NEONATAL ABSTINENCE SYNDROME:
BREASTFEEDING SUPPORT
FOR
MOTHERS AND BABIES
JOANNE M WESLEY, BA, IBCLC

MOTHERHOOD
There is a special magic
and holiness about women.
They are the bringers of life
to the people and
the teachers of the children.
Native American – Heartsong of our Ancestors
Culture and Spirituality

#MNBreastfeedingEquity

DEDICATION
It is with sincere gratitude and thanks that I dedicate this presentation to the women that have trusted me to assist them with breastfeeding their babies.

Thank you for teaching me about your challenges.
Thank you for listening to and following your instincts.
Thank you for working to provide your baby with breastmilk.

It has been my honor and privilege to share in your journey to mother your babies, while working towards your recovery.

Joanne M Wesley
OBJECTIVES

1. Understand the history and the challenges of breastfeeding for women who use drugs.
2. Describe behaviors typical of infants experiencing Neonatal Abstinence Syndrome (NAS).
3. Understand treatment protocols for both mothers with opioid use disorders and infants with NAS.
4. Explain reasons for supporting a mother to breastfeed her infant experiencing withdrawal symptoms or NAS.
5. Identify techniques that support infants with NAS and assist their mothers with breastfeeding or providing breastmilk for their infants.

Opportunities to find deeper powers within ourselves come when life seems most challenging.
Joseph Campbell

This quote helped me personally evaluate my thoughts to reach a greater understanding on how I could be more effective in providing care to families.

REALITY CHECK

According to the CDC:

- In 2015, 27 million people reported current use of illicit drugs or misuse of prescription drugs.
- In 2016, over 50,000 people died from opioid overdose in the United States.
- Which means - 142 people die each day.

REALITY CHECK

- Only 10 % of people with substance use disorder receive any type of treatment.
- Cost for illicit drug use is estimated at 193 billion dollars per year and rising.
  Caution: You probably don’t want to print it as it is over 400 pages.
REALITY CHECK

- In the 1990's, doctors began a more liberal use of pain medication as pain was considered the 6th vital sign.
- 32% of women give birth by cesarean section.
- Postpartum women are discharged from the hospital with prescriptions for opioid medication to treat pain.
- Once home, 93% of women have left over opioid medication and have not been given instruction on how to properly dispose of these medications.
- One in every 300 women given opioid medication after birth become addicted.

Six states have declared a state of emergency for opioid use: Arizona, Virginia, Florida, Maryland, Massachusetts, Alaska

Trump declared on October 26th that the opioid crisis is a public health emergency.

HISTORY

For 18 years (from 1983 until 2001), the American Academy of Pediatrics (AAP) recommended that methadone was only compatible with breastfeeding at maternal doses ≤ 20 mg per 24 hours.

This effectively eliminated breastfeeding for the majority of US women on methadone maintenance therapy.

Higher doses usually given in the third trimester offsets increases in methadone metabolism during pregnancy.

In the 2001 AAP statement, the dose restriction for methadone was eliminated, making methadone compatible with breastfeeding.

AAP recommendation required us to reexamine policies and create new guidelines for women on methadone maintenance who choose to breastfeed.

We needed to take a fresh look at our approach to the complex issues of mothers using drugs and infants with NAS.
Many women face significant hardships as a result of their history in terms of race, color and culture.

They have experienced discrimination or violent practices of social and cultural assimilation.

Many of these women have survived multiple traumas, experienced over many generations and this has multiplied the risks factors that can leads to drug use.

Risk factors (traumatic experiences) are cumulative - if one generation does not heal, problems are transmitted to subsequent generations.

Brokenleg (2012)

Multigenerational traumas, grinding poverty and lack of cultural identity create a higher risk for substance abuse, suicide and chronic disease in Native American communities.

Telis, 2013; Garrett, 1996

Sometimes it just takes a little kindness from one hurting soul to another to change us forever.

Karen Kostyla

What causes drug use or addiction?

What makes some women more at risk for drug use?

Why is drug use during pregnancy increasing?

What are the best solutions to this growing issue?

What is our role as lactation support in this complex situation?
DRUG USE OR ADDICTION?

- What if addiction isn't about the chemical hooks?
- What if addiction is an adaptation to your environment?
- Human beings have a natural and innate need to bond.

Johann Hari

DRUG USE OR ADDICTION?

In our society we:
- punish people with addiction problems
- shame them
- give them criminal records
- take their children away
- send them to jail or prison
- put barriers between them reconnecting

In my research, everything I read said, we should do the opposite!

RESILIENCE

- Capable of preparing for, responding to and recovering from difficult conditions.
- A process that involves interactions between families, communities and social and cultural environments.

Life doesn’t get easier or more forgiving; we get stronger and more resilient.

- Dr. Steve Maraboli
DURING PREGNANCY

The placenta does not act as a barrier

- Environmental contaminants
- Illicit or street drug
- Prescription drugs
- Alcohol
- Commercial Tobacco

All cross the placenta and all affect the fetus

DURING PREGNANCY

Maternal drug use leads to complications for the fetus with a higher incidence of:

- Stillbirths
- Premature rupture of the membranes
- Abruptio placentae
- Meconium-stained amniotic fluid
- Maternal hemorrhage
- Fetal distress

UNDERSTANDING TREATMENT

Opioid Use Disorder (OUD) treatment:

- Opioid Substitution Therapy (OST)
- Methadone Maintenance Treatment (MMT)
- Medication Assisted Treatment (MAT)
  - Methadone or Buprenorphine

Any of these treatments are effective in reducing relapse to illicit drug or legal substance misuse.

Maternal withdrawal from opioid use can be life threatening to the fetus.
MEDICATION ASSISTED TREATMENT IS:

- a synthetic, opioid drug substitute administered over a prolonged period of time (may be indefinite)
- treatment for persons addicted to opioids (such as heroin or prescription narcotics)
- a best practice for stopping illicit drug use or prescription drug misuse

UNDERSTANDING TREATMENT

People don’t need to fail at abstinence before using MAT

Methadone or buprenorphine should be plan A for stopping illicit drugs use

UNDERSTANDING TREATMENT

- Methadone is more often used during pregnancy in areas where methadone clinics exist and require daily visits by the individual.
- It is currently considered the best choice for treating opioid addiction during pregnancy.
- Buprenorphine (Subutex or Suboxone) is used more often where transportation is an issue and daily clinic visits are not feasible.

UNDERSTANDING TREATMENT

- Methadone may be more effective in reducing ‘return to drug use’ in women but has a higher incidence of NAS in infants.
- Buprenorphine results in fewer complications for the infant but may not be as effective in reducing ‘return to drug use’ in woman.
<table>
<thead>
<tr>
<th></th>
<th>Methadone</th>
<th>Buprenorphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of addiction</td>
<td>high</td>
<td>Lower than methadone</td>
</tr>
<tr>
<td>Risk of fatal overdose</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>Effectiveness-heavy addicts</td>
<td>high</td>
<td>Low to medium</td>
</tr>
<tr>
<td>Price</td>
<td>cheaper than Suboxone;</td>
<td>costlier than methadone</td>
</tr>
<tr>
<td>Dosage</td>
<td>monitored in OP clinic 30-160 mg/day</td>
<td>2 mg, 4 mg, 8 mg, 12mg sublingual dosages</td>
</tr>
<tr>
<td>Active ingredients</td>
<td>methadone</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>Forms</td>
<td>dispersible tablets, oral (liquid), an injection</td>
<td>Sublingual film, no longer available in tablet form.</td>
</tr>
<tr>
<td>FDA approval</td>
<td>1947</td>
<td>2002</td>
</tr>
<tr>
<td>Special populations</td>
<td>standard care for pregnant women, shown to reduce illicit opioid use.</td>
<td>used in pregnancy as a mono medication, Suboxone contains naloxone, not advised during pregnancy</td>
</tr>
</tbody>
</table>

**CASE STUDIES**

- Brings reality to this topic
- Identifiers removed to protect privacy

**CASE STUDY A**

BEST PRACTICE - PRENATAL

During pregnancy mother should receive counseling about:

- breastfeeding her infant or providing breastmilk
- possibility of her infant requiring a longer hospital stay or admittance to the NICU for treatment
- caring for an infant with NAS
- importance of learning how to calm her infant
BEST PRACTICE - PRENATAL

Schedule a Prenatal Breastfeeding Consult to discuss:

- the important role the mother plays in her infant’s recovery
- feeding plans to meet the baby’s needs effectively, which will likely include pumping and supplementing – so she is prepared
- positioning and pacing the feeding – demonstrate using a doll
- effective infant calming techniques

BEST PRACTICE – PRENATAL

Breastfeeding is a way for a woman to connect with her baby in a manner that strengthens the mother/baby bond in so many ways, right from the start.

Research has shown that women who were most connected with lactation support are more likely to:

- initiation breastfeeding in the hospital
- provide breastmilk and/or breastfeed their babies
- increase duration rates of breastfeeding across color and culture
- increase exclusive breastfeeding or breastmilk feeding

“...We found that a combined prenatal and postnatal breastfeeding support intervention integrated into routine primary care increased breastfeeding initiation and duration in a diverse, low income population.

These differences were achieved with an average of 3 hours of LC (lactation consultant) time per participant, suggesting that a full-time LC could deliver this protocol to more than 600 mother-infant dyads per year.”

Bonuck, Lischewski, Brittner (2009)

WHAT IS NEONATAL ABSTINENCE SYNDROME OR NAS?

A series of withdrawal symptoms that the infant may exhibit after birth, due to intrauterine exposure to street drugs or prescription narcotics.
WHAT DRUGS CAN CAUSE NEONATAL ABSTINENCE SYNDROME?

**Opioids:**
- Heroin
- Methadone
- Oxycodeone (Percocet, Oxycontin)
- Fentanyl
- Codeine
- Morphine
- Meperidine
- Buprenorphine

**Less Potent Opioids:**
- Propoxyphene HCl (Darvon, Darvocet)
- Codeine
- Pentazocine (Talwin)

**Stimulants:**
- Cocaine
- Methamphetamine

**CNS Depressants:**
- Tranquilizers and sedatives
- Chloralhydrate (Librium)
- Lorazepam (Ativan)
- Diazepam (Valium)
- Other benzodiazepines

**SSRIs:**
- Paroxetine (Paxil)
- Fluoxetine (Prozac)
- Sertraline (Zoloft)

NEWBORN: ADDICTED VS. DEPENDENCE?

Choosing our words carefully:

The infant is born addicted.

OR

The infant is born with a physiologic dependence.

NEONATAL ABSTINENCE SYNDROME:

Develops in 55-94% of newborns exposed to narcotics in utero.

NAS IS A PROBLEM

- Every 25 minutes a baby is born in the United States suffering from opiate withdrawal.
- Average hospital stay for an infant with NAS is 19 days at a cost close to $100,000.
NEWBORN

- NAS due to methadone withdrawal does not occur immediately after birth.
- In the first few days of life, methadone levels in the infant are similar to in utero levels, due to the placental transfer of the drug, and then begin to slowly decline because methadone has a long half-life.
- Withdrawal symptoms may not surface until 48 to 72 hours of life or later (sometimes even weeks later).

<table>
<thead>
<tr>
<th>Nonopioids</th>
<th>Approximate time to onset of withdrawal symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>3 – 12 hours</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>24 hours; duration of withdrawal up to 7-10 days; can see immediate withdrawal</td>
</tr>
<tr>
<td>TCAs</td>
<td>24-48 hours; duration of withdrawal up to 2-6 days</td>
</tr>
<tr>
<td>SSRIs</td>
<td>24-48 hours; duration of withdrawal up to 2-6 days</td>
</tr>
<tr>
<td>Inhalants</td>
<td>24-48 hours; duration of withdrawal up to 2-7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opioids</th>
<th>Approximate time to onset of withdrawal symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>24-48 hours; duration of withdrawal up to 8-10 days; earlier shorter withdrawal compared to prescription opioids</td>
</tr>
<tr>
<td>Prescription Opioids</td>
<td>36-72 hours; duration of withdrawal up to 10-30 days</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>36-60 hours; duration of withdrawal up to 28 or more days; onset maybe delayed especially with higher doses</td>
</tr>
<tr>
<td>Methadone</td>
<td>48-72 hours; duration of withdrawal up to 30 or more days; later onset and longer withdrawal</td>
</tr>
</tbody>
</table>

NEWBORN CONCERNS

Mortality and morbidity are high:
- increased incidence of asphyxia
- prematurity
- low birth weight
- infections (including sexually transmitted infections)
- pneumonia
- congenital malformations
- cerebral infarction
- drug withdrawal
- acquired immunodeficiency disease
NEWBORN CONCERNS

Long-term sequelae for infants may include:

- long hospitalization - separation of mother and infant
- delayed or interrupted bonding of mother and infant
- delays in physical growth
- delayed or impaired mental development
- sudden infant death syndrome
- life long learning disabilities

SIGNS OF NAS

- inconsolable crying
- high pitched crying
- restlessness
- jitteriness/tremors
- myoclonic jerking
- feeding problems
- sucking/swallow difficulty
- poor weight gain
- skin excoriation
- skin mottling
- difficulty sleeping
- tense arms and legs
- vomiting
- diarrhea or frequent stools
- yawning
- fever
- sweating
- excessive sneezing
- nasal stuffiness
- fast breathing
- seizures

HOW NAS IS EVALUATED

Six scoring systems for assessing the severity of NAS:

- Ostrea
- Lipsitz
- Rivers
- Finnegan (original and modified) (most widely used)
- NNNS – NICU Network Neurobehavioral Scale

Please be aware that any system is subject to user bias and requires staff training to learn how to score an infant appropriately.

FINNEGAN SCORING TOOL

- predominant tool used in the United States, more comprehensive
- assigns a cumulative score based on observation of 21 items relating to signs of neonatal withdrawal
- infants should be assessed for s/s of withdrawal every 3-4 hours.
- should infants be scored - BEFORE or AFTER feeding?
- latest info says to score before feeding
HOSPITAL - HOW NAS IS TREATED

Neonatal Withdrawal Inventory Scoring *:

- before every other feeding if the score is ≤ 5
- before every feeding if the score > 5

Treatment:

- not all infants require pharmacological support
- morphine initiated with 3 consecutive scores >8 or two >12
- small incremental increase in morphine dose until score < 8
- cardiac monitor required during morphine increase

*scoring assessment based on behaviors for full term infant, may not be appropriate for preterm infants

HOSPITAL NAS PROTOCOL

Protocol goals should include:

- accommodations to keep mother and infant together
- reliable monitoring of symptoms to determine if infant requires treatment and a NICU transfer
- standardized morphine protocol for dosing
- effectively working to reduced length of hospital stay
- avoiding infant readmission for NAS treatment

HOSPITAL - HOW NAS IS TREATED

Weaning from pharmacological support:

- after 24 to 72 hours of NAS scores <8, morphine weaning may begin

- clonidine may be added to assist, if weaning morphine fails due to increased NAS scores

- rescue dosing may be necessary during the weaning period

- phenobarbital reserved for severe withdrawal

Weaning From Pharmacological Support
CASE STUDY B

BEST PRACTICE: ADDRESS STAFF FEARS OR BIAS

In many hospitals, nursing staff, particularly NICU (neonatal intensive care unit) nurses, are often uncomfortable feeding infants with pumped breastmilk from their mothers receiving methadone.

Not knowing exactly what the milk contains ("if she takes methadone, what else might be in this milk?") is voiced in NICUs around the world.

BREST PRACTICE: ADDRESS STAFF FEARS OR BIAS

On occasion, a nurse may question:

“is it pumped breastmilk or something else?”

As lactation support, it is important to approach the situation of “questionable milk” without assumption or judgment.

BEST PRACTICE: ADDRESS STAFF FEARS OR BIAS

While it may seem like a reasonable concern, it is a question that may create an adversarial relationship between a mother and the nurse caring for her infant.

Mother becomes concerned, as she needs to keep a positive and trusting relationship with her infant’s nurse.
**BEST PRACTICE – USE SCIENCE**

**Look at the milk:**
- does the cream rise to the top?
- color concerns, what did mother eat?

**Smell the milk:**
- formula has a very distinct smell
- breastmilk with high lipase may have a sour or soapy smell
- maternal diet – garlic, broccoli, etc.

**Creamatocrit:**
- breastmilk separates in the tube
- homogenized milk or formula, no separation

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**BEST PRACTICES:**

**LACTATION WORKING WITH STAFF**

Genuinely thank those nurses taking care of the NAS baby and the family.

It can be a challenging day with a very high need infant.

Encourage nursing staff to welcome the mother and help her learn about her baby, so she can contribute to her infant’s care and recovery.

NICU nurses welcome help with breastfeeding support and encouragement for the mother.

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**BEST PRACTICES:**

**LACTATION WORKING WITH STAFF**

Ongoing in-service training for staff is critical to help staff process issues, concerns and challenges to improve the care for NAS babies and their relationships with families.

Sharing the responsibility for NAS infants by occasionally trading assignments, can provide a much needed break for the staff person.

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**HOSPITAL BEST PRACTICES**

The most effective interventions to date:
- mother and infant rooming in together
- development of a staff NAS education program to effectively and compassionately work with families and staff
- implementation of a standard treatment protocol
- formation of taskforce to improve communication, to disseminate vital treatment information to all clinical staff
LACTATION SUPPORT: WHAT IS OUR ROLE?

Prenatal Lactation Consults
- may need more than one consult during pregnancy
- very helpful in addressing concerns early
- discuss feeding and pumping options
- establishes a relationship for lactation care
- opportunity to discuss the importance of skin-to-skin time with her infant – early and often.

LACTATION SUPPORT - POSTPARTUM

Follow Linda Smith’s simple rules:
1. Feed the baby
2. Protect the milk supply
3. Maintain the relationship of mother and baby with skin-to-skin contact when possible
LACTATION SUPPORT - POSTPARTUM

- Do what you would normally do with any mother-baby dyad
- Keep mother and baby together early and often and as much as possible
- Encourage breastfeeding, help mother to initiate hand expression and pumping, as needed

LACTATION SUPPORT - POSTPARTUM

- Teach calming techniques and comfort measures
- Kindness, compassion, empathy and a respectful attitude help to create a therapeutic environment that is free of judgment or bias

LACTATION SUPPORT - BABY WITH NAS

Difficulty:
- Uncoordinated suck/swallow
- Hypersensitivity or hypertonicity
- Clamping, biting, oral aversion
- Nasal stuffiness
- Vomiting
- Sleepy or sleepy appearing
- Inconsolable crying

Things to try:
- Gentle handling or rocking
- Soft voice
- Skin-to-skin holding
- Pacifier or no pacifier
- Nipples shield
- Slow flow nipples
- Soft or firm swaddle
- Stable positioning at breast
- Stable position for bottle feeds

CALMING THE BABY - HOSPITAL

Environmental Control
- Private room if available, or quietest part of the nursery
- Avoid noisy equipment (ventilators, CPAP, air handlers)
- Avoid rooming near newly admitted infants who may require a lot of attention and lots of equipment
- Mother rooming-in can decrease length of stay and duration of therapy for the baby
CALMING THE BABY - HOSPITAL

Environmental Control

- Blanket over isolette to reduce light (check policy)
- Cluster cares to limit the number of times an infant requires handling by staff
- Maintain a moderate temperature – not too cool, not too warm

CALMING THE BABY – HOSPITAL OR HOME

Handling the NAS baby:

- Should be slow and gentle
- Gentle pressure over head and body may be calming
- Holding and gentle rocking may be effective
- Gentle rhythmic patting on infant's bottom can be soothing for some infants

Study of skin-to-skin holding for an infant with NAS for one hour after feeding resulted in:

- Decreased infant pain scores
- Improved infant sleep patterns
- Improved infant thermoregulation
- Increased mother's confidence in caring for and calming her baby
- Mothers felt good about their unique contribution to their infant's care
- Increased mother/infant bond

No studies of continuous Kangaroo Care in NAS infants – but research is needed

Swaddling:

- Firm swaddling may be effective for the infant with hypertonic and erratic movements
- Snug or soft swaddling may be effective – each baby has unique needs
- Swaddling provides boundaries which may prevent excoriation from excessive repetitive movements and scratching
- Helps maintain regulation, soothing and better tolerance of stimulation
- Hands to mouth vs. hands at the side? Mittens?
CALMING THE MOTHER
- recognize and address maternal anxiety, because an anxious mother may have difficulty with calming her infant
- a crying infant cannot latch to the breast, so careful handling is a critical issue
- putting an infant to the breast while he is still drowsy or before he is fully alert may eliminate some fussiness
- encourage stable positioning for both mother and infant during breastfeeding or during bottle feeding

MATERNAL CONCERNS
Irritable infants - the most common cause of maternal inability to establish lactation in women on MAT
- maternal guilt and anxiety aroused by a crying baby
- difficulty in latching baby to breast
- concerns that the baby “does not like me”
- concerns that baby does not like the breast
- infant clamping or biting, inducing maternal pain

FEEDING CONCERNS
Ideas for non-pharmacologic interventions during feeding:
- stable positioning, containment, handling
- paced breast or bottle feeding
- rubbing infant’s back or patting to elicit a burp
- patting may elicit a Moro reflex or it may be calming – each baby is different

FEEDING CONCERNS
- infants affected by NAS may have motor control and integration of feeding rhythms disrupted
- may try to eat excessively
- may not eat enough to meet their caloric needs
- monitor weight gain - too much or too little
- smaller, more frequent feeds with high caloric density may be required (consider hindmilk pumping)
COMPASSION

- withdrawal is painful for the infant
- hard for mother to see her baby going through withdrawal
- may be difficult for mother to cope, calm and feed her baby
- difficult for families to see mother and baby struggle
- challenging for caregivers assisting these complex situations

UNDERSTANDING

Many mothers experience feelings of guilt, shame, remorse, anxiety and have difficulty coping.

She may have other issues with alcohol, tobacco, food or other compulsive behaviors.

She may not want her family to know her infant has NAS.

It is important to respect her right to privacy.

HEALING

Healing doesn’t mean that the damage never existed.

It means that the damage no longer controls our life.

Akshay Dubey

FEEDING PLAN

Rule #1

Feed the baby!
FEEDING PLAN
Consider:
- feeding infant at breast more frequently than NICU 3 hours schedule
- use of a nipple shield may help to organize the infant
- allow the infant to pace the feeding
- assist mother with stable positioning of infant at breast, so both are comfortable
- stable, comfortable positioning is important with both breast and bottle feeding

FEEDING PLAN
Rule # 2
Protect the milk supply!

FEEDING PLAN
Pumping may be needed:
- to provide supplemental breastmilk as needed for infant
- if mother is unable to take advantage of “mother’s room status” (MRS) during her infant’s hospitalization
- to reduce and relieve engorgement which protects the breastmilk supply
- to increase breastmilk supply

FEEDING PLAN
Mother may not be able to follow the feeding plan; - so then what?
- work to support and encourage mother with what she is able to provide
- suggest alternatives to rigid scheduling of pumping or feeding
- accept her limitations to promote positive interaction – no guilt – keep communication open
- If formula is needed, teach her how to mix the formula, safely warm the bottle and how to pace the feeding
FEEDING PLAN

Rule # 3

Maintain the relationship of mother and infant with skin-to-skin contact whenever possible!

BEST PRACTICES – FEEDING PLAN

• value the mother’s presence
• value the available breastmilk
• thank her for the work she is doing to help her baby and provide breastmilk for her baby
• consider pasteurized donor human milk if infant requires supplementation during hospital stay
• if formula becomes necessary, gently remind the mother of the importance of Rule # 1 – Feed the baby

UNDERSTANDING THE MOTHER

Many women who use drugs may:

• come from multigenerational families who use drugs
• be without positive role models for breastfeeding
• lack support from family or friends

The father of the baby or other family members may:

• still be actively using drugs
• work overtly or covertly to make mother unsuccessful
• be threatened by the drug abstinence that breastfeeding mothers work to achieve

UNDERSTANDING THE MOTHER

Variety of reasons why women who use drugs often do not breastfeed:

• family and social factors – interpersonal relationships
• medical issues - previous attempts at substance abuse treatment
• psychiatric concerns – postpartum depression
• employment
• loss of custody of previous children
• food and housing security
• cultural, racial or ethnic factors
• concerns about milk supply
• concerns about maternal medications affecting her milk
• concern about the nutritional composition of her milk
Another common reason that women elect not to breastfeed their infants is their instability in their recovery process and their fear of relapse to illicit substances. Most women in treatment will recognize the difficulties associated with relapse to drug use. Women deciding to breastfeed to keep themselves from relapsing should be supported and she should be counseled regarding this decision.

Guilt and shame coupled with low self-esteem and self-efficacy can produce behaviors difficult for some staff members to tolerate, such as lateness, missed appointments, continued illegal drug use, and demanding or provocative behaviors. For successful treatment, care should be provided in a non-punitive, non-judgmental, nurturing manner, with attention to each patient’s fears and cultural beliefs. 

“Vitality shows in not only the ability to persist but the ability to start over.”

-F. Scott Fitzgerald

Kaltenbach et al. 1998; Ward et al. 1998c
Let us put our minds together and see what life we can make for our children.

Sitting Bull

ADJUSTING THE SUPPORT TO HELP A MOTHER BREASTFEED

Mother may:
- expect to have difficulty with breastfeeding and give up after a day or two, even with support
- have a low tolerance for discomfort, may request pain medication
- have sore nipples or uterine cramping which can discourage a woman from breastfeeding.

ADJUSTING THE SUPPORT TO HELP A MOTHER BREASTFEED

If the mother decides to discontinue breastfeeding:
- LC can help her learn paced bottle feeding
- insure she knows how to prepare/use formula safely
- discuss comfort measure to reduce engorgement
- help her down-regulate her milk supply comfortably

LACTATION SUPPORT AFTER DISCHARGE

Planning for discharge, mother should know:
- infant will likely remain sensitive at home
- how to identify feeding cues
- how to identify need for calming
- slowly introduce more stimulation based on infant cues/readiness for interaction
- discuss how long to anticipate symptoms
LACTATION SUPPORT AFTER DISCHARGE

Discharge Planning and Follow-up Care:
- address what to do if mother becomes overwhelmed
- discuss maternal self care - have a “go to” person for support
- recommend lactation counseling or support groups
- What other services does this mother need?
  - Addiction counseling
  - Supportive housing
  - WIC benefits
  - Social Services

Follow-up Care:
- set up a lactation appointment within a few days of discharge
- discuss when to call doctor
- discuss when to call the Lactation Consultant
- encourage the mother to try to keep appointments or call to reschedule
- if mother misses appt, call to see if she wants to reschedule

BEST PRACTICES

Build Rapport:
- while these families can be challenging to care for, they are still a family
- our priority is to assist and support them to be the best parents they can be
- consider self-reflection, know your attitude towards drug-dependent mothers
- be non-judgmental and give mothers the tools they need for success

Questions to consider:
- Do staff feel comfortable talking about OUD and NAS?
- Will you consider education on how to care for the mother who uses drugs?

Set Expectations:
- Do you have a caregiver agreement?

Educate:
- Do you offer prenatal consultations?
- What is your current education for families? Handouts?
- Does your discharge planning process need changes?
TED TALKS: KATHRYN SCHULZ
A thought provoking presentation:

“On Being Wrong”

“Most of us will do anything to avoid being wrong. But what if we’re wrong about that? “Wrongologist” Kathryn Schulz makes a compelling case for not just admitting but embracing our fallibility.”

REVIEW
- What causes drug use or addiction?
- What makes some women more at risk for drug use?
- Why is drug use during pregnancy increasing?
- What are the best solutions to this growing issue?
- What is our role as lactation support, in this complex situation?

TED TALKS: JOHANN HARI
Another thought provoking presentation about addiction:

“Everything you think you know about addiction is wrong”

“And I think the core of that message -- you’re not alone, we love you -- has to be at every level of how we respond to addicts, socially, politically and individually.

For 100 years now, we’ve been singing war songs about addicts. I think all along we should have been singing love songs to them, because the opposite of addiction is not sobriety.

The opposite of addiction is connection.”

Johann Hari

MAYA ANGELOU

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”
REFERENCES


- Minnesota Hospital Association: Neonatal Abstinence Syndrome (NAS) Toolkit: Risk Factors, Assessment and Treatment

REFERENCES


- Gyser Rasa. A review of Sam Quinones; Dreamland: The True Tale of America’s Opiate Epidemic is incredibly relevant to Native Communities. Indian Country Today Media Network.


- DHS Commissioner Jesson outlines state response to opioid addiction crisis, MINNPOST, 05/06/2015

We will be known forever by the tracks we leave…….

Dakota

Thank you for listening!