Substance Use In Pregnancy and Postpartum Behavioral Health Toolkit

Oregon Perinatal Collaborative

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Inclusive language notice:
This toolkit is intended to improve care and outcomes for pregnant and postpartum people who have a wide range of gender identities. For this reason, we use both gendered and non-gendered terms including “birthing person/people,” “patient,” “mother,” and “maternal,” to reflect this range of identities. We affirm that respecting individual patient preferences regarding gendered language throughout their care is essential to respectful, patient-centered care.

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Section I: Introduction and Background

This toolkit is created for teams providing treatment for substance use disorders and behavioral health care needs for pregnant and postpartum people with substance use disorders.

The toolkit is organized in what are referred to as the "5 R's," which comes from a national organization called the Alliance for Innovation on Maternal Health (AIM). The categories in the 5 Rs include **R**eadiness, **R**ecognition & Prevention, **R**esponse, **R**eporting & Systems Learning and **R**espectful, Equitable, and Supportive Care. These categories help the person/team using the toolkit to approach the care and strategies in a way that allows all necessary components to be addressed in smaller pieces that support each other.

Oregon has one of the highest rates of alcohol and non-prescribed drug use in the United States (SAMHSA). Untreated mental health conditions, including substance use disorders (SUDs), are the current leading cause of preventable maternal death in Oregon (MMRC, 2025; Bruzelius & Martins, 2022). While SUDs are more common among men than women, the gender gap is narrowing (McHugh, 2018). Women are more likely to begin substance use at an earlier age and experience more severe adverse medical, psychiatric, and functional consequences related to SUDs, when compared with men (McHugh, 2018). Violence and other forms of abuse, including early childhood adverse events, are common experiences for women with SUD (Duka, 2023). When people with SUD become pregnant, they often present late to care and receive limited or no care due in part to the stigma surrounding substance use during pregnancy, fear of child removal, and systemic barriers such as lack of coordinated perinatal and treatment service (Paris et al, 2020; SAMSA, 2024; Shadowen et al, 2021). Parental substance use, in turn, is the most common reason for early foster care placement and puts children at high risk for the long-term adverse health effects associated with foster care (McConnell, 2020).

Yet, substance use disorders are treatable conditions, and pregnancy provides a window of opportunity for intervention. In the perinatal period, people's motivation and capacity for change increase and there are opportunities to connect with care through hospitals, clinics, and community services. When met with key interventions--delivered with support, transparency, and respect--health outcomes for the birthing person and child are improved, and expensive and avoidable emergency room visits and hospitalizations for medical, obstetric, and newborn complications can be reduced (McConnell, 2020).

To make meaningful change related to perinatal SUD, clinical quality improvement work must be thoughtfully designed and consider the needs and priorities of this patient population both inside and outside of healthcare—including housing, social support, transportation, food, and other basic needs. The longstanding silos between physical and

behavioral/ mental healthcare must be addressed and integration of people with lived experience of substance use and pregnancy, including those in active recovery who have specific education and professional training, often called peer support specialists, into the design and implementation is necessary. The long history of systemic racism in the United States has shaped the access and experience of Black, Indigenous, and all people of color inside and outside of healthcare and the stigma associated with substance use during pregnancy can be amplified in communities of color. Quality improvement work aimed at the prevention of pregnancy related morbidity and mortality related to perinatal SUDs must consider these factors and work to advance health for all.

Perinatal Quality Collaboratives (PQCs), including the Oregon Perinatal Collaborative (OPC), are state or multistate networks of teams working to improve the quality of care for mothers, birthing people, and babies. Members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible (CDC). In 2025, the OPC facilitated a multidisciplinary workgroup in Oregon to create the full Perinatal SUD toolkit which will support clinical and non-clinical individuals and teams caring for pregnant patients with substance use disorder. The goal of the OPC Perinatal Toolkit, content for specific audiences such as this toolkit, and a planned hospital-based quality improvement initiative is to decrease preventable maternal morbidity and mortality from substance use disorders and improve the health and wellbeing of birthing women and babies in Oregon.

Additional detail/ information is available in OPC Perinatal SUD Toolkit

Section II: Steps for Improvement (The 5 Rs)

Readiness: Every Care Setting

Key readiness takeaway:

Treatment/ behavioral health providers and teams can improve the health of pregnant people with SUD by providing non-judgmental and evidence-informed treatment and linking them to healthcare during pregnancy and postpartum. By learning from people with lived experience of perinatal SUD, we increase our chances of getting treatment to those who need it.

- Provide access to residential, detoxification, opioid treatment, peer-led groups, harm-reduction services, and other treatment programs, for pregnant and postpartum people, including those with infants in their care.
- Provide all staff education on care for pregnant and postpartum people with SUD, including an overview of perinatal health care, MOUD recommendations in pregnancy and postpartum, benefits of breastfeeding, perinatal mental health, family-centered treatment models, peer and parenting mentorship, and family care plans.
- Develop trauma-informed protocols and anti-racist training to address biases and stigma related to substance use in pregnancy and postpartum.
- Provide clinical and non-clinical staff education on optimal care for pregnant and postpartum people and their newborns with SUD, including:
    - Assisting families to complete an Oregon Family Care Plan
    - Understanding federal, state, and organizational child welfare reporting requirements, and best practices for when a child welfare report needs to be made.
- Develop treatment plans that support parent/infant attachment and bonding, discourage physical separation, and support breastfeeding.
- Coordinate care with health clinics and opioid treatment programs to help people get appointments for while in treatment.
    - Consider partnering to provide integrated treatment and perinatal care by adopting the proven Oregon Nurture program model to treat perinatal SUD: Nurture Oregon & Project Nurture
- Develop and maintain a set of resources and referral pathways to coordinate with state and public health programs and access wrap-around services and support for pregnant and postpartum families for social determinants of health needs (WIC, Healthy Families, etc).
- Develop and provide client and family education related to substance use in pregnancy, prenatal and postpartum care, care of infants with substance

exposure during pregnancy, medication for opioid use disorder, perinatal mental health, and naloxone for overdose prevention.

- Establish a process to assist every pregnant and postpartum person to develop an Oregon Family Care Plan, starting during pregnancy whenever possible.
    - Include peers/ traditional health workers/ doulas as trusted support in these discussions when possible.

Recognition & Prevention: Every Patient

Key Recognition & Prevention Takeaway:

By asking every person about their pregnancy intent and reproductive life goals, treatment/ behavioral health providers and teams can connect people with SUD to health services that align with their goals and help prevent unintended pregnancy and prenatal substance exposure.

- Screen all people for pregnancy intent and reproductive life goals using validated screening tools and methodologies in all treatment/ behavioral health care settings.
- Screen each pregnant and postpartum person for reproductive, medical, and behavioral health needs and provide linkage to services.
- Screen for structural and social drivers of health that might impact health and provide linkage to resources.

Response: Every Event

Key response takeaway:

Standardize care pathways between treatment/ behavioral health and teams and pregnancy and other healthcare providers to coordinate and prioritize care during pregnancy and the postpartum year.

- Connect every person to a reproductive healthcare provider or counselor to discuss reproductive life planning goals and provide aligned care/ resources.
- Assist every pregnant and postpartum person with SUD to get comprehensive, evidence-based pregnancy and postpartum care that is welcoming and inclusive.
- Assist pregnant and postpartum people with SUD to access comprehensive, evidence-based treatment, including medications for treatment of opioid and other use

disorders, harm reduction services, and peer led groups that are welcoming and inclusive.
- Assist pregnant people with opioid use disorder to access medication for opioid use disorder that is managed according to best practice for pregnancy and postpartum.
- Establish specific care pathways that facilitate coordination among multiple treatment/ behavioral health/ reproductive health providers during pregnancy and the year postpartum.

Reporting & Systems Learning: Every Unit/Care Setting

Key reporting and systems learning takeaway:

By adopting briefing and debriefs, non-punitive case-reviews, and tracking of outcome and process measures, teams will continue to improve care over time and see the results of their work in improved health outcomes.

- Identify and monitor data related to SUD treatment, perinatal healthcare, and care outcomes and process metrics for pregnant and postpartum people with disaggregation by race, ethnicity, and payor as able.
- Establish a culture of huddles and debriefs that can help teams identify successes, opportunities for improvement and action planning for people with complex needs related to perinatal SUD.
- Convene treatment/ behavioral health providers and teams, and community stakeholders, including those with lived experience in an ongoing way, to share successful strategies and identify opportunities to improve outcomes and system-level issues.

Respectful, Equitable, and Supportive Care

Key respectful, equitable and supportive care takeaway:

By building a culture of support, transparency, and respect in care for pregnant and parenting people with SUD, we improve treatment and behavioral health outcomes. By inviting people with lived experience of perinatal SUD to participate in design and implementation of change, we improve our chances of success.

- Integrate peers with experience of perinatal SUD and specialized peer/ doulas as part of the treatment team to establish trust and ensure shared decision-making that incorporates the client's values and goals.

- Respect the pregnant and postpartum person's right of refusal to care in accordance with their values and goals.
- Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support people to understand diagnosis, options, and treatment plans.
- Support and advocate for pregnant and postpartum people with SUD and their families during healthcare, social services, and child welfare encounters.

Section III: Appendix

Key Resources:

Bias & stigma

- Reducing Stigma | Why Words About Addiction Matter BMC
- Video: What is Stigma?
- Anti Stigma Institute

Trauma-informed Care

- Trauma Informed Oregon: Trauma Informed Care Trainings and Courses
- Do No Harm: Building Trust, and Keeping Families Together (ACES Aware)

Building Effective Partnerships between Community-Based Organizations and Health Care

- CHCS: An Inside Look at Partnerships between Community-Based Organizations and Health Care Providers

Warm Hand-offs to Improve Care

- CMQCC Best Practice N.30: Warm Hand-Off

Peers/ Doulas/ Community Health Workers

- SAMHSA: Peer Support Role
- OHA: Oregon Traditional Health Worker Toolkit: Include overview, scope of practice and benefits of integration.

Family Care Plans (Plan of Safe Care)

- Oregon Family Care Plans: Includes guidance for healthcare professionals and downloadable fillable form
- Healthcare Provider Toolkit: Creating Safe Care for Pregnant and Parenting Patients Who Use Drugs (Camden Coalition) National information and tools (check lists, scripts, etc) to support pregnant and parenting people who use drugs)

Education for Providers and Teams:

Pregnancy related

- Oregon ECHO Network: Addiction Medicine Programs An interactive educational and community-building case-based learning series for healthcare professionals throughout the state of Oregon, including a course specifically focused on pregnancy called “Substance Use Disorder in Pregnancy and Postpartum Care” that is offered twice a year.

Newborn related

- American Academy of Pediatrics: Care of the Infant with Opioid Exposure Overview of the impact of the opioid crisis on the mother-infant dyad and recommendations for management of the infant with opioid exposure.
- A Public Health Response to Opioid Use in Pregnancy: Pediatrics, American Academy of Pediatrics

Lactation related

- Washington State Lactation and Substance Use: Guidance for Health Care Professionals

Perinatal Mental Health

- Postpartum Support International (PSI): Helpline 5am-8pm PST and other resources in English and Spanish.
- Oregon Psychiatric Access Line (OPAL): For co-occurring psychiatric consultation
- National Maternal Mental Health Hotline: 24/7 free hotline with call/ text options available in English and Spanish.

Treatment of Opioid Use Disorder in Pregnant Patients

- ASAM: Treatment of Opioid Use Disorder in Pregnant Patients (8-hour, online course. Learn to identify, assess, diagnose, and manage pregnant and postpartum patients with opioid use disorder (OUD). Covers all medications for OUD and education needed to prescribe. Fulfills the 8-hour opioid education requirement for DEA license renewal.
- SAMHSA: Clinical Guidance for Treating Pregnant Women with Opioid Use Disorder and Their Infants: Clinical guidelines for care
- SAMHSA Advisory: Low Barrier Models of Care for Substance Use Disorder

Harm Reduction and Overdose Prevention

- OHA Overdose Prevention
- Save Lives Oregon
- Academy of Perinatal Harm Reduction Education and resources for providers and patients on how to reduce the harms of substance use during pregnancy.
    - Their toolkit
- Screening for pregnancy intent/ reproductive health needs Reproductive Health Screening Tools | Upstream USA

Child Welfare Reporting

- Oregon Revised Statute (ORS) 430.915 Support for Pregnant People Using Substances
- Development of a Clinical Decision-Making Framework to Address Parental Substance Use and Child Safety

Definitions

Birth Doula: A birth companion who provides personal, non-medical support to birthing people and families throughout a person's pregnancy, childbirth and postpartum experience. A doula may receive additional training specific to support pregnant and postpartum people with SUD and/or also have specific education and training as a peer support specialist and may be referred to as a "specialized doula" in these situations.

Family care plan (Oregon Family Care Plans): CAPTA and CARA legislation requires states to develop **Family Care Plans** for infants with prenatal substance exposure and their families "to ensure the safety and well-being of such infant following release from the care of healthcare providers including through **addressing the health and substance use disorder treatment** needs of the infant and affected family or caregiver". The Oregon Family Care Plan is a document that providers and patients can use together to fulfill this requirement.

Harm reduction: A set of practical, evidence-based strategies aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on the belief in, and respect for, the rights of people who use drugs. (National Harm Reduction Coalition)

Mandatory Reporter of Child Abuse: A person in a role that is required by law in Oregon to make an immediate report when they have had contact with a child they reasonably suspect was abused or contact with a person who is believed to have abused a child. In Oregon, certified Traditional Health Workers are mandatory reporters. *NOTE: Mandatory reporting applies to adults with developmental disabilities as well but is not addressed specifically here.*

Medications for opioid use disorder (MOUD): Medications used to treat opioid use disorder. Methadone and buprenorphine are first line medication options to treat pregnant women with OUD. (CDC)

Opioid use disorder (OUD): A chronic, treatable disease that involves a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences. (ACOG)

Peer support specialist: A person in active recovery from an SUD and has had education and training to provide professional peer services to another individual with similar life experience. Some peers have additional training and certification specifically related to perinatal health, such as doula training. Note that this role title is designated by the Oregon

Health Authority (OHA) and other certifying bodies may use different terms for similar role (eg certified recovery mentor, etc).

Perinatal: While different definitions can be used, perinatal refers to the period before, during and following birth. For the purposes of this toolkit, perinatal refers to the beginning of pregnancy through 12 months following the end of pregnancy (regardless of pregnancy outcome).

Person with lived experience: An individual who has experienced a substance use disorder during pregnancy or postpartum periods.

Postpartum: The first 12 months following the end of a pregnancy, regardless of pregnancy outcome.

Screening for SUD: The first component of SBIRT (Screening, Brief Intervention, and Referral to Treatment), screening is the first step in identifying risky substance use and connecting women with substance use disorders to care. During pregnancy verbal screening tools, such as the 5 Ps, can help identify people who might benefit from more in-depth assessment of their substance use and care needs. (AMCHP)

Stigma: In the context of substance use disorders, stigma is a set of negative attitudes and stereotypes that lead to discrimination and can create barriers to treatment and health care and make these conditions worse. (NIDA) Types of stigma include individual/ internalized, interpersonal/ enacted, and organizational/ institutional.

Substance use disorder (SUD)/ addiction: A treatable chronic medical disease involving complex interactions among brain circuits, genetics, the environment and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. (ASAM)

Traditional health workers (THW): Trusted individuals from their local communities who may also share socioeconomic ties and life experiences with the people they work with. This term, used by the Oregon Health Authority (OHA), refers to multiple worker types including peer support specialist and birth doula defined above.