

Promoting Breastfeeding in an Inner-City Hospital: How to Address the Concerns of the Maternity Staff Regarding Illicit Drug Use

Sally is an IBCLC/RN working in the Labor and Delivery Unit of Jones Medical Center, a busy inner-city public hospital. Sally is also a member of the hospital breastfeeding task force. Currently, the task force is examining ways to increase the breastfeeding initiation rate among mothers giving birth at Jones Medical Center. Feedback from many of the maternity health care providers indicates that there is reluctance to encourage breastfeeding because of the high incidence of illicit drug use in the community. As a result, only those mothers who specifically ask are offered their baby immediately after birth for skin-to-skin contact and early suckling. Breastfeeding support is likewise available "upon request." Even regarding mothers who "test clean" upon admittance to Labor and Delivery, staff members express concern about encouraging breastfeeding in case the mother has a "relapse" or "binge" while lactating. Sally realizes that changes in hospital policy to increase the incidence of breastfeeding will not be successful without addressing the concerns of the maternity staff. What are the unique considerations related to breastfeeding promotion in such a setting? What approach might Sally recommend to the task force?

Invited Response by Anne Merewood, MA, IBCLC, and Barbara L. Philipp, MD, IBCLC, FABM

Use of illicit substances is 1 of just 5 contraindications to breastfeeding cited by the American Academy of Pediatrics.¹ While this can be a genuine problem,

Anne Merewood is an instructor of pediatrics at Boston University School of Medicine, director of research for the Breastfeeding Center at Boston Medical Center, and a practicing lactation consultant. **Barbara L. Philipp** is an associate professor of pediatrics at Boston University School of Medicine and medical director of the Breastfeeding Center at Boston Medical Center. She is a practicing pediatrician, lactation consultant, and a fellow of the Academy of Breastfeeding Medicine.

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exaggerated concern over this issue at Sally's hospital is denying the benefits of breastfeeding to the vast majority of mothers and infants in a vulnerable, high-risk population.

Breastfeeding rates in the United States are lowest among inner-city, minority populations,² so it is critical to offer these women extra support regarding breastfeeding initiation and extra help when they choose to breastfeed. Sally and her task force would be well advised to educate themselves and their coworkers with national goals for breastfeeding among such families,^{1,3} the types of support that are effective,⁴⁻⁹ and successful programs other hospitals have initiated in similar situations.¹⁰⁻¹³

Usually, staff doubts based on erroneous or outdated information are best countered by accurate, evidence-based data. For example, at Boston Medical Center (BMC), a Baby-Friendly, urban hospital with approximately 2000 births per year, clinicians recently expressed concern over promotion of breastfeeding among women on methadone maintenance therapy (used to treat a former opiate addiction), regardless of methadone dose. However, recent data suggest that methadone levels in the milk are extremely low, even at high maternal doses,¹⁴⁻¹⁶ and on the basis of this evidence, the American Academy of Pediatrics (AAP) changed their guidelines on breastfeeding and methadone. (From September 1983 until September 2001, the AAP stated that breastfeeding was compatible with methadone therapy only when the maternal dose was ≤ 20 mg in 24 hours¹⁷⁻¹⁹; the new recommendation approves methadone for use in breastfeeding women regardless of dose.²⁰) The new AAP guidelines, and the evidence on low methadone levels in milk, were strong enough to assuage staff concerns about methadone and breastfeeding. In addition, we developed a policy (Breastfeeding for Mothers on the Methadone Maintenance Program) to deal with concerns specific to these mothers.²¹

Unfortunately, no reliable data exist on rates of breastfeeding and illicit drug use. So, while in Sally's case the reluctant providers cannot produce any evidence to back up their fears, Sally cannot produce any evidence to show that women who breastfeed do not use illicit substances. However, data do exist to show that rates of drug use among pregnant women are proportionally low, even in a high-risk population. For example, Massachusetts has the highest estimated rate of illicit drug use in the United States,²² yet in Boston in 2002, only 122 pregnant women were treated for illicit drug use, and only 535 such cases were recorded in the entire state.²³ As clinicians in an urban setting, we have found that many women seek help and discontinue illicit drug use once the pregnancy is confirmed. A BMC study on breastfeeding initiation rates found that the percentage of women who were ineligible to breastfeed due to illicit drug use amounted to 2% of births in a high-risk population similar to Sally's.¹⁰ In addition, unless the woman has had no prenatal care, a review of her medical record from pregnancy confirms whether illicit substances have been an issue. Women who are actively using illicit drugs should be counseled against breastfeeding; however, at BMC, these women are encouraged to attend infant massage classes and are referred to parent support services within the community.

Even with 2% of women using illicit substances, reluctant providers should find it difficult to justify denying the benefits of breast milk to 98% of their patient population. Providing statistics on the risks of formula feeding (50% more ear infections in the first year of life,²⁴ more diarrhea,²⁵ and more bacterial meningitis, urinary tract infections, lower respiratory tract infections, bacteremia, botulism, necrotizing enterocolitis, chronic digestive diseases,¹ childhood cancers,²⁶ allergies,²⁷ obesity,^{28,29} and insulin-dependent diabetes mellitus,³⁰ not to mention tremendous protection against breast cancer for the mother³¹⁻³⁷) should further help to persuade providers that the risks of not breastfeeding for 98% of the population far outweigh the risks of illicit drug use in a small minority of cases.

In addition, the task force could create referral guidelines for a lactation consult that have no reference at all to this concern. So rather than being available "on request," guidelines would specifically list, for example, consults for women with inverted nipples, women with breast surgery, infants with hyperbilirubinemia,

and other such issues. In this way, lactation consults would become part of the standard of care and would have no connection with the issue of illicit drug use.

The bottom line, of course, is that no hospital has the right to deny breastfeeding-supportive policies to the many, based on an overblown concern around so few. UNICEF and the World Health Organization recommend breastfeeding within the first hour of life, based on evidence indicating that early suckling positively affects both breastfeeding duration and sucking ability.³⁸⁻⁴² The AAP guidelines state that breastfeeding is contraindicated among women who use illicit substances, not among entire hospital populations inopportunistically located in the inner city, or among women who test clean and, in the staff's opinion, may binge later. Undermining breastfeeding success by acting on such fears is as patronizing as keeping the baby in the nursery so the mother can rest. Ultimately, a woman who takes her baby home from the hospital has many choices to make, and as professionals, we can advise her based only on our medical knowledge of her current situation, not on our fears of what she might do or on our prejudices regarding her community. The benefits of breastfeeding are overwhelming, particularly in a vulnerable population that is more likely, by virtue of poverty, to suffer from a multitude of public health risks.^{43,44} Promoting and supporting breastfeeding in the urban setting offers families more than a nutritional advantage. In a study that demonstrates that Baby-Friendly policies decrease rates of infant abandonment, Lvoff stated, "The first hours and days of life are a sensitive period for the mother when she is especially psychologically prepared to accept her infant as her own."⁴⁵ The empowerment associated with breastfeeding can inspire a new mother—and, we would hope, her clinicians—to make the most of this sensitive window to start a new life, with implications for generations to come.

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