



Substance Use In Pregnancy and Postpartum **Pediatric Toolkit**

Oregon Perinatal Collaborative



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Substance Use Disorders in Pregnancy and Postpartum Leadership:

Silke Akerson, MPH, CPM, LDM, Oregon Perinatal Collaborative
Aaron Caughey, MD, Oregon Perinatal Collaborative
Laurel Durham, MPH, RN, Oregon Perinatal Collaborative

Ami Hanna, MPH, Comagine Health
Ana Sassano, MA-MCHS, Comagine Health
Diana Smith, CNM, MPH, Project Nurture

Substance Use Disorders in Pregnancy and Postpartum Workgroup Members

Amelia Baker, MD, PhD
C. Frederick W. Baker, MD
Francesca Barnett, LMFT, CADC III
Lydia Bartholow, DNP, PMHNP
Chelsea Barbour, LCSW, PMH-CL
Iris Bicksler, CHW, PSS
Sarah Bovee, PWS, Certified Doula
Amy Chapman, BSN, RN
Zheyang Jenny Chen, MD, PhD
Camille Cioffi, PhD
Adrian Cois, MBBS
Autumn Davidson, MD, MS
Jeremy Eckard
Kasey Edwards, CADC1, PSS
Brooke Evans, PhD, LCSW
Kerri Hecox, MD, MPH
Amy Hermes, MD, PhD
Bonnie Holdahl, MBA
Hannah Kamsky, BSN, RN
Alicia Kleen, OHDS, Prevention Coordinator
Karolina Kowalewska, Pharm.D, BCPP

Cat Livingston, MD, MPH
Linda Peng, MD
Kori Pienovi, CNM
Heidi Pollard-Hermann, PMHNP, PMH-C
Kristin Prewitt, MD, MPH
Joshua Reagan, MD, MS
Patrick Secrest, CADC-II
Emily Skogrand, Pharm. D
Emilia Smith, CPM, LDM
Wendy J Smith, MD, MPH
Heather Sonnenburg, PWS, PSS
Anna Stiefvater, RN
Brandon Togioka, MD
Meredith Walker, CADC II, MA
Rachael Waas Shull, MSN, PMHNP-BC
Shelley Weise, RN, BSN
Emily Wulff, MN, NNP-BC
Maria Wunderbro, LCSW
Emily Yeast, CNM
Angela Zallen, MD, MPH

Special thanks to the below individuals for sharing their role specific expertise in this document:

Anna Agnew, MD
Emily Wulff, MN, NNP-BC

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 pediatric teams who provide care for newborns and families impacted by substance use disorders. While much of the content is framed in the context of inpatient/hospital care, pediatric teams are encouraged to consider the value and adaptability of the content to the outpatient/clinic setting.

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:

Pediatric providers and teams can improve outcomes for people with perinatal SUD by adopting a non-judgmental and evidence-informed approach to care. By learning from people with lived experience of perinatal SUD, we increase our chances of successfully delivering care to those who need it.

- Develop trauma-informed protocols and anti-racist training to address health care team member biases and stigma related to SUDs.
- 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](#) and the process for public health data collection when it has been completed.
 - Understanding federal, state, and organizational child welfare reporting requirements, and [best practices](#) for when a child welfare report needs to be made.
- Ensure pediatric staff are aware of the federal requirement to assist families to complete an [Oregon Family Care Plan](#), organization processes for completion and sharing across settings/ teams, and the process for public health data collection when a Family Care Plan has been completed.
- Establish/engage a multidisciplinary care team to provide coordinated clinical pathways for the parent-infant dyad.
 - 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.
- Establish a pathway for a pediatric consult during pregnancy for pregnant people with SUD to build a relationship, plan for pediatric care needs, and provide anticipatory guidance and education.
- Work with social worker/ care management teams to establish communication pathways between pediatric teams, community-based organizations, and state and public health agencies to enhance services and support for families for social determinants of health needs, behavioral health, SUD treatment, parenting supports, peer supports, early intervention, etc.
- Develop and provide family education related to:
 - Perinatal SUD,
 - Support available for parents/ families,
 - Pediatric/ well child checks,
 - Care of infants with in-utero substance exposure,



- Developmental milestones and supports available,
- Naloxone for overdose prevention, and
- Safe storage of medications in the home.

Recognition & Prevention: Every Patient

Key Recognition & Prevention Takeaway:

The screening encounter is an opportunity for pediatric teams to build rapport with patients and families, offer interventions related to risky substance use, and help people engage with care and support for clinical and non-clinical needs.

- Review screenings for substance use done prenatally, and if not already completed screen all parents and care givers for risky substance use with a [validated self-reported screening tool](#) and methodologies during pediatric care.
- Work with social workers/ care management to screen all parents and care givers 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:

Standardized care pathways and warm handoff practices with community partners allow hospitals to provide priority care to people with perinatal SUD during pregnancy and through the first year postpartum.

- Assist pregnant and postpartum people with SUD to receive family-centered treatment that is inclusive of the parent-infant dyad, with warm hand-offs and close follow-up.
- Establish specific care pathways that facilitate coordination among multiple providers during pregnancy and the year that follows.



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 outcomes and process measures, pediatric 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 care outcomes and process metrics for parents with perinatal SUD and their children with disaggregation by race, ethnicity, and payor as able.
- Establish a culture of multidisciplinary planning, huddles and debriefs in the hospital that can help identify successes, opportunities for improvement and action planning for the parent-infant dyad with complex needs related to perinatal SUD.
- Bring the pediatric perspective to system level workgroups where inpatient and outpatient providers and community stakeholders, including people 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 parents/caregivers as part of the care team in infant care to establish trust and ensure shared decision-making that incorporates the parent/caregiver's values and goals.
- Respect the parent/caregiver's right to informed decision making for their infant in accordance with their values and goals.
- Engage in open, transparent, and empathetic communication with parents/caregivers to understand infant diagnosis, options, and treatment plans.



Section III: Appendix

Key Resources:

- [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](#)
- [Healthcare Provider Toolkit: Creating Safe Care for Pregnant and Parenting Patients Who Use Drugs \(Camden Coalition\)](#) National information and tools (checklists, scripts, etc) to support pregnant and parenting people who use drugs.
- [Oregon Family Care Plans](#) Includes guidance for healthcare professionals and downloadable fillable form
- [Washington State Lactation and Substance Use: Guidance for Health Care Professionals](#)
- [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.



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.