



Substance Use In Pregnancy and Postpartum **Social Work Toolkit**

Oregon Perinatal Collaborative



Acknowledgments:

The Oregon Perinatal Collaborative (OPC) gratefully acknowledges the volunteer multidisciplinary members, representing clinical and non-clinical expertise, of the Perinatal SUD Toolkit & Initiative Workgroup who helped develop and review the content of the toolkit, as well as plan for implementation.

We are especially grateful for the expertise of workgroup members with lived experience who helped shape this toolkit and initiative to meet the needs of pregnant and postpartum women and people.

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:

Stacie Westbrook, LCSW, MSW
Alicia Linton Ambrocio, MSW, LCSW

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.



Table of Contents

Section I: Introduction and Background	4
Section II: Steps for Improvement (The 5 Rs).....	6
Readiness: Every Care Setting	6
Recognition & Prevention: Every Patient.....	7
Response: Every Event	7
Reporting & Systems Learning: Every Unit/Care Setting	8
Respectful, Equitable, and Supportive Care	8
Section III: Appendix.....	9
Definitions	10



Section I: Introduction and Background

This toolkit is created for social workers, care managers and/or case managers who provide coordination services during pregnancy, birth and/or postpartum for women and birthing people with substance use disorders. While much of the content is framed in the context of inpatient/hospital care, all are encouraged to consider the value and adaptability of this content applied in community, behavioral health, or other clinic settings.

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

Oregon has one of the highest rates of alcohol and non-prescribed drug use in the United States (SAMHSA). Untreated mental health conditions, including substance use disorders (SUDs), are the current leading cause of preventable maternal death in Oregon (MMRC, 2025; Bruzelius & Martins, 2022). While SUDs are more common among men than women, the gender gap is narrowing (McHugh, 2018). Women are more likely to begin substance use at an earlier age and experience more severe adverse medical, psychiatric, and functional consequences related to SUDs, when compared with men (McHugh, 2018). Violence and other forms of abuse, including early childhood adverse events, are common experiences for women with SUD (Duka, 2023). When people with SUD become pregnant, they often present late to care and receive limited or no care due in part to the stigma surrounding substance use during pregnancy, fear of child removal, and systemic barriers such as lack of coordinated perinatal and treatment service (Paris et al, 2020; SAMSA, 2024; Shadowen et al, 2021). Parental substance use, in turn, is the most common reason for early foster care placement and puts children at high risk for the long-term adverse health effects associated with foster care (McConnell, 2020).

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

To make meaningful change related to perinatal SUD, clinical quality improvement work must be thoughtfully designed and consider the needs and priorities of this patient



population both inside and outside of healthcare—including housing, social support, transportation, food, and other basic needs. The longstanding silos between physical and behavioral/ mental healthcare must be addressed and integration of [people with lived experience](#) of substance use and pregnancy, including those in active recovery who have specific education and professional training, often called [peer support specialists](#), into the design and implementation is necessary. The long history of systemic racism in the United States has shaped the access and experience of Black, Indigenous, and all people of color inside and outside of healthcare and the stigma associated with substance use during pregnancy can be amplified in communities of color. Quality improvement work aimed at the prevention of pregnancy related morbidity and mortality related to perinatal SUDs must consider these factors and work to advance health for all.

Perinatal Quality Collaboratives (PQCs), including the Oregon Perinatal Collaborative (OPC), are state or multistate networks of teams working to improve the quality of care for mothers, birthing people, and babies. Members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible ([CDC](#)). In 2025, the OPC facilitated a multidisciplinary workgroup in Oregon to create the full Perinatal SUD toolkit which will support clinical and non-clinical individuals and teams caring for pregnant patients with substance use disorder. The goal of the OPC Perinatal Toolkit, content for specific audiences such as this toolkit, and a planned hospital-based quality improvement initiative is to decrease preventable maternal morbidity and mortality from substance use disorders and improve the health and wellbeing of birthing women and babies in Oregon.

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



Section II: Steps for Improvement (The 5 Rs)

Readiness: Every Care Setting

Key readiness takeaway:

Social workers/care/case management teams can improve outcomes for people with perinatal SUD, by championing a non-judgmental and evidence-informed approach to care. By including people with lived experience of perinatal SUD, we increase our chances of successfully delivering care to those who need it.

- Ensure all social work/ care management staff have education on and understand optimal care for pregnant and postpartum people and their newborns with SUD, including:
 - Assisting families to complete an [Oregon Family Care Plan](#) and the process for public health data collection when it has been completed.
 - Understanding federal, state, and organizational child welfare reporting requirements, and [best practices](#) for when a child welfare report needs to be made.
- Ensure social work/ care management staff are aware of the federal requirement to assist families to complete an [Oregon Family Care Plan](#), organization processes for completion and sharing across settings/ teams, and the process for public health data collection when a Family Care Plan has been completed.
- Participate in development of trauma-informed protocols and anti-racist training to address team member biases and stigma related to SUDs.
- Engage/join a multidisciplinary care team to provide coordinated care pathways for people experiencing SUDs.
 - Inclusion of THWs (peer support specialists, doulas, etc) in multidisciplinary teams is critical and efforts must be taken to address power dynamics that can prevent meaningful inclusion and contribute to burn out in this role.
- Develop and maintain a set of referral resources and communication pathways between your hospital social work/ care management team, 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, and SUD treatment.
- Develop and provide patient and family education related to perinatal SUD, [Oregon Family Care Plans](#), community support and resources, child welfare reporting policies, and what to expect if a child welfare report is made.
 - Include peers/ traditional health workers/ doulas as trusted support in these discussions when possible.



Recognition & Prevention: Every Patient

Key Recognition & Prevention Takeaway:

The screening encounter is an opportunity for social works/care/case management teams to build rapport with patients/families, provide intervention for risky substance use, and help people engage with care and support for clinical and non-clinical needs.

- Support implementation of universal screening of pregnant and postpartum people for SUDs using a [validated self-reported screening tool](#) and methodologies during prenatal care and during delivery admission.
- Screen each pregnant and postpartum person for medical and behavioral health needs and provide linkage to community services and resources.
- Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans and provide linkage to resources.

Response: Every Event

Key response takeaway:

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

- Offer every pregnant and postpartum person with SUD assistance to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive.
- Assess individual readiness to start treatment and for those who choose treatment, refer through warm hand-off with ongoing support to engage and close follow-up.
- Offer every pregnant and postpartum person with SUD assistance to connect with peer services.
- Connect pregnant and postpartum people with SUD who desire peer services to peer services.
- Establish specific prenatal, intrapartum and postpartum care pathways that facilitate coordination between care settings and among multiple providers (e.g. from prenatal clinic into the hospital and back; between perinatal, pediatric, care management, treatment providers, and peers) during pregnancy and the year that follows.



Reporting & Systems Learning: Every Unit/Care Setting

Key reporting and systems learning takeaway:

By adopting briefing and debriefs, non-punitive case-reviews, and tracking of outcome and process measures, teams will continue to improve care over time and see the results of their work in improved health outcomes.

- Offer every pregnant and postpartum person with SUD assistance to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive.
- Assess individual readiness to start treatment and for those who choose treatment, refer through warm hand-off with ongoing support to engage and close follow-up.
- Offer every pregnant and postpartum person with SUD assistance to connect with peer services.
- Connect pregnant and postpartum people with SUD who desire peer services to peer services.
- Establish specific prenatal, intrapartum and postpartum care pathways that facilitate coordination between care settings and among multiple providers (e.g. from prenatal clinic into the hospital and back; between perinatal, pediatric, care management, treatment providers, and peers) during pregnancy and the year that follows.

Respectful, Equitable, and Supportive Care

Key respectful, equitable and supportive care takeaway:

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

- Ensure shared decision-making that incorporates the pregnant and postpartum person's values and goals in care planning and all steps outlined above.
- 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.



Section III: Appendix

Key Resources:

- [Toolkit: Creating Safe Care for Pregnant and Parenting Patients Who Use Drugs \(Camden Coalition\)](#) National information and tools (checklists, scripts, etc) to support pregnant and parenting people who use drugs.
- [Oregon Family Care Plans](#): Includes guidance for healthcare professionals and downloadable fillable form
- [Oregon Revised Statute \(ORS\) 430.915 Support for Pregnant People Using Substances](#)
- [ODHS: Mandatory Reporting](#): Oregon Department of Human Services (ODHS) site that includes training and resources/ materials about mandatory reporting in Oregon.



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.