# Pregnancy, Opioid Use Disorder, and Opioid Agonist Treatment:

## A Fact Sheet for State-Level Advocates

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The worsening crisis of opioid-related harm in the U.S. touches all members of society, including pregnant people. People may use opioids during pregnancy for a variety of reasons, including pain management and because they have an opioid use disorder (OUD). Individuals who seek evidence-based care for OUD often experience a number of barriers, including a shortage of providers willing and/or able to provide treatment to people with OUD, concerns regarding the criminalization of people who use drugs, and limited availability of OUD treatment providers who accept Medicaid. These barriers are often compounded for pregnant people with OUD (PPOUD). As legal aid advocates, it is important to advocate for your clients so that they can receive the evidence-based care that best meets their needs and goals.

### What is the standard of care for treatment of pregnant people with opioid use disorder?

While opioid use during pregnancy is not necessarily problematic, untreated OUD during pregnancy may increase the risk of poor health outcomes for the parent and child, including preterm labor, fetal growth restriction, passage of meconium into the uterus, premature separation of the placenta from the uterus, and fetal death.[1] As evidence-based treatment dramatically reduces those risks, ensuring that PPOUD who seek evidence-based care are able to receive it should be a key priority for advocates.

The American College of Obstetricians and Gynecologists (ACOG) and the American Society of Addiction Medicine recently released guidance on best practices for the treatment of PPOUD.[2] According to both organizations, opioid agonist treatment (OAT) with methadone or buprenorphine is the recommended treatment for PPOUD.[3] OAT is preferable to supervised withdrawal, which is associated with high rates of relapse and other negative outcomes that may compromise the health of the pregnant person and fetus. Treatment with the opioid antagonist naltrexone (Vivitrol) is also discouraged by the ACOG guidance, as "significant concerns exist regarding unknown fetal effects, as well as risk of relapse and treatment dropout with subsequent return to opioid use and risk of overdose." This ACOG guidance finds that OAT helps to

[1] ACOG Committee Opinion 711: Opioid Use and Opioid Use Disorder in Pregnancy, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Aug. 2017), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy [hereinafter ACOG Opinion 711].

[2] Ibid.

[3] Opioid agonist treatment (OAT) is also sometimes referred to as opioid agonist pharmacotherapy, opioid substitution treatment, opioid maintenance treatment, or Medication Assisted Treatment (MAT).

prevent withdrawal symptoms, reduces the risk of relapse, and improves adherence to prenatal care and SUD treatment. Further, when combined with prenatal care, OAT reduces the risk of obstetric complications.[4] Research has also shown that OAT improves pregnancy outcomes for people with OUD, further providing support for the expert-recommended medical standard of care for PPOUD.[5]

Despite consensus from medical experts regarding the standard of care, some PPOUD continue to face barriers to accessing evidence-based OUD treatment. The most common barriers include:

- a shortage of OAT providers in general;
- a shortage of OAT providers willing and/or able to provide OUD treatment to pregnant people;
- concerns regarding the criminalization of drug use among pregnant people;[6]
- fear of being reported to the child welfare system resulting in the newborn child being forcibly removed from the parent;
- limited availability of OAT providers who accept Medicaid;[7]
- institutions and individual providers who refuse to provide care because of personal, ideological, and/or religious opposition; and
- state and federal laws and regulations restricting access to buprenorphine and methadone.

PPOUD are sometimes turned away from obstetric care and OAT because clinicians incorrectly believe that they must be specialized in both obstetrics and OAT in order to deliver care to PPOUD. For example, a state advocate in Ohio shared that their Medicaid clients with OUD were turned away from a county clinic that provides OAT, because the clinic providers felt they lacked the expertise to provide OAT to pregnant people. This belief is both incorrect and potentially harmful. While PPOUD can receive their care from an obstetrician with specific training on providing OAT, they can and often do receive prenatal care from an obstetrician and OAT from a separate OAT provider. Although there is a growing subset of obstetricians who have the specific training and waiver required to prescribe buprenorphine for OUD, this number is still exceedingly small.[8] It is therefore both unreasonable and unnecessary, not to mention impossible, to require that all PPOUD seek their

[4] ACOG Opinion 711, *supra* note 1.

[5] Corey Davis, et al., Nat'l Health Law Prog., *Medication-Assisted Treatment for Opioid Use Disorder: The Gold Standard* (2018), https://healthlaw.org/resource/medication-assisted-treatment-for-opioid-use-disorder-the-gold-standard/; Center for Substance Abuse Treatment. Medication-assisted treatment for opioid addiction in opioid treatment programs. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005 https://www.asam.org/docs/advocacy/samhsa_tip43_matforopioidaddiction.pdf?sfvrsn=0; H E Jones et al., Buprenorphine treatment of opioid-dependent pregnant women: a comprehensive review. ADDICTION 2012; 107 (suppl 1):5-27 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4506646/.

[6] For more on the criminalization of pregnant people, see the New York Times piece titled, "A Woman's Rights" at https://www.nytimes.com/interactive/2018/12/28/opinion/pregnancy-women-pro-life-abortion.html?mtrref=undefined, as well as the Amnesty International report titled, "Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA" at https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf.

[7] Medicaid covers 80% of all SUD-related neonatal hospital stays. In addition to improved patient outcomes, prenatal SUD treatment is much more cost-effective than neonatal hospital stays. Kathryn Fingar et al., (2015): Neonatal and Maternal Hospital Stays Related to Substance Use, 2006–2012, https://www.ncbi.nlm.nih.gov/books/NBK316155/.

[8] As of 2015, of the 41,722 obstetricians and gynecologists in the United States, only 181 (0.4 percent) have gone through the Drug Enforcement Administration (DEA)'s waiver process required to prescribe buprenorphine. Roger A. Rosenblatt et al., WWAMI Rural Health Research Center, *Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder,* https://www.ruralhealthresearch.org/assets/1176-4812/062515-opioids-webinar-ppt.pdf at slide 16. Meanwhile, Methadone for OUD treatment must generally be administered by a health care professional on site at a highly regulated clinic. Substance Abuse & Mental Health Servs. Admin., Methadone, https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone (last updated Sept. 28, 2015).

prenatal and OAT care from such an obstetrician. In fact, no accrediting body or regulatory agency has such a requirement.

**What guidelines should providers follow?**

Providers should utilize evidence-based guidelines when treating PPOUD. These include:

- SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants: Finds that pregnant and parenting people with OUD can be treated by any provider trained in OAT; the provider does not need to be, nor work with, an OBGYN.
- World Health Organization (WHO) guidelines for the identification and management of substance use and substance use disorders in pregnancy: Strongly recommends that PPOUD be encouraged to use OAT "whenever available rather than to attempt opioid detoxification." This guidance further explains that "the rate of relapse to opioid use following detoxification has been shown to be high and the risks of harm to both mother and fetus from failed detoxification are catastrophic compared to the very low risks of harm from opioid maintenance treatment." To optimize pregnancy and parenting outcomes, providers should encourage pregnant people with OUDs to receive SUD counseling and comprehensive, wrap-around services, in addition to OAT.[9]
- Provider-patient confidentiality guidelines and ethical guidelines: Providers should carefully review state and federal law to ensure that they do not violate provider-patient confidentiality guidelines, nor their ethical guidelines as providers. While state laws vary, information on federal laws regarding confidentiality for people with SUD can be found in the Health Privacy Principles by the Campaign to Protect Patient Privacy Rights. Legal aid advocates can help advise providers on these laws.

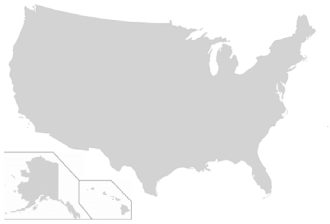
**What can legal aid advocates do to help?**

Without access to OAT, the standard of care for OUD treatment, PPOUD are at increased risk for relapse, overdose, and other harm. If you are working with a pregnant person with OUD who is seeking OAT, you can refer their providers to some of the guidance listed above. Most important is that the state/county agencies, providers, and other parties involved in helping pregnant people access SUD treatment know and understand that PPOUD can get their prenatal care from any obstetrician and their OAT from any OAT provider, and there is no legal or medical basis for requiring pregnant people with SUD to find a provider or clinic that specializes in both.

[9] North Carolina Pregnancy & Opioid Exposure Project, NC Department of Health and Human Services, Medication-Assisted Treatment (MAT) in Pregnancy – Overview, https://ncpoep.org/guidance-document/north-carolina-guidelines-medication-assisted-treatment-mat-in-pregnancy/mat-in-pregnancy/ (last visited March 20, 2019).

**Here are some additional resources for advocates seeking more information or assistance:**

**National level**: You may contact:



- The American College of Obstetricians and Gynecologists
- National Association of State Alcohol and Drug Abuse Directors' Women's Services Network (WSN)
- National Advocates for Pregnant Women at info@advocatesforpregnantwomen.org
- Legal Action Center

**State level**: Although the exact person and job title may vary by state, you can reach out to whoever is responsible for overseeing SUD services for pregnant people in your state. This person may work in the state's version of the Department of Health and Human Services, in a division such as the Division of Maternal and Child Health or the Division of Behavioral Health Services. They may hold a title such as Director of Women's Treatment Services in SUDs.

**Local level**: If you or your client are facing difficulties locating a SUD provider near you, you can refer to the following two provider directories:[10]

- Opioid Treatment Program Directory
- Behavioral Health Treatment Services Locator

[10] As these directories may not be up to date at the time of your search, further research may be needed.