BUILDING COMPREHENSIVE PERINATAL RECOVERY PROGRAMS IN ADDICTION MEDICINE

Clinical Design, Ethical Considerations, and Implications fo Pra

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OBJECTIVES:

- Describe and evaluate programmatic and structural components associated with successful integrated perinatal recovery models, including multidisciplinary staffing, clinical workflows, and peer recovery support roles.
- Identify common ethical challenges in perinatal addiction care, including the management of positive toxicology screens and the impact of punitive institutional policies.
- Apply ethical frameworks that prioritize patient autonomy, shared decision -making, and harm reduction when caring for pregnant and postpartum individuals with substance use disorders.
- Implement trauma -informed strategies to reduce stigma, promote psychological safety, and support sustained engagement across pregnancy and the postpartum period and align clinical practices to strengthen continuity of care and improve maternal and infant outcomes.

STRENGTHENING MATERNAL AND INFANT OUTCOMES THROUGH INTEGRATED CARE

Disproportionately high rates of:

- Stigma
- Untreated mental health conditions
- Housing instability
- Children & youth involvement
- Carceral system involvement
- Fragmented healthcare access

OVERDOSE REMAINS A LEADING CAUSE OF PREGNANCY-ASSOCIATED DEATH

POSTPARTUM VULNERABILITY OFTEN EXCEEDS PRENATAL VULNERABILITY

integrated care models are most effective when they prioritize dignity, safety, trust, and long-term quality of life

DEFINING INTEGRATED PERINATAL RECOVERY MODELS

> “Integrated perinatal recovery models coordinate obstetric, addiction medicine, behavioral health, social support, and peer services into a unified, patient-centered care approach”

CORE PRINCIPLES

- Whole-person care
- Harm reduction
- Continuity across pregnancy and postpartum
- Relationship-centered practice
- Interdisciplinary collaboration
- Recovery defined by improved quality of life, not solely abstinence

integrated care is not simply co-location of services; it requires active communication, collaborative workflows, and shared treatment philosophy

PROGRAMMATIC COMPONENTS OF SUCCESSFUL MODELS

CLINICAL SERVICES

- Prenatal and postpartum care
- (MOUD)
- Mental health treatment
- Infectious disease screening/treatment
- Lactation support
- Family planning and reproductive health

SUPPORTIVE SERVICES

- Transportation
- Housing navigation
- Childcare support
- Legal advocacy
- Recovery community linkage

STRUCTURAL SUPPORTS

- Flexible scheduling
- Warm handoffs
- Integrated documentation systems
- Reduced appointment burden

MULTIDISCIPLINARY STAFFING MODELS

KEY TEAM MEMBERS

- Obstetricians / Midwives
- Addiction medicine specialists
- Nurses and care coordinators
- Behavioral health clinicians
- Social workers
- Pediatric providers
- Peer recovery specialists
- Lactation consultants
- Community health workers

WHY MULTIDISCIPLINARY TEAMS MATTER

- Reduce fragmentation
- Improve communication
- Increase patient trust
- Support early intervention
- Improve retention in care

THE ROLE OF PEER RECOVERY SUPPORT

> Peers should be integrated as valued team members, not tokenized additions

PEER RECOVERY SPECIALISTS PROVIDE:

- Lived experience credibility
- Navigation of healthcare systems
- Emotional support and advocacy
- Harm reduction education
- Appointment accompaniment
- Reduced shame and isolation

EVIDENCE-BASED BENEFITS:

- Increased engagement and retention
- Improved trust in providers
- Enhanced postpartum follow-up
- Improved patient satisfaction

CLINICAL WORKFLOW CONSIDERATIONS

EFFECTIVE CLINICAL WORKFLOW STRATEGIES

- Same-day access when possible
- Universal verbal screening practices
- Non-punitive assessment processes
- Coordinated prenatal and addiction appointments
- Rapid MOUD initiation pathways
- Standardized postpartum follow-up planning
- Warm transitions to community supports

HIGH-RISK TRANSITION POINTS

- Hospital admission
- Delivery hospitalization
- NICU involvement
- Postpartum discharge
- Loss of custody concerns

ETHICAL CHALLENGES IN PERINATAL ADDICTION CARE

COMMON ETHICAL TENSIONS

- Mandatory reporting requirements
- Positive toxicology screening management
- Informed consent concerns
- Surveillance versus support
- Balancing fetal considerations with maternal autonomy
- Punitive institutional practices
- Fear-driven clinical decision -making

“Does this policy improve safety, or does it increase disengagement and harm?”

POSITIVE TOXICOLOGY SCREENS
CLINICAL AND ETHICAL CONSIDERATIONS

CHALLENGES

- Variable institutional policies
- Implicit bias in screening practices
- Patient mistrust and fear of disclosure
- Risk of disproportionate reporting

BEST PRACTICES

- Universal and transparent screening policies
- Informed consent whenever possible
- Explain purpose and implications of testing
- Avoid stigmatizing language
- Focus on treatment engagement and safety planning

HARM OF PUNITIVE RESPONSES

- Reduced prenatal care engagement
- Increased concealment of substance use
- Increased overdose risk
- Damaged therapeutic relationships

HARM REDUCTION IN PERINATAL CARE

HARM REDUCTION PRINCIPLES

- Meet patients where they are
- Reduce risk without requiring abstinence
- Respect patient autonomy
- Recognize recovery as nonlinear
- Prioritize survival and stability

EXAMPLES IN CLINICAL PRACTICE

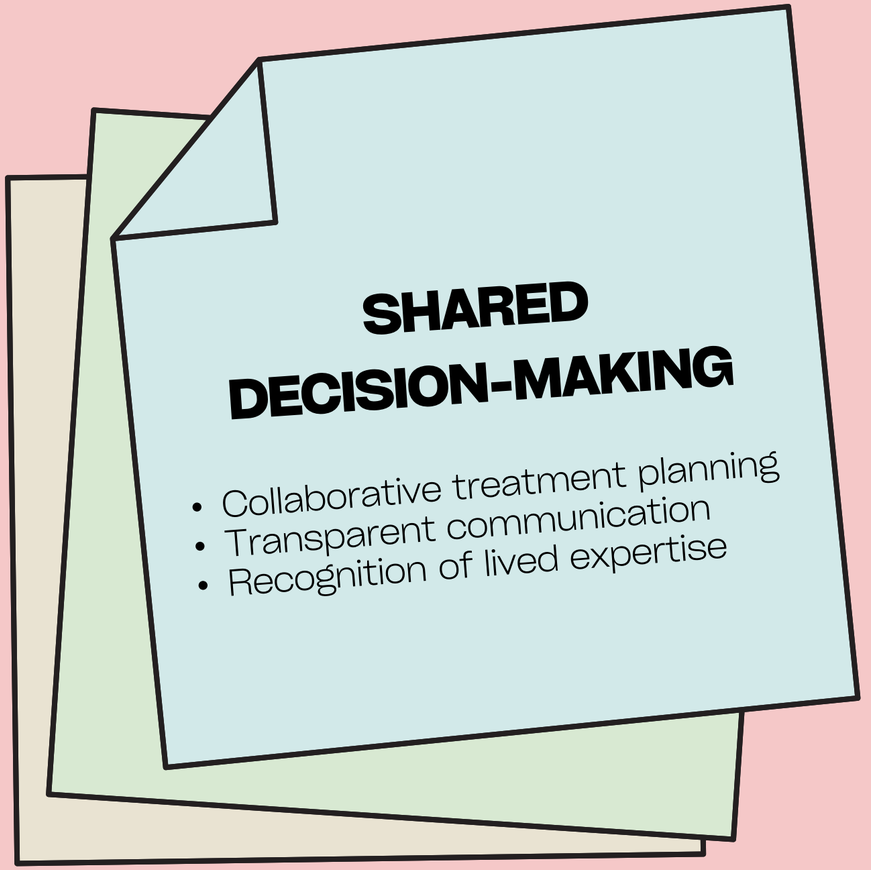
- Naloxone distribution
- Safer use education
- MOUD access
- Breastfeeding support when appropriate
- Nonjudgmental counseling
- Contraception discussions without coercion

Harm reduction is not incompatible with recovery
it is often the pathway that keeps people alive long enough to pursue recovery goals

ETHICAL FRAMEWORKS FOR DECISION-MAKING

ETHICAL PRINCIPLES

- **Autonomy**
  - Respecting patient choice and bodily autonomy
- **Beneficence**
  - Acting in the patient's best interest
- **Nonmaleficence**
  - Avoiding policies or interventions that increase harm
- **Justice**
  - Ensuring equitable and non-discriminatory care



TRAUMA-INFORMED CARE IN PERINATAL SETTINGS

CORE PRINCIPLES

- Safety
- Trustworthiness
- Peer support
- Collaboration
- Empowerment
- Cultural humility

WHY IT MATTERS?

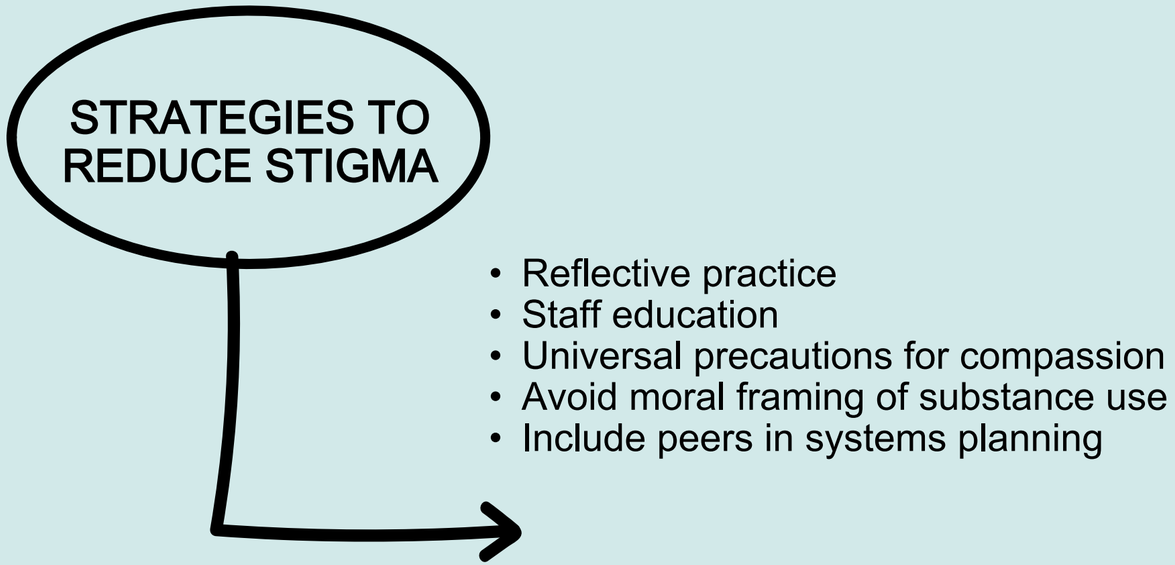
- Childhood trauma
- Intimate partner violence
- Medical trauma
- Child welfare trauma
- Criminal legal system involvement

Trauma-informed care is not a checklist
it is a shift in how providers interpret behaviors and build relationships

REDUCING STIGMA IN CLINICAL PRACTICE

STIGMATIZING LANGUAGE VS PERSON-CENTERED LANGUAGE

- **Addict/Alcoholic**
  - Person with substance use disorder
- **Clean/dirty**
  - Negative/positive toxicology
  - Presence or Absence of
- **Failed treatment/Relapse**
  - Return to use or Recurrence
- **Drug-seeking**
  - Expressing unmanaged symptoms
- **AMA**
  - Patient directed discharge
- **Addicted baby/NAS baby**
  - baby born exposed



PSYCHOLOGICAL SAFETY AND SUSTAINED ENGAGEMENT

PATIENTS STAY ENGAGED WHEN THEY FEEL

- Heard
- Respected
- Emotionally Safe
- Included in Decisions
- Supported During Setbacks

PRACTICAL ENGAGEMENT STRATEGIES

- Flexible communication methods
- Consistent care teams
- Postpartum outreach
- Family-inclusive support when appropriate
- Non-punitive return-to-care policies

THE POSTPARTUM PERIOD
A CRITICAL WINDOW

INCREASED RISKS POSTPARTUM

- Overdose risk
- Mental health destabilization
- Loss of insurance coverage
- Sleep deprivation
- Isolation
- CPS involvement stressors

CONTINUITY OF CARE STRATEGIES

- Extended postpartum support
- Ongoing MOUD access
- Integrated pediatric -maternal visits
- Home visiting programs
- Peer follow -up support
- Mental health monitoring

ALIGNING CLINICAL PRACTICES WITH OUTCOMES

STRONG SYSTEMS IMPROVE:

Prenatal care engagement
MOUD retention
Maternal mental health
Breastfeeding rates
Family stability
Reduced overdose risk
Reduced NICU length of stay
Long-term maternal -child outcomes

Let’s be safe spaces for
the brave stories of women

Thank You!

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