth/postpartum planning including reviewing options and preferences.
- Consider available support people, including peer recovery coaches/doulas in the birth plan.
- Review UDS considerations and policies for labor and delivery.

KEY POINT: There are many ways to cope in labor: a menu of options is important to find the right approach(es) for each patient.

NON-PHARMALOGIC PAIN MANAGEMENT STRATEGIES

- Movement and positions
- Labor support devices (peanut ball, labor chair)
- Heat and/or ice
- Mindfulness
- Labor support (e.g., doula, support person)
- Hydrotherapy

PHARMALOGIC PAIN MANAGMENT STRATEGIES

- Nitrous oxide
- IV opioid (should discuss patient's comfort)
- Epidural

COUNSELING: MANAGE PAIN POSTPARTUM

KEY POINT: Return to use rates are highest during postpartum.

NON-PHARMALOGIC PAIN MANAGMENT STRATEGIES

- Heat and/or ice
- Abdominal binder
- Mindfulness
- Support person (e.g., doula, support person)
- Cognitive Behavioral Therapy

PHARMALOGIC PAIN MANAGMENT STRATEGIES

- Using non-opioid medications, like ibuprofen and acetaminophen
- Use of topical analgesia, like lidocaine patches/spray
- Prolonged epidural
- Regional pain blocks
- When necessary and with consent, opioids can be prescribed.

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COUNSELING: PREPARATION FOR BABY

Talk with the patient about expectations for when baby is born:

- Counsel about Neonatal Opioid Withdrawal Syndrome (NOWS):
  - **NOWS is a group of signs a baby may display after being exposed to opioids during pregnancy.**
  - NOWS is temporary and treatable.
- Counsel on The Eat-Sleep-Console model - which focuses on non-pharmacologic care as the first step in caring for neonates withdrawal symptoms.
- Review infant feeding preferences including the safety of breastfeeding in the absence of return to use.
- Review child protective services involvement and expectations.

KEY POINT: Addiction requires a pattern of behaviors related to substance use, which babies can't do. Instead babies are experiencing withdrawal. It is important to use non-stigmatizing language when discussing NOWS.

SCREENING

And Drug Testing For Substance Use

VERBAL DRUG SCREENING

Verbal drug screening includes a series of standardized questions (e.g. NIDA quick screen) asked to all patients about substance use. Universal screening reduces inequities in urine drug testing. Begin by explaining the rationale: substance use can impact health and wellbeing, and screening enables you to connect patients with appropriate support and resources. Normalize the screening process by integrating screenings into routine workflows and informing patients these questions are asked to everyone. Discuss implications of a positive screen with patients before asking the questions. These strategies can help build trust and transparency.

URINE DRUG TESTING

Urine drug testing is a method used to detect or confirm recent substance use. Always obtain informed consent before testing. Clearly explain the purpose of the test and discuss the possible implications of a positive result as part of the consent process. When used properly, drug testing can be a helpful tool to confirm engagement with MOUD and to support patients in their recovery journey. Providers may consider a written informed consent process.

POSITIVE SCREEN NEXT STEPS

Provide Brief Intervention and Referral to Treatments (SBIRT).

- Screening: Identify Substance Use with a validated questionnaire
- Brief Intervention:
  - Ask permission to share information about identified substance use.
  - Share risk of use for general health and pregnancy.
  - Assess readiness for behavior change and provide support for next steps.
- Referral to Treatment: Ask permission to connect patient with available resources

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KEY POINT: Receiving information from a patient is a privilege. If a patient is not comfortable discussing substance use, respect their readiness and offer to revisit the questions at a later time.

MENTAL HEALTH

In Pregnancy

More than 80% of patients who have a substance use disorder have a lifetime history of trauma and >80% have concurrent mental health diagnoses. To properly manage OUD/SUD, it is critical to address and treat the co-occurring mental health conditions. There are many evidence-based strategies for managing and treating mental health.

TRAUMA AFFECTS MENTAL HEALTH

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MENTAL HEALTH IN PREGNANCY

- Routine Mental Health Screening: Use validated screening tools like PHQ-9, GAD-7, Edinburgh Postnatal Depression Scale (EPDS), and PCL-5 for depression, anxiety, and trauma.
- Trauma-Informed, Person-Centered Care: This approach amplifies each patient's strengths while creating safety and trust in each clinical interaction. Focus on collaborative decision-making.
- Collaborative Care Models: With permission, collaborate with psychiatrists, behavioral health consultants, or social workers using warm hand-offs for mental health referrals. If possible, deliver services in co-located spaces to promote collaboration and reduce patient burden.
- Crisis Planning and Safety: Use shared decision-making when developing a Plan of Safe Care with patients
- Social and Peer Support: Connect patients with peer support groups, parenting programs, and community resources when desired.
- Brief Interventions: techniques like motivational interviewing during visits can support behavioral change and engagement.
- Evidence-Based Psychotherapy: When appropriate, refer patients to or provide access to therapies such as cognitive-behavioral therapy (CBT) or dialectical behavior therapy (DBT).
- Medication Management: Consider pharmacotherapy when indicated. Some medications may help manage other pregnancy specific symptoms like sleep, nausea, and appetite. See the Pharmacotherapy Cards for additional information on medications safe to use during pregnancy.

PAIN MANAGEMENT

Postpartum

Pain management can be more complex for birthing people with OUD/SUD. When discussing postpartum pain management with patients, it's essential to set realistic expectations and emphasize individualized, safe care. Reassure patients that effective pain management strategies are available, and discuss the role of insufficient pain management in return to substance use. Discuss that some discomfort is expected, and that they should reach out with any concerns.

KEY POINTS:

- **Protocols for patients with complex pain should start with standardized elements, but allow for tailoring to individual needs using shared decision-making.**
- **Patients receiving MOUD may require additional opioid agonist medication to overcome the blockage at the opioid receptor.**
- **Do not use partial agonist (e.g., nalbuphine, butorphanol) or antagonists (e.g., naloxone) for patients receiving MOUD with methadone or buprenorphine.**
- **Buprenorphine has an analgesic ceiling effect beyond 24-32 mg. Doses higher than this do not provide additional pain relief.**

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PAIN MANAGEMENT EXPECTATIONS

Preparation	• Early education and counseling help patients make informed decision. • Counseling topics include anticipated pain, pain management options, short term vs long term opioid therapy, risks of poorly controlled pain and return to use postpartum, naloxone. • Discuss a patient's preferences around the receipt of an opioid medication if needed.
Receiving MOUD	• Postpartum pain may be difficult to manage with MOUD. • Maintain the dose that works and consider split dosing during episodes of acute pain. • Consider how MOUD affects other medications used in pain management.
Non-Opioid Medication	• Scheduled non-opioid medications (e.g., NSAIDs, and acetaminophen) should be administered for patients without contraindications. • Toradol can be used postpartum throughout the admission. • Sample discharge regimen: acetaminophen 1000mg TID; ibuprofen 800mg TID).
Non-Pharmacologic	• Ice, heat and abdominal binders can be helpful adjuncts. • CBT can help prepare patients for postpartum pain management. • Doula support can help patients cope with postpartum pain. • Topical sprays, creams or patches may offer pain relief.
Opioid Medications	• If pain management is insufficient with other strategies, consider an opioid medication. • Best practices include: confirm existing opioid prescriptions, prioritize returning to original regimen, short time (2-3 days) intervals, discuss safe storage and harm reduction.

PAIN MANAGEMENT BEST PRACTICES

Plan for pain management early.

Ideally, pain management conversations begin BEFORE the labor and delivery admission, and include discussions of expected pain, options for pain management, risks specific to individuals with OUD, and an understanding of patients preferences for pain management. An interprofessional approach including the obstetric, anesthesia, addiction, and psychiatry teams where available is ideal.

Labor and postpartum pain plans are different.

Postpartum pain plans should start with neuraxial and regional anesthesia as appropriate during labor and/or delivery. Postpartum, clinicians should start with optimizing non-opioid options, including scheduled acetaminophen and NSAIDS, along with non-pharmacologic approaches.

PAIN MANAGEMENT BEST PRACTICES

Discuss opioids if pain is not managed.

If pain is not managed with these approaches, clinicians can discuss opioid medications with the patient. It is important to emphasize that insufficiently managed pain is a risk factor for return to substance use. Patients receiving MOUD may require higher doses of opioid medication or opioids with higher affinity for the opioid receptor (e.g., hydromorphone). If patients require an opioid prescription at discharge, it is important to discuss safe medication storage and naloxone. Consider short interval follow-up through in-person or virtual visits (within 3-5 days) to adjust pain management plans.

Collaborate with the patient.

It is crucial to create a safe space for patients to share their recovery goals and any concerns about medications. Collaborate with the patient to develop a pain management plan that aligns with their needs and supports their recovery, adjusting the approach as needed. Encourage patients to communicate if their pain is not well-controlled or if issues arise so that the care plan can be tailored appropriately.

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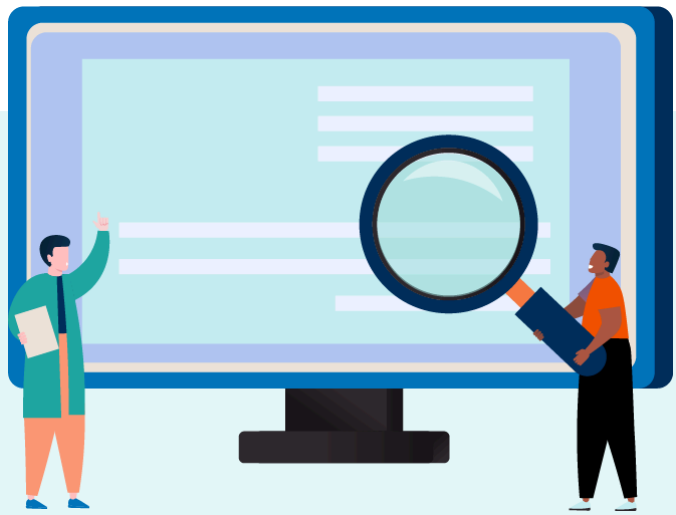

Deepen your understanding of caring for patients who are pregnant and may be experiencing substance use disorder by exploring the expanded educational content at michigan-open.org.

OPEN offers detailed clinical guidance, evidence-based best practices, and links to authoritative resources such as professional guidelines, research publications, and patient care toolkits. As you navigate the site, you'll find sections that break down assessment strategies, treatment planning, harm-reduction approaches, and considerations for both obstetric and addiction care. Additionally, integrated references and downloadable materials make it easy to dive further into topics, access continuing education opportunities, and connect with national organizations that specialize in perinatal substance use, ensuring your practice is informed by the latest standards and multidisciplinary perspectives.

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