Substance Use In Pregnancy and Postpartum Lactation 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.

Table of Contents

Section I: Introduction and Background

This toolkit is created for those who provide lactation support and care for families impacted by substance use disorders. While much of the content is focused on inpatient/hospital care, lactation teams are encouraged to consider what could or should be applied in other settings, recognizing that the role of lactation specialists may vary by setting (especially as it relates to screening and referrals to resources).

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:

Lactation consultants, counselors, and educators can improve outcomes for people with perinatal SUD by adopting a non-judgmental and evidence-informed approach to care. By learning from the lived experiences of people with perinatal SUD, we increase our chances of successfully delivering care to those who need it.

- Seek out education on optimal care for pregnant, lactating, and postpartum people with SUD.
- Establish communication with multidisciplinary care team members to provide coordinated care for people experiencing SUDs.
    - Inclusion of THWs (peer support specialists, doulas, etc) in multidisciplinary teams is critical and efforts must be taken to address power dynamics that can prevent meaningful inclusion and contribute to burn out in this role.
- Seek out training on trauma-informed care, bias and sigma, and racism to reduce biases and stigma related to SUDs.
- As appropriate per setting, develop and maintain a set of referral resources and communication pathways with obstetric providers, community-based organizations, and state and public health agencies to enhance services and support for pregnant and postpartum families for basic needs (food, housing, transportation etc.), behavioral health supports, and SUD treatment.
- Provide patient and family education related to substance use disorder (SUD), naloxone use, harm reduction strategies, and care of infants with in-utero substance exposure.

Recognition & Prevention: Every Patient

Key Recognition & Prevention Takeaway:

The screening encounter is an opportunity to build rapport between patients and care teams, provide intervention for risky substance use, and help people engage with care and support for clinical and non-clinical needs.

NOTE: *Below screenings may be outside the role of lactation, depending on the setting/ other team member roles. If the lactation team is not performing screening, awareness of validated tools and processes is important.*

- Ask all pregnant and postpartum people about substance use, including past and current use of prescribed and non-prescribed substances, as it pertains to lactation and plan of care for infant feeding.
- If use or misuse of substances is identified, refer/ connect with appropriate provider for further assessment for SUD during prenatal care and/ or delivery admission.
- Screen each pregnant and postpartum person for medical and behavioral health needs and provide linkage to community services and resources.
- Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans and provide linkage to resources.

Response: Every Event

Key response takeaway:

Lactation consultants, counselors, and educators should provide supportive, non-judgmental, and evidence-informed lactation support to people with perinatal SUD.

- Provide pregnant and postpartum people with SUD with evidence-based, person-directed lactation and infant feeding information and support.
    - Evidence regarding risks and benefits of breastfeeding recent drug use is limited, especially while newborns receive limited amounts of colostrum. The most updated information available, including limitations of data, should be shared with patients for shared decision making and individualizing a feeding plan for each parent-infant dyad.
- Support the mother/birthing parents feeding choices. Breast/chest feeding is recommended for birth parents taking MOUD and a tailored plan to support breast/chest feeding/lactation can be made in the setting of recent substance use.
- Establish communication pathways for care coordination among multiple providers during pregnancy and the year that follows as appropriate per role in setting.

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 and care outcomes and lactation for pregnant and postpartum people with disaggregation by race, ethnicity, and payor as able.
- Establish a system for multidisciplinary planning and debriefs that can help identify successes, opportunities for improvement and action planning for patients with complex needs related to perinatal SUD and lactation.
- Bring the lactation perspective to system level workgroups where inpatient and outpatient providers and community stakeholders, including those with lived experience 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 families impacted by SUD, we improve our care and 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 pregnant and postpartum people as part of the care team to establish trust and ensure shared decision-making that incorporates the pregnant and postpartum person's values and goals.
- Respect the pregnant and postpartum person's right of refusal 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 lactation and infant feeding options and plans.

Section III: Appendix

Key Resources:

Lactation And Substance Use Guidance for healthcare Professionals – Washington Department of Health
Patient Education Material on Lactation and Substance Use – Washington Department of Public Health

- Available in Arabic, Chinese, Korean, Marshallese, Russian, Somali, Spanish, Tagalog, Ukrainian, and Vietnamese

References

Harris M, Schiff DM, Saia K, Muftu S, Standish KR, Wachman EM. Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023). Breastfeed Med. 2023 Oct;18(10):715-733. doi: 10.1089/bfm.2023.29256.abm. PMID: 37856658; PMCID: PMC10775244.

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.