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Clinical Opinion Letters Regarding Breastfeeding and Neonatal Abstinence Syndrome for Child Apprehension Family Court Proceedings

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Abstract

The accelerating reach of opioid use disorder in North America includes increasing prevalence among pregnant people. In Canada, the rate of Neonatal Abstinence Syndrome (NAS) rose 27% between 2012-2013 and 2016-2017, and it is estimated that 0.51% of all infants now experience NAS after delivery. Pregnant people are a priority population for access to opioid replacement therapy programs. Participation in such programs demonstrates significant commitment to self-care among pregnant people and concern for fetal and infant wellbeing. Participation in opioid replacement therapy often results in family surveillance by Child Protection Services and infant apprehension. Children of Indigenous descent are held in foster care at high and disproportionate rates.The Convention on the Rights of the Child principle of Best Interests of the Child governs family law and child access decisions. The value of breastfeeding for all children and in particular for children recovering from NAS can be a consideration in the Best Interest of the Child. Clinicians with expertise in lactation may support the breastfeeding dyad to remain together by preparing Clinical Opinion Letters for the court. This Insights into Policy presents a how-to description of the content of clinical opinion letters in such cases, including context and process considerations, client background, breastfeeding science, and factors specific to neonatal abstinence syndrome.

Keywords

Breastfeeding barriers, breastfeeding benefits, breastfeeding support, infant development, maternal health

Background

The accelerating reach of opioid use disorder in North America includes increasing prevalence among pregnant people. The American College of Obstetrics and Gynecology (ACOG) reports that between 2000 and 2009 perinatal opioid use disorder in the United States increased 600% and between 1999 and 2013 the rate of neonatal abstinence syndrome (NAS) rose from 1.5 cases per 1000 births to 6.0 cases per 1000 births (ACOG, 2017). In Canada, the rate of NAS rose 27% between 2012-2013 and 2016-2017, and it is estimated that 0.51% of all infants now experience NAS after delivery (Canadian Institutes of Health Information, n.d.; Lacze-Masmonteil, O'Flaherty, Canadian Pediatric Society, 2018).

Pregnant people are a priority population for access to opioid replacement therapy (ORT) programs such as methadone or buprenorphine therapy (Zedler et al., 2016). Opioid replacement therapy reduces parental and fetal withdrawal symptoms that increase risk of miscarriage and harm to the fetus. Available in oral preparations, methadone and buprenorphine reduce potential exposure to blood-borne infectious diseases such as HIV and Hepatitis C, and reduce the risk of survival crime to access opioids (Welle-Strand et al., 2013). The programs usually require a daily appearance at the program site or participating pharmacy, observed administration of the medication, random urine screening for other substances, and may also include other therapeutic modalities such as group discussions or assistance with social issues including housing. Participation in such programs demonstrates significant commitment to self-care among pregnant people, and concern for fetal and infant wellbeing. Opioid replacement treatment (ORT) is a key harm reduction strategy. However, methadone and buprenorphine will cross the placental barrier in pregnancy. It is estimated that 50-80% of opioid-exposed babies will develop NAS (Bagley et al., 2014).

Despite the value of ORT for reducing clinical and social harm, it remains stigmatized (Stone, 2015). In Canada,

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participation in ORT often results in surveillance by Child Protection Services. In the province of Manitoba, with a population 1.2 million, more than one child is apprehended per day, and 45% of apprehended infants experience medical concerns including NAS (Puxley, 2015). The disproportionate rate at which children of Indigenous descent are held in foster care in Canada was described by Minister Jane Philpott as a "humanitarian crisis" echoing the Residential School System (The Guardian, 2017). Denison, Varcoe and Browne (2014) found that fear of child apprehension influenced Aboriginal women's healthcare service-seeking behaviors in the province of British Columbia. Among the many disproportionate health burdens experienced by children of Indigenous descent is that they experience lower rates of breastfeeding in Canada than non-Indigenous children, and higher risks of harm associated with not breastfeeding (Badets, Hudon & Wendt, 2017).

Canada ratified the United Nations' Convention on the Rights of the Child (UNCRC) in 1991. The third article of the Convention is the principle of Best Interests of the Child (BIC), a principle that is integrated in family law legislation, under provincial/territorial jurisdiction, across Canada. The UNCRC does not define BIC. It is understood to have three parts: That it is a substantive legal right; that it is an interpretive principle such that all conflict must be resolved in such a way that best serves the child's interests; and that it is a rule of procedure with regards to the child's representation, timely decisions, and reasoning behind decisions (Canadian Bar Association, n.d.) Provincial legislation, such as the Family Law Act of British Columbia (2011), specify that considerations of BIC include health and well-being. Article 24 of the UNCRC states that children have a right to "enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." The ample evidence of health promotion through breastfeeding and human milk supports continuous contact with the lactating parent to achieve these health outcomes.

The apprehension of infants experiencing NAS from parents in ORT may not sufficiently consider the BIC and Article 24 if there is a deficit of understanding in relation to the value of breastfeeding. There is a persistent social belief that although breastfeeding may be accepted as *better* in terms of infant nutrition, it is not conceptualized as *necessary.* There is a misunderstanding that breastfeeding among participants in ORT is harmful. In fact, breastfeeding for the infant with NAS by a parent in ORT improves recovery (Welle-Strand et al., 2013). Rooming-in has been shown to improve infant recovery from NAS, reducing length of stay and the need for pharmacotherapy (Newman et al., 2015).

Rephrasing value of breastfeeding from something additive and positive to the harm of not breastfeeding as something harmful may be supportive of BIC. However, this strategy runs the risk of further penalizing families who struggle with breastfeeding, and thus should be used only when parents are committed to breastfeeding but prevented from doing so for external reasons such as apprehension. Evidence shows separation of the breastfeeding dyad is an impediment to breastfeeding (World Health Organization, 2003). Not breastfeeding may impede infant recovery from NAS. Not breastfeeding reduces infant nutrition and development of healthy attachment. Furthermore, not breastfeeding also creates risks to parental health. Breastfeeding is protective against postpartum depression, to which women with histories of trauma are vulnerable (Seng, Sperlich, Kane, Ronis & Muzik, 2013). Childhood exposure to trauma is also strongly linked to adult experience of substance use disorder (Khoury, Tang, Bradley, Kubells, Ressler, 2016).

It would be beneficial for the Clinical Opinion Letter to be sought prior to child apprehension as a preventative measure. Improving collaboration between nursing, family law, and Child Protection Services may facilitate earlier introduction and communication of the major considerations regarding rights to breastfeed and value of breastfeeding, and reduce the harm of infant-parent separations.

Key Messages

- Increasing opioid dependence is resulting in more infants born with neonatal abstinence syndrome (NAS) at risk of apprehension from their breastfeeding parents.
- Nurses can play a key role in providing clinical opinion letters in custody proceedings to support access between lactating parent and child for breastfeeding.
- Clinical opinion letters should explain the context of the family, the intention to breastfeed, and the benefits of breastfeeding for both parent and for the infant with NAS.

Statement of the Issue

In this *Insights into Policy*, I present an argument for the use of Clinical Opinion Letters by nurses, lactation consultants and physicians to provide the Family Court with expertise on breastfeeding and the Best Interests of the Child in apprehension cases. As clinicians caring for breastfeeding dyads, we may feel powerless when we learn of Child Protection Services involvement with patients. Clinical Opinion Letters present one tangible tool we may use to support breastfeeding among clients with substance use disorder in our hospitals and in our communities.

Presentation of the Recommendations

This article presents a how-to description regarding the preparation of Clinical Opinion Letters (COL). The letter must be requested by defense counsel. The author should interview the client to understand their living context, breastfeeding experience, and family court matter(s). The COL may include

a cover page that outlines administrative details, including the limitations of the letter, such as its basis on limited interviews with the client; a discussion of the process through which the author was introduced to the client specific to names, places, and dates; an explanation of how the author came to be involved in the case; and any conflicts of interest, such as direct clinical relationships of care between author and client.

Introduction

The Introduction should state that the letter is in response to a defense counsel request for a COL regarding breastfeeding and the BIC and that there are several clinical factors the Court may wish to consider in the custody and access decisions regarding the infant. For example, there is ample evidence that human milk provides optimal nutrition, without equal, for all infants (Martin, Ling, Blackburn, 2016). Harms to children associated with not breastfeeding include increased risk of sudden infant death syndrome (SIDS) and postneonatal death (Chen & Rogan, 2004), infection, obesity, chronic illness, and lower cognitive function (Victora et al., 2016). The World Health Organization (WHO), UNICEF (2003), and Health Canada (2015) recommend exclusive breastfeeding to six months of age. The UNCRC (UN, 1989) Article 3, Best Interests of the Child, and Article 24, Right to Enjoy Health, support the right to breastfeed and access human milk. The UN (2013) argues that "suboptimal breastfeeding practices" (p.7) contribute to infant deaths and states are obligated to devote "particular attention to ensuring full protection and promotion of breastfeeding practices" (p.9) to support exclusive breastfeeding to six months of age (p.11).

The introduction may state that there are unique considerations for the client and child that should be taken into consideration, including but not limited to client motivation to breastfeed; challenges to breastfeeding for this dyad; the importance of breastfeeding for this dyad; and the importance of rooming in and skin to skin contact for infant recovery from neonatal abstinence syndrome.

Background

The background section should provide demographic information about the client, such as age, race, Indigenous identity, age of child(ren), and care arrangements for the children. It is useful to explain whether or not the client comes from a family in which breastfeeding is practiced, if the client was breastfed themselves, and if they breastfed other children, in order to develop the Court's understanding of the client's motivation, education, and experiences of breastfeeding.

This section can be used to describe the client's concern regarding maintaining breastfeeding while separated from their child. It should also do the following: Provide clinical descriptions of Lactogenesis III and emphasize that it is a 'supply and demand' system controlled at the breast that improves with skin to skin contact; describe the client's effort to maintain supply during separation, for example, their pumping schedule and human milk storage arrangements; and clarify that pumping milk, a substitute process for feeding at breast, is not necessarily adequate to maintain supply, nor is it predictive of longterm success with breastfeeding (Flaherman et al., 2016; Johns et al., 2013).

Furthermore, this section should provide a picture of the client's context; describe the client's housing and community breastfeeding supports, such as local drop-in groups and home visits from Public Health nurses; acknowledge any history of criminalization the client has experienced, and status, such as probation; outline the client's history of substance use disorder, whether they are receiving ORT, and the program's adherence protocol, such as random urine screening; and explain that there may be other relevant prescription medications such as psychotropics.

Finally, this section should describe the experience of the apprehension for the client, the access visit schedule and circumstances, if applicable, and whether or not the client has been permitted to provide pumped milk or nourish the infant at the breast during those visits.

Barriers to Breastfeeding

In this section, describe how knowledge, attitudes, and social support are known factors in the decision to breastfeed (Buckner & Matsubara, 1993; Casal, Lei, Young & Tuthill, 2016); outline the specific barriers faced by marginalized populations, such as lack of family role models and exposure to breastfeeding from which to develop knowledge and positive attitudes (Paynter & Snelgrove-Clarke, 2017); attend to issues of class, race, and indigeneity, and whether or not there are lower breastfeeding rates in these populations (Jones, Power, Queenan & Schulkin, 2015; Moffitt & Dickinson, 2017); use current statistics – for example, in 2012, the rate of breastfeeding initiation among Aboriginal women in Canada was 77.8%, compared with 86.7% among white women, and 87.3% among women in Canada as a whole (Health Canada, 2012).

Finally, describe how these intersecting issues demonstrate challenges for the client, how the client may have developed an understanding and motivation to breastfeed despite these challenges, and the client's commitment to the effort and time involved in maintaining milk supply while separated.

Breastfeeding and Neonatal Abstinence Syndrome (NAS)

The COL should provide a basic description of neonatal abstinence syndrome (NAS) as manifesting in gastrointestinal, neurological, and general symptoms of irritability, such as tremors, crying, and feeding intolerance. In this section explain that NAS results from prenatal substance use.

Explain the dangers of withdrawal during pregnancy, and that ORT is recommended as it reduces the risk of infection and of miscarriage. Provide details regarding when the client began ORT.

Explain that methadone and/or buprenorphine is transferred into human milk. A systematic review of the evidence has found that breastfeeding reduces NAS severity, the need for and length of pharmacological intervention, hospital length of stay, and that it delays NAS onset (Bagley, Wachman, Holland & Brogly, 2014). Methadone transfer into breastmilk varies because of differences in dose, cytochrome polymorphisms, breastfeeding frequency and duration, and production of fore versus hind-milk, as the latter has higher fat content and methadone is lipophilic (Bogen et al., 2011). Even at high parental doses, breastfed infants receive less than 0.1 mg/kg/day of methadone through the parent's own milk (Bogen et al., 2011). Trace amounts of methadone in human milk may mediate NAS. Skin-to-skin contact while breastfeeding and the dietetic quality of breastmilk may also relieve NAS symptoms (Welle-Strand et al., 2013).

Breastfeeding and Parental Health

Although the focus of the COL is the BIC and the child's Right to Enjoy Health, you may acknowledge in this section that breastfeeding has significant health benefits to the parent. Positive health impacts of breastfeeding include weight loss; bonding; and reduced risk of reproductive cancers, metabolic diseases including diabetes, cardiovascular disease, and depression (Dietrich et al., 2013; Watkins et al., 2011). Psychosocial factors such as stress and lack of support negatively influence breastfeeding duration (de Jager et al., 2013). Emphasize that the client should not only be allowed to breastfeed, but should be encouraged and supported in the practice.

Summary

Close with a clinical opinion statement saying that despite intersecting socio-political factors challenging client's ability to breastfeed, the client exhibits motivation to succeed in breastfeeding; client and child will benefit from breastfeeding; breastfeeding success is facilitated by continuous contact; and that there are significant clinical harms caused by not breastfeeding for both parent and child health.

Conclusion

A Clinical Opinion Letter that applies the United Nations Convention on the Rights of the Child principles of Best Interests of the Child, and of the Right to Enjoy Health, to a clinical analysis of the harm of not breastfeeding for infants recovering from NAS, may support access and custody for breastfeeding parents.

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