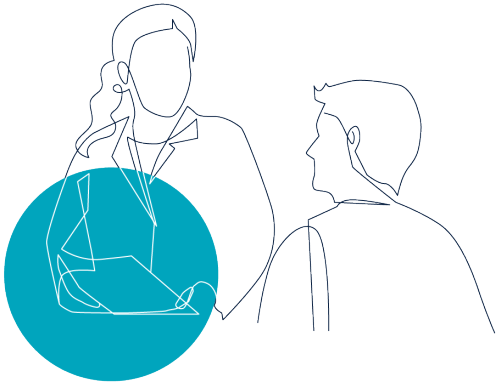
Perinatal Mental Health and Substance Use: Clinical Insights from Pregnancy Through the Newborn Period

March 30, 2026 | 1830–2000 PT



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TERRITORIAL ACKNOWLEDGMENT

We acknowledge that UBC CPD is located on the traditional, ancestral and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Sə́lílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

What is your relationship to the territory or the land that you're on?

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FUNDING ACKNOWLEDGEMENT

Funding for this webinar has been provided by the Perinatal Community of Practice, an initiative of the Shared Care Committee and Joint Collaborative Committees.

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SharedCare
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Joint Collaborative Committees

DR. HAYLEY BOS

MD, FRCSC, OB-GYN

Maternal Fetal Medicine in Victoria;
Co-chair, Perinatal Community of Practice

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INTERESTED? STAY CONNECTED!

The Perinatal Community of Practice (CoP) works to unite physicians, midwives, and perinatal care providers across BC by equipping them with practical tools, skills, and resources. Through collaboration and knowledge, they work to advance culturally safe, high-quality care for all patients.

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- Perinatal care forums and networking opportunities
- Educational webinars hosted with UBC CPD
- Project highlights

LEARNING OBJECTIVES

1. Identify key perinatal mental health conditions and substance use patterns in pregnancy, including associated risk and protective factors.
2. Describe the clinical implications of in-utero substance exposure for newborns, including assessment and early care considerations.
3. Apply trauma-informed, family-centred, and interdisciplinary approaches to support coordinated care for pregnant individuals and newborns affected by mental health concerns and substance use.

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DISCLOSURES

Speakers

- **Dr. Hayley Bos (moderator):** Received payments from Pfizer for presentations for local community advisory board for RSV vaccination. **These topics will not be discussed in this webinar.**
- **Dr. Phillippa Houghton:** Received payments from Shared Care, Physician Quality Improvement. **There is no potential conflict of interest** between this funding and this webinar.
- **Dr. Charissa Patricelli:** Voluntary role with Canadian Society of Addiction Medicine Conference Planning Committee 2025 and 2026; Perinatal Mental Health and Substance Use Conference Planning Committee 2026. Received funding CIHR (Canadian Institute of Health Research) $100,000 Bridge Funding Grant for POETIC (Perinatal Opioid Exposures, Trajectories, Insights and Concentrations WHRI (Grant Funding) IOAT-App Research study $25,000 Catalyst Grant. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Marie-Noelle Trottier-Boucher:** Nothing to disclose

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DISCLOSURES

Planning Team

- **Dr. Bruce Hobson:** Has received funding from UBC CPD, Doctors of BC, PHSA, PainBC, Cowichan Valley Division of FP, Qathet Division of FP as a Medical Lead, Director, and Committee Member. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Tracy Monk:** Received payments from PathwaysBC as Medical Director. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Kathleen Ross (moderator):** Received payments from the Perinatal Community of Practice, Shared Care Committee as Co-Chair and PathwaysBC as the Co-Chair of their Board. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Chris Morrow**: nothing to disclose
- **Stephanie Din, Shreyasi Dutiya, Caldon Saunders** are employees of UBC CPD.

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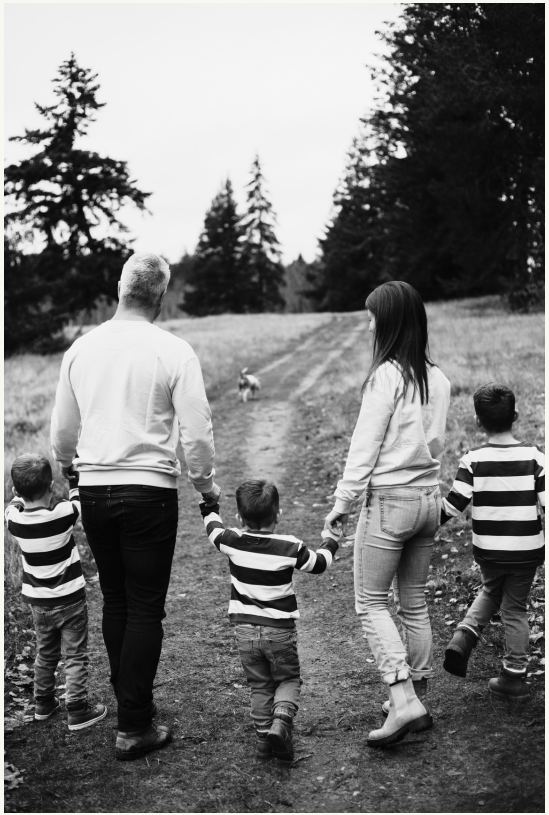
The Interplay of Perinatal Mental Health and Substance Use

Recognizing distress, reducing stigma, and creating opportunities for care



Dr. Phillippa “Pip” Houghton

MBBS | CCFP | Perinatal Mental Health Certified | CanReach Mental Health in Pediatric Primary Care Certified | Provincial Opioid Addiction Treatment Support Program | BCAPOP Perinatal Substance Use Training | Fair Play Facilitator

Perinatal Mental Health Conditions Are Common ➔

84%

Of postpartum people report high levels of stress after having a baby

1 in 5

Globally, 1 in 5 will experience a perinatal mood or anxiety disorder

23%

Of birthing people, 23% report clinically significant mood or anxiety symptoms

Likely an underestimate

As many cases remain undiagnosed and untreated

Postpartum Vulnerability

➔

Sleep Deprivation

Chronic sleep deprivation impacts mood, worsens anxiety and thought intrusion and increases the risk of suicidal ideation in people with PPD

Hormonal Fluctuation

Rapid changes in hormones from pregnancy to postpartum, some people are more sensitive to this shift than others

Identity Change

Transition to parenthood, overwhelm, distrubution of mental load within the family unit

Isolation

Reduced supports, increased demands, seperation from peers and usual activities that promote wellbeing and resilience

Substance Use and Mental Health Symptoms

Increase risk

Depressive symptoms increase risk of substance use

Coping Strategy

Often used to manage anxiety, insomnia, stress

Common Substances

Cannabis, alcohol, nicotine

Clinical Signal

Distress is here, more screening is needed

Pre-Existing Substance Use

➔

Higher Risk

Substance use disorder in pregnancy increases risk, both obstertric risk as well as mental health risk

Motivation To Change

Pregnancy can be a profound opportunity for behavioural change and may represent a window a to recovery if the right supports are in place

Stigma is High

Disclosing or discussing substance use in pregnancy can be very scary, stigma is high

Trauma Informed Care

Trauma is high in these patients and they are vulnerable to added, compounded trauma during their pregnancies, use your TIC lense

Recovery is Vulnerable

➔

Early Recovery

Loss of familiar coping strategies

Emerging symptoms

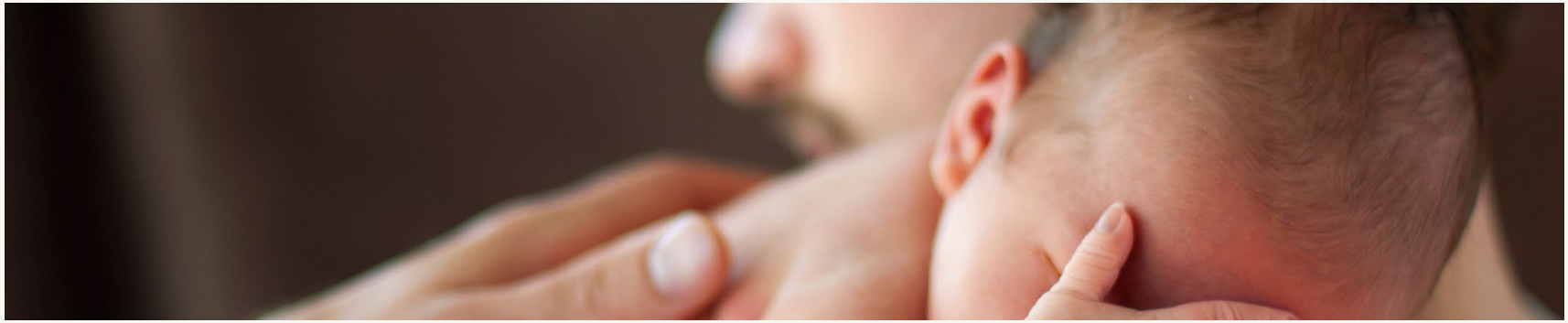
Anxiety, insomnia, thought intrusion, depression, hypervigilance

Postpartum Risk

Postpartum pain, sleep deprivation, stress can all contirbute to destabilizing recovery

Relapse Risk

Unrecognized and untreated distress increase risk of relapse



Screen Often

Frequent Care

You have regular, reoccuring touch points, every encounter is an opportunity for brief screening

Prenatal Screening

Early intervention and care planning

Postpartum Screening

Remember to book your well-parent visits alongisde evey well-baby visit, this will trigger you to dedicate time to check-in with the parent

Baby Care

Anyone involved in baby care continuum (maternity care provider, primary care, public health, pediatrics) is a touch point for brief screening

Ask without Stigma

Start Gently

Ask open, normalizing questions

Normalize Distress

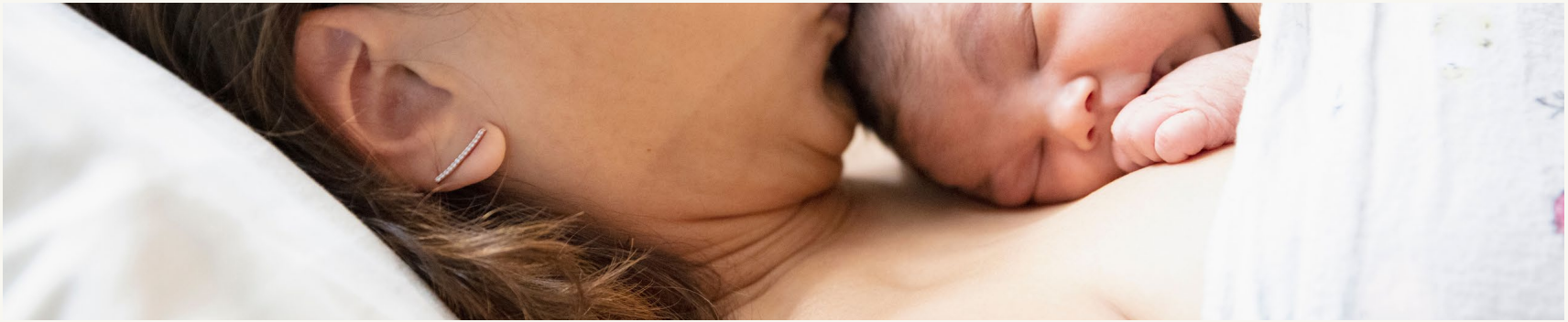
Make it clear that all new parents struggle and you check-in with everyone

Then Tools

If indicated after a gentle inquiry, reach for your tools (EPDS, PHQ-9, GAD-7), but make sure to sign post and explain the purpose

Create Safety

Listening allows space for disclosure



Validate, reassure, respond

Validate

Acknowlegde the distress/disclosure without judgement

Reassure

Normalize their experience, make sure they know they are not alone

Respond

Offer more in depth screening, detailed assessment, connection with services

The perinatal period is a time of extraordinary joy and transformation, but also a time of real fragility. Sometimes the most powerful intervention we can offer isn’t a medication or a referral, but simply taking the time to ask about distress and how someone is coping.

References

DeRoche, M. E., Dennis, C. L., Brown, H. K., Vigod, S. N., & the Society of Obstetricians and Gynaecologists of Canada. (2023). Guideline No. 454: Screening and management of perinatal mood and anxiety disorders. Journal of Obstetrics and Gynaecology Canada, 45(5), 520–536. https://doi.org/10.1016/j.jogc.2023.01.015

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TERMINOLOGY

Substance Exposed Newborn

Neonatal Abstinence Syndrome (NAS)

Neonatal Opioid Withdrawal Syndrome (NOWS)

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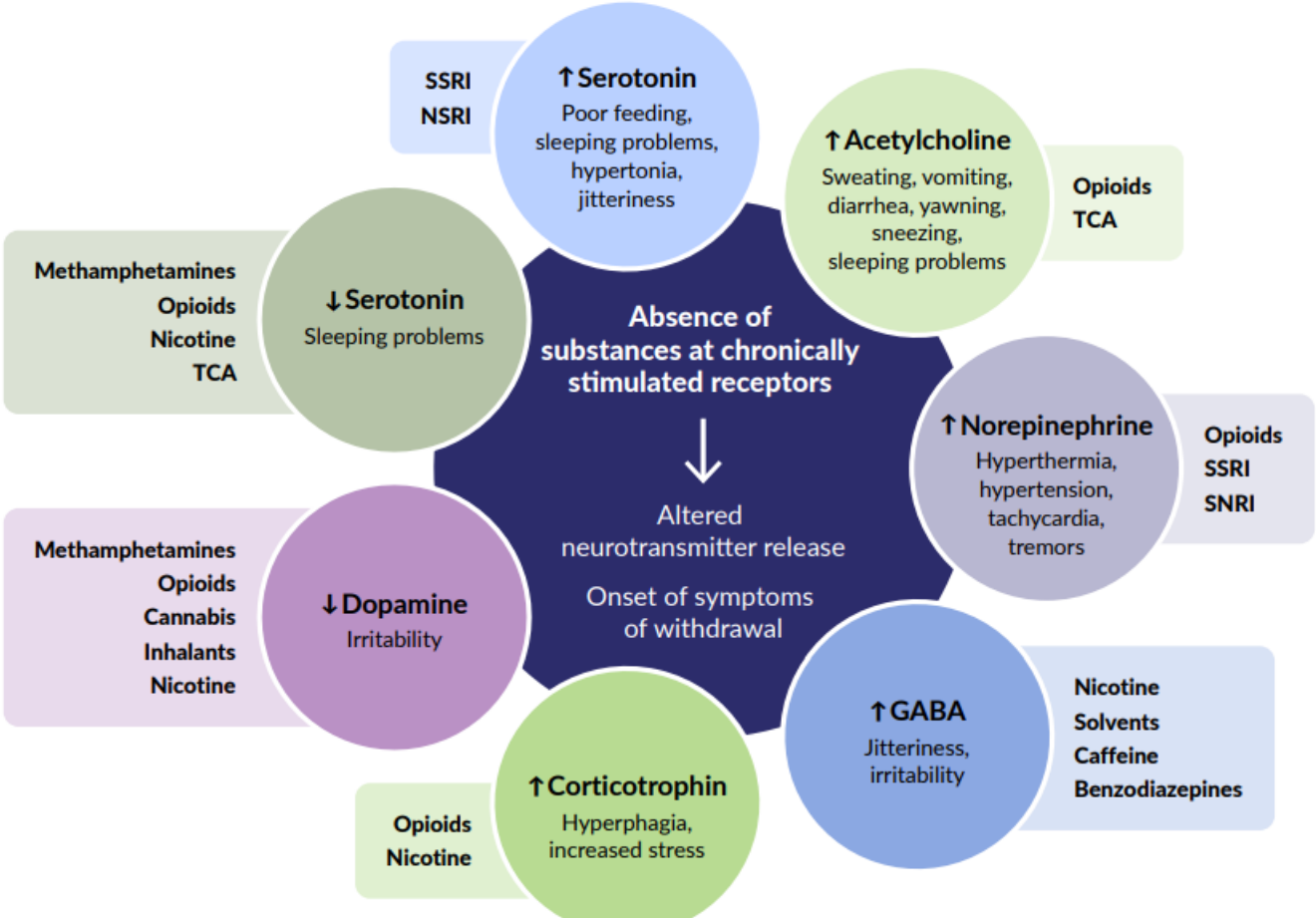
SUBSTANCES & WITHDRAWAL



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Perinatal Substance Use. https://ubccpd.ca/learn/learning-activities/course?eventtemplate=41-perinatal-substance-use.

TIMING OF WITHDRAWAL

TABLE 1 Onset, Duration, and Frequency of NAS Caused by Various Substances

Drug	Onset, h	Frequency, %	Duration, d
Opioids			
Heroin	24–48	40–80[27]	8–10
Methadone	48–72	13–94[37]	Up to 30 or more
Buprenorphine	36–60	22–67[46,48]	Up to 28 or more
Prescription opioid medications	36–72	5–20[56,60]	10–30
Nonopioids			
SSRIs	24–48	20–30[64]	2–6
TCAs	24–48	20–50[64]	2–6
Methamphetamines	24	2–49[101]	7–10
Inhalants	24–48	48[70]	2–7

Table 1. Adapted Kocherlakota P. (2014). Neonatal Abstinence Syndrome. *Pediatrics*. 134(2); e547-e581. doi:10.1542/peds.2013-3524.

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VARIABLES

- **Type of opioids exposed to**
- **Time of last dose**
- **Duration of exposure**
- **Total dose accumulation**
- **Mother, baby & placenta pharmacodynamics**
- **Gestational age**
- **Presence of other risk factors**

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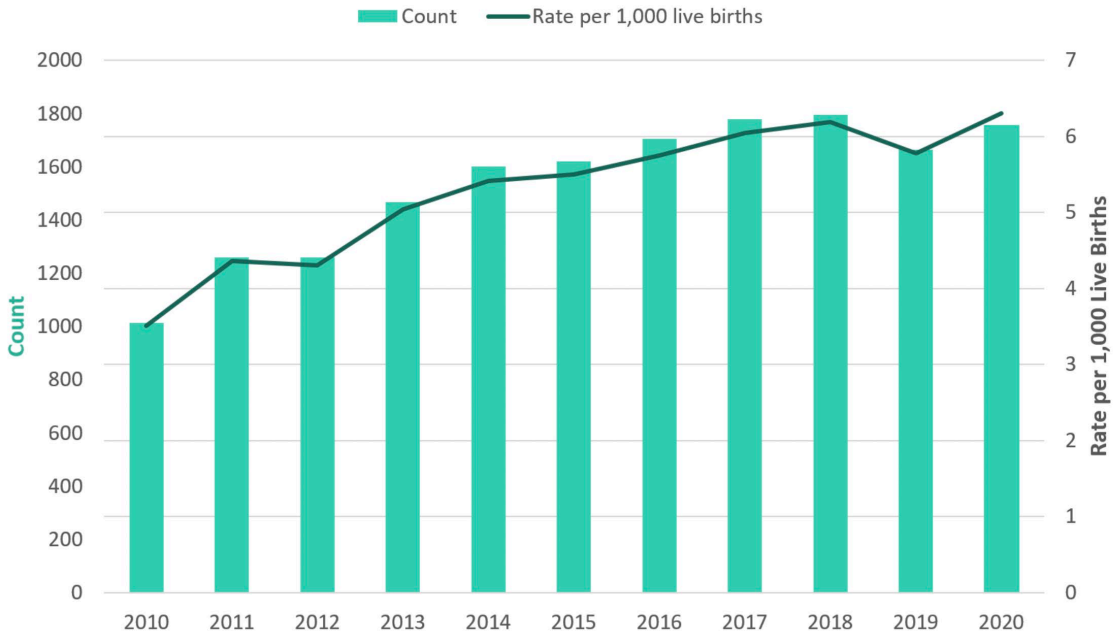
EPIDEMIOLOGY

Figure 1: Counts and crude rates of hospitalizations for neonatal abstinence syndrome from 2010 to 2020, by calendar year



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Neonatal abstinence syndrome in Canada: a descriptive analysis of hospitalization data. Ottawa: Public Health Agency of Canada; December 2021. www.canada.ca/en/health-canada/services/opioids/data-surveillance-research/neonatal-abstinence-syndrome-descriptive-analysis-hospitalization.html

TAKEAWAY # 1

- **We need to acknowledge the complexities and variables in neonatal withdrawal and shift attention to how the infant is functionally impacted.**

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EVALUATION

Modified Finnegan scoring tool	ESC care tool
Designed for infants with opioid exposure only	Can be used for infants with any substance exposure
Focuses on physiologic symptoms & signs of withdrawal	Focuses on how withdrawal sx impact a baby's function
Requires infant to be disturbed	Does not require infant to be disturbed
Nursing/health care provider focused tool	Parent integral to assessment & supportive treatment
Lengthy & complicated	Short & simple

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Eat Sleep Console

Can the baby eat?

- Unable to coordinate feeding within 10 minutes of cues

AND/OR

- Unable to sustain feeding for age-appropriate duration at breast OR take in appropriate volume

Can the baby sleep?

- Unable to sleep for 1 hour after a feed

Can the baby be consoled?

- Unable to be consoled (and stay) within 10 minutes

Grossman MR, et al. (2018). A Novel Approach to Assessing Infants With Neonatal Abstinence Syndrome. *Hospital Pediatrics 8*(1)1-6. doi: 10.1542/hpeds.2017-0128

Weight lost more than 10%?

Nurse + Parent/ Caregiver Huddle: Maximized Non-Pharmacological?

Due to withdrawal?

Yes

Full Team Huddle: Pharmacological management needed?

NON-PHARMACOLOGICAL CARE INTERVENTIONS
Rooming – in
Parent/caregiver presence
Optimal feeding at early hunger cues
Cue based care
Skin-to-skin contact
Baby held by parent/care giver
Safe swaddling
Quiet, low light environment
Non-nutritive sucking/pacifier
Rhythmic movement
Additional help/support in room
Parent/caregiver self-care and rest
Other (Describe in Narrative Notes)

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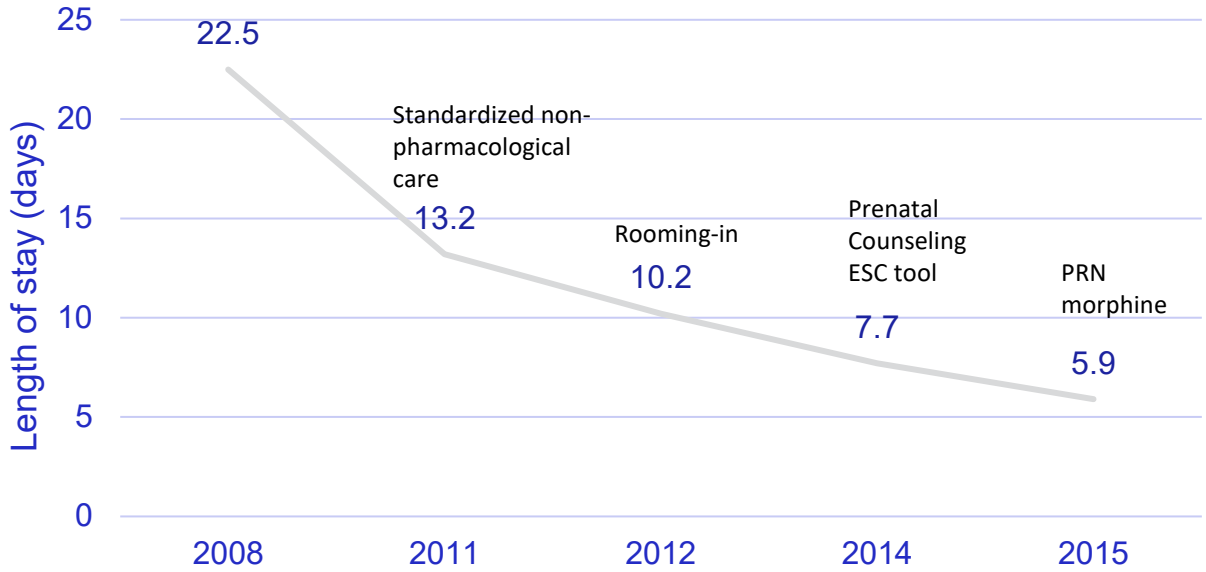
EVALUATION & SUPPORT: EAT, SLEEP & CONSOLE



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- Morphine treatment decreased from 98% to 14%

Wachman E, Grossman M, Schiff D, Philipp B, Minear S, Hutton E et al. Quality improvement initiative to improve inpatient outcomes for Neonatal Abstinence Syndrome. Journal of Perinatology. 2018;38(8):1114-1122

TAKEAWAY # 2

- **Eat Sleep Console is an evidence informed, functional assessment tool that shows a positive change in the way we care for opioid exposed infants.**

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PHARMACOLOGICAL TREATMENT

Table 3. Pharmacokinetics of Opioids Used for Neonatal Abstinence Syndrome.[4-7]

	Buprenorphine	Morphine	Methadone
Clearance	3.5 L/h/kg	75.3 L/h/70 kg	8.94 L/h/70 kg
Half-life	11 hours	9.0 ± 3.4 hours (preterm neonates) 6.5 ± 2.8 hours (term neonates) 2.0 ± 1.8 hours (infants and children)	Highly variable; 3.5 to 60 hours
Bioavailability	7% (sublingual)	48.5%	Variable; 41% to 99%
Metabolism	N-dealkylation via CYP3A4 to norbuprenorphine	Glucuronidation to morphine-3-glucuronide and morphine-6-glucuronide	N-demethylation via CYP3A4, CYP2B6, and CYP2C19 to inactive metabolites

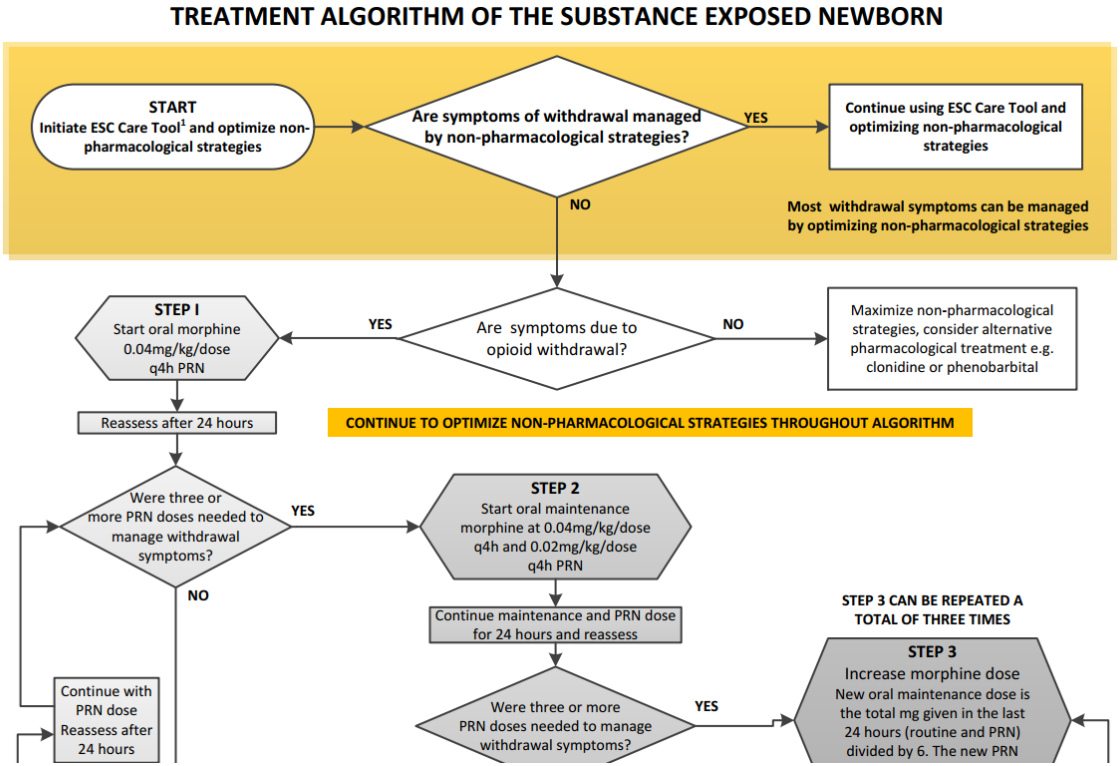
Abbreviation: CYP = cytochrome P450 enzyme.

Adjuvant:

- Clonidine
- Phenobarbital

Bishop BM. Journal Buprenorphine for the Treatment of Neonatal Abstinence Syndrome. Journal of Pharmacy Technology. 2018 Dec;34 (6): 266-272

PHARMACOLOGICAL TREATMENT: PRN MORPHINE



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Care of the Newborn Exposed to Substances During Pregnancy Practice Resource for Health Care Providers (2022). Perinatal ServiceBC. http://www.perinatalservicesbc.ca/Documents/Education/Practice%20Resource%20ESC_WEB%202020_11_20.pdf

TAKEAWAY # 3

- **Pharmacological treatment is available when non-pharmacological options have been optimized.**

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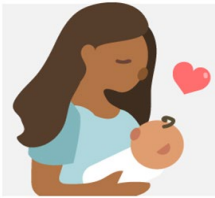
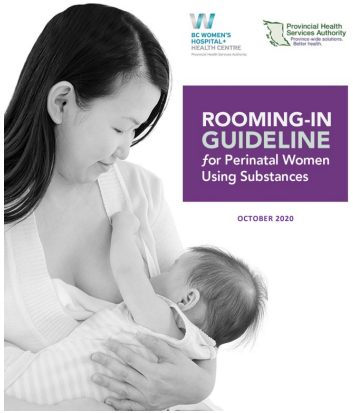
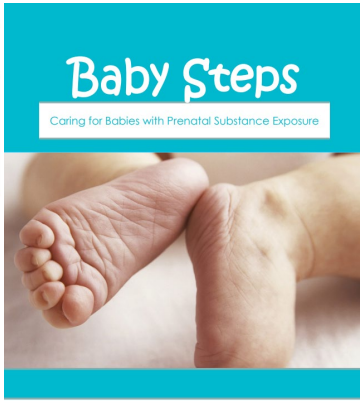
RESOURCES



Perinatal Substance Use

https://elearning.ubccpd.ca/





SafeBabies Program

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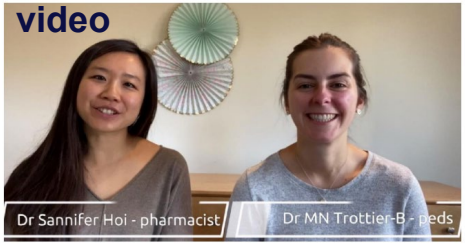
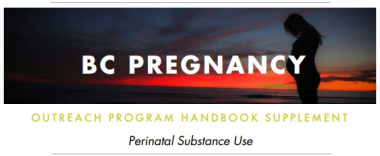
RESOURCES

PRN morphine education video



NEW QR CODE !!!



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Perinatal Mental Health and Substance Use: Clinical Insights from Pregnancy Through Newborn Period

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Clinical Associate Professor, UBC Dept of Family Practice
Educational Co-Lead UBC Health Clinic

WOMEN'S HEALTH RESEARCH INSTITUTE AT BC WOMEN'S
THE UNIVERSITY OF BRITISH COLUMBIA
BC WOMEN'S HOSPITAL+ HEALTH CENTRE

Our work takes place on the traditional, ancestral and unceded territory of the Coast Salish peoples – xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), Stó:lō and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

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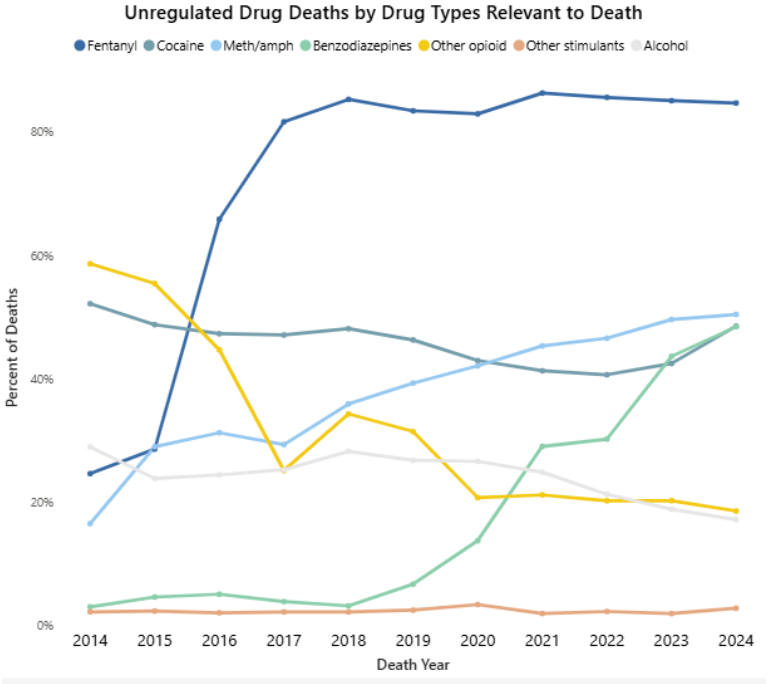
BC WOMEN'S HOSPITAL+ HEALTH CENTRE

Dr. Elder Roberta Price

POETIC Network Matriarch Elder

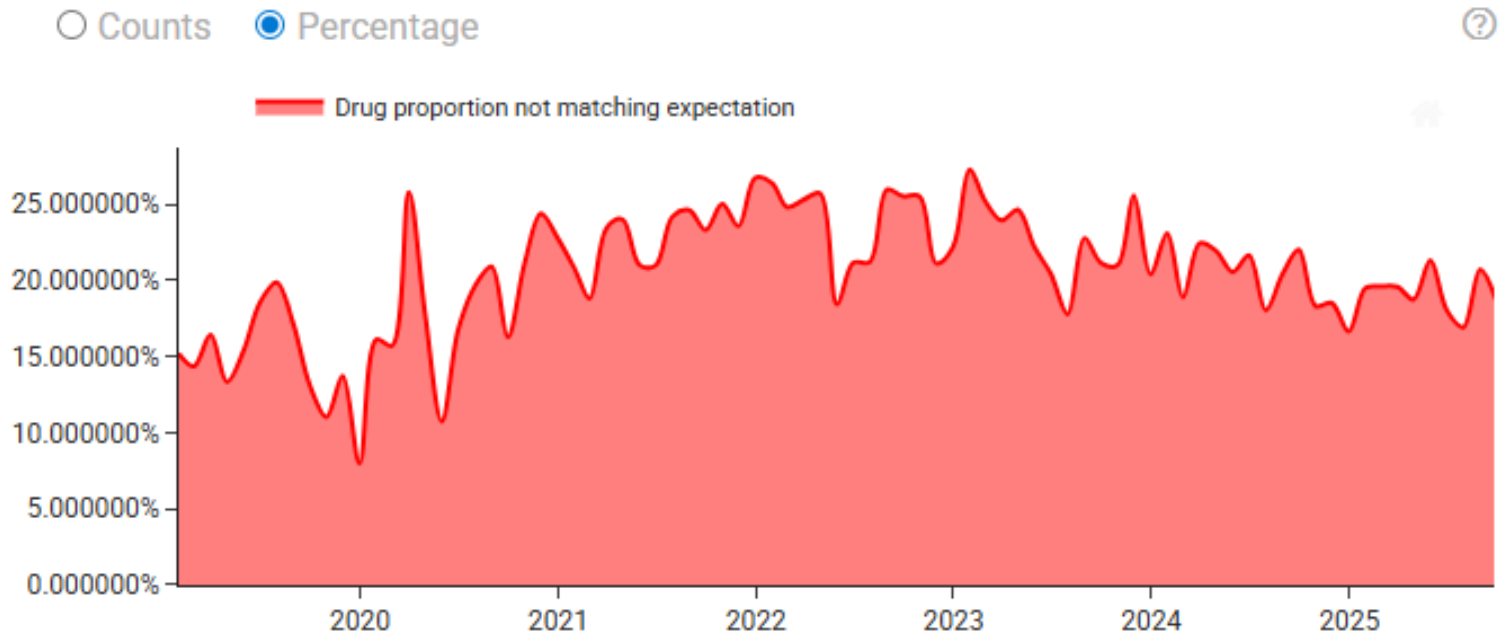
British Columbia Coroners Service. 2025

Unregulated drug deaths



Contaminated Supply

Expected Drug Present | Expected Drug Present Over Time



Primary Goal of Prenatal Care in SUD is Trust

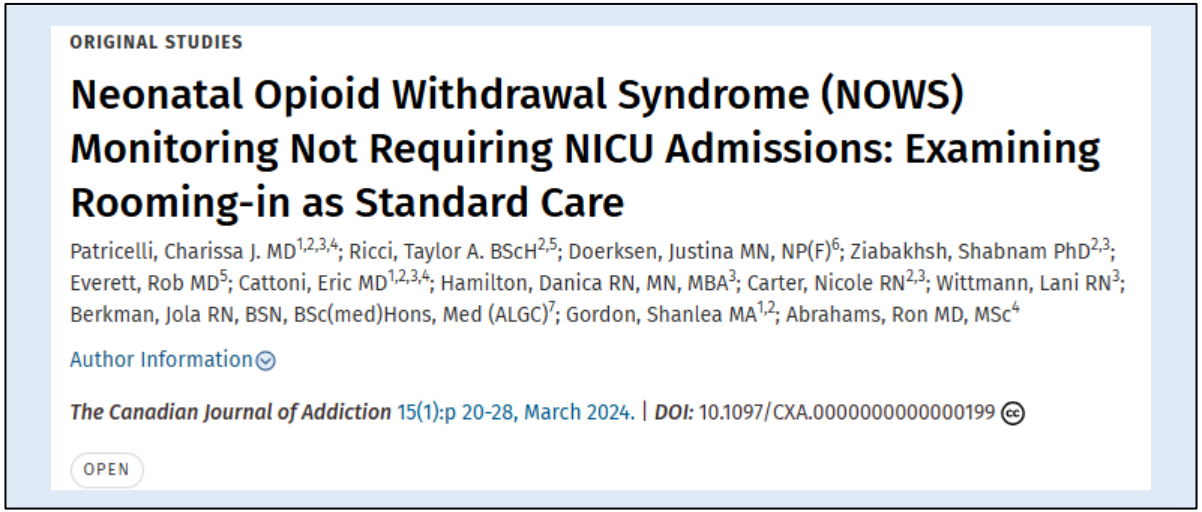
- Build Engagement and Trust thru Compassion, Listening and Suspending Stigma
- Build a ‘wrap a round’ with people they already trust
- Determinants of Health: Food, Shelter, Safety
- Keep the door open despite ongoing use, relapses, trauma responses
- Demonstrate hope
- Tx SUD as a health issue; a symptom of trauma and mental health disorders
- Be an advocate; the system needs it

Rooming-In is Associated With:

- Reduced morphine treatment length
- Decreased NICU admissions
- Lower hospital costs for infants born with NOWS
- Decreased apprehension rates
- Increased engagement with substance use treatment

- 2007: Rooming-in compared with standard care for newborns of mothers using methadone or heroin Ronald R. Abrahams MD CCFP FCFPC S. Ann Kelly MPH Sarah Payne RN MA Paul N. Thiessen MD FRCPC Jessica Mackintosh Patricia A. Janssen PhD

Neonatal Opioid Withdrawal Syndrome (NOWS) Monitoring Not Requiring NICU Admissions: Examining Rooming-In as Standard Care



ORIGINAL STUDIES

Neonatal Opioid Withdrawal Syndrome (NOWS) Monitoring Not Requiring NICU Admissions: Examining Rooming-in as Standard Care

Patricelli, Charissa J. MD[1,2,3,4]; Ricci, Taylor A. BScH[2,5]; Doerksen, Justina MN, NP(F)[6]; Ziabakhsh, Shabnam PhD[2,3]; Everett, Rob MD[5]; Cattoni, Eric MD[1,2,3,4]; Hamilton, Danica RN, MN, MBA[3]; Carter, Nicole RN[2,3]; Wittmann, Lani RN[3]; Berkman, Jola RN, BSN, BSc(med)Hons, Med (ALGC)[7]; Gordon, Shanlea MA[1,2]; Abrahams, Ron MD, MSc[4]

Author Information

The Canadian Journal of Addiction 15(1):p 20-28, March 2024. | **DOI:** 10.1097/CXA.0000000000000199

OPEN

Methods

- All infants born/admitted to BCWH, = or >35 weeks GA diagnosed with NOWS and given MOS (Morphine Oral Sulfate) to manage withdrawal over a 5 year period were reviewed (82 infants)
- Data gathered included morphine doses, duration of pharmacologic treatment, vital signs, clinical assessments if RR <40 or >60, reasons for Neonatal Intensive Care Unit (NICU) admission/transfer and subsequent length of stay
- Vitals reviewed included all data from NICU (continuous monitoring and FIR (q4 vitals while on MOS)

Summary of Findings

- Infants >35 wk and >2400g on MOS for NOWS management without comorbidities did not demonstrate Respiratory Rates < 30 bpm or SaO2<95%
- These infants can be safely managed without continuous cardiorespiratory monitoring outside the NICU setting, promoting the Rooming-In model of care and mitigating financial burden on the healthcare system.
- RR 30-40 and 60-70 was very common in the chart review and did not correlate with change in SaO2 in the FIR patients or NICU and had no associated adverse outcomes

Breast/Chestfeeding is an infant and parent human right

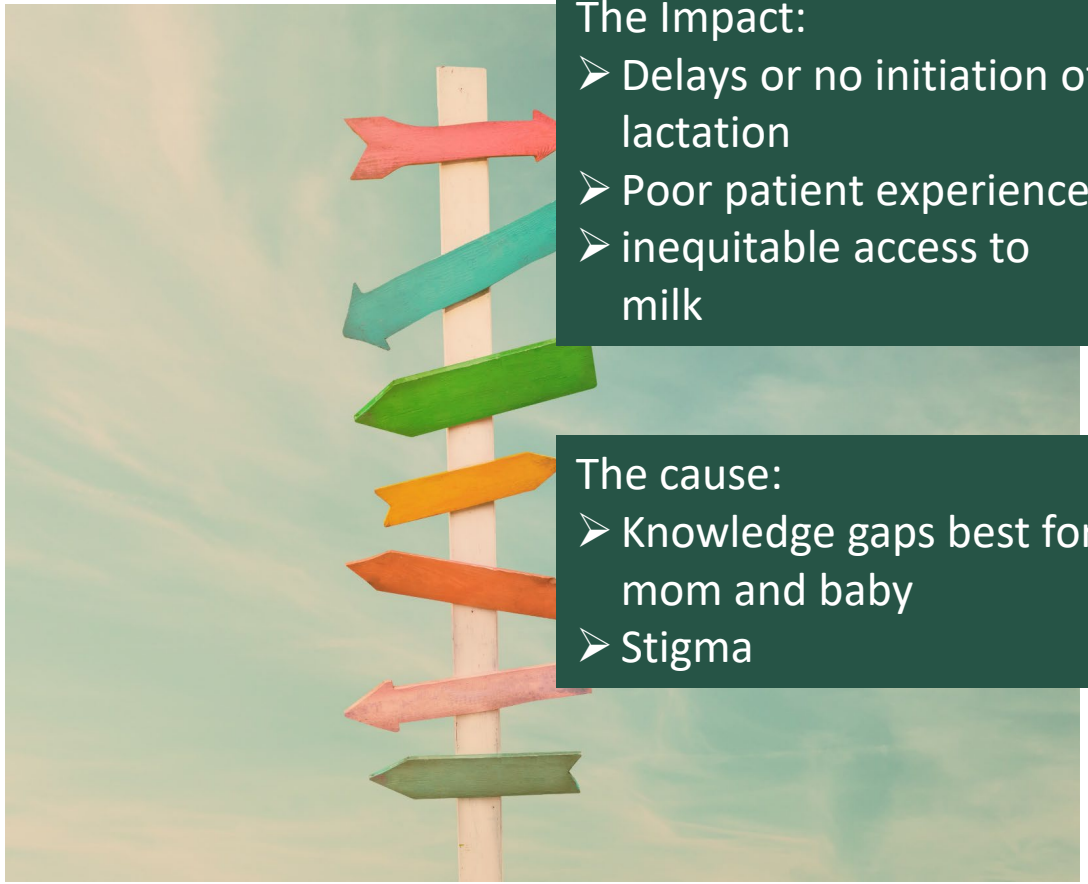
- Unequalled method of infant feeding
- Health benefits for adults and children alike
- "Women have the right to accurate, unbiased information needed to make an informed choice about breastfeeding
- "Children have the right to... the highest attainable standard of health, of which breastfeeding must be considered an integral component."

- United Nations, 2016

The Problem

Inconsistent messaging and practices for safe breast/chestfeeding in the context of:

- Opioid agonist therapy
- Recent access to the unregulated supply before delivery
- Relapse or intermittent use in the postpartum period

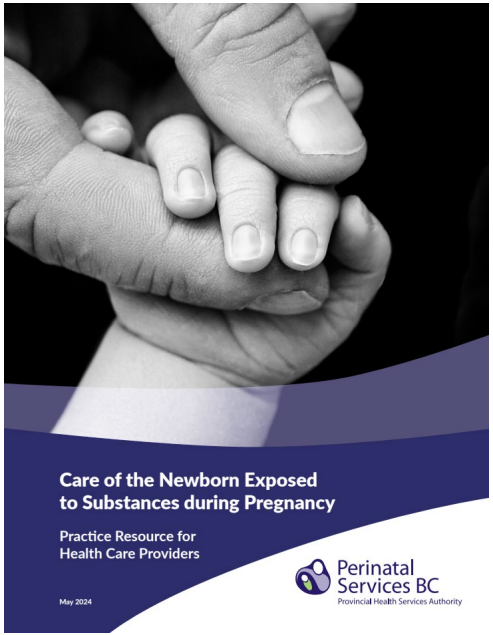


The Impact:

- Delays or no initiation of lactation
- Poor patient experience
- inequitable access to milk

The cause:

- Knowledge gaps best for mom and baby
- Stigma



Mothers/parents are encouraged to breastfeed or chestfeed unless there is concern related to continued substance use or other medical contraindication present such as HIV.

Informed Decision Making about Infant Feeding and Unregulated Substance Use

B

Benefits

All known benefits to parent and infant of human milk feeding, PLUS

Parent:
Continued motivation to stay substance-free.

Infant: Can delay and reduce withdrawal symptoms. less pharmacotherapy, and shorter hospitalization)

R

Risks

Reduced parental ability to respond to feeding cues

Infant exposure to substance / contaminated supply, including possible impact on brain development)

Infectious risk (HIV, Hepatitis C)

Opioids
Sedation, respiratory depression, withdrawal, associated feeding difficulties

Benzos
Sedation, respiratory depression, withdrawal, inadequate weight gain

Stimulants
GI and cardiorespiratory symptoms, hypothermia, irritability, tremors, sleep disturbance, seizures

A

Alternatives *skin to skin

Skin to skin care
Maintain lactation by “pump and dump” milk
Feeding alternatives: previously stored expressed milk or formula; bottle, cup feeding

I

Intuition / Information

“What do you feel and think about these options?”
Harm reduction approaches

N

Nothing / Next Steps

What do you need next? Time, talk, information?
Relapse plan

- Safe childcare
- Lactation support (electric pump, bottles, storage info)

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

HUMAN MILK FEEDING IN THE CONTEXT OF UNREGULATED SUBSTANCE USE

GUIDELINE

Due to the current toxic and contaminated drug supply, and until there is further evidence of infant safety, **current recommendations are to encourage breastfeeding parents to pump and discard breast milk for a minimum of 96 hours after substance use with unregulated stimulants or opioids.**

This recommendation is based on the available data on methamphetamine clearance from human milk (Chomchai et al., 2016) and is endorsed based on expertise from a multidisciplinary panel of subject matter experts, including Perinatal Addictions Service, Pediatrics, and Pharmacy.

Note: There is no information on unregulated opioids, benzodiazepines, and other contaminants in breastfeeding, therefore the risk of exposure of the infant to unregulated substances is not zero after 96 hours. This decision requires full disclosure and a shared decision-making conversation with the patient, including providing infant monitoring parameters.

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

HUMAN MILK FEEDING IN THE CONTEXT OF UNREGULATED SUBSTANCE USE

GUIDELINE

Recommendations

For safe breastfeeding in patients with a SUD involving unregulated opioids or stimulants, the recommendations are:

A. **All patients should have a thorough assessment of drug history, HIV status, and ongoing HIV risk factors** and if relevant, referral for discussion / prescription of PrEP.

B. **All patients should be offered antenatal breastfeeding/infant feeding education.**

C. **Breastfeeding/EBM is not recommended for infants of parents who are HIV positive. However, there are ways to support people living with HIV who have a suppressed viral load and who can be very adherent to their own medications to breastfeed in an evidence-informed manner.**

D. **Human milk feeding is not recommended in patients who regularly access the unregulated drug supply.**

E. **Human milk feeding is encouraged for patients stabilized on Opioid Agonist Therapies**, including Methadone, buprenorphone-naloxone (Suboxone), slow-release oral morphine (Kadian), and injectable OAT (iOAT), if other risk factors are absent. Please see informed consent document regarding limited safety data on breastfeeding and iOAT, and infant monitoring requirements.

F. **Monitor infants for signs of intoxication or neonatal abstinence syndrome (NAS), including sedation and respiratory depression, or neurologic, gastrointestinal, and musculoskeletal disturbances as described in the Eat, Sleep, Console Care Tool (PSBC, 2024).**

G. **Promote rooming-in and skin-to-skin contact, supported by Caregiver Behavioral Assessment Form on SHOP.**

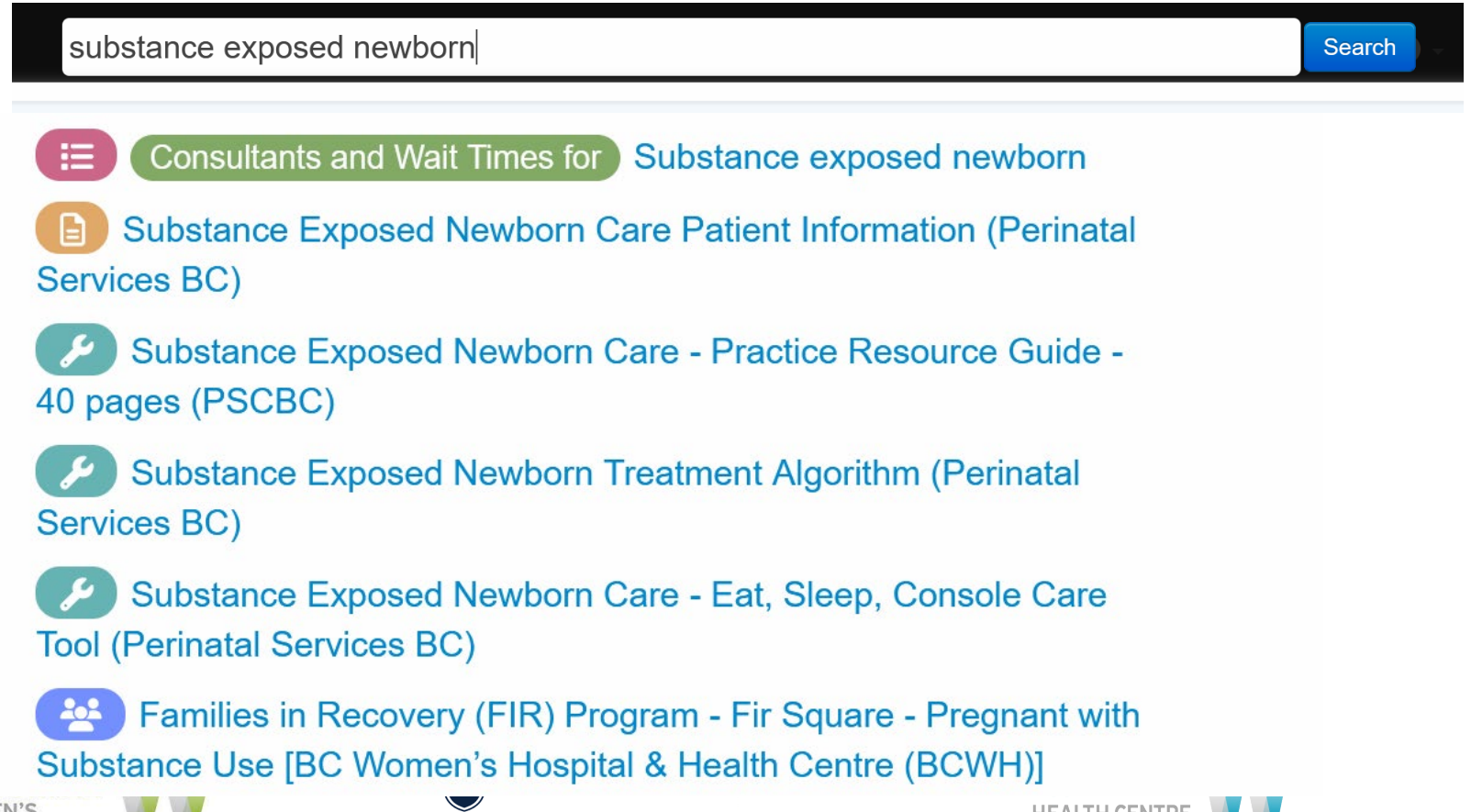
Education, Celebrate and Normalize Birth

Parent/family antepartum education

Dyad/family togetherness

Decrease stigma

Search Substance Exposed Newborn in Pathways



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