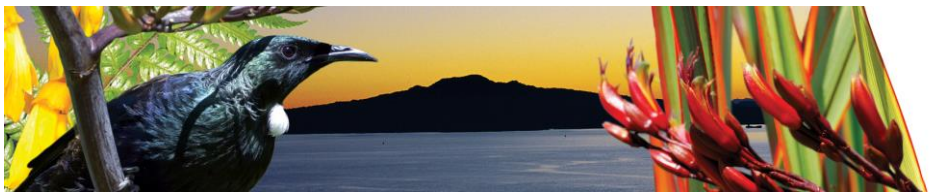

Waitemata District Health Board
Best Care for Everyone

AOTS 12. Pregnancy and OST

For more information see *OST and You pp.37-38* for information on pregnancy, breastfeeding and 'neonatal abstinence syndrome' – when babies go through withdrawal at birth

Pregnant women who are dependent on opiates are encouraged to enter OST as early as possible as it much safer for both mother and baby than continuing to use any other opiates, drugs or alcohol because:

- Being on a stable dose of a substitution medication means there's no unexpected periods of drug withdrawal/hanging out which can be harmful to the baby
- Receiving OST can result in a more settled lifestyle, improved nutrition and less stress, which all contribute to a healthier baby
- Medication supplied by a pharmacy or treatment centre hasn't been cut/mixed with any other potentially harmful substances that may be passed on to the baby.

Most pregnant women with an opioid dependency are prescribed methadone and thousands of women have taken methadone through their whole pregnancy with no adverse effects on them or their baby.

In other countries, pregnant women who cannot or will not take methadone may be advised to take buprenorphine instead. However, in NZ the available buprenorphine formulation (Suboxone) is not licensed for use in pregnancy. *See info below on Pregnancy and Suboxone.*

Who is involved in your care when you are pregnant and taking OST?

Your pregnancy care will be managed by your Lead Maternity Carer/LMC and it is up to you to decide who this will be. (All pregnant women need a LMC.) It could be a midwife, an obstetrician, or your GP. You may also be able to access an LMC through Maternity Services at your nearest public hospital. This is the person ultimately responsible for your maternity care.

Your OST will be managed by your key worker and AOTS doctor while you are pregnant and for a short period after the birth of your baby. (You may need to see the AOTS doctor more often than you have in the past for ongoing assessment and monitoring.) AOTS will work closely with maternity services to ensure your needs relating to methadone and pregnancy are attended to.

Your key worker may consult with CADS Pregnancy and Parental Service around pregnancy and treatment issues.

Pregnancy and Suboxone

Although it seems to make no difference whether you take methadone or buprenorphine during your pregnancy, buprenorphine on its own (Subutex) is not funded for use here in New Zealand. We only have access to Suboxone contains naloxone to discourage injecting. When taken sublingually only a very small amount of the naloxone gets into the body so it does not cause you to go into withdrawal like it would if it is injected.

Suboxone has not been used for OST as long as methadone so it is still too early to say if Suboxone is as safe in pregnancy as buprenorphine on its own or as safe as methadone.

If you are taking Suboxone for OST and become pregnant (or are planning a family) speak to your AOTS key worker and they will talk you through your options.

The good news is that the transfer from Suboxone to methadone is a relatively simple process and you will be fully supported by your OST team to ensure you are on the correct and safe dose. Often during pregnancy women find they require an increased dose of methadone and this can be reduced after pregnancy or you could return to Suboxone if that is the medication you prefer.

Hopefully this information will help you make a decision as to whether you continue with Suboxone or change over to methadone during your pregnancy.

Please ask your prescribing doctor more questions if you have more questions.

While you are pregnant

- Any medication taken during pregnancy needs to be carefully monitored and methadone is no exception. It is especially important that any change in methadone dose is reviewed by a doctor.
- The way your body metabolises methadone during pregnancy may change. You might need an increase in your methadone dose early in the pregnancy or later in the third trimester. Increasing your methadone dose doesn't increase the likelihood that your baby will experience withdrawal.
- You may be asked to do a serum level test to help ensure your blood methadone levels remain stable throughout pregnancy, which is important for you and your baby. (See *AOTS Information Sheet 7 Clinical tests: blood, urine, etc*.)
- If you are considering withdrawing from methadone whilst pregnant the best time is during the second trimester (3rd - 6th month). You'll need to discuss this with your key worker and doctor; they will help you to assess your situation and give you more information so you can make an informed decision for you and your baby.

We are here to support you and your baby. Please ask us if you have more questions.

Other AOTS info sheets available

1. Opioid treatment with AOTS
2. Facts about OST meds
3. Accidental OD
4. Recovery and treatment planning
5. Clinical tests
6. OST at a community pharmacy
7. Managing your scripts
8. OST and holidays in NZ and overseas
9. Shared care: OST and your GP
10. Coming off OST
11. Involuntary withdrawal
12. Pregnancy and OST
13. Driving and OST
14. Methadone and medication interactions
15. First aid box