Mother & Baby Substance Exposure Toolkit

Best Practice No. 9

A part of the California Medication Assisted Treatment Expansion Project

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Encourage breastfeeding for women with opioid use disorder

Best Practice No. 9

Outpatient, Labor and Delivery, Nursery/NICU, and Treatment

Overview

Women should feel empowered to make an informed decision about newborn feeding. Women should be given information about the benefits of breastfeeding, as well as information that addresses concerns specific to opioid use disorder (OUD) and breastfeeding.

Why we are recommending this best practice

The first few hours and days of a newborn's life constitute a critical window for establishing lactation. Breastfeeding confers many advantages on both mother and infant. The United States Surgeon General, World Health Organization (WHO), and American Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months unless contraindicated.

California State Bill (SB) 402, signed into law in 2013, states "This bill would require all general acute care hospitals and special hospitals that have a perinatal unit to adopt, by January 1, 2025, the 'Ten Steps to Successful Breastfeeding,' as adopted by Baby-Friendly USA, per the Baby-Friendly Hospital Initiative, or an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes, or the Model Hospital Policy Recommendations as defined."

Although a stable mother being treated for OUD with pharmacotherapy is encouraged to breastfeed her infant, there are some situations where breastfeeding is not recommended, including if the mother is HIV-positive, has active tuberculosis, has active herpes simplex lesions, is Hepatitis B or C-positive and has cracked or bleeding nipple(s), or has returned to illicit or inappropriate drug use.

HIV: In resource rich areas such as the United States, the CDC recommends AGAINST breastfeeding in mothers with HIV regardless of the viral load or treatment history.

Hepatitis B, Hepatitis C, Herpes Simplex: The CDC recommends breastfeeding for women with Hepatitis B infection when infants have been appropriately immunized with Hepatitis B Immunoglobulin and vaccine; and for women with Hepatitis C infection, as long as nipples are not cracked or bleeding. If the mother with Herpes Simplex Virus has lesions on the breast, or who has Hepatitis B or C and has cracked or bleeding nipples, the CDC recommends to temporarily stop nursing and to express and discard the breastmilk. When the nipple(s) are well-healed and no longer bleeding, the mother may return to breastfeeding. If only one side is affected, the mother may continue to breastfeed on the unaffected side.

Active (untreated) tuberculosis: The AAP recommends against breastfeeding in the setting of active, infectious tuberculosis. In this situation, expressed milk can still be given to the

newborn. Breastfeeding can resume after a minimum of 2 weeks of treatment for tuberculosis, and when the mother is documented to no longer be infectious.

Illicit or Inappropriate Drug Use*:* According to the AAP "maternal substance abuse is not a categorical contraindication to breastfeeding" and therefore well-nourished narcotic dependent mothers being treated for OUD with pharmacotherapy are encouraged to breastfeed in the absence of illicit drug use. Breastfeeding is contraindicated if "relapse" occurs, or a return to any illicit drug use or frequent legal substance misuse, especially if relapse has occurred in the 30-day period prior to delivery. Infrequent substance use, especially if outside of the 30-day window before delivery, may not necessarily be a contraindication to breastfeeding, but each woman must be carefully and individually evaluated for type of substance used, length of time since last use, and other risk factors. Refer to ABM Clinical Protocol #21 in the References section of this Best Practice for more detailed guidelines.

Strategies for Implementation

- **Develop breastfeeding protocol for women with OUD.** Create a multidisciplinary team ideally including obstetricians, midwives, family physicians, pediatricians, nurses, lactation specialists, pain/addiction specialists, pharmacists, and social workers to create a facility-specific protocol addressing the following topic areas:
  - Information for women with OUD and clinicians caring for them: Create user-friendly resources on the benefits of breastfeeding for women with OUD and their newborns and include important contraindications.
  - Develop a protocol for identification of women with OUD and mobilization of required resources to support breastfeeding, emphasizing best practices such as early skin-to-skin care.
  - Develop a plan for outpatient breastfeeding and newborn nutritional support. Develop a workflow to ensure pregnant patients with OUD are discharged with a plan to support breastfeeding and the overall nutrition for their newborns; this plan should include appropriate short interval pediatric follow-up, access to advice on lactation continuation, and access to local or online breastfeeding support resources.

- **Train the workforce on breastfeeding for women with OUD.** Educate physicians, nurses, and other care team members on the benefits of breastfeeding for women with OUD and institute multimodal strategies for implementation of developed protocols.
  - Educate clinical staff on the strength of evidence and criteria for safety of breastfeeding for women with OUD. Determine appropriate avenues through which to educate hospital staff (e.g., emails, physical bulletin boards, staff meetings) and mitigate discrimination and bias toward patients with OUD.
  - Train providers on OUD treatment protocols. Create standards for providers caring for pregnant patients to provide information relevant to breastfeeding decisions and ask questions about the mother's concerns and barriers surrounding breastfeeding.

- **Implement quality improvement strategies to improve breastfeeding in women with OUD:** Create process metrics that allow for regular evaluation of facility-based

breastfeeding support protocols.

- Define target metrics for breastfeeding in OUD. Develop facility-specific metrics for tracking implementation and effectiveness of the breastfeeding program for women with OUD, including measurement of initiation and continuation of breastfeeding.
- Delineate role(s) for OUD treatment assessment and improvement. Designate either an individual or a team to take accountability for ongoing facility-level assessment and improvement of metrics for breastfeeding in women with OUD.

Baby M

As soon as Baby M is born, the maternity nurse asks if she can place him on Kayla skin-to-skin. Although Kayla had been unsure about breastfeeding, with encouragement from the nurse with whom she has begun to establish a trusting relationship, she decides to place Baby M on the breast. This makes Kayla feel happy and helps her bond with Baby M. She feels that she can soothe his cries by breastfeeding.

Breastfeeding is beneficial for the health of both the mother and newborn. It reduces the risk of infection, immune mediated disorders, and obesity in the newborn; and it reduces the risk of postpartum hemorrhage, hypertension, diabetes, and breast and ovarian cancer in the mother. In newborns at risk for NAS, breastfeeding reduces the need for pharmacologic treatment. The process of breastfeeding stimulates the release of oxytocin. Oxytocin induces the dopaminergic pathway of the reward system, which mediates a mother's behavioral response to her newborn's cues, promoting bonding and attachment between mother and newborn. Supporting breastfeeding in a woman with OUD empowers her to provide the best care for her newborn. The reward and stress response pathways may be altered in women with OUD, making it especially important that providers promote breastfeeding in this vulnerable population to optimize emotional and behavioral outcomes for both mother and newborn.

While promoting breastfeeding and skin-to-skin care, it is important to emphasize safe sleep methods. If a mother is fatigued or too sleepy to safely hold her newborn, she should lay the newborn on its back on a firm sleeping surface to decrease the risk of sudden infant death syndrome.

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Dr. Martha Tesfalul is currently a Maternal-Fetal Medicine Fellow at at the University of California, San Francisco. Having served as the Quality Improvement (QI) Chief in her final year of residency, she has a professional interest in health systems strengthening and health equity. She has received local, regional and national recognition for her efforts in clinical care, education, and research including awards from the Pacific Coast Obstetrical and Gynecological Society and the Foundation for the Society for Maternal-Fetal Medicine. In addition to her commitment to improving the care of pregnant patients in California, Dr. Tesfalul engages in QI-focused research in in the East African country Eritrea.

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Mimi Leza is the Perinatal Services Coordinator for Ventura County Public Health and currently the co-chair of the Perinatal Substance Use Taskforce of Ventura County. Her background is in Pediatric nursing with extensive experience in caring for NICU babies with NAS and children with prenatal substance use exposure. As a Public Health Nurse, she specialized in providing case management for pregnant and parenting women with SUD and recruiting and training perinatal providers in the SBIRT process.

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Dr. Pamela Flood is Professor of Anesthesiology, Perioperative, and Pain Medicine at Stanford University. Her research interests include prevention and reduction of pain and opioid use in women after delivery. She divides her clinical time between labor and delivery and her outpatient pain management clinic. She clinical work is directed toward compassionate weaning of high dose opioids and management of pelvic pain syndromes.