SUBSTANCE USE AND MATERNAL HEALTH:

Childbirth and Early Postpartum

Supporting recovery, bonding, and the transition to motherhood

The period surrounding childbirth and the first 6 to 12 weeks after delivery is a critical time for the health and well-being of both mother and baby.[1] Because childbirth brings most women in Iowa into contact with the healthcare system, it serves as a crucial touchpoint for identifying health concerns and connecting families with care, services, and recovery supports. This can be especially important for women with a history of substance use who may have had limited prenatal care or inconsistent healthcare engagement during pregnancy.[1]

> ***Childbirth is a critical touchpoint for connecting with moms and building pathways to care, resources, and support.***[1]

Becoming a parent can be a powerful source of resilience, motivation, and purpose in recovery.[2] The childbirth and early postpartum period offers an important opportunity to support moms and babies through trauma-informed, recovery-oriented care.[3]

Risks During Childbirth and Early Postpartum Period

Women with a history of substance use may face elevated risks during childbirth and the first weeks after delivery, including:

- **Severe obstetric complications during and around delivery** such as placental abruption, postpartum hemorrhage, preeclampsia, preterm birth, and cardiovascular complications. [4,5]
- **Missed or untreated health concerns and conditions**, which could have gone undetected if the mom had delayed or inconsistent prenatal care.[1,6]
- **Increased vulnerability during the early postpartum period** to mental health difficulties, return to substance use, overdose, and postpartum mortality.[1]
- **Higher rates of complications and readmissions to the hospital after delivery**, which may indicate serious health issues such as infection, cardiovascular events, psychiatric crises, overdose, or other unmet health needs. [7,8]
- **Increased health risks for their babies around childbirth** include respiratory complications, low birth weight, preterm birth, and stillbirth.[6] The early days of the child's life may involve Neonatal Abstinence Syndrome (NAS) or Neonatal Opioid Withdrawal Syndrome (NOWS). Some infants may also require extended stays in the Neonatal Intensive Care Unit (NICU), requiring rural families to travel for specialized care and spend time away from home and existing support systems.[9]

> ***In Iowa, 95% of pregnancy-related deaths between 2019-2021 were preventable.***[10]

Barriers & Challenges

Many women with a history of substance use enter childbirth carrying experiences of trauma, intimate partner violence, stigma, and previous negative encounters with healthcare systems, all of which shape how they experience labor, hospitalization, and postpartum care.[11,12,13] Rather than viewing the hospital as a place of support, some mothers arrive worried that they will be judged, punished, or separated from their baby. Mothers report being reluctant to disclose substance use because they fear harsh treatment, criminal consequences, or involvement with Child Protective Services.[12]

These fears are not unfounded. A 2017 study of Iowa hospitals found that nearly 87% reported positive newborn drug tests to Child Protective Services, yet only 35% reported informing mothers that a report had been made.[14] Against this backdrop, mothers describe feeling terrified when separated from their infants, even for routine medical procedures.[12] Trust can also be strained when women feel excluded from decisions about their own care or their infant's care.[2,12]

During labor and the early postpartum period, women with a history of substance use often report concerns that their pain will not be taken seriously or adequately treated.[12,15] Some mothers have described lower-quality postpartum care, being discouraged from holding their baby, or receiving limited information about their infant's condition and care.[3] Yet mothers consistently express a strong desire to care for, bond with, and advocate for their babies, and many describe motherhood as a powerful source of motivation in recovery.[2,12] Those efforts can become more challenging when families are navigating NICU stays, NAS/NOWS, breastfeeding difficulties, or concerns about their infant's health.[2,9,16] For rural Iowa families, extended NICU stays may also require travel away from home and existing support networks, creating additional stress during an already vulnerable time.

Support for moms often decreases just as new challenges emerge. After discharge, many mothers experience a sudden drop in healthcare contact and other supports while managing recovery, physical healing, sleep deprivation, infant care, and mental health needs.[17,18] Although childbirth can be a stigmatizing experience, it is also a powerful opportunity to build trust, strengthen parent-infant relationships, connect families to care, and support long-term recovery and wellbeing for both mothers and babies.

Key Takeaway: Childbirth is a critical touchpoint and opportunity to identify screen for concerns, strengthen recovery supports, and connect Iowa mothers and families with needed services. Women with a history of substance use may face increased risks of medical complications, mental health challenges, and disruptions in support during childbirth and the early postpartum period. Providing trauma-informed and recovery-supportive care can strengthen recovery and improve outcomes for both moms and babies.

Making informed breastfeeding decisions

Empowering moms with individualized support

Breastfeeding decisions are personal and should be made with the support of knowledgeable, nonjudgmental healthcare professionals. A history of substance use does not automatically mean breastfeeding is unsafe, but recommendations may vary depending on the substances involved and the mother's circumstances.[19,24]

Breastfeeding can support mother-infant bonding and may improve outcomes for infants experiencing NAS/NOWS, including reduced need for pharmacologic treatment and shorter hospital stays when appropriate and safe.[2,19,24] However, infant medical needs, recovery-related challenges, extended NICU stays, and inconsistent support can complicate breastfeeding goals.[9,16]

Mothers with a history of substance use frequently report a lack of breastfeeding support.[12,16] Providing individualized, evidence-based guidance and reinforcing mothers' confidence and self-efficacy can support both breastfeeding and recovery goals.[2,24]

**Note: Clinical guidance evolves over time, and healthcare should be tailored to the individual patient. Providers should consult the American College of Obstetricians and Gynecologists (ACOG) for the most up-to-date recommendations.*

Policy and Practice Recommendations	
Implement universal screening for all moms at childbirth to identify potential vulnerabilities and needs. Connect families with support before they leave the hospital.[10,11,17,18,19,20]	Screening all patients identifies who may need support for substance use disorders, mental health concerns, safety risks, and practical barriers to care. Use evidence-based approaches such as **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**, which combines substance use screening with referral to appropriate resources. Families should leave the hospital with concrete connections to the services, recovery supports, and community resources that best match their identified needs.
Keep mothers and newborns together, whenever medically safe, by 'rooming-in' and encouraging family-centered newborn care.[2,9,21,22]	**Rooming-in and the Eat, Sleep, Console (ESC) model are evidence-based interventions** that promote mother-infant bonding and improve outcomes, particularly for opioid-exposed infants. Keeping mothers and newborns together and actively involving caregivers in feeding, soothing, skin-to-skin contact, and daily care is associated with reduced need for medication treatment and shorter hospital stays. If temporary separation is necessary, providers should clearly explain why it is happening and when the infant can return.
Use trauma-informed, patient-centered approaches that build trust and keep patients engaged in care.[3,9,12,13,23]	Trauma-informed practices like clear communication, patient choice, transparency, and respectful, nonjudgmental care can help build trust, improve engagement, and create a safer environment for mothers to discuss concerns and accept support.
Create a discharge plan that promotes continuity of care, recovery support, and overdose prevention through the first 12 weeks postpartum.[1,7,8,17,18,19]	Service providers should work with families to confirm follow-up appointments, address practical barriers such as transportation, and establish integrated plans for continuing substance use treatment. Before discharge, connect families with appropriate resources and services like peer support, medication-assisted treatment, or naloxone for overdose prevention before discharge.

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