EXPLAINER

Medication for Opioid Use Disorder (MOUD) During Pregnancy

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Opioid use is a leading cause of maternal mortality during and after pregnancy.

Introduction

Opioid use disorder (OUD) is a chronic health condition that involves the misuse of prescription opioids or the use of illicit opioids like heroin or fentanyl. It affects people from all walks of life, including those who are pregnant. Medication for opioid use disorder (MOUD) is the gold-standard treatment, even during pregnancy. For pregnant and postpartum people, Methadone and buprenorphine are the two types of MOUD typically recommended for pregnant and postpartum people, and methadone, specifically, has been used to treat OUD during pregnancy since the 1970s. Use of these medications during pregnancy and in the postpartum period has been shown to improve outcomes for both infants and parents.

Opioid Use and Pregnancy: By the Numbers

0.4%

In 2020, about 0.4 percent of pregnant women reported using illicit opioids.

7%

Another survey of women from 2019 found that about 7 percent said they had used prescription opioid pain relievers during pregnancy.

1.4%

About 1.4 percent reported misusing prescription opioids.

131%

Although the number of people using opioids during pregnancy may be small, it is increasing. From 2010 to 2017, there was a 131 percent increase in the number of women with a documented opioid-related diagnosis at delivery.

Effects of Untreated OUD During Pregnancy

Untreated OUD can result in many unfavorable health and social outcomes for parents and children. Opioid use is a leading cause of maternal mortality during and after pregnancy. In fact, opioid use was a factor in one out of every 10 pregnancy-associated deaths in 2016. More recent data shows that overdose deaths during pregnancy and the postpartum period are increasing, with opioids driving much of this rise.

Opioid misuse can also lead to pregnancy complications and is associated with a lack of prenatal care. A study that assessed pregnancy outcomes among Canadian women who used opioids during pregnancy found that preterm birth occurred more frequently than it did among women who did not use opioids, even after accounting for concurrent alcohol and tobacco use. The same study found that infants born to women who used opioids weighed less on average at birth and were more likely to be small for their gestational age. However, the study did not find opioid use to be associated with a higher risk of stillbirth. And although the evidence is mixed, opioid exposure during pregnancy may also be associated with a small increase in birth defects.

Family separation is another possible outcome of untreated opioid use that can be harmful to parents and children and taxing on the foster care system. In 2022, 33 percent of foster care entries involved parental drug use. Because many states consider substance use during pregnancy a form of child abuse or neglect, people who use opioids during pregnancy may also become involved with the legal system.

MOUD and Pregnancy

The Food and Drug Administration has approved three options for MOUD: methadone, buprenorphine, and naltrexone. The choice of MOUD should be based on patient needs and availability of the medications. Methadone and buprenorphine are the more common choices for those with OUD who are pregnant because naltrexone's safety during pregnancy has not been established, it does not decrease overdose risk, and its use is recommended by the American College of Obstetricians and Gynecologists (ACOG) only in certain limited circumstances.

Methadone and buprenorphine work slightly differently from each other, but both are synthetic opioids that bind to opioid receptors, reducing or eliminating cravings and preventing withdrawal symptoms without producing the euphoric effects of other opioids.

Many organizations deem buprenorphine and methadone safe, first-line treatments for people with OUD during pregnancy, including the Substance Abuse and Mental Health Services Administration, Society for Maternal-Fetal Medicine, ACOG, American Society of Addiction Medicine, and the World Health Organization. This is unsurprising because MOUD use is associated with a significantly decreased risk of death, including from overdose, suicide, and cardiovascular-related mortality. It is also linked to better pregnancy outcomes relative to no treatment or medically supervised withdrawal, due to OUD's high rate of relapse.

Although buprenorphine and methadone are recommended first-line OUD treatments for those who are pregnant, each has unique benefits and challenges. Accessibility is one important consideration when choosing between these two medications. Methadone is highly restricted, and patients must present to an opioid treatment program (OTP) in person to receive the medication, often daily. Additionally, OTPs are not evenly distributed throughout the country, leaving many people without easy, local access to methadone.

Buprenorphine is available from a pharmacy, and although it has fewer known interactions with other medications than methadone does, some evidence suggests that people taking buprenorphine may be more likely to drop out of early treatment. Initiating treatment with buprenorphine can also be difficult for some patients because they must experience moderate opioid withdrawal symptoms before starting the medication. This is especially relevant because fentanyl (which has proliferated in the illicit drug market) is particularly potent and can persist in fatty tissues long after chronic consumption has stopped, creating unique challenges for starting buprenorphine without triggering a rapid onset of full withdrawal symptoms.

With respect to infant outcomes, buprenorphine is less likely than methadone to cause neonatal opioid withdrawal syndrome (NOWS). However, NOWS is a treatable condition that does not always occur from opioid exposure during pregnancy and does not have lasting effects on infant wellbeing. In fact, evidence shows that methadone-exposed infants have similar cognitive development through age five as non-exposed infants with similar health and social circumstances. Despite the potential for NOWS, MOUD is preferable to medically supervised withdrawal because the latter is associated with high relapse rates and there is a lack of evidence regarding both its efficacy and health outcomes for the fetus and pregnant person. Similarly, the risks associated with MOUD use during pregnancy pale in comparison to the risks associated with continued illicit opioid use or prescription opioid misuse.

Thus, MOUD use during pregnancy can help more parents have healthy pregnancies and give infants the best chances for a healthy start. It also improves adherence to prenatal care and has been shown to reduce the risk of complications during pregnancy and delivery.

Conclusion

Despite being the recommended treatment for OUD during pregnancy, MOUD is underutilized. Although some states have implemented policies intended to increase MOUD access for pregnant people, evidence suggests that these programs are not having the intended effects, as only 50 to 60 percent of pregnant people with OUD receive MOUD. In addition to limited access to providers and programs with the authority, skill, and willingness to facilitate MOUD use during pregnancy, fear of legal repercussions can deter patients from disclosing their opioid use to providers or prevent them from seeking care altogether. Addressing these challenges will take a multifaceted approach, but success will ensure that expecting parents with OUD can access health resources that support a healthy pregnancy and a healthy infant.

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