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The Right to Mother's Milk: A Call for Social Justice That Encourages Breastfeeding for Women Receiving Medication-Assisted Treatment for Opioid Use Disorder

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Inequitable access to mother's milk represents a social injustice with the potential to negatively impact the health and well-being of future generations (Jones, Power, Queenan, & Schulkin, 2015). Mother's milk is globally accepted as the optimal source of infant nutrition, yet breastfeeding initiation and duration rates among minority populations (e.g., women with opioid use disorders [OUDs]) continue to lag those of the general population (Demirci, Bogen, & Klionsky, 2015). For example, 56% of women receiving medication-assisted treatment (MAT) for an OUD initiate breastfeeding (Schiff et al., 2018) compared to the national initiation rate of 82% (Centers for Disease Control and Prevention [CDC], 2017). Further, only 50% of mothers receiving MAT for an OUD who initiate breastfeeding continue beyond the first week of life (Demirci et al., 2015; Wachman, Byun, & Phillip, 2010). These numbers reflect some of the lowest breastfeeding rates in the United States (Demirci et al., 2015).

Considering the current U.S. opioid crisis and its increasing influence on women of reproductive age (CDC, 2015), women with an OUD and their infants represent an emerging disparate population that may have inequitable access to breastfeeding and the benefits of mother's milk. More than 50 years of evidence now exists to support the safety and benefits of MAT, particularly the use of methadone, during pregnancy and lactation (Sachs, 2013); however, a delay in the implementation of this evidence into clinical practice continues (McGlothen, Cleveland, & Gill, 2017). Therefore, this policy paper serves as a call for social justice with the intent of empowering lactation support providers to advocate for the use of scientific evidence that informs breastfeeding practices for women receiving MAT for an OUD.

OUD is a serious global health concern (National Institute on Drug Abuse [NIDA], 2014) with an estimated 15 million people experiencing opioid dependence worldwide (*Information Sheet on Opioid Overdose*, 2014). As a result of the current U.S. opioid crisis, the rate of opioid use among American women has doubled since 2004 (NIDA, 2014) and has also had an influence on pregnant women and their infants. It is estimated that 21,000 pregnant, American women misuse opioids annually (Smith & Lipari, 2017). Prenatal opioid use can contribute to numerous pregnancy complications (e.g., placental abruption, preterm birth, and low birth weight) (Minozzi, Amato, Bellisario, Ferri, & Davoli, 2013).

Medically supervised opioid detoxification during pregnancy is not recommended since it can contribute to high rates of maternal relapse into opioid use and risk for overdose due to the reduction in opioid tolerance that results from detoxification (American College of Obstetricians & Gynecologists [ACOG], 2017). Thus, stabilization of pregnant, opioid-dependent women, with the long-acting opioids methadone or buprenorphine, is considered the standard of care (ACOG, 2017). Further, pregnant opioid-dependent women who are stabilized on MAT tend to receive more consistent prenatal care, have better nutrition, and experience more positive pregnancy outcomes (Cleveland, Paradise, Borsuk, Courtois, & Ramirez, 2015; Jones et al., 2013).

Although MAT during pregnancy is considered the standard of care for this population of women, neonatal abstinence syndrome (NAS) may still result from in utero exposure to medications used for MAT. NAS is a predictable

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and manageable group of withdrawal symptoms observed in infants who have been prenatally exposed to opioids (Cleveland, 2017–2019; Reece-Stremtan & Marinelli, 2015). Common symptoms of NAS are (a) feeding difficulties; (b) irritability; (c) an inconsolable, high-pitched cry; (d) fever; and (e) poor weight gain (Cleveland, 2017–2019; Reece-Stremtan & Marinelli, 2015). Mother's milk has been shown to decrease the severity of these symptoms (Bagley, Wachman, Holland, & Brogly, 2014).

Infants with NAS who receive mother's milk experience a shorter and less costly hospital stay than infants receiving other sources of nutrition (Bagley et al., 2014). Further, providing mother's milk results in a reduction in infants' Modified Finnegan Neonatal Abstinence Syndrome Tool (MFNAST) scores, an assessment instrument used to quantify the severity of NAS symptoms (Isemann, Meinzen-Derr, & Akinbi, 2011). Mother's milk also has been found to reduce the need for pharmacologic intervention to control infants' withdrawal symptoms with medications including morphine, methadone, or buprenorphine (Welle-Strand et al., 2013). While the evidence in support of mother's milk for infants with NAS is compelling, lack of provider and treatment team awareness of the current recommendations regarding breastfeeding and MAT may influence the level of support and anticipatory guidance that women receive during the perinatal period (Hicks, Morse, & Wyant, 2018).

Women with OUDs face many of the same barriers to breastfeeding as other women, including (a) lack of family support, (b) inadequate lactation education, (c) limited access to lactation support services, and (d) perceived milk insufficiency (Demirci et al., 2015; Hicks et al., 2018; McGlothen et al., 2017). However, women in this population are more acutely affected by these barriers and experience additional barriers that are unique to their disorder (McGlothen et al., 2017). For example, women with OUDs express apprehension about the safety of their milk while receiving MAT and describe inconsistent and non-evidence-based institutional policies and practices that negatively influence their initiation and duration of breastfeeding (McGlothen et al., 2017). These inconsistencies create additional barriers for mothers who are attempting to establish a strong attachment with their infants in the early days following birth (Cleveland, Bonugli, & McGlothen, 2017; Cleveland & Gill, 2013). Further, some women have explained that these mixed messages may even discourage them from visiting their infants in the hospital (Cleveland & Bonugli, 2014). This type of messaging may influence the emotional well-being of mothers who have explained that providing their milk allowed them to "atone" for the guilt and shame they felt for having exposed their infants to opioids (Demirci et al., 2015; McGlothen et al., 2017).

Since the evidence supporting breastfeeding for women receiving MAT for an OUD is strong, numerous professional health organizations have published position statements and practice briefs endorsing breastfeeding in this population, when no other contraindications exist. These organizations include the (a) American Academy of Pediatrics (Sachs, 2013), (b) ACOG (2017), (c) Academy of Breastfeeding Medicine (Reece-Stremtan & Marinelli, 2015), and (d) Association of Women's Health, Obstetric, and Neonatal Nurses (Cleveland, 2016). Thus, International Board-Certified Lactation Consultants (IBCLC) are well positioned to provide clinical expertise and advocacy for this population of women and infants. Further, mothers with OUDs desire greater breastfeeding assistance and may seek out lactation professionals to aid in prenatal and postpartum education about breastfeeding and lactation management (Demirci et al., 2015; McGlothen et al., 2017). They value the expertise of lactation support providers and maternal-newborn nurses and view these professionals as trusted sources of information (McGlothen et al., 2017).

In 2011, the International Lactation Consultants' Association (ILCA) issued the position paper *The Role and Impact of the IBCLC* (Henderson, 2011). The purpose of this paper was to provide an evidence-based advocacy document defining the role and influence of the IBCLC. The authors emphasized the unique knowledge and invaluable role of IBCLCs in healthcare. They further underscored the IBCLC's influence on breastfeeding management and success and the affect this has on mother–infant dyads, families, and society. Just as the profession has worked to lift the voices of breastfeeding advocates and justify the role of IBCLCs, we must now continue to advocate for the voices of this minority population of women and infants.

Although OUD is recognized as a chronic illness (American Society of Addiction Medicine, 2017), stigma remains a substantial barrier to breastfeeding and access to lactation management (Demirci et al., 2015; McGlothen et al., 2017). Pregnant and parenting women are at risk for stigmatization due to the issues of morality surrounding motherhood (McGlothen et al., 2017). Additional barriers to seeking lactation management include healthcare providers with limited obstetrical and addiction treatment expertise and fear of criminal or child welfare consequences (McGlothen et al., 2017).

Moreover, current U.S. medical guidelines and varying state legislation may impede this minority population of women from accessing lactation assistance due to punitive laws. For example, over the last several decades, numerous U.S. states have passed laws or applied existing laws to criminalize substance use during pregnancy (Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2015; Guttmacher Institute, 2014). Four states now mandate that healthcare professionals test for prenatal drug exposure, and 18 states require them to report suspected prenatal use of illicit substances to Child Welfare. In these states, substance use during pregnancy is considered child abuse under civil child-welfare statute (Guttmacher Institute, 2014; Saia et al., 2016).

The influences of punitive policies on low-income women and women of color must be considered carefully (Bishop

et al., 2017). In the context of racially discriminatory practices that have inundated broader drug policies in the United States, minority populations of pregnant women are disproportionately affected by profiling, criminalization, and punitive policies (Bishop et al., 2017; Drug Policy Alliance, 2016). Legislation that criminalizes drug use during pregnancy may discourage women from seeking care, including prenatal services and effective SUD treatment when needed (Bishop et al., 2017), further jeopardizing pregnancy outcomes and negatively impacting breastfeeding.

Therefore, this paper is a call for IBCLCs and other lactation support providers to advocate for the right to breastfeed for women receiving MAT for OUDs, as an act of social justice. Breastfeeding is a personal, gendered experience and should be viewed as a health and reproductive right of mothers and their infants. All infants should have the right to mother's milk despite moral conflicts society may have with maternal behaviors (Bronson, 2017). Yet practices on OUD during pregnancy and breastfeeding remain inconsistent among healthcare settings across the United States (Holmes, Schmidlin, & Kurzum, 2017). This lack of consistency serves to further disenfranchise mothers with OUDs and denies them agency to breastfeed their infants.

Implementation of structured breastfeeding programs results in greater breastfeeding initiation, exclusivity, and duration among the general population, as well as opioid-using women (Beake, Pellowe, Dykes, Schmied, & Bick, 2012; Pritham, 2013). For example, early mother–infant skin-to-skin contact has been shown to increase breastfeeding initiation and duration as well as facilitate bonding (Moore, Bergman, Anderson, & Medley, 2016). Researchers have demonstrated similar findings in opioid-exposed mother–infant dyads (Pritham, 2013). Further, like the general population, rooming-in of opioid-exposed mother–infant dyads has resulted in better breastfeeding success (Holmes et al., 2016) since early postpartum separation may have a lasting effect on attachment and breastfeeding initiation rates (Pritham, Paul, & Hayes, 2012). While these findings are promising, additional research is needed to address the unique needs of breastfeeding, opioid-using women. Thus, healthcare systems and policymakers must work collaboratively to tailor the care of this minority population of women and infants and ensure that supportive practices and protocols are established to address their needs.

With that said, the Academy of Breastfeeding Medicine (Reece-Stremtan & Marinelli, 2015) recommends the use of a standard policy or protocol to determine when mothers should be encouraged to breastfeed. This breastfeeding authority recommends that breastfeeding eligibility be conditionally based upon a negative maternal history of drug use during the 30-day period prior to delivery, rather than on the half-life of substances used and their potential risks to the nursing infant. There is no scientific evidence to support this recommendation, which seems punitive and implies that the mother must prove herself to earn the right to breastfeed her infant. Opioid use relapse rates are high (ACOG, 2017); however, the half-life of heroin and most prescription opioids is somewhere between 4 and 48 hours (Stover & Davis, 2015), not 30 days. Therefore, additional research is needed to support the establishment of reasonable practices and policies for use in the case of maternal relapse.

Ultimately, women need to be counseled on the risks and benefits of breastfeeding, as they relate to their specific substance use (Reece-Stremtan & Marinelli, 2015). If necessary, a provider specializing in addiction science could be consulted. Further, representation from lactation support providers is essential as part of multidisciplinary teams caring for opioid-affected mother–infant dyads, as they can provide a wealth of knowledge specific to individual dyad needs (Henderson, 2011). Open dialogue between the mother and her healthcare provider supports an optimal environment for shared decision-making regarding infant feeding. As the voice of those affected is often absent in both policy development and the development of targeted approaches to care, mothers should also play an important role in determining those outcomes of importance in both research and routine care, including breastfeeding management (Kelly et al., 2016).

Without evidence-based policies, healthcare professionals are ill-equipped to manage breastfeeding for mothers receiving MAT. Further, local and state agencies and healthcare providers must work together to identify gaps in community resources to address the needs of this minority population (Stoller, Stephens, & Schorr, 2016; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Policies at the state and local level should reflect community needs and be grounded in evidence rather than outdated, stigma-laden, beliefs about MAT. Finally, lactation support providers need to be familiar with services for opioid-using women and work collaboratively with the interprofessional team when policies are being created that influence breastfeeding mothers with OUD.

Lactation support providers can positively affect the health of societies through education, support, and participation in the development of policies and protocols that challenge current practice. Special attention should be focused on the intersection of oppression and structural and contextual conditions that lead to inequities in infant feeding policies across diverse populations. Further, policies that support breastfeeding in mothers receiving MAT for an OUD are essential for addressing stigma. Thus, the expertise of IBCLCs is needed, now more than ever, for policy development and the resolution of health disparities throughout the global community.

Authors' Note

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