Illicit Drugs and Lactation

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Speaker Disclosures

Celebrating 40 Years of OLCA Breastfest 2026

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Objectives

- Define common illicit substances and describe their use during the prenatal and postpartum periods
- Interpret guideline recommendations and available literature on illicit substance use during lactation
- Discuss how to best support patients/clients who inquire about illicit substance use during lactation

Definitions

- **Illicit**- "Forbidden by laws, rules, or custom"
- **Drug abuse**- the use of an illicit drug or the excessive or non-medical use of a licit drug
- **Controlled Substance**- a drug or chemical whose manufacture, possession, or use is regulated by a government
- **Intoxication**- A state in which a person's normal capacity to act or reason is inhibited by alcohol or drugs
- **Overdose**- an excessive and dangerous dose of a drug
- **Withdrawal**- Physical and mental symptoms that occur after stopping or reducing intake of a drug or substance
- **Detoxification ("detox")**- the process of drugs or substances leaving the body
- **Substance use disorder (SUD)**- a disorder defined by the inability to control the use of a particular substance(s) despite harmful consequences
- **Recreational drug use**- the use of one or more psychoactive drugs to induce an altered state of consciousness, either for pleasure or for some other casual purpose or pastime

Controlled Substance Act of 1970 (CSA)

- Places all regulated substances under existing federal law into one of five schedules based on medical value, harmfulness, and potential for abuse/addiction
  - **Schedule I (CI):** high potential for abuse and physical/psychological dependence, no currently accepted medical use
  - **Schedule II (CII):** high potential for abuse, with use potentially leading to severe psychological or physical dependence
  - **Schedule III (CIII):** moderate to low potential for abuse and physical/psychological dependence
  - **Schedule IV (CIV):** low potential for abuse and dependence
  - **Schedule V (CV):** lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics
- Proceedings to add, delete, or change the schedule of a drug or other substance may be initiated by the Drug Enforcement Administration (DEA), the Department of Health and Human Services (HHS), or by petition from any interested party

Drugs of Abuse

Psychostimulants	Opioids	Cannabinoids	Hallucinogens	Sedative-hypnotics
• Amphetamines • MDMA • Cocaine	• Heroin • Fentanyl • Oxycodone • Morphine	• Tetrahydrocannabinol (THC)	• Ketamine • Mescaline • Psilocybin • Phencyclidine (PCP) • Lysergic acid diethylamide (LSD)	• Ethanol • Benzodiazepines • Z-drugs • Barbiturates

Urine Drug Screen (UDS)

Drug	Window of Detection	Substance Detected	Possible False Positives*	Comments
Amphetamines	1-2 days (acute) 2-4 days (chronic)	Amphetamine, methamphetamine	Poor specificity (phenylephrine, pseudoephedrine, bupropion, etc)	- Atomoxetine and methylphenidate are [redacted] detected by routine screening
Benzodiazepines	3-5 days (short-acting) Up to 30 days (long-acting)	Oxazepam (most common) or other metabolites	Oxaprozin, sertraline	- Poor sensitivity - Will [redacted] detect "T-drugs" (zolpidem) - No single assay is known to detect all benzodiazepines. Depending on metabolites detected, commonly used benzodiazepines such as alprazolam and lorazepam might not be detected
Cocaine	2 days (acute) 7 days (chronic)	Benzoylecgonine (cocaine metabolite)		- High specificity
Cannabis (THC)	~3 days (acute) > month (chronic)	Tetrahydrocannabinol (THC)	Hemp containing foods (?)	- Will [redacted] detect synthetic cannabinoids
Opioids	1-3 days (most)	Codeine, morphine	Dextromethorphan, diphenhydramine, poppy seeds, verapamil	- Routine opioid screening **does not detect synthetic opioids** (buprenorphine, fentanyl, methadone, tramadol, and loperamide) - Oxycodone is poorly detected by many routine opioid screening assays. Specific assays are needed
Phencyclidine (PCP)	4-7 days	Phencyclidine (PCP)	Dextromethorphan, diphenhydramine, doxylamine, tolazoline, metronidazole, tramadol, venlafaxine	- Many causes of false-positive screening exist, and due to the low prevalence of PCP use in most settings, the likelihood of a true positive test is low

*Possible false positive screen by assay; not an all-inclusive list

Background

- The 2022 National Survey on Drug Use and Health (NSDUH), revealed that 20.8% of females aged 15-44 had used illicit substances within the past month
  - 9.6% of them were pregnant at the time (NSDUH detailed tables 2022)
  - Cannabis is reported as being the predominant substance
- Many women with substance use disorder (SUD) avoid seeking prenatal care

Considerations

- Postpartum period is a high-risk time for return-to-use
- Drug exposure
- Exposure to other chemicals, irritants, and carcinogens
  - Smoke, pesticides, contaminants
- Impaired maternal judgement

Psychostimulants

- **Amphetamines**
  - Consists of illegal methamphetamine and C2 prescription stimulants (e.g. Adderall)
  - May be ingested orally, smoked, injected, or snorted
  - Highly addictive
  - In 2023, 2.6 million Americans aged 12 or older reported using methamphetamine in the past year
- **MDMA (ecstasy, Molly)**
  - Stimulant and psychedelic
  - Taken orally (capsules, tablets, or powder)
  - Conflicting evidence about addictiveness and dependence
- **Cocaine**
  - May be snorted, smoked, injected, or rubbed on the gums
  - Highly addictive
  - Metabolite concerns
  - In 2023, 5 million Americans aged 12 or older reported using cocaine in the past year

Psychostimulants and Breastfeeding

- According to the 2019 National Survey on Drug Use and Health (NSDUH), **1.79 million women** aged 15-44 years used non-prescribed stimulants in the past month
- Infants exposed in-utero may show signs of **irritability, poor suck, excessive suck,** and **autonomic stress symptoms** *(Bauer 2005, Shah 2012)*
- In one study, mothers who used methamphetamine prenatally (n=204) were significantly less likely to be breastfeeding at hospital discharge (38% vs. 76%; p<0.001) compared to non-users (n=208) *(Shah 2012)*
- Little data on pharmacokinetics in breastfeeding, but would **assume high relative infant dose (RID)**
  - Infant exposure to amphetamine via breastmilk appears similar regardless of route of administration

Psychostimulants and Breastfeeding

Transfer of Methamphetamine (MA) into Breast Milk and Urine of Postpartum Women who Smoked MA Tablets during Pregnancy: Implications for Initiation of Breastfeeding (Chomchai 2016)

- Collected samples of breastmilk and urine from 33 women who had a positive urine drug screen (UDS) for methamphetamine prior to delivery
  - Methamphetamine was undetectable in 22 samples
  - Of the 11 mothers whose initial breastmilk samples were positive, only 2 participants, had detectable methamphetamine levels in at least 4 consecutive samples of breastmilk
  - Calculations showed the excretion half-life in breastmilk was **11.3 hours** and **40.3 hours**
  - The absolute infant doses were 21.3 and 51.7 mcg/kg/day
  - **Methamphetamine levels in breastmilk became undetectable in ~100 hours** after use for both cases, however UDS remained positive for an additional 30-75 hours
  - Conclusion: **methamphetamine is eliminated from breastmilk approximately one day before the mat en at UDS becomes negative**

Psychostimulants and Breastfeeding

Cocaine intoxication in a breast-fed infant (Chasnoff 1987)

- Case report of a 2-week-old infant whose mother used ~500 mg of cocaine intranasally over a 4-hour period and breastfeeding five times during this period
- Three hours after ingestion, the infant became irritable, had dilated pupils, diarrhea, and was vomiting
- The infant also had a high-pitched cry, hyperactive reflexes, frequent startling after minimal stimulation, mood lability, and hypertension
- The infant's urine contained 100 mcg/L of cocaine at 4 and 12 hours after exposure and was detectable up to 60 hours after the mother's last dose
  - Theurine benzoylecgonine concentrationwas 4900 mcg/L at 12 hours post-ingestion and remained near 200 mcg/L until 60hour spost-ingestion
- The mother's milk contained 10-15 mcg/L of cocaine 12 hours after ingestion and was undetectable at 36 hours
- Irritability and tremulousness resolved 12-24 hours after the exposure
- Mild hypertension persisted for up to 72 hours after the exposure

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Psychostimulants and Breastfeeding

- **Potential harms to infants exposed via breastmilk:** GI symptoms, weight loss, tachycardia, tachypnea, hypertension, hypothermia, irritability, tremors, sleep disturbances, and seizures
- There are at least 2 documented cases of infant death related to potential methamphetamine exposure via breast milk *(Arlegno 1995, Kenneally 2020, TSE 2020)*
- Cocaine and its metabolites are excreted in breastmilk (concentrations vary widely)
  - Several case reports of infants exposed to cocaine via breastmilk
  - Newborn infants eliminate cocaine much more slowly than adults

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Substance	Half-Life	Peak effect	RID	Protein Binding	Oral Bioavailability	Molecular Weight	Potential side effects in milk-fed infant	Recommendations*
Methamphetamine	4-13 hours	2.5 hours	?	~20%	67-90%	18.6 Da	Monitor for insomnia, irritability, reduced weight gain, decreased appetite, hyperactivity	Discard milk for 48-96 hours after recreational use (or when mothers urine is negative)
MDMA	3-15 hours	2-4 hours	?	~20%	?	19.3 Da	Monitor for tachycardia, hypertension, seizure, hyperthermia, agitation	Discard milk for 48-72 hours after recreational use
Cocaine	1 hour	0.5 hours	0.03-1.62 (?)	91%	~80%	30.3 Da	Irritability, tremulousness, hypoxia, vomiting, diarrhea, dilated pupils, cyanosis, respiratory distress, tachycardia, and arterial hypertension	Discard milk for 24-36 hours after recreational use

*The use of any illicit substance is contraindicated in lactation. Recommendations are based on pharmacokinetic data, which may vary. Milk should be expressed and discarded regularly to maintain supply

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Illicit Opioids

- **Heroin**
  - Metabolized to morphine
  - May be injected or smoked
- **Fentanyl**
  - 50-100 times more potent than morphine
  - May be injected, taken orally, or snorted
  - High lipophilicity
  - Many illicit substances are adulterated with fentanyl

Opioids and Breastfeeding

- Illicit opioids can vary widely in strength and may contain harmful contaminants
- Infants exposed to opioids in-utero may show signs of **neonatal opioid withdrawal syndrome (NOWS)**, including central nervous system (CNS) hyperirritability, gastrointestinal (GI) dysfunction, respiratory symptoms, and autonomic instability
- The amount of opioids transferred into breastmilk is not enough to treat NOWS, however breastfeeding has been shown to have a positive impact on babies with NOWS
- Patients on methadone or buprenorphine for opioid use disorder (OUD) should be encouraged to breastfeed

Opioids and Breastfeeding

- Fentanyl has been detected in human milk *(Leuschen 1990, Nitsun 2006, Cohen 2009)*
  - Studies estimate that after a 100mcg dose, a fully breastfed infant would receive a fentanyl dosage of 0.005 to 0.02 mcg/kg daily
  - Fentanyl (6.4 ng/ml) was detected in a sample of milk from a mother who chronically used a 100mcg transdermal patch
- There are case reports of infants and children experiencing opioid withdrawal symptoms after their breastfeeding mother stopped utilizing opioids *(Lichtenstein 1990, Eslami-Shahrbabak 2015)*
- Use of short-term (3-5 days) prescribed opioids are generally compatible with lactation
  - Avoid codeine and tramadol due to concerns of variable infant metabolism
  - Oxycodone doses should not exceed 40mg total per day
  - Monitor infants for sedation, poor feeding, and respiratory depression

Illicit Opioids

- The use of injectable illicit drugs also poses the risks of contracting infections (HIV, hepatitis C, etc.)
- Drugs obtained from non-prescribed sources may also be contaminated with other substances
  - Fentanyl
  - Xylazine
- **Naloxone** is available as a reversal agent for opioid induced respiratory depression
  - Infants and children <5 years or ≤ 20 kg: IV (preferred) naloxone 0.1 mg/kg/dose once or 5 mg prefilled syringe IM/SUBQ (absorption may be delayed or erratic) once or 4-8 mg (contents of 1 nasal spray) intranasal as a single dose
  - May repeat every 2-3 minutes if needed
  - Alternate nostril if using intranasal formulation

Substance	Half-Life	Peak effect	RID	Protein Binding	Oral Bioavailability	Molecular Weight	Potential side effects in milk-fed infant	Recommendations*
Heroin	2-8 mins (morphine 2 hours)	Immediate	9-35 % (morphine)	35 %	<3 5%	369 Da	Sedation, respiratory depression, hypotonia	Discard milk for 24 hours after recreational use
Fentanyl	2-4 hours (IV)	Within minutes	2, 9-5%	80-85 %	50-75 %	336 Da	Irritability, tachycardia, confusion, drowsiness, lethargy, miosis, respiratory depression	Discard milk for 24 hours after recreational use (No discarding of milk is needed if pharmaceutical fentanyl is used for short procedures)

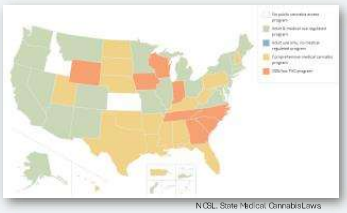
*The use of any illicit substance is contraindicated in lactation. Recommendations are based on pharmacokinetic data, which may vary. Milk should be expressed and discarded regularly to maintain supply.

Cannabis

- Made from the hemp plant *Cannabis sativa*
  - Δ9-Tetra Hydro Cannabinol (THC) has psychotropic properties
    - Other effects: analgesia, antiemetic, appetite stimulant, anticonvulsant, muscle relaxant, sedation
  - Cannabidiol (CBD), cannabigerol, cannabinol and Δ8-tetrahydrocannabinol lack psychoactive effects
    - Effects: anticonvulsant, analgesia, sedation, antiemetics, antispasmodic, anti-inflammatory, anti-anxiety
- World's most used illicit psychoactive substance
  - Among adults aged 19-22 years, cannabis usage has been reported to be as high as 43%
- Routes of use: smoked, eaten (mixed in food ("edibles") or brewed as tea), vaporized
- Highly lipophilic and accumulates in fat tissue
- Federally as schedule I controlled substance (CI)
- Not regulated by the U.S. Food and Drug Administration (FDA)

Cannabis

- As of 06/26/2025:
  - 40 states, 3 territories, and the District of Columbia have approved measures to regulate cannabis for medical use
  - 24 states, 3 territories, and the District of Columbia have approved measures to regulate cannabis for non-medical adult-use
  - 8 states allow the use of "low THC, high cannabidiol (CBD)" products for medical reasons in limited situations or as a legal defense



NCSL State Medical Cannabis Laws

Cannabis

- Prevalence of cannabis use among pregnant and lactating individuals ranges from 3.9-22.6%
- Return to use or increased use within 6-12 months postpartum is common
- Individuals who use cannabis are more likely to use alcohol, tobacco, and other substances as well
- Common reasons for cannabis use during pregnancy include nausea and vomiting relief, pain relief, and management of anxiety or depression
- Cannabis use in pregnancy *(especially after the first trimester)* is associated with placental dysfunction, anemia, hypertensive disorders, low birth weight, and preterm birth
- Neonates exposed in utero often demonstrate altered arousal patterns, regulation, and excitability in the first month of life
- Additional concerns include exposure to smoke and pesticides

ACOG Clinical consensus no. 10: cannabis use during pregnancy and lactation. *Obstetrics & Gynecology*. 2025;145(4):606-611.

Cannabis and Pesticide Risk

- Because the US Environmental Protection Agency (EPA) can only regulate federally approved substances, cannabis is not included
- Grow houses may be using illegal pesticides or pesticides approved for outdoor use only, on indoor cannabis crops
- A 2013 study, published in the Journal of Toxicology, found that up to 69.5% of pesticide residues can remain in smoked cannabis *(Sullivan 2013)*
- Most common illegal pesticides that have been found in cannabis:
  - Myclobutanil ("slightly hazardous")
  - Imidacloprid ("moderately hazardous")
  - Etoxazole
  - Spiromesifen
- Potential health effects of pesticide exposure may be acute (nausea, dizziness, respiratory problems) or chronic (cancer, neurologic problems, reproductive concerns)
- Mothers should be educated on potential risks of pesticide exposure via cannabis use

Cannabis and Breastfeeding

Transfer of Inhaled Cannabis Into Human Breast Milk (Baker 2018)

- Objective: evaluate the transfer of delta-9-THC in human breast milk
- Breast milk samples were collected from mothers (N=8) who regularly consumed cannabis, were 2–5 months postpartum, and exclusively breastfeeding their infants
- Methods: Abstained from use for 24 hours, then smoked 100mg cannabis containing 23.18% delta-9-THC and pumped at 20 minutes and 1, 2, and 4 hours
- Results:
  - The median concentration of delta-9-THC in breast milk was **44.7 ng/mL (IQR 12-42 0.3)**
  - Concentration peaked at one hour with a mean maximum concentration of 194 ng/mL (12.2-42 0.3 ng/mL)
  - The estimated RID was calculated at **2.5% (0.4-8.7%)**, and the average absolute infant dose was estimated at **8 mcg/kg/day**

Cannabis and Breastfeeding

Marijuana Use by Breastfeeding Mothers and Cannabinoid Concentrations in Breast Milk (Bertrand 2018)

- Objective: to quantify cannabinoids in human milk after maternal marijuana use
- Over 3 years, 50 breastfeeding women who reported marijuana use provided 54 breast milk samples to a research repository
- Results:
  - Delta-9-THC was detectable in 34 (63%) of the 54 samples up to ~6 days after last reported use; the median concentration of Δ9-THC was **9.47 ng/mL (IQR 1.01–32 3.00)**
  - Five samples had detectable levels of 11-hydroxy-Δ-9-tetrahydrocannabinol (IQR 1.33-12.50 ng/mL) or cannabidiol (IQR 1.32-8.56 ng/mL).

Cannabis and Breastfeeding

Cannabis use and measurement of cannabinoids in plasma and breast milk of breastfeeding mothers (Moss 2021)

- Prospective observational study of mothers who used cannabis and were breastfeeding (N=20)
  - 89% used cannabis within the last 24 hours and 63% within the last 6 hours
- Milk and plasma samples were collected at 2 weeks and 2 months postpartum
- Results:
  - 38 plasma and 35 breast milk samples were collected between two visits, all except one breast milk sample had at least one cannabinoid or metabolite detected. The sample with no detectable cannabinoids was collected 40 h after last cannabis use
  - Breast milk samples contained a median of **27.5 ng/mL THC (IQR 0.8–19 0.5 ng/mL)** compared to 3.7 ng/mL in plasma, yielding a median **milk-to-plasma (M/P) ratio of 7.0**
  - Based on the THC concentrations found in breast milk, the estimated infant dose is **0.83 mcg/kg (0.024–5.7 mcg/kg)** yielding an estimated daily infant dose of **17.7 mcg/day (or 4.12 mcg/kg/day)** with a range of 0.52–123 mcg/day

Cannabis and Breastfeeding

- There are few studies about the effects of maternal cannabis use on breastfed infants and it is difficult to separate them from use during pregnancy
- In one study, cannabis exposed infants (n=68) had slightly reduced motor development at 1 year of age (compared to unexposed infants (n=68)), especially among those who reported smoking cannabis more than 15 days per month during the first month of lactation. No effect was found on mental development *(Astley 1990)*
- A cross-sectional survey (n=3207) conducted in Colorado in 2014-2015 found that both prenatal and postnatal cannabis use were associated with a shorter duration of breastfeeding *(Crume 2018)*
  - Among women who used cannabis during pregnancy, 88.6% initiated breastfeeding, compared with 93.8% of women who did not use cannabis during pregnancy (P = .1)
  - Among women who reported using cannabis during pregnancy, 64.4% breastfed for > 9 weeks compared with 78.3% of women who did not use cannabis during pregnancy (P = .02)
  - Among women who reported postpartum cannabis use, 57.6% breastfed for > 9 weeks compared with 78.7% of women who did not use cannabis postpartum (P = .001)

Cannabis and Breastfeeding

- THC and its metabolites are detectable in breast milk
- THC metabolism varies greatly among users
- THC levels in milk peak around 60 minutes
- THC has a predicted half-life in breast milk of 12-39 hours
- THC has been detected in breast milk for up to 6 weeks after reported abstinence post-delivery *(Wymore 2021)*
- THC and its metabolites have been detected in blood and urine samples of breastfed infants whose mothers reported chronic cannabis use *(Mabey 2022, Bouquet 2023)*
- Some studies suggest cannabinoids may alter the composition of breast milk (lipids, free fatty acids, secretory IGA, etc.)

Substance	Half-Life	Peak effect	RID	Protein Binding	Oral Bioavailability	Molecular Weight	Potential side effects in milk-fed infant	Recommendations*
THC	25-56 hours	15-30 mins	0.4-8.7%	99%	10-35%	314 Da	Sleepiness, seizure, apnea, poor feeding, weight gain, neurobehavioral or psychomotor delays?	Use should be limited especially in the first month postpartum, assess risk vs. benefit

*The use of any illicit substance is contraindicated in lactation. Recommendations are based on pharmacokinetic data, which may vary. Milk should be expressed and discarded regularly to maintain supply.

Sedative-hypnotics

- Use of sedative-hypnotics (prescribed and nonprescribed) affects 1.9% of pregnancies globally
  - Rates of nonprescribed use affect ~1.2% of women in the United States
- Infants exposed in-utero may experience neonatal abstinence syndrome (NAS), preterm delivery, low birth weight, floppy baby syndrome, and respiratory depression
- Prescribed benzodiazepines and z-drugs (zolpidem, eszopiclone) generally have a RID <10%
- Potential infant harms include risk of respiratory depression, sedation, tremors, and poor weight gain

Substance	Half-Life	Peak effect	RID	Protein Binding	Oral Bioavailability	Molecular Weight	Potential side effects in milk-fed infants	Recommendations*
Alprazolam (Xanax)	12-15 hours	1-2 hours	8.5%	80%	90%	309 Da	Sedation, respiratory depression, poor feeding/weight gain, withdrawal	L3 Okay when prescribed at low doses for short-term or intermittent use
Diazepam (Valium)	43 hours	30-60 mins	0.86-7.14%	99%	100%	285 Da	Sedation, respiratory depression, poor feeding/weight gain, hypotonia, bilirubinemia	L3 Okay for prescribed one-time doses in surgery. Consider alternative if needed for long-term use
Lorazepam (Ativan)	12 hours	2 hours	2.6-2.9%	85-93%	90%	321 Da	Sedation, respiratory depression, poor feeding/weight gain	L3 Preferred prescription benzodiazepine for postpartum use
Clonazepam (Klonopin)	18-50 hours	1-4 hours	2.8%	50-85%	100%	316 Da	Sedation, respiratory depression, poor feeding/weight gain, hypotonia	L3 May use at low doses for short-term use with caution. Consider alternative if needed for long-term use

*The use of any illicit substance is contraindicated in lactation.

Substance	Half-Life	Peak effect	RID	Protein Binding	Oral Bioavailability	Molecular Weight	Potential side effects in milk-fed infants[Δ]	Recommendations*
Ketamine	2-3 hours	5-30 minutes	0.65-0.76%	10-50%	20-30%	274 Da	None reported via milk. Monitor for sedation, irritability, poor feeding	Discard milk for 24 hours after recreational use (No discarding of milk is required if used for short procedures)
Mescaline	6 hours	1-3 hours				211 Da	Monitor for hypertension, tachycardia, hyperthermia, seizure, irritability, flushing, ataxia	Discard milk for 48 hours after recreational use
Psilocybin	2-3 hours	30-60 minutes			50%	284 Da	Monitor for hypertension, tachycardia, hyperthermia, seizure, irritability	Discard milk for 24 hours after recreational use
Phencyclidine (PCP)	24-51 hours	30-90 minutes		65%	50-90%	243 Da	Monitor for tachycardia, hypertension, nystagmus, seizure, hyperthermia	Recommend cessation of breastfeeding or consider discarding milk for 15-45 days after recreational use
Lysergic acid diethylamide (LSD)	3-21 hours	30-60 minutes			71%	268 Da	Monitor for hypertension, tachycardia, hyperthermia, seizure, irritability	Recommend cessation of breastfeeding or consider discarding milk for 7 days after recreational use

Δ Extracted from reported side effects in adult users
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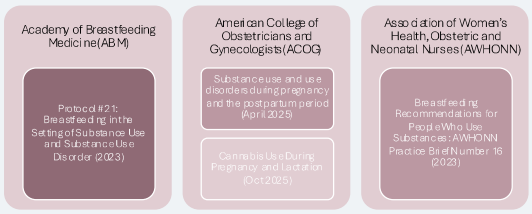
Guidelines



Academy of Breastfeeding Medicine (ABM)

- **Stimulants:** Breastfeeding should be avoided during the use of non-prescribed stimulants. Individuals prescribed stimulants for the treatment of ADHD may safely breastfeed
- **Opioids:** Breastfeeding should be avoided during the use of non-prescribed opioids. Pumping should be recommended in cases of recent use if future abstinence is supported
- **Cannabis:** Encourage cessation and/or reduction of cannabis use during lactation
- **Sedative hypnotics:** Breastfeeding should be avoided during the use of non-prescribed sedative hypnotics. Individuals prescribed benzodiazepines for the treatment of benzodiazepine use disorder or for anxiety disorders may safely breastfeed.

Academy of Breastfeeding Medicine (ABM)

- "Breastfeeding initiation timing: **women who discontinue non-prescribed substance use by or during the delivery hospitalization can be supported** in breastfeeding initiation"
- "**Establish consistent approaches**: Individual programs and institutions should establish breastfeeding guidelines to mitigate bias, facilitate consistency across providers, and empower individuals with SUD."
- "Targeted perinatal dyadic breastfeeding care such as prenatal education, inpatient and postpartum lactation support, and ongoing multidisciplinary SUD treatment can facilitate breastfeeding continuation"

American College of Obstetricians and Gynecologists (ACOG)

- **Stimulants:** Breastfeeding discouraged with illicit use; prescribed stimulants at therapeutic dosages may be safe
- **Opioids**: Breastfeeding encouraged if using methadone or buprenorphine
- **Cannabis:** Secreted into breast milk; abstinence recommended

American College of Obstetricians and Gynecologists (ACOG)

- "…obstetric health care professionals should be knowledgeable and educate all individuals presenting for pregnancy, pregnancy, and postpartum care on specific perinatal and newborn risks of cannabis use during pregnancy and lactation. … there are no medical indications for cannabis use during pregnancy and the postpartum period."
- "…should be aware of procedural, social, and legal consequences of positive screens…should actively work to address inequities inherent in many existing systems"
- "…perform universal screening by interview, self-report, or validated screening tools for cannabis use…. Biologic testing should not be used as a screening assessment for cannabis use."
- "…should advise cessation of cannabis use during pregnancy and lactation. However, **continued cannabis use is not a contraindication to breastfeeding, and breastfeeding should not be discouraged**."

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

- Ongoing cocaine and/or amphetamine use is contraindicated during breastfeeding. In this situation, alternative sources of infant nutrition should be provided
- Following methamphetamine use, 48 to 100 hours (72 hours average) are needed to ensure the safety of breast milk. As such, resumption of breastfeeding should be delayed until 24 hours after a methamphetamine-negative urine analysis result *(Blandthorn et al., 2017; Chomchai et al., 2016; Drugs and Lactation Database, 2022)*
- While the chemical components of marijuana are known to transfer into breast milk, the dose of these substances and polysubstance use can affect the level of exposure experienced by nursing infants *(Metz & Borgelt, 2018)*
- Since marijuana has been linked to adverse birth and neonatal outcomes, such as intrauterine growth restriction and preterm birth, breastfeeding people should abstain from marijuana use *(Metz & Borgelt, 2018; Ryan et al., 2018; Thompson et al., 2019)*

PRACTICE POINTERS FOR LACTATION CONSULTANTS

Counseling

- Ask about substance use in a non-judgmental way
  - Substance, frequency, amount
- Ask purpose for using
- Ask about care for child when use occurs
- Ask if mother is open to alternative medications or treatment

Considerations

- Utilize shared decision-making to discuss the risks and benefits
  - Benefit/impact of taking or not taking the drug for the mother
  - Effect on milk supply
  - Infant exposure
  - Potential harm to infant
  - Risk of not breastfeeding/ risk of formula feeding

Considerations

- Consider creating a relapse plan in patients with a history of substance abuse
- Stress the importance of avoiding co-sleeping in active users
- Remind mothers to avoid second-hand smoke exposure in infants and keep substances out of reach of children
- Educate on concerns for parenteral sedation and reduced ability to respond to infant cues

10 Things Pregnant and Parenting Women Who Use Substances Would Like Practitioners to Know

1. Mothers **want to succeed**. Don't assume we are not trying, or that we chose the challenges we face.
2. **Language matters** – Say things like "I have seen this help others, maybe this will work for you" not "you should."
3. Show **empathy,** not pity.
4. Show more **compassion**, less condescension.
5. Be a **support**- get behind us.
6. Listen, **be curious** about what might work for each of us.
7. Be **educated**. There are a lot of things that play into addiction.
8. Just because you are still using **does not make you a bad mother.**
9. Not everyone takes the same path to recovery. **Listen** to where each woman is at in her journey and what will work for her.
10. **Don't judge.** Instead care

Schmidt, R. et al (2019)

Examining Language

Words to avoid	Words to use	Why this helps
Addict, junkie	Person who uses substances or women with OUD	Person first language
Being "clean" or former addict	In recovery	Non-judgmental language
Relapsed	Had a setback or recurrence of use	
Opioid misuse or abuse	Opioid use, "experience with opioids"	
Suffering from…, Victim of…	Has a history of…, Working to recover from…, Living with…, or Experiences of…	Recovery-oriented language
Opioid replacement therapy	Medication for Opioid Use Disorder (MOUD)	Medically accurate language
Born addicted to opioids, addicted babies	Experienced withdrawal symptoms at birth, exposed to substances in utero, neonatal withdrawal	

Schmidt, R. et al (2019) and "Caring for Women with Opioid Use Disorder" (2020)

Trauma-Informed Care

- A comprehensive approach to patient care
- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma
- Responds by fully integrating knowledge about trauma into policies, procedures and practices
- Seeks to actively avoid re-traumatization

"What's wrong with you?" → "What happened to you?"

Providing Trauma-Informed Care

Provide a safe and calm environment | Build and maintain trust | Offer support | Collaborate | Empower | Avoid stereotypes and cultural biases

Ohio Substance Abuse Resources

- Maternal Opiate Medical Supports (MOMS) Project (moms.ohio.org)
- Ohio Perinatal Quality Collaborative (OPQC)
- The Rainbow Interdisciplinary Substance Exposure (RISE) program at University Hospitals (216-675-6770 RISE@UHhospitals.org)
- Substance Abuse, Treatment, Education and Prevention Program (STEPP) at The Ohio State University Wexner Medical Center's Maternal Fetal Medicine practice
- The Helping Opiate-addicted Pregnant women Evolve (HOPE) program at TriHealth in Cincinnati
- Ohio Crisis Text Line: Text the keyword "4HOPE" to 741741 to be connected to a trained Crisis Counselor

Other Substance Abuse Resources

- U.S. Department of Health and Human Services, Health Resources and Services Administration, Caring for Women with Opioid Use Disorder. Rockville, Maryland: U.S. Department of Health and Human Services, 2020.
- Schmidt, R., Wolfson, L., Stinson, J., Poole, N., & Greaves, L. (2019). Mothering and Opioids: Addressing Stigma and Acting Collaboratively. Vancouver, BC: Centre of Excellence for Women's Health
- Substance Abuse and Mental Health Services Administration (SAMHSA). Substance abuse treatment facility locator.

Take Away Points

- More data is needed on the use of illicit substances, and cannabis in lactation
- Not everyone who uses substances abuses them or has a substance use disorder
- Breastfeeding should be encouraged in all mothers who are stable on medication for opioid use disorder
- Breastfeeding may improve outcomes in infants with NAS or NOWS
- The use of any illicit substance is contraindicated in lactation, however you can provide nursing mothers with information to allow them to make an informed decision on when/if to resume breastfeeding after using a substance
- Practice using a trauma-informed approach
- Your approach and the words you use matter

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Questions?

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