OREGON HEALTH AUTHORITY

Public Health Division
Family and Child Health

Oregon Perinatal Collaborative

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Oregon Care Recommendations Related to Opioids

Before, During, and After Pregnancy

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Review and Update (2025)

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Background

Opioid use among pregnant and postpartum people and newborn opioid withdrawal syndrome (NOWS) require a public health response coordinated across families, community-based organizations, local and state public health, physical and behavioral health, child welfare, and criminal legal systems. The standard of care focuses on the well-being of the whole family. Caregivers who have their care needs met are better equipped to provide care to their infants with the goal of keeping families together to mitigate the negative impacts of family separation across generations.

A variety of life experiences can lead to opioid-exposed pregnancies, including chronic pain or other conditions managed by opioid medication, misuse of prescribed medication, recovery from opioid use disorder (OUD) and receiving medication for opioid use disorder (MOUD), and illicit opioid use (including heroin, fentanyl, and other novel opioids). In addition to considering family strengths and resources, each of these experiences presents differing and varied opportunities for prevention and intervention. Although the focus of this document is opioids, concurrent use of other substances is common, and it is important to address other substance use disorders (SUDs) and polysubstance use when they occur.

These recommendations are informed by the principles of the World Health Organization: prioritizing prevention; ensuring access to prevention and treatment services; respecting patient autonomy; providing comprehensive care; and safeguarding against discrimination and stigmatization. The recommendations highlight the need for trauma-informed approaches to prevent and treat OUD and the importance of culture change within healthcare to eliminate stigma that prevents people with SUDs from seeking care.

Recommendations regarding care for pregnant people apply regardless of pregnancy outcome, and in cases of pregnancy or infant loss and/or child removal, compassionate and coordinated close follow-up care is particularly important. Although clinically focused, this document recognizes the real and complex burden of societal inequity, racism, housing instability, food insecurity, and economic strain on families, and the disproportionate impact on individuals and communities who have been and are currently marginalized. The recommendations further highlight the importance of culturally and linguistically aligned services, care plans that address medical *and* social needs, and connection to community-based support and services that bolster individual and family well-being, strength, and resilience.

In 2017, the Oregon Pregnancy and Opioids Workgroup (The Workgroup)—recognizing the need for an effective comprehensive approach with collaboration from state health agencies, health systems, health care providers, and community organizations—came together to develop the original statewide recommendations on opioids and pregnancy. Published by OHA in 2018, the original recommendations guided health care providers in incorporating maternal and newborn best practices and providing coordinated care for families with opioid exposure during pregnancy and the postpartum year.

Starting in 2025, the Oregon Perinatal Collaborative (OPC) facilitated a multidisciplinary initiative to decrease morbidity and mortality related to perinatal substance use disorder through trauma-informed best practices. OPC created tools and resources to support clinical and non-clinical teams caring for pregnant and postpartum patients with SUD. In alignment with this initiative, the OHA and OPC co-facilitated a new workgroup to update the 2017 Workgroup's recommendations.

The major updates include:

- Updated links and references to align with standards of care and the OPC Toolkit
- Language updates (e.g. MOUD instead of MAT, SUD instead of addiction)
- New information related to fentanyl use
- New information about harm reduction/ safer-use practices and overdose prevention/ response
- New information related to the Traditional Health Worker role in care teams.

This document is intended to serve as an important supplement to the OPC Toolkit and continue to provide perinatal care teams and health systems in Oregon with best practice guidance. Perinatal care teams, including but not limited to physicians, nurse practitioners, nurses, social workers, doulas, and treatment providers, are the intended audience. The content complements and further operationalizes existing evidence-based guidelines for medical practice from the World Health Organization, American College of Obstetrics and Gynecologists, American Academy of Pediatrics, and the American Society of Addiction Medicine (see Key References below) and aligns with other Oregon-specific initiatives and guidance including the Maternal Mortality and Morbidity Review Committee (MMRC), Opioid Settlement Prevention, Treatment, and Recovery Board, and Small Hospital Improvement Program (SHIP).

Recommendations in Brief

Care Recommendations

For all people

1. Ask all people with potential to conceive about their pregnancy intentions prior to initiation and continuation of opioids (including medication for OUD (MOUD)).
2. Ask all people seeking pregnancy or preconception care about substance use, including opioid use, using an evidence-based screening tool.
3. For individuals without OUD, avoid or minimize the use of opioids for pain management, first offering non-pharmacological or non-opioid alternatives.
4. Offer information and resources, including naloxone, to prevent opioid overdose and overdose deaths.
5. Upon discharge after delivery, encourage all birthing people without an OUD or chronic pain who need ongoing pain treatment to use non-opioid therapies (e.g., NSAIDs). If opioids are indicated, providers should prescribe a limited number of opioid pills to last until a scheduled follow-up visit and no more than 7 days at the lowest effective dose.

For birthing people with an OUD and their infants

6. Coordinate care for pregnant and postpartum people with an OUD.
7. Manage OUD during pregnancy by following evidence-based approaches.
8. Include additional screenings and services when caring for pregnant and birthing people with an OUD.
9. Implement a trauma-informed approach to care for pregnant and birthing people with an OUD.
10. Provide appropriate pain control for birthing people with an OUD during labor and birth.
11. Provide necessary postpartum services and support for birthing people with an OUD.
12. Encourage breastfeeding or chestfeeding for birthing people with an OUD receiving MOUD.
13. Closely monitor an infant born to a birthing person who used opioids during pregnancy and manage their care with a standardized protocol for the assessment and treatment of infants at risk for NOWS.

14. Follow best practice guidance related to assessment of child welfare risk, risk mitigation, and reporting.

Health System and Policy Recommendations

15. Identify and invest in evidence-based primary prevention, harm reduction, treatment, and recovery for opioid use and OUD.
16. Work to remove barriers to care for pregnant and postpartum people with an OUD and to change the culture of care in the health system.
17. Implement a statewide public health monitoring strategy for in-utero opioid exposure and NOWS to define prevalence and trends, inform improvements in clinical care, evaluate the impact of interventions, and ultimately improve health outcomes for families.
18. Provide funding and facilitate increased systems coordination to build a comprehensive statewide network of care for families affected by OUD and other substance use disorders.

Care Recommendations

Recommendations for all people

Recommendation 1: Ask all people with potential to conceive about their pregnancy intentions prior to initiation and continuation of opioids (including medication for OUD (MOUD)).

a. Screen all people with a reproductive health screening tool and offer pregnancy tests, reproductive health counseling, and contraceptive care. All counseling should respect everyone's right to decide whether or when they want to have a family.
b. Offer reproductive health counseling services in multiple settings where individuals already receive care, such as syringe service programs, SUD treatment settings, emergency rooms, and primary care. Consider providing incentives for engaging in reproductive health planning conversations.
c. Offer all people who are pregnant comprehensive pregnancy options counseling including the options of abortion, adoption, and parenting. All counseling should be grounded in reproductive justice, respecting everyone's right to decide whether or when they want to have a family.
d. For people with OUD who desire pregnancy, offer information on treatment of OUD during pregnancy and while breast/chestfeeding. MOUD is the most effective treatment available and should be offered, encouraged, and sustained prior to pregnancy, during pregnancy, while breast/chestfeeding, and postpartum, along with regular prenatal healthcare and wraparound support services. They should also receive two doses of naloxone upon discharge from the hospital
e. Offer all people who desire pregnancy an Oregon Family Care Plan.

Recommendation 2: Ask all pregnant people and people seeking pregnancy or preconception care about substance use, including opioid use, using an evidence-based screening tool.

a. All pregnant people and people seeking pregnancy or preconception care should be routinely asked about use of opioids, including appropriate use of prescription opioids, illicit use of prescription opioids and other illicit opioids such as heroin or fentanyl. Because polysubstance use is common, rely on short, validated tools that screen for other substance use such as CAGE-AID, SBIRT Oregon's Brief Screen for all adults, 5 Ps for people who are pregnant, or CRAFFT for adolescents.
b. Any positive initial screen should prompt more in-depth discussion, screening with interview tools like Drug Abuse Screen Test (DAST) or other strategies to determine if an OUD exists.
c. All pregnant people and people seeking pregnancy or preconception care should be asked about current and past participation in SUD treatment programs. If a pregnant

person is currently in treatment, appropriate consents should be signed to facilitate communication and coordination of care between care providers.

d. Offer to discuss with the pregnant person or person seeking pregnancy or preconception care with past or current SUD more about their SUD history (i.e. substances used, length of time in recovery, recent returns to use, medical sequelae, history of injection drug use) and past and current program participation to support their goals, reduce risks related to pregnancy, birth and postpartum.

> Prenatal substance exposure alone does not form a sufficient basis to make a mandatory report of child abuse in Oregon. Oregon does not include in-utero substance exposure in the statutory definition of child abuse.

Toxicology testing

e. Toxicology tests should only be requested when necessary to inform a clinical decision and should not be done without obtaining the patient's informed consent.
f. Document clearly any prescribed medications that the patient received during their care that will result in a positive toxicology test.
g. A positive toxicology screen must be followed by a confirmatory drug assay (such as gas chromatography/mass spectrometry). The window of detection varies greatly across substances, and like other screening tests, false positive and false negative results are common. Do not base clinical decision making on presumptive positive test results—confirmatory testing is critical to obtain first.
h. A positive toxicology screen for a birthing person or infant should never be used as the basis for a report to child welfare. (See recommendation 14 related to child welfare assessment and reporting best practices).
i. A toxicology test may be done at the patient's request to support and document their recovery efforts or as part of a comprehensive substance use disorder treatment plan made collaboratively with the patient. The result of the test should be reviewed with the patient, as with any other lab test.

> Toxicology tests have high rates of false results and are not a substitute for verbal, interactive screening with patients for substance use disorders. Universal drug toxicology testing is not recommended. Before ordering a drug toxicology test, consider whether the test result will change your clinical plan of care and whether it is necessary.

Recommendation 3: For individuals without OUD, avoid or minimize the use of opioids for pain management, first offering non-pharmacological or non-opioid alternatives.

> When considering whether to continue a person on opioids prescribed for chronic pain, consult the Oregon Opioid Prescribing Guidelines and reference the Oregon Pain Education Toolkit to facilitate nonpharmacological care.

a. If a pregnant or birthing person without an OUD needs pharmacologic management for acute pain (dental, surgical, injury), pain should be managed with a multi-modal approach, minimizing the use of opioids, following the Oregon Opioid Prescribing Guidelines. Clinicians and patients can also refer to the OHA Heal Safely campaign for information and resources for managing acute pain.
b. Before prescribing opioids to a pregnant or birthing person, clinicians should check the Oregon Prescription Drug Monitoring Program (PDMP). The patient should be informed that clinicians are checking PDMP, and this should be documented in the medical record. Guidance on best practice for PDMP use is available from the American Society for Addiction Medicine (ASAM).
c. If a person becomes pregnant while using prescription opioids for chronic pain and the prescriber is not the perinatal care clinician, the prescriber and the perinatal care clinician should have a conversation to determine: 1) whether an assessment for physical dependence or OUD is needed, 2) who will prescribe during the pregnancy episode, 3) a schedule for ongoing consultation, and 4) a plan for care after the pregnancy episode. The ongoing consultation is meant to facilitate co-management and prevent the prescriber from discharging the patient from care due to pregnancy.
d. If a person becomes pregnant while using prescription opioids for treatment of chronic pain, the care team (prenatal provider and prescriber) should engage the patient in discussion to inform a shared decision regarding the plan of care for ongoing pain management during pregnancy. This discussion should be informed by current pain management guidelines, and include discussion of obstetric and newborn risks, benefits, and alternatives to continued opioid treatment versus opioid taper; non-pharmacological pain management options; assessment of functioning with and without opioid pain management; and careful consideration of timing and pace of an opioid taper, if elected. The second trimester of pregnancy is the optimal time to taper (slowly, with close follow-up and ongoing assessment of the plan and patient response).
e. Pain management specialists are encouraged to initiate and continue care for pregnant and birthing people in need of services, in collaboration with the perinatal care clinician.

f. Every patient receiving an opioid medication prescription should receive education on safe storage of medication and how to prevent opioid misuse and overdose.

Recommendation 4: Offer information and resources, including naloxone, to prevent opioid overdose and overdose deaths.

a. Make pregnant and birthing people taking opioids aware of the risk of overdose and how to prevent overdose. Anyone taking opioids should be dispensed naloxone in case of overdose and know how to use it.
b. Providing every pregnant and postpartum person with any SUD two doses of naloxone upon discharge from the hospital is a best practice. This supports compliance with Oregon Administrative Rule (OAR) 333-505-0055.
c. Provide education on how to use naloxone to pregnant people with SUD and their support people.
d. Provide education that naloxone can be safely used during pregnancy, while breast/chestfeeding and for infants and children in the event of accidental ingestion.
e. Provide education to people with OUD that their risk of overdose is highest after a period of reduced use or abstinence from use, including following a hospitalization or incarceration event, due to decreased opioid tolerance.
f. Offer, encourage, and sustain MOUD for people with OUD, to decrease risk of overdose.
g. Avoid prescribing other sedating medications (e.g. benzodiazepines) to pregnant people using opioids due to the risk of enhanced respiratory depression. If benzodiazepines are needed in the acute care setting, use caution and monitor vital signs closely.
h. For people with OUD who are in active use, offer information on harm reduction strategies and safer use practice, and offer referral to harm reduction services.
i. Coordinate close follow-up and ongoing care for people who experience pregnancy or infant loss and/or family separation/child removal, as they are at increased risk of a return to use and opioid overdose.

Recommendation 5: Upon discharge after delivery, all birthing people without an OUD or chronic pain who need ongoing pain treatment should be encouraged to use non-opioid therapies (e.g., NSAIDs). If opioids are indicated, providers should prescribe a limited number of opioid pills to last until a scheduled follow-up visit and no more than 7 days of treatment at the lowest effective dose.

a. Make pregnant and birthing people who are prescribed opioids aware of the risk of overdose and how to prevent overdose. Anyone taking opioids should be dispensed naloxone in case of overdose and know how to use it.
b. Provide education on how to use naloxone to birthing people who are prescribed opioids and their support people.

c. Provide education that naloxone can be safely used during pregnancy, while breast/chestfeeding and for infants and children in the event of accidental ingestion.
d. Avoid prescribing other sedating medications (e.g. benzodiazepines) to birthing people who are prescribed opioids due to the risk of enhanced respiratory depression. If benzodiazepines are needed in the acute care setting, use caution and monitor vital signs closely.

Recommendations for birthing people with an OUD and their infants.

Recommendation 6: Coordinate care for pregnant and birthing people with an OUD.

> An essential component of effective, coordinated care is reducing discrimination and punitive approaches associated with opioid use disorders during pregnancy and supporting birthing people in feeling safe when accessing the treatment services they need. All professionals involved in care need to understand the different contexts of opioid use by pregnant and birthing people to accurately assess their distinct needs and those of their family members to implement the most appropriate medical plan of care and Oregon Family Care Plan.

a. Connect patients to a program specializing in care of people with perinatal OUD (e.g. Project Nurture and Nurture Oregon), where available. When not available, consider consulting with a program or clinician specializing in care of people with perinatal OUD (e.g. OHSU Addiction Consult Line).
b. Develop a comprehensive Oregon Family Care Plan collaboratively with the patient, in addition to a medical plan of care that supports patients in identifying their own goals for health and social services and collaborate with them to determine and document how individuals will be connected to services in each domain. Providing a sustained relationship and care management to support the family in creating a Family Care Plan is a best practice. This could include a peer support specialist, home visitor, family coach, or individuals in other community service professional roles.
c. Patients should consent to any communication and coordination between substance use disorder treatment providers, perinatal care clinicians, behavioral health providers, child welfare (when involved), and local social services organizations. Collaboration can support an optimal continuum of care.
d. Ensure consent forms are in place to secure information releases necessary to coordinate care. Special permission to share information about SUD treatment is required.

e. Connect patients to traditional health workers, and specifically peer support specialists and doulas with lived experience of SUD, to help with support needs and complex care navigation throughout pregnancy, as soon as possible during the delivery hospitalization, if not connected during pregnancy, and the first year postpartum.
f. Provide access to interpreter services and provide culturally and linguistically aligned care whenever possible.
g. Coordinate close follow-up and ongoing care for people who experience pregnancy or infant loss and/or child removal/family separation, as they are at increased risk of return to use and opioid overdose.

Recommendation 7: Manage OUD during pregnancy by following evidence-based approaches.

> Engaging pregnant women with opioid use disorders in comprehensive services is essential for optimal recovery and parenting outcomes. The standard of care for pregnant women and birthing people with an opioid use disorder is medication for opioid use disorders (MOUD) and evidence-based behavioral interventions. The efficacy of MOUD has been widely acknowledged and endorsed as a highly effective tool in recovery, including for pregnant women and birthing people.

a. All pregnant and birthing people with OUD should be offered, encouraged, and sustained on MOUD during pregnancy, birth, breast/chestfeeding, and postpartum, with or without engagement in other forms of treatment. If MOUD is not available through local resources, offer and coordinate a consultation with OHSU's Addiction Consult Line. Telemedicine care through OHSU Harm Reduction and Bridges to Care Clinic or another telemedicine buprenorphine provider, Perinatal care team members should document if available services are inadequate and advocate for more services in their community.
b. Recommend and connect all pregnant and birthing people with OUD who have concurrent stimulant use disorder to contingency management.
c. Both buprenorphine and methadone are appropriate medications for treatment of OUD. Sublingual and long-acting injectable (LAI) formulations of buprenorphine should be considered on a case-by-case basis. Patient preference, clinical indications, and access should guide the choice between the two medications and medication formulation.
d. Initiate MOUD as early in pregnancy as possible. Hospitalization for a pregnancy complicated by OUD should be considered and prioritized to address medical comorbidities, expedite stabilization with MOUD, and coordinate a comprehensive treatment and care plan. Fentanyl use disorder makes it difficult to transition onto buprenorphine in the outpatient setting or onto methadone in a timely fashion.

e. Provide a prescription for or dispense MOUD on discharge from the hospital to support continuation and a bridge to outpatient follow-up.
f. A person who becomes pregnant while on buprenorphine or buprenorphine/naloxone should continue their medication.
g. A person who becomes pregnant while using a buprenorphine long-acting injectable formulation should discuss the pros and cons of remaining on it while pregnant versus transitioning to sublingual buprenorphine with their perinatal care clinician.
h. A person who becomes pregnant while on methadone should continue methadone and not transition to buprenorphine.
i. A person previously stable on buprenorphine should be assessed for a dose increase and twice daily (split) dosing during pregnancy. Dose increases and twice daily dosing are typically needed in the third trimester, and sometimes three- or four-time daily dosing. Care should be coordinated with the SUD treatment provider. An increased dose does not increase the risk for newborn opioid withdrawal syndrome.
j. A pregnant or birthing person, previously stable on buprenorphine or methadone, who has a return to opioid use should have their treatment plan reevaluated and care coordinated among providers. Return to substance use is common and should not be viewed as treatment failure or a reason to discontinue treatment.
k. A person on MOUD during pregnancy should be encouraged to continue MOUD postpartum to prevent return to use and reduce risk of overdose. Care planning and patient education should address the increased risk of MOUD discontinuation following pregnancy and subsequent risk to the infant, care plan, and health of the pregnant or postpartum person.
l. Medically supervised withdrawal of a pregnant or birthing person from opioids should only be considered on a case-by-case basis if intensive behavioral health supports are in place. The clinician should assess the patient's motivation and risk of returning to use should be discussed. If medically supervised withdrawal is unsuccessful, there are substantial adverse risks such as return to use and overdose. The option to restart MOUD to prevent return to use or overdose should be considered and discussed with the patient.
m. All pregnant and birthing people with an OUD should be offered referral to SUD treatment, including access to regional Behavioral Health Resource Networks. If local resources are not available, consultation through OHSU's Addiction Consult Line is recommended, in addition to transfer of care (if a patient is willing/able to travel).
n. All pregnant and birthing people with an OUD should be offered information on safer use practices and referral to harm reduction services.
o. All pregnant and birthing people with an OUD should be assessed by an individual familiar with American Society for Addiction Medicine (ASAM) Levels of Care to determine the recommended treatment setting. Treatment setting recommendations

should include the patient, consider barriers to treatment, and include active coordination to ensure follow through.

p. Providing every pregnant and postpartum person with any SUD with two doses of naloxone upon discharge from the hospital is a best practice. This supports compliance with OAR 333-505-0055.

Recommendation 8: Include additional screenings and services when caring for pregnant and birthing people with OUD.

> Pregnant and birthing people with opioid use disorders often have co-occurring health conditions that need timely assessment and care, in addition to routine pregnancy care.

a. Obtain ultrasound measurement as early as possible in pregnancy. Pregnant people with OUD often present to care later and/or have irregular menses. To establish accurate dating of pregnancy, see the recommendations from the American Congress of Obstetricians and Gynecologists, the American Institute of Ultrasound in Medicine, and the Society for Maternal Fetal Medicine.

b. Use fundal height measurements and ultrasound surveillance to assess fetal growth more frequently if signs of growth restriction are present. There is higher risk of fetal growth restriction in pregnant people who are using opioids during pregnancy.

c. Screen for other substance use at presentation for care. If a birthing person with an OUD is also using other substances such as stimulants, alcohol, cannabis, sedative/hypnotics, and/or tobacco/nicotine products, they should be offered evidence-based services to support the discontinuation of these substances at the same time as initiating MOUD. Concurrent use of substances besides opioids can complicate management of OUD and assessment of opioid withdrawal. Thorough assessment and care planning for management of polysubstance use disorders often is necessary.

d. Assess iron deficiency, vitamin D deficiency, and macronutrient imbalance. Prenatal vitamin use throughout pregnancy and nutrition counseling are especially important as many pregnant and birthing people with OUD experience poor nutrition, malnutrition and eating disorders. Provide food/nutrition resources.

e. Screen for hepatitis C, hepatitis B, and HIV at start of prenatal care and repeat during the third trimester. Screen for syphilis at the start of care, during the third trimester and then again at delivery. Screen for other STIs more frequently than in non-OUD patients. Plan prenatally with the patient for Hep A and B vaccination and/or Hep C treatment, if indicated, once no longer pregnant.

f. Refer early for dental cleaning and care. Plan and coordinate care with the patient, treatment and dental providers and put safeguards in place, if pain management is necessary.

g. Ask about skin infections, monitor and treat as needed. Provide education on infection prevention and infection prevention supplies.
h. Have a baseline EKG on file for people who are using methadone for MOUD.
i. Add a comprehensive metabolic panel (CMP) to the routine prenatal panel to assess liver and renal function.
j. Discuss prenatally the possible effects of drugs on the newborn, risk of NOWS, and available treatments. Advise on possibility of extended stay for the newborn and consider extended stay for the birth parent to allow for dyadic care.
k. Discuss Eat, Sleep, Console (ESC); the important role the birth parent and family play in care of an infant with NOWS; and that symptoms are treatable and temporary. Arrange postpartum support and advocacy for parents during an extended newborn hospitalization to support successful implementation of ESC.
l. Consider prenatal pediatric consultation as a bridge to pediatric care. This provides an opportunity to facilitate a trusting patient-provider relationship and make a plan for anticipated newborn care.
m. Provide education on the benefits of human milk for all newborns and specifically for those with in-utero opioid exposure. Provide education and plan to establish and maintain milk supply and support breast/chestfeeding, to those who make this choice.
n. Provide close follow-up and ongoing care for people who experience pregnancy or infant loss and/or child removal/family separation to reduce their risk of a return to use and opioid overdose.
o. Offer patient-centered reproductive life planning and contraceptive counseling and support development of a plan.
p. Check the Oregon Prescription Drug Monitoring Program (PDMP) as part of routine screening and management for pregnant and birthing people with an OUD.
q. Schedule more frequent visits to build the patient-provider relationship and to facilitate care for medical and psychosocial needs early and ongoing.
r. Screen for intellectual disability and provide appropriate referrals and resources.
s. Birthing people with OUD may have a history of trauma, abuse or neglect. They may have mental health conditions such as depression, anxiety, or post-traumatic stress disorder (PTSD). Screening for mental health conditions should occur during the first prenatal care visits and be repeated during pregnancy. Treatment of mental health conditions may require pharmacotherapy. Keep in mind possible drug interactions with MOUD.
t. Pregnant and birthing people with OUD are disproportionately more likely to be in an abusive relationship and struggling with social isolation, housing instability, economic strain, and food insecurity. Screening for behavioral health conditions, intimate partner violence (IPV), and social needs should occur during the first prenatal care visits and be repeated during the pregnancy. Provide referrals and support to connect

to services that address identified needs is paramount to support health and family well-being (see Recommendation 6b and the Oregon Family Care Plan).

Recommendation 9: Implement a trauma-informed approach to care for pregnant and birthing people with an OUD.

a. Provide continuity with a perinatal care team whenever possible.
b. Create a patient-centered plan to facilitate blood draws if intravenous access is challenging or raises past trauma.
c. Use strengths-based charting, documenting individual and family protective factors. Incomplete, inaccurate, and biased documentation that is only focused on risk factors can have devastating legal consequences for individuals and families.
d. Provide care to patients who present without an appointment or who arrive late for an appointment, whenever possible, recognizing the barriers they work to overcome to access care.
e. Use warm hand-offs to known and trusted providers and care teams experienced in care for birthing people with OUD, to facilitate access to care and community resources.

Recommendation 10: Provide appropriate pain control for birthing people with an OUD during labor and birth.

a. Consider an antenatal anesthesia consultation and make a plan prenatally for managing pain during labor.
b. Do not hesitate to offer pain management including an epidural and/or a short-acting opioid analgesic to a birthing person with an OUD (including people on MOUD) to manage pain during labor.
c. A pregnant or birthing person with an OUD should not receive butorphanol, nalbuphine, or pentazocine.
d. A pregnant or birthing person with an OUD who is currently maintained on either methadone or buprenorphine should be continued on their same daily dose during the hospital stay, and patients should be reassured of this plan to reduce anxiety. When possible, contact the substance use treatment provider to confirm dose of methadone or buprenorphine and notify of admission. Dividing the usual daily maintenance dose of buprenorphine or methadone into three or four doses every 6–8 hours may provide partial pain relief; however, additional analgesia will likely be required. While the patient is admitted to the hospital, any attending clinician who can prescribe opioids may order buprenorphine and methadone to maintain a patient's outpatient dose during hospitalization.
e. A pregnant person with an OUD who is currently maintained on either methadone or buprenorphine may require higher doses of opioid analgesics to experience pain relief, whether they are having a vaginal delivery or a C-section. Perinatal Care Team

members may be anxious about the high dosages required. If the birthing person is alert and has a normal respiratory rate, Perinatal Care Team members can be reassured that the patient has not been overdosed. Aggressive pain management during labor will not worsen opioid dependence or use disorder and may help the postpartum medical course go more smoothly.

f. Opioid medications administered intrathecally may be present in a subsequent urine drug toxicology test.
g. Buprenorphine should not be administered to a patient who takes methadone.
h. Consider non-pharmacological pain management strategies such as continuous support from doulas/peers, movement, mindfulness and relaxation training, massage, transcutaneous electrical nerve stimulation (TENS) units, heat, laboring in water and pudendal blocks. Nitrous oxide could also be considered with caution for patients receiving systemic opioids. MOUD is not an absolute contraindication, and use in laboring people with OUD, should be for the same indications as for patients without OUD, with close monitoring for sedation and respiratory depression (e.g., sedation scores, respiratory rate monitoring, continuous pulse oximetry).

Recommendation 11: Provide necessary postpartum services and support for birthing people with an OUD.

a. After vaginal delivery, adequate pain relief can generally be achieved with nonsteroidal anti-drugs (NSAIDs) and acetaminophen.
b. After a C-section, a person who is stable on buprenorphine or methadone for OUD should be continued on their outpatient dose. If medication is needed to treat pain, this should be in addition to continuation of the OUD treatment medication at their outpatient dose.
c. After a C-section, the option of an extended epidural or Transversus Abdominis Plane (TAP) block should be considered and discussed with the patient.
d. Let the patient know if any opioid medications will be or have been administered intrathecally, as they produce opioid-related side effects and may be present in subsequent urine drug toxicology tests.
e. Judicious use of injectable nonsteroidal anti-inflammatory agents can be highly effective in postpartum and post-cesarean pain control. Alternative pain management strategies including gabapentin, lidocaine patches, and transversus abdominus plane blocks may also be considered.
f. If opioids are needed for pain control postpartum, birthing people with an OUD may require higher than usual doses of opioid analgesics to accomplish pain relief due to tolerance to opioids.
g. After delivery, immediate dosage adjustments of methadone or buprenorphine are usually not required; however, patients should be monitored for sedation. If a person

is experiencing drowsiness, they should be assessed for (1) medical illness, (2) return to substance use and (3) dose adjustment.

h. Avoid discontinuation of MOUD and encourage continuation in a SUD treatment program. Give the patient a list of medications administered during hospitalization as well as those prescribed at discharge. Counsel the patient regarding what medications were given during hospitalization that could be present in subsequent urine drug toxicology test. Notify the substance use treatment provider upon discharge to confirm the patient has a follow up appointment. Be sure to indicate the timing of the last dose. Confirm who will reevaluate the patient's dose postpartum and provide outpatient prescriptions. Check hours of methadone clinic prior to discharge so that the patient does not miss a dose.
i. Provide a prescription or dispense MOUD when necessary to bridge to their follow-up appointment or treatment.
j. Any new birth parent with OUD should be screened for behavioral health disorders before discharge.
k. If an Oregon Family Care Plan was not completed prenatally, support completion to help families identify their needs and connect with services postnatally.
l. Patient-centered contraception counseling should be provided to all birthing people before discharge and at postpartum care appointments.
m. Consider sooner and more frequent postpartum follow-up with the perinatal care clinician. The discharge plan should include strategies for the birthing person to get support through community-based programs like peer support specialists, doulas, home visiting (e.g., Healthy Families and Babies First!) and Oregon Relief Nurseries.

Recommendation 12: Encourage breastfeeding or chestfeeding for birthing people with an OUD on MOUD.

a. Provide education on the benefits of human milk and offer lactation support. Any amount of human milk can decrease the infant's need for pharmacological treatment for NOWs.
b. When breastfeeding or chestfeeding is not a part of the plan, encourage skin-to-skin contact early and often.
c. During any separation of the birthing person and infant or when breastfeeding or chestfeeding is not possible, provide lactation support and a pump at the bedside and support and educate on how to establish and protect milk supply if they desire lactation.
d. Treatment with methadone or buprenorphine is not a contraindication to breastfeeding or chestfeeding. While the current buprenorphine package insert advises against breastfeeding, the Academy of Breastfeeding Medicine Clinical Protocol 21 states breastfeeding should be encouraged for birthing people being treated with methadone or buprenorphine; this is the recommended standard of care.
e. Birthing people should be encouraged to breastfeed or chestfeed unless they are HIV-positive or hepatitis C positive with cracked or bleeding nipples. A person who is HIV-positive or hepatitis C positive can pump and discard human milk until nipples heal. A

nipple-shield can be considered for prevention of nipple damage in HIV-positive or hepatitis C positive birthing people and education on nipple care to prevent nipple damage should be provided proactively.

f. An individualized feeding plan should be developed with each patient, taking into consideration their goals, treatment plan, and care needs.
g. If a lactating parent returns to substance use, carefully review the situation before recommending a discontinuation of breastfeeding or chestfeeding.

Recommendation 13: An infant born to a birthing person who used opioids during pregnancy should have close monitoring and be managed with a standardized protocol for the assessment and treatment of infants at risk for Newborn Opioid Withdrawal Syndrome (NOWS).

> NOWS is an anticipated, time-limited, and treatable condition that can occur when there is in-utero opioid exposure.

a. Infants with prenatal opioid exposure should be monitored collaboratively by the family and care team for symptoms of NOWS. When using a standardized scoring system to assess NOWS, neonatal care providers should undergo training and periodic updates to ensure interrater reliability. Best practice is to also provide families with a tool to participate in assessment of their newborn's symptoms.
b. Educate caregivers about the signs of opioid withdrawal in infants, techniques to soothe the infant, and safe sleep recommendations.
c. First line therapy for infants with NOWS symptoms should include non-pharmacological care such as non-nutritive sucking, swaddling, uninterrupted sleep, a low-stimulation environment, skin-to-skin contact, frequent feeding, and rooming-in with the birth parent. These strategies should also be employed proactively in an infant at risk of developing NOWS.
d. Offer information to caregivers about best practices for caring for an infant with NOWS before symptoms need management so families can prepare. NOWS should not be framed as evidence of harm to the infant and is not considered evidence of harm in the eyes of the law. Look for opportunities to praise caregivers to reduce the experience of stigma and emphasize opportunities for care and treatment for the whole family during the postpartum period. Clinical notes should also frame caregiver support in ways that are strengths based and non-judgmental.
e. Infants with NOWS can often be managed outside of neonatal intensive care. Perinatal care teams should determine whether the infant can remain in low-acuity settings or be transferred depending upon the need for pharmacologic therapy, the severity of symptoms, local protocols and the comfort level of the care team.
f. The first 96 hours is a critical period for assessing whether the NOWS symptoms can be managed without pharmacologic treatment. NOWS symptoms can also develop

after this window of time. Monitoring may occur in the hospital or in an outpatient setting based on clinical judgement if flexible and prompt follow-up is available. Caregivers should be informed and involved in monitoring whenever possible.

g. If pharmacologic treatment for NOWS is indicated, the American Academy of Pediatrics (AAP) recommends initiating treatment with oral morphine or oral methadone, preferably preservative-free formulations. When a second-line agent is indicated, clonidine is preferable to phenobarbital.
h. While little is currently known about the neurodevelopmental effects of intrauterine opioid exposure and postnatal pharmacologic treatment for NOWS, any infant with significant NOWS symptoms and any infant requiring pharmacologic treatment should receive routine assessments and close attention to development following AAP guidance for developmental screening for all young children.
i. Refer caregivers to a pediatric clinician who is knowledgeable about NOWS and care of families impacted by substance use, and who is accessible around the time of infant hospital discharge. The AAP recommends evaluation, ideally within 48 hours of discharge, to monitor weight gain and for any continued signs of withdrawal. Close follow-up also provides opportunities to support infants and families to meet their health and parenting goals.
j. Offer referral to evidence-based parenting programs, home visiting programs (e.g. Healthy Families, Babies First!), infant mental health services, and early intervention depending on community availability.
k. Assess for smoking in the home. All people who smoke should be encouraged to quit; home and car should be smoke-free; and people who smoke should wash hands and change clothes after smoking.

Toxicology testing

l. Infant toxicology testing should not be the primary way to screen for substance use during pregnancy. If there is suspicion of substance use, the birth parent should first be asked about their medical and substance use history.
m. Infant toxicology testing (using urine, meconium, or cord blood) should only be performed if there are clear clinical indications (unable to obtain a history from the birth parent, infant with unexplained symptoms, severe obstetrical complications such as placental abruption, etc.). Seek parental consent for infant toxicology testing in all cases. Proceeding with infant toxicology testing without parental consent may sometimes be necessary. The decision to perform infant toxicology testing without parental consent should be based on perceived risk of substantial harm to the infant and should be clearly documented in the medical record.
n. See Recommendation 14 regarding child welfare risk, mitigation, and reporting.

Recommendation 14: Follow best practice guidance related to assessment of child-welfare risk, risk mitigation, **and** reporting.

a. Screen each family prenatally for risk and protective factors for child welfare involvement. If a family has risks for child welfare involvement, discuss this with the family as soon as possible and support planning to increase protective factors and mitigate risk in accordance with Oregon Law (ORS 430.915). This plan should align with and support the parents' articulated goals regarding care, treatment, and parenting.
b. According to Oregon law, substance use during pregnancy is not de facto child neglect or abuse and does not automatically require a mandatory report to child welfare. Identification of substance use during pregnancy should prompt an assessment by a trained professional to identify individual and family needs, identify and connect to services to mitigate risk for child welfare involvement (See Oregon Family Care Plan).
c. The decision as to whether a child welfare report should be made should not fall to one individual care team member. Engage a multi-disciplinary team and use a clinical-decision making framework to address parental substance use and child safety and to reduce opportunities for bias and over-reporting. This should include an assessment and discussion of 1) safety of the child while substance use is occurring; 2) safety of parental use patterns; 3) parental treatment engagement; 4) parental willingness to escalate treatment and support services; and 5) stability of the home environment.
d. If reporting to child welfare is needed, discuss this action with the parents and family prior to making the report, whenever possible. Prior to making the report, provide the family with information regarding what happens after a report is made. Offer to include the parent in the phone call when a report is made and respect their choice regarding how they want to be involved, whenever possible.
e. More information on mandatory reporting can be found on the Oregon Family Care Plan website and the Oregon Department of Human Services (ODHS) Child Welfare website. Register for the Mandatory Reporting of Child Abuse in Oregon training through the ODHS website. This interactive course is hosted through Oregon State's Professional and Continuing Education (PACE) platform and includes the most up-to-date guidance on child abuse and reporting in Oregon. The training takes 45-60 minutes to complete, and participants receive a certificate of completion.

Health System and Policy Recommendations

Recommendation 15: Identify and invest in evidence-based primary prevention, harm reduction, treatment, and recovery for opioid use and OUD.

a. Health care systems and SUD treatment agencies should integrate evidence-based parenting programs into perinatal and SUD services, increase access and engagement through a coordinated approach, and support community partnership.

b. State policy makers should adopt and advocate for evidence-based policies and interventions to address social needs, including but not limited to economic strain, housing insecurity, food insecurity, and IPV.

Recommendation 16: Work to remove barriers to care for pregnant and postpartum people with OUD.

> Note: The OPC Substance Use Disorders in Pregnancy and Postpartum Toolkit and the OPC Naloxone Toolkit have extensive appendices that provide examples/details supporting below.

a. Health care systems and perinatal care teams should work to remove barriers to care for people with perinatal OUD and other SUDs, taking a "through any door" approach and advocating for patient needs within and across systems.
b. Health care systems and perinatal care teams should provide continuing education to all hospital staff on trauma-informed care with the goal of eliminating stigma and bias.
c. Health care systems and perinatal care teams should review and update hospital policies to make them trauma-informed and to optimize access to care for pregnant people with OUD. For example, policies related to toxicology testing, mandatory reporting, smoking, leaving the unit, in-hospital substance use, security, naloxone, discharge protocols, and harm reduction.

Recommendation 17: Implement a statewide public health monitoring strategy for in-utero opioid exposure and Neonatal Opioid Withdrawal Syndrome (NOWS) to define prevalence and trends, inform improvements in clinical care, evaluate the impact of interventions, and ultimately improve health outcomes for families.

a. Health care systems and perinatal care teams should collect data on screening for substance use in pregnancy.
b. Health care systems and perinatal care teams should participate in and support efforts to collect data on use of opioids in pregnancy, rates of OUD in pregnant and birthing people, infants exposed to opioids in utero, and all adverse perinatal outcomes related to opioid use.
c. Health care systems and public health should consider health outcomes that include the birthing parent, consider infant and family well-being, and go beyond the immediate prenatal and postpartum period.

Recommendation 18: Provide funding and facilitate increased systems coordination to build a comprehensive statewide network of care for families affected by OUD and other substance use disorders.

a. Public health and health care organizations should continue educating perinatal care teams on the use of validated substance use screening tools as the standard of care.

b. Public health and health care organizations should continue educating and training clinicians on prescribing MOUD during pregnancy.
c. Perinatal care teams should educate patients in non-opioid treatment of pain.
d. State policy makers should support expansion of Nurture programs in Oregon.
e. State policy makers should support expansion of telemedicine services.
f. SUD treatment agencies and systems should increase access to residential and other treatment programs for pregnant people and parents with an OUD throughout the state. This is a particular challenge in rural and remote areas of Oregon.
g. SUD treatment agencies and systems should support innovation to bring more family-centered, wraparound services to communities, including peer support.
h. SUD treatment agencies should promote attachment and bonding by support strategies that discourage separation of the birthing person and infant (e.g. residential treatment allowing birth parents and infants to remain together).
i. Child welfare should have systems in place to facilitate access to the supports families need for long-term stability (e.g., ongoing MOUD and other substance use treatment services, early intervention services for infants, home visiting services).
j. Correctional facilities and jails should facilitate access to MOUD without interruption for all individuals and especially pregnant and parenting people with OUD.

Definitions used in this Document

Behavioral health
The condition of well-being aligned with the prevention and intervention, treatment and recovery support for people with mental and substance use problems or disorders.

Clinician
Licensed Independent Practitioners (LIP) (e.g. Physician or midwife)

Oregon Family Care Plan
Plan that supports patients in identifying their own goals for health and social services and collaborates with them to determine and document how individuals will be connected to services in each domain. The best practice is for an individual who can provide a sustained relationship and care management to support the family in creating a Family Care Plan. This could include a peer support specialist, home visitor, family coach, or individuals in other community service professional roles.

Perinatal care team
All care providers including but not limited to physicians, midwives, nurses, perinatal social workers, peers, and doulas.

Perinatal care
Health care services provided during pregnancy, labor and delivery and postpartum.

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

Neonatal opioid withdrawal syndrome (NOWS)
Group of physiological and neurobehavioral signs of withdrawal that may occur in a newborn who was exposed to opioids in utero.

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)

Postpartum
The 12-month period following the end of a pregnancy, regardless of the pregnancy outcome.

Substance use disorder (SUD)

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

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 people 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)

Key References

For a comprehensive list of resources related perinatal substance use disorder, please refer to the OPC Perinatal SUD Toolkit and Initiative

1. **American College of Obstetricians and Gynecologists and American Society of Addiction Medicine:** Opioid Use and Opioid Use Disorder in Pregnancy
   https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy
2. **American Society of Addiction Medicine: Clinical Guidelines**
   Opioid Use Disorder in Pregnancy
3. **American Academy of Pediatrics: Neonatal Drug Withdrawal**
   http://pediatrics.aappublications.org/content/129/2/e540
4. **American Academy of Pediatrics:**
   A Public Health Response to Opioid Use in Pregnancy
   http://pediatrics.aappublications.org/content/early/2017/02/16/peds.2016-4070
5. **CDC Guideline for Prescribing Opioids for Chronic Pain** — United States, 2022
6. **CDC Clinical Practice Guideline for Prescribing Opioids for Pain** — United States, 2022 | MMWR
7. Consensus Statement on Pain Management for Pregnant Patients with Opioid Use Disorder from the Society for Obstetric Anesthesia and Perinatology, Society for Maternal-Fetal Medicine, and American Society of Regional Anesthesia and Pain Medicine

   https://oregonperinatalcollaborative.org/wp-content/uploads/2025/11/Pain-Management-Pregnant-Patients-OUD-Society-for-OB-Anesthesia-and-Perinatology.pdf
8. **Oregon Opioid Prescribing Guidelines**
   https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/Opioid%20Prescribing%20Guidelines.pdf
9. **Oregon Prescription Drug Monitoring Program**
   https://www.oregon.gov/oha/ph/preventionwellness/safeliving/pdmp/pages/index.aspx
10. **National Center on Substance Use and Child Welfare:**
    Overview: Improving Early Childhood Outcomes and Systems for Families

Affected by Parental Substance Use, Substance Use Disorders, and Co-Occurring Mental Health Disorders

11. **Substance Abuse and Mental Health Services Administration:** Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants

12. **World Health Organization:** Guidelines for identification and management of substance use and substance use disorders in pregnancy

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https://www.oregon.gov/oha/ph/healthypeoplefamilies/datareports/pages/index.aspx