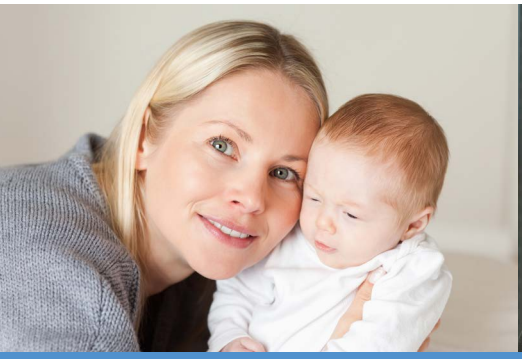
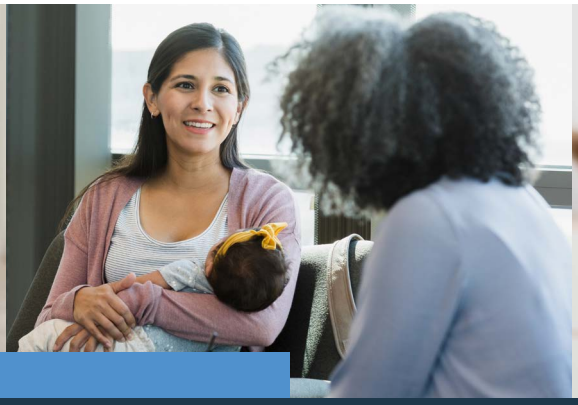
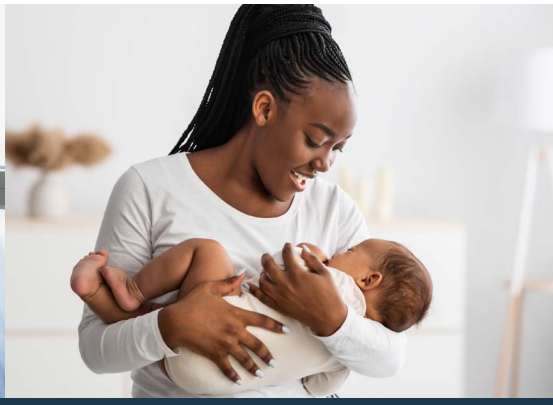
SAMHSA
Substance Abuse and Mental Health Services Administration

Healthy Starts: Postpartum OUD Care Transitions for Mother and Infant

The postpartum period is a critical time for connecting mothers, parents, and caregivers with services and supports that promote bonding, well-being, and healthy outcomes for families. For women with opioid use disorder (OUD), engaging in these services is not only beneficial for family well-being—it can also be lifesaving. The first postpartum year is an especially high-risk period for women with OUD, during which the likelihood of fatal overdose and other preventable deaths increases.[1-3] Evidence-based treatment options, such as medication for opioid use disorder (MOUD), can help reduce these risks.[4]

This publication highlights best practices for managing OUD during and after pregnancy to ensure the healthiest outcomes for mother and baby. It summarizes the most current evidence available at the time of publication, presents an innovative program as a case study, and offers practical advice for providers and care teams on comprehensive, collaborative perinatal care. This publication does not offer postpartum guidance on supporting patients with OUD who do not end up parenting (e.g., adoption, miscarriage, infant loss).

Core Principle of Care

Effective perinatal OUD care depends not only on clinical treatment (e.g., MOUD), but on early engagement, trust building, and coordinated service delivery across systems.

Perinatal Care

Perinatal care occurs across three stages: antepartum (before birth), intrapartum (during labor and delivery), and postpartum (after birth). The Substance Abuse and Mental Health Services Administration's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* offers detailed recommendations for care across all stages of the perinatal period, as well as infant care.

Caring for Patients With OUD During Pregnancy

OUD is a serious concern among women of reproductive age because overdose is a leading cause of death for people ages 18–44 in the United States.[5] In 2024, an estimated 0.8 percent of girls and women ages 15–44 (approximately 565,000 people) reported opioid misuse within the past month.[6,7] In 2024, 0.6 percent of pregnant women (12,000 people) reported opioid misuse in the past month, a threefold increase from 2023.[6,7] Untreated OUD during pregnancy is associated with health risks for mothers and their babies.[8] These risks include obstetric complications and poor fetal growth, preterm delivery, birth defects and stillbirth, and maternal death—including death from overdose.[9,10]

Addressing OUD during pregnancy with compassion and evidence-based care improves maternal and fetal outcomes and helps strengthen the transition into postpartum care.[11] Providers and other care team members can help support positive outcomes by identifying OUD through validated screening methods, offering nonjudgmental support, and ensuring access to evidence-based care throughout pregnancy and the postpartum period. The diagram below depicts the continuum of perinatal care for mothers with OUD, emphasizing engagement across clinical and community-based supports.

Screening for Substance Use Disorders

Care teams should universally screen pregnant women for substance use,[8] using a validated screening instrument, such as the 5Ps (parents, peers, partner, past, and pregnancy) or the Substance Use Risk Profile Pregnancy Scale. These conversational tools can help providers build trust through nonjudgmental, compassionate dialogue.[12] They also support deeper understanding of patients' health and social needs, allowing providers to offer brief interventions, linkages to treatment, and connections to supportive services that promote safety and stability throughout pregnancy and the postpartum period.

To ensure accurate results and appropriate care, providers should not use biologic toxicology tests for screening purposes.[8] With a patient's informed consent, toxicology testing can give insight into current substance use. However, the test results do not provide enough information about the patient's use to determine if she meets criteria for a substance use disorder (SUD) diagnosis, characterized by continued substance use despite negative life consequences. Also, current testing methods have limitations, such as the risk of a false negative or positive result, and they frequently do not detect novel synthetic adulterants like nitazenes or new fentanyl analogs. Thus, these methods cannot reliably detect the use of multiple substances by pregnant women with OUD.[9]

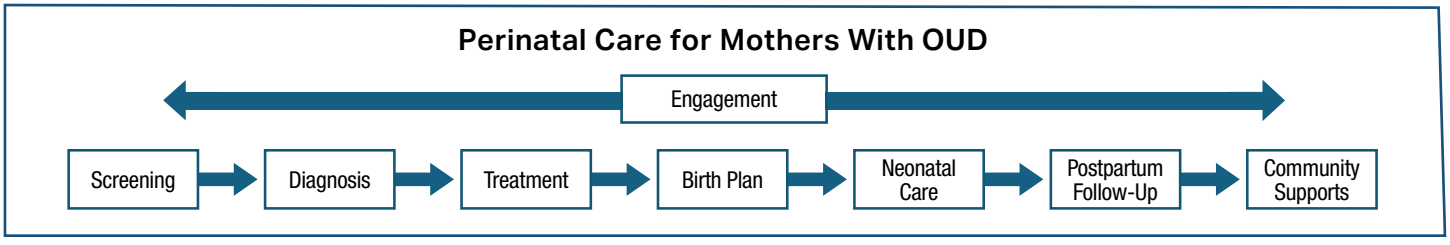
Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Pregnant and Postpartum Women by the Association of Maternal and Child Health Programs and the National Association of State Alcohol and Drug Abuse Directors offers comprehensive information about SBIRT.

When care teams screen for SUDs with a validated verbal tool, they have an opportunity to offer patient education and perform additional health and social screenings to promote whole-person wellness for mother and baby. Women with untreated SUDs may be more likely to contract infectious diseases, experience criminal justice involvement, and become involved with the child welfare system, which may include the loss of parental rights.[8] In addition, women who use drugs through injection or intranasally are at greater risk of contracting HIV, hepatitis B and C, soft tissue, and cardiac infections.[8] Untreated SUDs are also associated with an increased likelihood of engaging in the sex trades and other high-risk behaviors.[8] Care teams should provide infectious disease screenings for all pregnant patients, as well as support services that address risk behaviors.

Treating Perinatal OUD

MOUD is most effective when delivered as part of a comprehensive, integrated care approach that includes behavioral therapies and social supports.[8] Perinatal MOUD treatment reduces obstetric complications, improves prenatal care adherence, and supports physical stability by reducing cravings and withdrawal symptoms and offering overdose protection. Additionally, perinatal MOUD can improve health outcomes for infants.[13] Medications should be combined with behavioral therapies, such as counseling, to ensure whole-person care.[14] Evidence-based behavioral therapies, such as cognitive



behavioral therapy and motivational interviewing, complement MOUD treatment and can enhance engagement and strengthen provider–patient relationships.

Providers should discuss the risks and benefits of methadone or buprenorphine with pregnant patients with OUD, whether they are continuing medication from before pregnancy or initiating MOUD during pregnancy. Most patients will require increases in their total daily MOUD dose throughout pregnancy—particularly during the third trimester—to reduce cravings and address withdrawal symptoms that may reoccur because of pregnancy-related metabolic changes.[11] Split dosing—taking partial doses of methadone or buprenorphine more than once per day—is recommended to optimize stability for pregnant patients.[8,11,15]

Data on the safety of taking naltrexone during pregnancy remain limited; however, there is no consistent evidence of fetal harm with its use.[8,11] Therefore, providers should discuss the risks and benefits of continuing or discontinuing naltrexone in pregnancy, as they do for many medications in routine obstetrical care.

Ongoing patient education about the risks and benefits of continuing or discontinuing MOUD is a critical component of care and supports informed, shared decision-making. Abrupt discontinuation of opioids or MOUD is not recommended for pregnant women because it is associated with an increased risk of overdose death, substance use recurrence, and poor retention in care.[16-18] Tapering typically involves gradual dose reductions over time, individualized to the patient, with frequent follow-up visits to assess withdrawal symptoms, mental health status, and risk of return to use.[19] Research suggests that well-supported and motivated patients may be able to gradually decrease, or taper, their dose under a provider's care with minimal risk of harm to the fetus, although the evidence is limited.[18,20] Ultimately, the patient drives her care decisions. If a patient chooses to pursue dose reduction or discontinuation, providers should support a carefully monitored, patient-centered approach and discuss the potential risks and benefits of this option.[21,22] Providers and care teams can learn more about tapering in Recommendation 5 of the Centers for Disease Control and Prevention's (CDC's) *Clinical Practice Guideline for Prescribing Opioids for Pain*.

Neonatal Opioid Withdrawal Syndrome

Prenatal opioid exposure—including the use of prescribed opioid agonist medications—may cause neonatal opioid withdrawal syndrome (NOWS). Providers should give anticipatory guidance to pregnant patients about NOWS, including postdelivery expectations, such as recommended length of hospital stay for newborns at risk of NOWS, potential admission of the infant to the neonatal intensive care unit, and the likelihood of frequent travel to the hospital. Mothers of newborns with NOWS are often discharged from the hospital before their babies but choose to stay overnight at the hospital to "room in" with their infants (a recommended evidence-based strategy to address NOWS). These mothers may need assistance coordinating the continuation of their medication for opioid use disorder (MOUD)—such as by ensuring they obtain take-home doses of methadone or have transportation to and from the clinic to receive doses—so they can continue to spend time with their hospitalized infants.

To best prepare mothers to care for newborns at risk of NOWS, providers should counsel all patients during pregnancy on recommended practices for addressing NOWS, including nonmedication techniques (e.g., rooming in, breastfeeding) and the potential use of medication to manage infants' withdrawal symptoms. In these provider–patient conversations, providers should not recommend discontinuing MOUD to prevent NOWS. NOWS is a temporary, treatable condition that, when recognized and promptly addressed, is associated with lower neonatal mortality rates than opioid exposure without a NOWS diagnosis.[23] Maintaining consistency in MOUD treatment is important because maternal health is paramount to addressing NOWS.

NOWS treatment might include managing withdrawal symptoms using the Eat, Sleep, Console (ESC) protocol. In a randomized controlled trial, the ESC approach significantly decreased lengths of stay for infants, compared with usual care.[24] Care teams should assess the labor, delivery, and neonatal intensive care unit capabilities of local hospitals to provide mothers with accurate information about what to expect.

Care teams should include patients at the center of decision-making when tailoring treatment regimens to patients' unique circumstances, social and environmental needs, and medical conditions. Knowing a patient's pregnancy stage, substance use profile, and medical and mental health conditions can help providers prepare for patient–provider discussions about an appropriate level of care, MOUD dose, supplemental medication, and treatments that do not involve medication.

Providers should also offer a comprehensive, multidisciplinary approach to care that addresses patients' physical, emotional, and social needs. Medical providers can offer linkages to the following supports and services:

- Behavioral support (e.g., counseling, therapy, peer support, mutual aid support groups)
- Birth and pain management planning
- Breastfeeding support
- Family planning services
- Overdose education and opioid overdose reversal medications

Caring for Patients With OUD in the Postpartum Period

The postpartum period significantly increases a woman's vulnerability to perinatal mood and anxiety disorders (PMADs), which are a common complication after childbirth. For example, up to 85 percent of women experience "baby blues," and 1 in 7 experience a postpartum depressive episode.[25] Baby blues are a common, short-term mood disturbance, typically resolving within the first 2 weeks after childbirth. The postpartum period can also worsen symptoms of anxiety disorders, psychosis, post-traumatic stress disorder, obsessive–compulsive disorder, and other mental disorders. To address mental health symptoms, care teams should adopt routine mental health screening and treatment approaches, such as referrals to behavioral health counseling and initiation of psychiatric medication management.

Women with existing mental health conditions and OUD face increased risks of recurrence of substance use and mental health symptoms—overdose and suicide are leading causes of pregnancy-associated death, including those during the postpartum period.[1-3] Maternal Mortality Review Committees (MMRCs) are local multidisciplinary committees that evaluate factors contributing to the deaths of women during pregnancy and within the first postpartum year. According to 2022 MMRC data, mental health conditions accounted for 27.7 percent of maternal deaths.[26] Within that group, 45.4 percent of deaths were attributed to suicide, and SUDs were the underlying cause in another 51.0 percent of deaths.[26] Care teams should discuss safe medication storage and disposal practices with all patients to prevent diversion and accidental injury or death.

Postpartum OUD Treatment Considerations

MOUD acts as a protective factor by significantly reducing overdose risk. In a national cohort study, treatment with methadone or buprenorphine was associated with a 76-percent reduction in overdose at 3 months (after treatment initiation) and a 59-percent decrease at 12 months, compared with no treatment.[4]

The American College of Obstetricians and Gynecologists (ACOG) and the Substance Abuse and Mental Health Services Administration (SAMHSA) recommend continuing treatment with MOUD during the postpartum period.[8,11] Providers should monitor patients for signs of sedation or recurrence of craving and withdrawal symptoms—after birth and during the postpartum period—that warrant a dose decrease or increase.[8]

Providers should prioritize frequent discussions with patients about the role of MOUD in their recovery throughout the first postpartum year. These discussions should include ongoing education about the risks and benefits of continuing or discontinuing MOUD and reinforce evidence supporting continuation during the first postpartum year.[16,17,27] When a patient chooses discontinuation, the medication should be tapered over a period of time that works best for the patient, with close monitoring for withdrawal symptoms and relapse risk, and with a documented safety plan. The provider and patient should also develop a safety plan that includes steps to take if a return to use occurs and where to pick up opioid overdose reversal medications such as naloxone and ensure patients and family members are trained in its use.

Addressing Comorbidities, Social Factors, and Postpartum Stressors

Providers should address comorbid medical and mental health conditions, polysubstance use (including nicotine), and overdose risk throughout pregnancy and the postpartum period. This includes expanding the care team by linking patients to additional services in their communities, such as primary care, mental health treatment, recovery support, and other supportive services.

The demands of caring for an infant, sleep deprivation, PMADs, and potential loss of insurance or access to treatment can increase stress for new mothers and increase the risk of recurrence of substance use.[8,28] Care teams can support patients through frequent encounters during the first postpartum year that focus on stress management, education about PMAD symptoms, and safety planning for recurrence of substance use.[28] Patients may face obstacles to attending follow-up visits—such as inadequate access to transportation, housing, or childcare, high cost of treatment, or a lack of telehealth options.

Maternal SUDs are associated with experiences of childhood trauma, stigma, intimate partner violence, poverty, and involvement with the criminal justice and child welfare systems—factors that can negatively affect parents' functioning and their children's healthy development.[29] Coordinated approaches, especially with the guidance of a social worker or case manager, help pregnant women with OUD access support services that improve outcomes. Such integrated treatment approaches are associated with a higher likelihood of treatment completion, reductions in substance use, and children remaining in their parents' care.[30]

Supporting Mother and Infant

Women may feel greater motivation for behavior change during pregnancy[11,31]; however, postpartum care is often fragmented, creating challenges to women seeking to maintain abstinence or reduce substance use after birth. According to one study, 80 percent of women who abstained from substances in their last month of pregnancy returned to use during the postpartum period.[32]

Although many pregnant women with OUD receive support through treatment and recovery services or through prenatal care, the postpartum period provides an opportunity to continue supporting mothers and their babies to ensure successful health outcomes.

The patient's care team should focus postpartum support for the mother–infant dyad by:

- Ensuring adequate and appropriate postpartum pain management.
- Supporting ongoing engagement in OUD treatment and recovery services, including linkage to patient navigators and peer support specialists.
- Integrating family members and other supportive people into treatment and recovery.
- Linking partners to substance use treatment.
- Addressing mental health symptoms or conditions by linking patients to mental health treatment and support services.
- Offering breastfeeding and lactation support.
- Encouraging bonding and providing guidance for creating a safe, stable, home environment.
- Supporting the adjustment to motherhood, including offering guidance on managing anxiety, the demands of caring for an infant, comorbid conditions, and sleep deprivation.
- Promoting safe sleep to reduce infant death and referring the patient to a local Cribs for Kids partner for safe sleep training advice and a free crib.
- Offering family planning resources, such as contraceptive options.
- Addressing additional needs of the family.

Care teams can offer guidance on hospital policies related to breastfeeding, toxicology testing, visitors, kangaroo care (skin to skin), treating NOWS—such as the Modified Finnegan Neonatal Abstinence Score and the Eat, Sleep, Console model—and procedures for discharging opioid-exposed infants. In addition to clinical guidance, coordinating care with the patient's obstetric, mental health, and SUD

care teams; peer support workers; the infant's pediatrician; and any other supportive services helps ensure continuity of care for the family.

Assessing the family's needs and connecting them with supportive services can help families navigate challenges during the postpartum period. Such services include case management, parenting classes, housing support, job training or skill development programs, employment assistance, education, and financial support. The resources at the end of this guide can help.

Child Welfare System Involvement

Concerns about child welfare system involvement are common. Care teams should offer support and provide accurate information when discussing with families how the child welfare system might be involved when an infant is born to a mother with OUD.

Social workers and case managers should offer guidance to families about expectations for child welfare system involvement after birth and about plans of safe care. All care teams should be familiar with their state's policies, including designated roles and reporting guidelines, to ensure consistent messaging with patients. For example, care teams can include language about their state's requirements in their phone intakes so all patients receive the same information about what to expect. The National Center on Substance Abuse and Child Welfare offers a Plans of Safe Care Learning Modules Series for additional information.

In February 2026, the Administration for Children and Families announced that funding for prevention services through Title IV-E of the Social Security Act can be used to provide MOUD to parents when their children are at risk of entering foster care. More information can be found in the U.S. Department of Health and Human Services' Dear Colleague letter.

Example of an Evidence-Based Program That Provides OUD Care Transitions for Mother and Infant

This section features an example of a perinatal OUD program that uses a comprehensive, integrated, and person-centered approach to treat pregnant and parenting women. An environmental scan, a literature review, and consultation with subject matter experts helped identify effective programs. Program selection was based on:

- **Evidence of effectiveness:** The program demonstrated success in implementing evidence-based practices and provided sufficient data to substantiate intended outcomes through published research articles or comprehensive program evaluations.
- **Adaptability:** The program can be adapted across urban and rural communities, populations, and settings.
- **Credibility:** The program, its supporting research, and its outcomes were determined to be reputable.
- **Implementation:** The program can describe its implementation process, including key steps, necessary tools, processes, and lessons learned.

There are many innovative and enduring perinatal SUD programs available to support women and families. The examples provided in this publication are for illustrative purposes and do not constitute an endorsement of any specific program, organization, or model by SAMHSA, the U.S. Department of Health and Human Services, or the Federal Government.

Children and Recovering Mothers (CHARM) met the above criteria and is included to illustrate how coordinated, team-based perinatal care for mothers with OUD can be implemented across clinical and community settings. The CHARM program lead provided information for the case study.

Case Study: Children and Recovering Mothers (CHARM)

Program Overview

CHARM is a collaborative model serving pregnant and postpartum women with OUD across several counties in Vermont. Using a multidisciplinary approach, CHARM helps women coordinate OUD treatment and prenatal care and connects them to housing, financial, peer, and other support services to promote successful outcomes. A neonatologist developed this model in the late 1990s to address the need for specialized care for pregnant women with OUD.[33] The CHARM collaborative team works with women during pregnancy, childbirth, and the postpartum period. This case study focuses on the postpartum period.

Approach

CHARM is not a clinic or a standalone organization; rather, it is a network of community partners that together form a multidisciplinary team providing care to pregnant and parenting women with OUD. These partners consult with one another about each woman's needs to ensure seamless care coordination across systems. CHARM relies on shared decision-making and strong relationships among multiple service providers and community-based programs. The CHARM model includes these key partners[34,35]:

- A comprehensive obstetrics and gynecology clinic where staff offer prenatal care, provide SUD assessments, prescribe buprenorphine, and coordinate care. The clinic also has SUD treatment providers, social workers, and mental health treatment providers.
- Nurses and caseworkers.
- Pediatric and neonatology care providers.
- Comprehensive SUD treatment programs (within larger healthcare or behavioral healthcare organizations) with providers who offer SUD and perinatal support assessments.

> **"These people saw something in me I could not even begin to see in myself....They were letting me know that I am a good mom, that I deserve to have this baby. They treated me like a human being."**
>
> *—Program Participant*

- Hospitals (including a children's hospital).
- A residential treatment program for mothers and infants with stepdown outpatient support following discharge.
- Peer support services.
- Child welfare services.
- A state health agency.
- Financial and benefits assistance programs.
- Home visiting services.

The CHARM team meets monthly to review cases and ensure families receive coordinated care that meets their needs. This team operates under a memorandum of agreement and comprehensive releases of information that authorize members to discuss cases and share information. Case reviews typically include new clients, women who are expected to deliver in the next month, women who recently delivered, and women for whom the CHARM team has concerns. Team members develop plans of safe care and make appropriate referrals using Vermont's comprehensive process, which includes a template, flowcharts, and a notification form. The child welfare system only becomes involved with families if there are safety concerns. When disagreements about child safety or possible removal arise between child welfare representatives and care team members or families, CHARM team members resolve conflicting perspectives through facilitated discussions.[34]

Case Study: CHARM, *cont.*

The CHARM team works with women across all stages of pregnancy and provides service coordination for mothers and their children until the child is 12–18 months old. After a child's birth, providers coordinate with families to schedule well-child visits. Vermont uses a "hub and spoke" model for MOUD treatment, and CHARM mothers can access their medication of choice through community providers. Mothers who received prenatal care and buprenorphine from their obstetrics and gynecology providers can continue receiving care for 8 weeks after delivery. Then, through a coordinated process, they can transition to receive MOUD treatment from a primary care or community provider. Care is coordinated through monthly CHARM case review meetings to address any potential obstacles, plan for additional support, if needed, and to ensure seamless transitions.

Outcomes and Other Benefits

CHARM's comprehensive, collaborative approach enables providers to stay informed and aligned about family needs, allowing providers and care teams to address those needs quickly and effectively. Since CHARM's inception, participating mothers, on average, started OUD treatment earlier in their pregnancies, and fewer infants have required medication for NOWS.[36] One academic paper suggested modeling guidelines for NOWS follow-up care after CHARM's multidisciplinary approach.[37]

Cross-System Insight

Coordinated, multidisciplinary care models such as CHARM demonstrate that structured collaboration across healthcare, behavioral health, and social service systems can improve engagement, continuity of care, and outcomes in the postpartum period.

CHARM has demonstrated success in implementing evidence-based practices and has substantiated intended outcomes through published research and recognition in publications. CHARM is listed as a cutting-edge practice in the Maternal and Child Health (MCH) Innovations Database and was featured as a case study in SAMHSA's *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders*. Due to the cross-system nature of the CHARM model, no formal program evaluations exist as of 2026. However, internal process assessments suggest that case review meetings streamline service coordination and reduce redundancies. In addition, Vermont's child welfare system reported that CHARM participants required fewer emergency interventions compared to non-CHARM counterparts across the state.[35]

Lessons Learned

Based on the lessons CHARM learned during their implementation process, organizations planning to implement a similar model should evaluate how stakeholders will[34,35]:

- Navigate legal restrictions on confidentiality and information sharing, especially when shared information could initiate child welfare system involvement. Business associate agreements, memoranda of agreement or understanding, and comprehensive releases of information developed with legal team guidance can help ensure compliance with privacy laws.
- Address fearful preconceptions about the child welfare system, which can hinder open discussion and prevent clients from signing consent forms. These beliefs can be countered by emphasizing the team's shared goals of parental well-being and healthy, safe children.

Case Study: CHARM, *cont.*

Resources Required for Implementation

Successful replication of CHARM requires a dedicated coalition of medical, behavioral health, and community partners. Partners may vary depending on local service availability and population needs. Communities implementing an adaptation of the CHARM model should consider[34,35]:

- Designating a dedicated administrator.
- Securing a skilled facilitator who keeps the case review meetings productive and on task and resolves conflicts that arise.
- Assigning a coalition member to manage releases of information and update the list of families discussed in the case review meetings.
- Engaging coalition members in care coordination for families.
- Establishing processes for resolving conflicts, using shared outcome measures, sharing information and data, and managing releases of information.
- Maintaining partner organization buy-in through a shared commitment to common goals.
- Offering cross-training opportunities for coalition members.
- Planning for long-term program sustainability, including funding, data systems, incentives for families, and meeting space.

Adaptability

Many programs have modeled their approaches after CHARM, including Arizona's Maricopa Safe, Healthy Infants, and Families Thrive (SHIFT) collaborative and North Carolina's Perinatal Substance Use Disorder Network and Substance Use Network Project. New initiatives in Kentucky and New York also draw on CHARM principles, demonstrating the model's adaptability across different geographic regions and populations.

Related Resources

SAMHSA's *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders* includes a sample memorandum of agreement.

> **"There are hundreds of other women... that [CHARM] did the exact same thing for... supported them, walked with them, and held their hand along the way. We have to do the work. We have to walk the path, but they made the path an option for us to walk in the first place."**
>
> *—Program Participant*

Two other programs were identified during the research process:

- **The Building Resilience Through Intervention: Growing Healthier Together (BRIGHT Intervention)** is listed as a best practice in the MCH Innovations Database. BRIGHT is an attachment-focused intervention for developing parenting skills that uses mother–child dyadic techniques to support healthy child development and parental reflective function (the caregiver's ability to reflect on their own and their child's emotional needs). This intervention recognizes that many mothers with SUDs have experienced trauma and attachment complications during their own childhoods, which influence their parenting abilities and increase the risk for child maltreatment. BRIGHT focuses on improving maternal mental health, parental emotion regulation and reflective capacity, parent–child relationships, children's growth and development, and SUD treatment and recovery.[38] Sessions are offered within various professional settings, in the home or community, and through telehealth.[39]

  The MCH Innovations Database Practice Summary and Implementation Guidance: BRIGHT Intervention handout offers detailed implementation guidance, including information on training, supplies needed to facilitate dyadic connection and play, programmatic activities, staffing, and budgeting, including a sample budget.

- **The University of Kentucky Perinatal Assistance and Treatment Home (UK PATHways)** program supports pregnant and parenting women with SUDs. Using a comprehensive, trauma-informed, evidence-based model of care, PATHways is a one-stop model that integrates obstetric care, MOUD treatment, behavioral health services, peer support, and perinatal education. PATHways provides continuing care for up to a year after birth to minimize interruptions in MOUD treatment, support women, and reduce overdose deaths during the postpartum period. If patients need to relocate after delivery, the care team provides warm handoffs to providers who offer bridge treatment with MOUD and ensures smooth care transitions. For additional information, refer to the PATHways website and the Kentucky Maternal Morbidity and Mortality Task Force website, which includes testimonials from patients.

Resources

The following resources offer additional information for providers and stakeholders seeking guidance on addressing opioid use disorder in the context of care provided to women during pregnancy or the postpartum period. The resources may also be helpful for women and families seeking information on the topic.

For Providers and Other Stakeholders

- *Advisory:* Evidence-Based Whole-Person Care of Pregnant Women Who Have Opioid Use Disorder: SAMHSA's guidance for healthcare providers on supporting pregnant women with OUD and their babies.
- CDC Levels of Care Assessment Tool (CDC LOCATe®) Toolkit: A levels-of-care assessment tool developed by the CDC to provide a consistent approach to assessing risk-appropriate care.
- Checklist of Evidence-Based Recommendations for Caring for Pregnant Women with Opioid Use Disorder: A comprehensive checklist, developed by the MaineMOM initiative managed by the Maine Department of Health and Human Services, to support healthcare teams who treat women with OUD during pregnancy through the postpartum period.
- Comprehensive Substance Use Disorder Services for Pregnant and Postpartum Women: A Closer Look at SAMHSA's Pregnant and Postpartum Women (PPW) Program: A report on SAMHSA's PPW family-based approach to treatment.
- Maternal Opioid Use During Pregnancy: A toolkit from the Institute for Health and Recovery with information about OUD and MOUD, as well as a full list of helpful resources.

- Medications To Treat Opioid Use During Pregnancy Information Sheet: SAMHSA's resource about the importance of prenatal and postpartum care, OUD treatment, and patient education.
- Opioid Response Network: Free training and education on opioid and stimulant use from SAMHSA's State Opioid Response/Tribal Opioid Response–Technical Assistance program.
- Patient Safety Bundles: A collection of evidence-based practices on a variety of topics provided by the Alliance for Innovation on Maternal Health (AIM).
- Providers Clinical Support System–MOUD: A SAMHSA-funded national program with free training, mentoring, and resources for healthcare providers who treat patients with MOUD; includes the 8-hour training that meets U.S. Drug Enforcement Administration requirements.
- *Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum:* An American College of Obstetrics and Gynecology (ACOG) clinical practice guideline with reviews of diagnosis and medication management recommendations for patients experiencing perinatal mood and anxiety disorders.

For Managing NOWS

- Consensus Bundle on Obstetric Care for Women With Opioid Use Disorder: The National Partnership for Maternal Safety's clinical guidance on perinatal OUD treatment.
- *Newborn Critical Care Center Clinical Guidelines:* University of North Carolina's resource for managing infants with neonatal opioid withdrawal syndrome.
- Treat and Manage Infants Affected by Prenatal Opioid Exposure: A CDC resource on NOWS/neonatal abstinence syndrome with a variety of tools, including a discharge planning checklist.

For Patients and Families

- 211: A support line hosted by United Way that connects people to local help for meeting basic needs like food, housing, and health care; women seeking shelter or supportive services can call 211 and choose option 6 (homeless services).
- 988 Suicide & Crisis Lifeline: SAMHSA's emergency and crisis services hotline accessible via call, text, or chat.
- Early Head Start: A webpage with information about programs that serve pregnant women, infants, and toddlers through age 3; Head Start Center Locator connects families to local Head Start programs.
- Early Intervention: A CDC webpage explaining early intervention services and how to determine a child's eligibility, with links to local contacts.
- FindTreatment.gov and Opioid Treatment Program Directory: SAMHSA's locator tools that help connect families with local treatment providers.
- Maternal, Infant, and Early Childhood Home Visiting Program: A Health Resources and Services Administration (HRSA) website with information about home visiting and a local program locator.
- National Domestic Violence Hotline: A hotline providing tools and support for people experiencing domestic violence, accessible by calling 1-800-799-SAFE (7233) or texting START to 88788. A list of shelters can be found at DomesticShelters.org.
- National Maternal Mental Health Hotline: HRSA's free, confidential support service accessible via call or text at 1-833-TLC-MAMA (1-833-852-6262).
- National Recovery Support Directories: A resource directory hosted by SAMHSA's Center for Addiction Recovery Support that helps people find peer recovery organizations, state peer certification authorities, and recovery support programs.
- Opioid Use Disorder and Pregnancy, Treating Opioid Use Disorder During Pregnancy, Treating Babies Who Were Exposed to Opioids Before Birth, and Good Care for You and Your Baby While Receiving Opioid Use Disorder Treatment: A series of four SAMHSA fact sheets with guidance for pregnant women with OUD on ensuring a healthy pregnancy and baby.
- Pregnancy Planning for Women Being Treated for Opioid Use Disorder: A SAMHSA fact sheet for women with OUD who are pregnant or of reproductive age.
- PSI HelpLine: Postpartum Support International's noncrisis support line offers help and resources accessible via call or by texting HELP to 1-800-944-4773.

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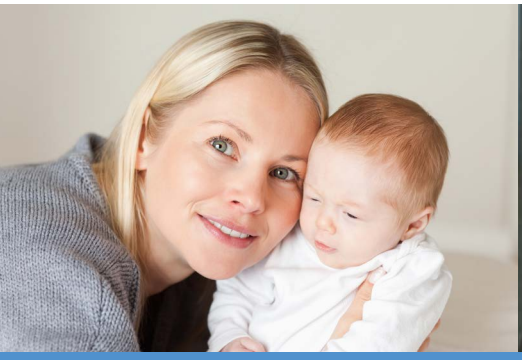

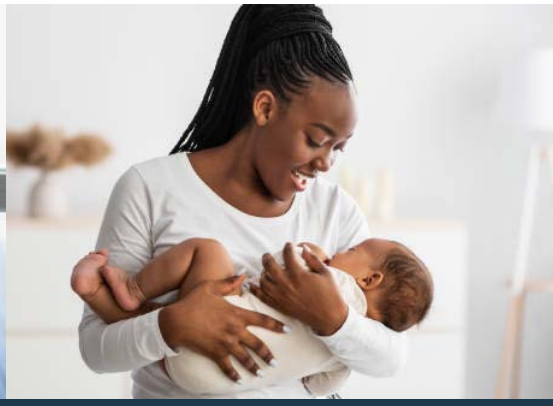

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