



**Substance Use In Pregnancy and
Postpartum Peer Support Specialist,
Doula, & Traditional Health Worker Toolkit**

Oregon Perinatal Collaborative



Traditional Health Worker/Peer Support Specialist Perinatal SUD Toolkit

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Substance Use Disorders in Pregnancy and Postpartum Leadership:

Silke Akerson, MPH, CPM, LDM, Oregon
Perinatal Collaborative

Aaron Caughey, MD, Oregon Perinatal
Collaborative

Laurel Durham, MPH, RN, Oregon Perinatal
Collaborative

Ami Hanna, MPH, Comagine Health

Ana Sassano, MA-MCHS, Comagine Health

Diana Smith, CNM, MPH, Project Nurture

Substance Use Disorders in Pregnancy and Postpartum Workgroup Members

Amelia Baker, MD, PhD

C. Frederick W. Baker, MD

Francesca Barnett, LMFT, CADC III

Lydia Bartholow, DNP, PMHNP

Chelsea Barbour, LCSW, PMH-CL

Iris Bicksler, CHW, PSS

Sarah Bovee, PWS Certified Doula

Amy Chapman, BSN, RN

Zheyang Jenny Chen, MD, PhD

Camille Cioffi, PhD

Adrian Cois, MBBS

Autumn Davidson, MD, MS

Jeremy Eckard

Kasey Edwards, CADC1, PSS

Brooke Evans, PhD, LCSW

Kerri Hecox, MD, MPH

Amy Hermes, MD, PhD

Bonnie Holdahl, MBA

Hannah Kamsky, BSN, RN

Alicia Kleen, OHDS, Prevention Coordinator

Karolina Kowalewska, Pharm.D, BCPP

Cat Livingston, MD, MPH

Linda Peng, MD

Kori Pienovi, CNM

Heidi Pollard-Hermann, PMHNP, PMH-C

Kristin Prewitt, MD, MPH

Joshua Reagan, MD, MS

Patrick Secrest, CADC-II

Emily Skogrand, Pharm. D

Emilia Smith, CPM, LDM

Wendy J Smith, MD, MPH

Heather Sonnenburg, PWS, PSS

Anna Stiefvater, RN

Brandon Togioka, MD

Meredith Walker, CADC II, MA

Rachael Waas Shull, MSN, PMHNP-BC

Shelley Weise, RN, BSN

Emily Wulff, MN, NNP-BC

Maria Wunderbro, LCSW

Emily Yeast, CNM

Angela Zallen, MD, MPH

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

Kasey Edwards, CADC1, PSS

Molly McArt, BS, PSS

Inclusive language notice:

This toolkit is intended to improve care and outcomes for pregnant and postpartum people who have a wide range of gender identities. For this reason, we use both gendered and non-gendered terms including “birthing person/people,” “patient,” “mother,” and “maternal,” to reflect this range of identities. We affirm that respecting individual patient preferences regarding gendered language throughout their care is essential to respectful, patient-centered care.



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Section I: Introduction and Background

This toolkit is created for [Traditional Health Workers \(THWs\)](#), including [peer support specialists](#), who provide critical non-clinical support and coordination services during pregnancy, birth, and postpartum for women and birthing people with substance use disorders. People in the THW role may use different titles and have different education and training. While this toolkit was designed to be inclusive, it likely does not specifically name all, and any inclusion or not is not intended to reflect any difference in value.

Importantly, in this document, “person with lived experience” refers to an individual who has experienced substance use disorder during pregnancy/ postpartum. Peer support specialist specifically refers to a person with lived experience who is in active recovery from a SUD and who has education and training to provide professional peer services to another individual with similar life experience. Some peers have additional education, training, and certification specifically related to perinatal health, such as doula training.

This toolkit is organized into sections called the “5 R’s,” which comes from a national organization called the [Alliance for Innovation on Maternal Health \(AIM\)](#). The categories in the 5 Rs include **R**eadiness, **R**ecognition & Prevention, **R**esponse, **R**eporting & Systems Learning and **R**espectful, Equitable, and Supportive Care. These categories help the person/team using this toolkit to approach the care and strategies in a way that ensures all necessary components are addressed in smaller pieces that support each other.

There is a lot of clinical and technical language used in this toolkit. Peer support specialist experts who reviewed this toolkit recommended including this language to support THWs to understand and be understood, when working with clinical teams. However, use of clinical language can require more mental and emotional effort, especially initially, for some THWs. It may be helpful to seek support when exploring/ using this toolkit, both through supervision from someone in same/ similar role, and through translation and shared learning with a team of other people in the same/ similar roles.

For more information about Traditional Health Workers: [Oregon Health Authority : About Traditional Health Workers : Equity and Inclusion Division : State of Oregon](#)

Oregon has one of the highest rates of alcohol and non-prescribed drug use in the United States (SAMHSA). Untreated mental health conditions, including substance use disorders (SUDs), are the current leading cause of preventable maternal death in Oregon (MMRC, 2025; Bruzelius & Martins, 2022). While SUDs are more common among men than women, the gender gap is narrowing (McHugh, 2018). Women are more likely to begin substance use at an earlier age and experience more severe adverse medical, psychiatric, and



functional consequences related to SUDs, when compared with men (McHugh, 2018). Violence and other forms of abuse, including early childhood adverse events, are common experiences for women with SUD (Duka, 2023). When people with SUD become pregnant, they often present late to care and receive limited or no care due in part to the stigma surrounding substance use during pregnancy, fear of child removal, and systemic barriers such as lack of coordinated perinatal and treatment service (Paris et al, 2020; SAMSA, 2024; Shadowen et al, 2021). Parental substance use, in turn, is the most common reason for early foster care placement and puts children at high risk for the long-term adverse health effects associated with foster care (McConnell, 2020).

Yet, substance use disorders are treatable conditions, and pregnancy provides a window of opportunity for intervention. In the perinatal period, people's motivation and capacity for change increase and there are opportunities to connect with care through hospitals, clinics, and community services. When met with key interventions--delivered with support, transparency, and respect--health outcomes for the birthing person and child are improved, and expensive and avoidable emergency room visits and hospitalizations for medical, obstetric, and newborn complications can be reduced (McConnell, 2020).

To make meaningful change related to perinatal SUD, clinical quality improvement work must be thoughtfully designed and consider the needs and priorities of this patient population both inside and outside of healthcare—including housing, social support, transportation, food, and other basic needs. The longstanding silos between physical and behavioral/ mental healthcare must be addressed and integration of [people with lived experience](#) of substance use and pregnancy, including those in recovery who have specific education and professional training, often called [peer support specialists](#), into the design and implementation is necessary. Peer support specialists and other THWs not only support individual patient needs but also function as system navigators and build trust within and across systems. The long history of systemic racism in the United States has shaped the access and experience of Black, Indigenous, and all people of color inside and outside of healthcare and the stigma associated with substance use during pregnancy can be amplified in communities of color. Quality improvement work aimed at the prevention of pregnancy related morbidity and mortality related to perinatal SUDs must consider these factors and work to advance health for all.

Perinatal Quality Collaboratives (PQCs), including the Oregon Perinatal Collaborative (OPC), are state or multistate networks of teams working to improve the quality of care for mothers, birthing people, and babies. Members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible (CDC). In 2025, the OPC facilitated a multidisciplinary workgroup in Oregon to create the full Perinatal SUD toolkit which will support clinical and non-clinical individuals and teams caring for pregnant patients with substance use disorder. The goal of the OPC Perinatal



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Toolkit, content for specific audiences such as this toolkit, and a planned hospital-based quality improvement initiative is to decrease preventable maternal morbidity and mortality from substance use disorders and improve the health and wellbeing of birthing women and babies in Oregon.

Additional detail/ information is available in [OPC Perinatal SUD Toolkit](#)



Section II: Steps for Improvement (The 5 Rs)

Readiness: Every Care Setting

Key readiness takeaway:

THWs including peer support specialists and doulas are important members of a multidisciplinary care team who can help improve outcomes for people with perinatal SUD by modeling a non-judgmental approach to care and ensuring the needs of the birthing person are centered.

- Train on [optimal care](#) for pregnant and postpartum people with SUD. Explore the following opportunities to learn more:
 - Consider [Oregon ECHO Network](#) programs on substance use in pregnancy and postpartum or the [Academy of Perinatal Harm Reduction](#) for unique needs/considerations during pregnancy and postpartum.
 - Assisting families to complete an [Oregon Family Care Plan](#) and the process for public health data collection when it has been completed.
 - Understanding federal, state, and organizational child welfare reporting requirements, and [best practices](#) for when a child welfare report needs to be made.
NOTE: The THW role as a mandatory reporter is an ethically complex part of this role and supervision and team support from others in same/ similar role is important.
- Advocate for the integration of THWs, including peer support and doulas into multidisciplinary care teams supporting people experiencing SUDs. Help organizations that you partner with/work within understand your role and professional standards.
- Complete trauma-informed care and anti-racist training to address biases and stigma related to SUDs.
- Develop and maintain a set of referral resources for obstetric providers, community-based organizations, and state and public health agencies to enhance services and support for pregnant and postpartum families for social determinants of health needs, [behavioral health supports](#), and [SUD treatment](#).
- Provide client and family education, within [scope of role](#), related to substance use disorder (SUD), [naloxone use](#), [harm reduction strategies](#), and care of infants with in-utero substance exposure.
- Participate in the development of [Oregon Family Care Plans](#), starting in the prenatal setting.



Recognition & Prevention: Every Patient

Key Recognition & Prevention Takeaway:

The screening encounter is an opportunity to build rapport between clients and care teams and help people engage with care and support for clinical and non-clinical needs.

- Become familiar with substance use [screening tools](#) (often referred to by clinical team as validated self-reported tools) used by clinical care teams during pregnancy/delivery.
 - While THWs are not responsible for administering, interpreting or documenting screening, they can support clients with understanding.
- Become familiar with [structural and social driver of health screening](#) and support linkage to resources.

Response: Every Event

Key response takeaway:

Traditional health workers, including peers and doulas are important facilitators of the warm handoff practices between hospitals and community partners that support priority care to people with perinatal SUD during pregnancy and through the first year postpartum.

- Assist pregnant and postpartum people with SUD to connect with evidence-based, person-directed SUD treatment that is welcoming and inclusive.
- Contribute to the development of specific prenatal, intrapartum and postpartum care pathways that facilitate coordination among multiple providers during pregnancy and the year that follows.
- Share comprehensive reproductive life planning resources and assist in connection to a clinician for education and access to services as requested.



Reporting & Systems Learning: Every Unit/Care Setting

Key reporting and systems learning takeaway:

By participating in briefing and debriefs, THWs including peers and doulas will support continued improvement of care over time and see the results of their work in improved health outcomes.

NOTE: Systems learning activities should be, by design, non-punitive, supportive and protect all participants, including THWs, from blame or retaliation.

- Participate in multidisciplinary planning, huddles and debriefs that can help identify successes, opportunities for improvement and action planning for patients with complex needs related to perinatal SUD in the hospital, and other settings when available.
- Bring the THW perspective to system level workgroups where inpatient and outpatient providers and community stakeholders, including those with lived experience, share successful strategies and identify opportunities to improve outcomes and system-level issues.

Respectful, Equitable, and Supportive Care

Key respectful, equitable and supportive care takeaway:

By building a culture of support, transparency, and respect in care for families impacted by SUD, we improve our care and outcomes. By inviting people with lived experience of perinatal SUD to participate in the design and implementation of change, we improve our chances of success.

- Support integration of pregnant and postpartum people in the care team to establish trust and ensure shared decision-making that incorporates the pregnant and postpartum person's values and goals occurs.
- Respect the pregnant and postpartum person's right of refusal in accordance with their values and goals.
- Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support people to understand diagnosis, options, and treatment plans.
- Consider cultural and community specific needs in all peer delivered services and plans of care, and refer to resources when desired and available.



Section III: Appendix

Key Resources:

- [Academy of Perinatal Harm Reduction](#)
- [The Center on Parenting and Opioids Substance Use and Recovery](#)
- [Harm Reduction Doula Collective](#)
- [Intentional Peer Support \(IPS\)](#)
- [National Black Doula Association](#)
- [OHA THW Continuing Education](#)
- [OHA Traditional Health Worker Toolkit](#)
- [Oregon Family Care Plans](#)
- [The PEER Company](#)
- [Project Nurture](#)
- [Recovery Ready Workplace-US Department of Labor](#)



Definitions

Birth Doula: A birth companion who provides personal, non-medical support to birthing people and families throughout a person’s pregnancy, childbirth and postpartum experience. A doula may receive additional training specific to support pregnant and postpartum people with SUD and/or also have specific education and training as a peer support specialist and may be referred to as a “specialized doula” in these situations.

Family care plan ([Oregon Family Care Plans](#)): CAPTA and CARA legislation requires states to develop **Family Care Plans** for infants with prenatal substance exposure and their families “to ensure the safety and well-being of such infant following release from the care of healthcare providers including through **addressing the health and substance use disorder treatment** needs of the infant and affected family or caregiver”. The Oregon Family Care Plan is a document that providers and patients can use together to fulfill this requirement.

Harm reduction: A set of practical, evidence-based strategies aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on the belief in, and respect for, the rights of people who use drugs. ([National Harm Reduction Coalition](#))

Mandatory Reporter of Child Abuse: A person in a role that is required by law in Oregon to make an immediate report when they have had contact with a child they reasonably suspect was abused or contact with a person who is believed to have abused a child. In Oregon, certified Traditional Health Workers are mandatory reporters. *NOTE: Mandatory reporting applies to adults with developmental disabilities as well but is not addressed specifically here.*

Medications for opioid use disorder (MOUD): Medications used to treat opioid use disorder. Methadone and buprenorphine are first line medication options to treat pregnant women with OUD. ([CDC](#))

Opioid use disorder (OUD): A chronic, treatable disease that involves a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences. ([ACOG](#))

Peer support specialist: A person in active recovery from an SUD and has had education and training to provide professional peer services to another individual with similar life experience. Some peers have additional training and certification specifically related to perinatal health, such as doula training. Note that this role title is designated by the Oregon



Health Authority (OHA) and other certifying bodies may use different terms for similar role (eg certified recovery mentor, etc).

Perinatal: While different definitions can be used, perinatal refers to the period before, during and following birth. For the purposes of this toolkit, perinatal refers to the beginning of pregnancy through 12 months following the end of pregnancy (regardless of pregnancy outcome).

Person with lived experience: An individual who has experienced a substance use disorder during pregnancy or postpartum periods.

Postpartum: The first 12 months following the end of a pregnancy, regardless of pregnancy outcome.

Screening for SUD: The first component of SBIRT (Screening, Brief Intervention, and Referral to Treatment), screening is the first step in identifying risky substance use and connecting women with substance use disorders to care. During pregnancy verbal screening tools, such as the 5 Ps, can help identify people who might benefit from more in-depth assessment of their substance use and care needs. ([AMCHP](#))

Stigma: In the context of substance use disorders, stigma is a set of negative attitudes and stereotypes that lead to discrimination and can create barriers to treatment and health care and make these conditions worse. ([NIDA](#)) Types of stigma include individual/ internalized, interpersonal/ enacted, and organizational/ institutional.

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

Traditional health workers (THW): Trusted individuals from their local communities who may also share socioeconomic ties and life experiences with the people they work with. This term, used by the Oregon Health Authority (OHA), refers to multiple worker types including peer support specialist and birth doula defined above.