

Pregnancy and Opioid Use Disorder: Clinical Challenges

1. Course Learning Objectives

Terminal Learning Objective (TLO)				
By the end of this module, participants will be able to apply evidence-based strategies for the treatment of opioid use disorder in pregnant and postpartum individuals, including safe medication management and approaches to reduce neonatal complications, while supporting patient-centered, equitable care.				
Enabling Learning Objectives (ELOs)				
1. Describe at least two historical and current influences shaping the opioid crisis and their impact on pregnancy.	2. Compare and contrast the risks and benefits of medication treatment versus medication-assisted withdrawal during pregnancy and postpartum.	3. Differentiate between methadone and buprenorphine treatment during pregnancy, including maternal, fetal, and child health considerations.	4. Identify at least three clinical or social factors that reduce NAS/NOWS severity among prenatally exposed infants.	5. Apply principles of shared decision-making and equity-focused care to support pregnant and postpartum patients with OUD.

2. Course Sections

a. Section 1: Historical and Current Context of the Opioid Crisis (ELO 1)

- i. This is not the first opioid crisis in U.S. history. In the 1800s, opioid use was widespread, and interestingly, the majority of those identified as opioid users were white women. Many of them were prescribed opioids directly by physicians for a range of conditions. Over time, as policies shifted and laws became stricter, use of these medications was increasingly stigmatized and even criminalized. This shift didn't just affect the individuals using opioids - it also had long-lasting impacts on the way providers, policymakers, and society viewed women

who used substances. Stigma and harmful stereotypes, such as labeling women as ‘bad mothers’ or ‘unfit parents,’ became deeply entrenched and unfortunately continue to influence perceptions today.

- ii. Fast forward to the modern opioid crisis: what we see now is largely driven by prescription practices in the late 1990s and early 2000s, when pain was labeled the ‘fifth vital sign.’ The widespread availability of prescription opioids was followed by an increase in heroin use and, most recently, the rise of synthetic opioids like fentanyl. Fentanyl, in particular, has fueled a steep increase in overdose deaths because of its potency and unpredictability.
- iii. It’s also important to recognize that this crisis does not affect all communities equally. Overdose deaths have risen sharply among Black, Hispanic, American Indian, and Alaska Native populations. These inequities point to the broader structural discrimination that shapes access to care, treatment outcomes, and, ultimately, survival.
- iv. When we consider pregnant people in this context, the risks are particularly concerning. Pregnancy does not shield individuals from the dangers of opioid use disorder. In fact, stigma, fear of criminalization, and fear of child removal can prevent many pregnant people from seeking care. Untreated opioid use disorder during pregnancy is linked with serious health risks for both the birthing person and the fetus, including preterm birth, low birth weight, and even overdose-related death. Understanding this history and the current drivers of the crisis helps us frame why evidence-based, compassionate, and equitable treatment approaches are so critical for this population.

b. **Section 2:** Treatment Approaches During Pregnancy and Postpartum (*ELO 2*)

- i. Next, let’s talk about treatment approaches.
- ii. The evidence is clear: medication-assisted withdrawal, or detoxification, is not recommended during pregnancy. It often leads to return to use and increases risks for both parent and fetus. Instead, medication treatment (with methadone or buprenorphine) is the gold standard.
- iii. These medications stabilize patients, reduce cravings, and prevent overdose. They also improve prenatal care engagement and support healthier pregnancies.

- iv. Still, every patient is different. Shared decision-making is critical: presenting the evidence, but also listening to patient values and preferences.
 - v. **Knowledge Check** (ask audience):
 - 1. True or false: Detoxification alone is a safe and effective treatment option for opioid use disorder during pregnancy."
 - 2. Answer: False (detoxification alone is not recommended.)
- c. **Section 3: Methadone and Buprenorphine in Pregnancy (ELO 3)**
- i. Now, let's look more closely at methadone and buprenorphine.
 - ii. Research shows that both are safe and effective during pregnancy. The MOTHER study found similar maternal outcomes, but babies exposed to buprenorphine needed less medication for withdrawal and spent less time in the hospital. Methadone, however, is linked to higher treatment retention, which is often critical for long-term recovery. Switching a stable patient's medication during pregnancy is not recommended.
 - iii. Both medications are compatible with breastfeeding, and both support healthier outcomes when integrated into comprehensive care.
 - iv. Case Study Pause:
 - 1. Imagine a patient in your clinic who is stable on methadone, recently found out she is pregnant, and is asking whether she should switch to buprenorphine for the baby. What would you say?
 - 2. Include a way for reflection, then reinforce: If a patient is stable on methadone, the safest approach is to continue treatment rather than switch.
- d. **Section 4: Reducing NAS/NOWS Severity (ELO 4)**
- i. Let's shift now to neonatal outcomes.
 - ii. NAS and NOWS occur when infants experience withdrawal after prenatal opioid exposure. Symptoms can include irritability, feeding difficulties, and tremors. These conditions are treatable, and not all infants require medication.

- iii. Research shows several factors can reduce severity: breastfeeding, rooming-in, standardized protocols like 'Eat, Sleep, Console,' and reducing tobacco use. These strategies empower families, improve bonding, and shorten hospital stays.
 - iv. Quick Poll (virtual poll):
 - 1. What does it look like to work in a setting that uses Eat, Sleep, Console instead of the Finnegan scoring system?
- e. **Section 5: Patient-Centered and Equitable Care (ELO 5)**
- i. Clinical management is only part of the picture. We also need to address stigma, equity, and patient-centered care.
 - ii. Pregnant people with OUD often avoid care because of fear: fear of being criminalized, incarcerated, or losing custody of their children. As providers, our language matters. Using respectful, recovery-oriented terms like 'person with OUD' helps reduce stigma. Documentation should avoid shaming terms like 'addict' or 'non-compliant.'
 - iii. Shared decision-making is critical. It shows respect for patient autonomy and helps build trust. And we must acknowledge inequities: Black and Indigenous families are more likely to be reported to child protective services. Equitable care means advocating for supportive, not punitive, responses.
 - iv. Reflection Prompt: Think about a time you may have seen stigma or bias affect the care of a pregnant patient. How might you respond differently now, with an equity-focused lens?
- f. **Section 6: Integration and Application (TLO application)**
- i. Let's bring it all together.
 - ii. We know untreated OUD in pregnancy carries major risks. Methadone and buprenorphine are evidence-based treatments, and care practices like breastfeeding and rooming-in reduce NAS severity. But just as importantly, respectful, patient-centered, and equitable care builds trust and helps families thrive.
 - iii. Case Study Application:

1. A 24-year-old, 15 weeks pregnant, comes to you seeking treatment. She has been using fentanyl daily, has a three-year-old at home, and reports tobacco use. What are your first steps? How would you build trust, stabilize her health, and plan for her pregnancy and postpartum care?"
 2. Establish trust, initiate medication treatment, support prenatal care engagement, and create a dyadic care plan that includes NAS reduction strategies.
- iv. Closing Thought: Each of us has the opportunity to shift outcomes - not just with medications, but with compassion, respect, and equity. By combining evidence-based treatment with patient-centered care, we can improve health and resilience for both parents and their children.