Substance Use and Pregnancy

Opportunities for change, support, and recovery

Pregnancy is a critical window of opportunity to support recovery from substance use and a time of elevated risk.[1] Many women report increased motivation to stop using substances during pregnancy, driven by concern for their baby and their emerging identity of who they want to be as a mother.[1,2]

At the same time, this life stage transition can be challenging to navigate. Alongside their efforts to overcome substance use, many pregnant women also struggle with mental health challenges, limited access to care that meets their needs, unstable environments, and growing tension between their past substance use and their emerging identity as a mother. These competing pressures mean that while pregnancy can act as a key motivator and catalyst for change, the road to recovery for pregnant women is not without its challenges.

> Substance use is a leading cause of pregnancy-associated death, and rates of substance use during pregnancy continue to rise.
>
> *Haffajee et al., 2022; Campbell et al., 2021*

Risk Factors and Harms of Substance Use During Pregnancy

Substance use is associated with significant risks for both moms and babies during pregnancy. These risks include:

- Escalation of existing health conditions. Individuals with a history of substance use often enter pregnancy with existing health conditions that can be exacerbated by pregnancy, in addition to having an increased risk for additional pregnancy-related complications.[5,6]
- Increased likelihood of severe maternal morbidity and pregnancy complications (e.g., infections like sepsis, cardiovascular conditions, hypertensive disorders).[7]
- Worsening mental health symptoms, particularly when substance use has served as a coping mechanism for trauma.[8]

- Higher risk of complications for the developing baby, including preterm birth, low birth weight, fetal growth restriction, stillbirth, and increased likelihood of requiring care by a neonatal intensive care unit (NICU).[6] If substance use occurs during pregnancy, there is also a risk of substance-specific conditions, such as fetal alcohol spectrum disorders and neonatal opioid withdrawal syndrome.

While many women reduce or stop substance use during pregnancy, not all are able to do so.[9] Often, continued use during pregnancy is connected to ongoing risk factors. Understanding these factors is critical to identifying patients who may benefit from additional support. Key risk factors for continued use throughout pregnancy include frequent or heavy substance use prior to pregnancy, co-occurring mental health conditions (including depression, anxiety, and PTSD), and spending time in social environments that favor substance use, such as having a partner or household members who use substances.[8]

Stopping substance use during pregnancy improves outcomes for mom and baby, especially when cessation of use is during the early weeks of pregnancy.[6] However, even when women find recovery during pregnancy, it doesn't eliminate the risk ofcomplications. Hence the continued need for timely, evidence-based treatment and ongoing care.

Challenges & Barriers for Pregnant Women

Despite increased motivation to seek care during pregnancy, many women with a history of substance use face significant barriers to accessing prenatal care and treatment. Experiences of stigma, fear of negative consequences, and prior negative interactions with healthcare systems can make it difficult to disclose substance use or seek help.[2] **Some women report delaying or avoiding prenatal care due to concerns about being reported to child welfare or law enforcement**, which can result in missed opportunities for early intervention.[10]

A lack of knowledge about support for overcoming substance use during pregnancy further complicates this process. Many pregnant women are not aware of the full range of safe and effective treatment options available to them, including evidence-based approaches to support recovery during pregnancy. At the same time, healthcare providers may lack training or confidence in treating substance use during pregnancy, contributing to inconsistent care, negative interactions, and missed opportunities to connect patients with appropriate support.[11,12]

Even when women are ready and motivated to seek treatment, barriers still limit access. Barriers might include difficulty finding programs that accept pregnant women, limited availability in rural areas, and practical challenges such as transportation, childcare, and program requirements.[11] **Together, these factors highlight a gap between the desire for support during pregnancy and the ability to access care that meets patients' needs.**

MOUD and Pregnancy

An evidence-based recovery support for pregnant women

MOUD is the standard of care for substance use in pregnancy. A growing evidence base shows that medications for opioid use disorder (MOUD) are the recommended treatment and are associated with improved outcomes for both mom and baby.[13,14]

MOUD is safer and more effective than withdrawal. Compared with medically supervised withdrawal, MOUD is associated with higher treatment retention, reduced risk for return to use, and better overall maternal–infant outcomes. [13,15] Certain medications like buprenorphine are associated with less severe neonatal opioid withdrawal syndrome (NOWS), but changing medications during pregnancy is generally not recommended. [13,15,16]

Misinformation and barriers limit the use of MOUD for pregnant women. Confusion about safety among patients and providers, along with persistent stigma, contributes to underuse of MOUD in pregnancy. **Although it is the recommended standard of care, studies show that only about 50% of pregnant individuals with opioid use disorder receive MOUD.**[17] Access varies across populations, with some groups being less likely to get access to MOUD, including individuals in rural areas, certain racial groups, and people referred through the criminal justice system. [16,17]

**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

Provide non-stigmatizing, patient-centered care	People should have the opportunity to disclose their history with substance use to their healthcare provider without fear of punishment or judgment.
Expand access to comprehensive, evidence-based treatment	Medications for Opioid Use Disorder (MOUD) is an effective treatment for pregnant and postpartum individuals, and should be widely available.
Ensure universal screening for substance use during pregnancy	Employing screening tools like SBIRT and 4 P's is different than drug testing. Screening during pregnancy can help identify women struggling with substance use who can then be referred to appropriate supports.
Increase provider training and guidance on substance use in pregnancy	Misinformation and gaps in training can limit access to appropriate care during pregnancy. Training should include trauma-informed care, safe treatment approaches, and non-stigmatizing communication.
Establish more treatment and recovery programs that accommodate pregnant and parenting women	Expanding treatment options tailored to the needs of pregnant women should be paired with efficient referral and placement systems to improve access to care.
Support integrated, interprofessional, whole-person care models	Comprehensive, team-based approaches help people access and sustain recovery during pregnancy by connecting them with medical care, behavioral health supports, and social services in one place.
Promote policies that reduce legal and child welfare consequences for people seeking support	Fear of arrest or loss of custody can prevent pregnant women with a history of substance use from accessing prenatal care. Supportive policies can improve outcomes for moms and babies.

Works Cited

1. Arabin, B., & Baschat, A. A. (2017). Pregnancy: An underutilized window of opportunity to improve long-term maternal and infant health—An appeal for continuous family care and interdisciplinary communication. *Frontiers in Pediatrics, 5*(69). https://doi.org/10.3389/fped.2017.00069
2. Frazer, Z., McConnell, K., & Jansson, L. M. (2019). Treatment for substance use disorders in pregnant women: Motivators and barriers. *Drug and Alcohol Dependence, 205*, Article 107652. https://doi.org/10.1016/j.drugalcdep.2019.107652
3. Haffajee, R. L., Faherty, L. J., & Zivin, K. (2021). Pregnant women with substance use disorders: The harm associated with punitive approaches. *The New England Journal of Medicine, 384*(25), 2364-2367. doi: 10.1056/NEJMp2101051
4. Campbell, J., Matoff-Stepp, S., Velez, M. L., Cox, H. H., & Laughon, K. (2021). Pregnancy-associated deaths from homicide, suicide, and drug overdose: Review of research and the intersection with intimate partner violence. *Journal of Women's Health, 30*(2), 236–244. https://doi.org/10.1089/jwh.2020.8875
5. Edelson, P. K., & Bernstein, S. N. (2019). Management of the cardiovascular complications of substance use disorders during pregnancy. *Current Treatment Options in Cardiovascular Medicine, 21(*73). https://doi.org/10.1007/s11936-019-0777-5
6. Jiménez-Fernández, A. A., Grajeda-Perez, J. A., García-Alcázar, S. de la P., Luis-Díaz, M. G., Granada-Chavez, F. J., Peña-Durán, E., García-Galindo, J. J., & Suárez-Rico, D. O. (2025). Drugs, mother, and child—An integrative review of substance-related obstetric challenges and long-term offspring effects. *Drugs and Drug Candidates, 4*(40). https://doi.org/10.3390/ddc4030040
7. Jarlenski, M., Krans, E. E., Chen, O., Rothenberger, S. D., Cartus, A., Zivin, K., & Bodnar, L. M. (2020). Substance use disorders and risk of severe maternal morbidity in the United States. *Drug and Alcohol Dependence, 216*, 108236. https://doi.org/10.1016/j.drugalcdep.2020.108236
8. Kruger, E. S., Rodriguez, A., Leeman, L., & Sanjuan, P. M. (2025). Prenatal substance use and mental health comorbidities predict continued use. *Psychology of Addictive Behaviors, 39*(3), 301–310. https://doi.org/10.1037/adb0001017
9. Peltier, M. R., Roberts, W., Verplaetse, T. L., Burke, C., Zakiniaeiz, Y., Moore, K., & McKee, S. A. (2022). Licit and illicit drug use across trimesters in pregnant women endorsing past-year substance use: Results from National Survey on Drug Use and Health (2009–2019). *Archives of Women's Mental Health, 25*(4), 819–827. https://doi.org/10.1007/s00737-022-01244-6
10. Nidey, N., Kair, L. R., Wilder, C., Froehlich, T. E., Weber, S., Folger, A., Marcotte, M., Tabb, K., & Bowers, K. (2022). Substance use and utilization of prenatal and postpartum care. *Journal of Addiction Medicine, 16*(1), 84-92. 10.1097/ADM.0000000000000843
11. Apsley, H. B., Brant, K., Brothers, S., Harrison, E., Skogseth, E., Schwartz, R. P., & Jones, A. A. (2024). Pregnancy- and parenting-related barriers to receiving medication for opioid use disorder: A multi-paneled qualitative study of women in treatment, women who terminated treatment, and the professionals who serve them. *Women's Health, 20*. https://doi.org/10.1177/17455057231224181
12. Renbarger, K. M. (2024). Factors influencing maternal substance use and recovery in the perinatal period. *Western Journal of Nursing Research, 46*(9), 725–737. https://doi.org/10.1177/01939459241266736
13. American College of Obstetricians and Gynecologists. (2017). Opioid use and opioid use disorder in pregnancy [Committee Opinion 711]. *Obstetrics & Gynecology, 130*(2), 81-94. doi:10.1097/AOG.0000000000002235
14. Substance Abuse and Mental Health Services Administration. (2018). *Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants, HHS Publication No. 18-5054.* https://library.samhsa.gov/sites/default/files/sma18-5054.pdf
15. Henkhaus, L. E., Buntin, M. B., Hendersen, S. C., Lai, P., & Patrick, S. W. (2022). Disparities in receipt of medications for opioid use disorder among pregnant women. *Substance Abuse, 43*(1), 508–513. https://doi.org/10.1080/08897077.2021.1949664
16. Curran, L., & Manuel, J. (2024). The receipt of medications for opioid use disorder among pregnant individuals in the USA: A multilevel analysis. *Drugs, Habits and Social Policy, 25*(1), 51–66. https://doi.org/10.1108/DHS-08-2023-0030

Suggested Citation

Johnson, M., Dorius, S., Van Selous, K., & Hlavacek, A. (2026). *Substance use and pregnancy: An opportunity for change, support, and recovery*. Public Science Collaborative. https://recovery-iowa.org/substance-use-and-pregnancy

This project is supported by State Opioid Response funds through the Iowa Department of Health and Human Services, Bureau of Substance Use (IowaHHS) via a subaward from the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, IowaHHS, SAMHSA/HHS, or the U.S. Government.