Provincial Clinical Guideline	

Title: Substance Use and Breastfeeding

Level: Provincial
Service Area: Postpartum and Neonatal Care
Applicable to: All healthcare providers, organizations, and facilities across Manitoba involved in delivering health services provided or funded by the government or a health authority.

Approved by: Provincial Women and Children Program

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1.0. Purpose

1.1. To provide information to health care providers caring for people exposed to prescribed and non-prescribed substances and who wish to breastfeed to support breastfeeding success, when appropriate.

Note: The term breastfeeding is used throughout this guideline. This term may not always be the preferred term for all clientele. Please ask each client what language they feel most comfortable with regards to infant feeding (e.g., chestfeeding) and other gendered terms. Please see 3.1.3 and 3.1.4 for more information regarding Gender Inclusivity and Gender Identity.

Note: The term client is used throughout this guideline to represent the recipient of health care in both acute care and community settings.

2.0. Scope

2.1. Applies to all health authorities in Manitoba, where postpartum and neonatal care is provided.

2.2. Applies to all healthcare providers (nurses, midwives, physicians, allied health professionals) in acute care facilities and community settings in all health authorities where postpartum and/or neonatal care is provided.

3.0. Definitions

3.1. Defined Terms

3.1.1 Cultural Humility: A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience (First Nations Health Authority, n.d.).

3.1.2 Cultural Safety: An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when integrating their identity, culture and communication into their health care decisions and interactions (Schmidt et al., 2019; Perinatal Services BC, 2021).

3.1.3 Gender Identity: How someone thinks and feels about the sex they are. For example, how someone emotionally or spiritually identifies as a man, woman, both, or neither. Sometimes gender identity does not match biological sex (Sexuality Education Resource Centre [SERC], 2023).

3.1.4 Gender Inclusivity: As the medical community grows in its understanding of the spectrum of gender, our language, assumptions, and implicit biases must evolve away from binarism and over evaluation of biologic sex. Traditional perinatal care is heavily gendered and parents who identify outside of explicit cisgendered norms encounter barriers and discrimination in care. Gender inclusion results in a safe and dignified space for all parenting persons, with less emphasis on newborn sex. It is respectful to ask what terms a person is most comfortable using (e.g., chestfeeding over breastfeeding).

3.1.5 Harm Reduction: A client centered approach to care that helps people reduce the harmful impacts of substance use and addictions through informed decision making in a non-judgmental non-coercive setting to live safer and healthier lives (Canadian Mental Health Association, n.d.).

3.1.6 Neonatal Abstinence Syndrome (NAS): Inclusive of neurologic, gastrointestinal, and musculoskeletal signs and symptoms associated with withdrawal when substance sources are interrupted at birth (Perinatal Services BC, 2020).

3.1.7 Neonatal Opioid Withdrawal Syndrome (NOWS): Inclusive of clinical features specific to withdrawal from opioids. The severity of the effects experienced by the infant, as well as the onset and duration of the symptoms is dependent on the half-life of the substance used, but overall is not well understood. For example, methadone and buprenorphine have a longer half-life resulting in later onset of withdrawal, whereas most other opioids have a shorter half-life and results in early onset of symptoms (Perinatal Services BC, 2020).

3.1.8 Stigma: A set of negative attitudes or beliefs about a person or a group based on a quality, behaviour, or circumstance (Schmidt et al., 2019). Language can be stigmatizing; therefore, healthcare providers should be aware of the language they use when communicating with clients. See Appendix A - Stigmatizing Language.

3.1.9 Strengths-Based Health Care (SBHC): Recognizing, mobilizing, capitalizing on, and developing a person's strengths to promote health and facilitate healing. It is a means of empowering not only clients and their families, but also clinicians, practitioners, leaders, and managers. SBHC has the potential to transform a depersonalized and fragmented health care system into a personal and collaborative model that fosters opportunities for self-healing, engenders hope, and enables clients to draw upon their strengths even in the most difficult circumstances.

3.1.10 Substance Use Disorder: A chronic condition where there is a pattern of continued substance use despite negative medical or social consequences.

3.1.11 Trauma Informed Care (TIC): A framework that is comprised of 6 principles: safety, trustworthiness/transparency, peer support, collaboration/mutuality, empowerment (voice and choice), and cultural/historical/gender issues (Sperlich et al., 2017). TIC also recognizes the widespread impact that trauma has on individuals and the risk of unintentional re-traumatization in the healthcare setting.

3.1.11(a) Experiences that feel isolating, overwhelming, or evoke a feeling of helplessness can trigger a trauma response. Actions that may be triggering can include, but are not limited to:

- Addressing a client in diminutive terms like “sweetie”;
- Excluding a client from care decisions;
- Using depersonalized language or labelling an individual with terminology such as “an addict” or “drug user”.

3.1.11(b) Settings and circumstances that may prompt a trauma response can include:

- Large group settings;
- Sudden change;
- Limited explanations.

3.1.11(c) Trauma-informed strategies reinforce/protect autonomy, personhood, and parental voice. This can include actions such as:

- Inviting parents/guardian or designated support person to lead the discussion with their observations;
- Reading all chart notes to avoid needless repetition of client story;
- “Sports-casting” (i.e., offering step by step narration of actions) during exams and interventions to engage parent more like a peer;
- Considerate language that is non-judgmental (e.g., sensitivity with the term “withdrawal” since the adult experience is one of profound pain and suffering. “Symptoms that can cause weight loss,” for example, is

more neutral and sets the stage for solution-oriented conversation).

3.1.11(d) Seeking opportunities to maximize safety, relationship and agency are meaningful antidotes to the features of trauma.

3.1.12 Truth & Reconciliation Commission (TRC) - Informed Cultural Safety: The first Call to Action of the TRC is to honour and preserve the family unit and community ties of Indigenous persons (Truth and Reconciliation Commission of Canada [TRC], 2015). This Call identifies a history of cultural bias and inequity that has been evident in Canada's Child Protection Service agencies, and challenges Canadians to seek healing within and between communities. Parents who have been supported on Opioid Agonist Therapy during pregnancy have had a disproportionate and sometimes unindicated involvement with CFS, exacerbating these racialized inequities. Providers should be aware of the risk of infant apprehension that is linked to substance use disorders, and the deep sense of anxiety clients feel about losing their child as an unintended consequence of their medical therapy. This is also Trauma Informed Care.

3.2. Abbreviations

3.2.1 ADHD: Attention Deficit Hyperactivity Disorder

3.2.2 AWHONN: Association of Women's Health, Obstetric, and Neonatal Nurses

3.2.3 CFS: Child and Family Services

3.2.4 CPS: Canadian Pediatric Society

3.2.5 HIV: Human Immunodeficiency Virus

3.2.6 MBq: Megabecquerel

3.2.7 NAS: Neonatal Abstinence Syndrome

3.2.8 NOWS: Neonatal Opioid Withdrawal Syndrome

3.2.9 PCP: Phencyclidine

3.2.10 SBHC: Strengths-Based Health Care

3.2.11 SIDS: Sudden Infant Death Syndrome

3.2.12 SSRIs: Selective Serotonin Reuptake Inhibitors

3.2.13 STBBI: Sexually Transmitted and Bloodborne Infections

3.2.14 TIC: Trauma-Informed Care

3.2.15 TRC: Truth and Reconciliation Commission

3.3. Professional Groupings

3.3.1 Nurse: Applies to a Registered Nurse, Registered Psychiatric Nurse, Licensed Practical Nurse, or Nurse Practitioner.

4.0. Guideline

4.1. Breastmilk can help infants attain optimal growth and development. As such, whenever possible, breastfeeding is supported. Healthcare providers will ask all pregnant and breastfeeding people about medication and substance exposure, throughout the perinatal period. All disclosed substances, both prescribed or not prescribed, are reviewed for compatibility with breastfeeding. When compatibility of a substance with breastfeeding is unclear, abstinence from the substance is the only completely safe option to prevent adverse health outcomes in the newborn. However, there may be times when breastfeeding paired with harm reduction strategies, and support from health and social services may allow the birth parent to meet their breastfeeding goals, while simultaneously addressing their substance exposure issues (i.e. “Work with me where I’m at, not where you want me to be” (Shared Health, n.d.). See 4.13 for Substance Specific Guidance and Appendix B - Substance Use and Breastfeeding Traffic Light.

4.2. Follow guidance on care for newborns at risk for Neonatal Abstinence Syndrome (NAS) & Neonatal Opioid Withdrawal Syndrome (NOWS) in acute care facilities as appropriate. See Resource 6.1 – Shared Health, Provincial Clinical Guideline: Eat Sleep Console.

4.3. Please refer to resources such as the Drugs and Lactation Database (LactMed®) (See Resource 6.2) or a recent copy of *Hale’s Medications &*

Mother's Milk: A Manual of Lactational Pharmacology by Thomas W. Hale and Kaytlin Krutsch to review breastfeeding recommendations in relation to specific substances used while breastfeeding (Hale & Krutsch, 2023).

4.4. Substance use may be disclosed at any point during the perinatal period, however, self-reported substance use declines as gestation increases (Barry et al., 2021). Health care providers are mindful of creating a welcoming and safe space for clients in order to promote open communication and trust. This requires an awareness of using non-stigmatizing language, being non-judgmental, and offering choice, voice, and control to each client, as well as, considerations related to social and cultural context, gender inclusion and identity, trauma, and the impact of colonization the direction of the TRC (Schmidt et al., 2019). See Resource 6.4 - Doorways to Conversation: Brief Intervention on Substance Use with Girls and Women.

4.4.1 Motivational Interviewing may be used to facilitate conversations around substance exposure (Goyer et al., 2022). Consider education to enhance Motivational Interview skill sets at your site.

4.4.2 Apply the 6 principles of being trauma informed (Sperlich et al., 2017):

4.4.2(a) Safety;

4.4.2(b) Trustworthiness/Transparency;

4.4.2(c) Peer Support;

4.4.2(d) Collaboration and mutuality;

4.4.2(e) Empowerment, voice and choice;

4.4.2(f) Cultural, Historical, and Gender issues.

4.4.3 Consult Mental Health and Addiction support as applicable any time during the perinatal period.

4.5. Assess substance use of household members in addition to the client as substance use by household members may impact health and well-being (e.g., second and third hand smoke).

4.6. Clients who have disclosed any type of substance use may benefit from a discussion about readiness to change, capacity to identify variances that may require further action, and harm reduction strategies to

contemplate/implement in the perinatal period. Discussions pertaining to harm reduction strategies within the Strength Based Health Care model may include (Goyer et al., 2022):

4.6.1 Recording the amount and frequency a substance is used;

4.6.2 Setting limits on when or where a substance can be used;

4.6.3 Avoiding use of downers when alone or feeling vulnerable;

4.6.4 Switching to safer methods of use (e.g. smoking or snorting instead of injecting, chewing tablets instead of crushing and snorting);

4.6.5 Making a safety plan for transportation (before use);

4.6.6 Making a parenting plan (before use), this may include; planning where the infant will be, who will be caring for the infant, safe storage of substances, preventing exposure of second/third hand smoke/vape, and having a plan of what to do/who to call in an emergency (Nathoo et al., 2018);

4.6.7 Connecting with peer supports;

4.6.8 Taking good care of your body and mind (e.g. healthy food, water, sleep, reduce stress, exercise, etc.);

4.6.9 Planning to smoke/vape outdoors. Then making sure to wash hands, use mouth wash, and change clothing prior to touching the infant (Nathoo et al., 2018).

4.7. Advise the client to put their infants on their back and alone on a firm and uncluttered sleep surface (i.e., no bedsharing or other unsafe sleep surfaces like on the sofa) after using substances. Parental alcohol, marijuana, opioid, and/or illicit drug use in combination with bed sharing places the infant at particularly high risk for SIDS and suffocation. Discuss safe sleep practices and share resources with the client. See Resource 6.3 - Safe Sleeping for Your Baby.

4.8. Clients who have polysubstance exposure or injection substance exposure should be offered a HIV point of care (POC) test anytime they are in contact

with the health care system or formal STBBI serology every 3 months or more frequently as requested.

4.9. Anticipatory guidance should be provided to the client in the prenatal period, when possible. This may include information about Eat Sleep Console, impact of withdrawal on the newborn (NAS and NOWS), and factors that may impact breastfeeding. A prenatal consult to a lactation consultant is recommended for all clients wishing to breastfeed their newborn. See Resource 6.1 - Eat Sleep Console provincial clinical guideline.

4.10. The client should be offered all of the following services and consults while in the acute care setting (if available):

4.10.1 Social Work;

4.10.2 Indigenous Services;

4.10.3 Spiritual Care;

4.10.4 Mental Health and Addiction;

4.10.5 Lactation Consultant/Expert Breastfeeding Support.

4.11. **Contraindications for Breastfeeding and Substance Use**

4.11.1 Polysubstance use is generally contraindicated with breastfeeding. However, every client is assessed on a case-by-case basis by a knowledgeable care provider(s) who is/are able to assess the risks and benefits of breastfeeding and polysubstance use. Necessary knowledge includes drug interactions, half-lives, frequency of use, and dosing of the substances in relation to the timing of breastfeeding (Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2023).

4.11.2 For this reason, it is recommended that individuals using illicit substances abstain from breastfeeding or pump and dump based on half-life of the substance. Illicit substances are not regulated and, therefore, may contain unknown and potentially harmful substances.

4.12. Discharge planning from an acute care facility should commence as soon as possible to ensure a coordinated plan of care (Lacaze-Masmonteil & O'Flaherty, 2018) and seamless access to services in the community.

4.12.1 Realistic feeding plans are put into place in collaboration with the parent/caregiver. This feeding plan is communicated to public health and primary care at discharge from acute care.

4.12.2 The health care provider ensures that the client has information about agencies, resources, and information they can access in the community to help them meet their infant feeding goals.

4.13. Substance Specific Information

4.13.1 Alcohol

4.13.1(a) Alcohol passes into breastmilk at similar concentrations to blood alcohol levels (AWHONN, 2022; Goyer et al., 2022) and may also decrease milk production (Drugs and Lactation Database - Alcohol, 2024).

4.13.1(b) Clients planning to consume more than one serving of alcohol in a time period, are encouraged to feed their infant prior to drinking and ensure that they have pumped and stored enough breastmilk to account for 1-2 infant feeds, prior to ingesting any alcohol (Goyer et al., 2022).

4.13.1(c) Breastfeeding should be stopped if moderate to high alcohol consumption begins (Harris et al. 2023).

4.13.1(d) For occasional modest alcohol consumption waiting for 2-4 hours for every serving of alcohol consumed is likely safe (Harris et al., 2023). See Appendix C - Standard Alcohol Drink Sizes.

4.13.1(e) If the client feels engorged while consuming alcohol, they may express their milk to ease discomfort, however, this milk should be discarded (AWOHNN, 2022; Goyer et al., 2022).

4.13.1(f) The client is advised that if they still feel intoxicated or hungover after 2-4 hours (for every serving of alcohol consumed) to continue to delay breastfeeding until feeling fully better (Goyer et al., 2022).

4.13.1(g) Clients with an alcohol dependency, who wish to decrease use, are supported to access resources to support their goals. Quitting suddenly may lead to serious complications such as fatal seizures. (Goyer et al., 2022).

4.13.2 Amphetamines

4.13.2(a) Although neurological development of the infant has not been well studied, prescribed small doses of amphetamines for narcolepsy and ADHD are generally considered safe while breastfeeding (Drugs and Lactation Database - Amphetamines, 2024; Virani, 2024).

4.13.2(b) Monitor the breastfeeding infant for insomnia, agitation, irritability, and poor weight gain.

4.13.2(c) Large doses of amphetamines may decrease milk production; so, clients interested in breastfeeding are counselled on methods to increase milk production in pregnancy and supported to implement said methods in the early postpartum hours and days (Drugs and Lactation Database - Amphetamines, 2024).

4.13.2(d) Breastfeeding should be avoided for clients using amphetamines outside of prescribed doses (Drugs and Lactation Database - Amphetamines, 2024).

4.13.2(e) Regular methamphetamine use and breastfeeding is contraindicated (Goyer et al., 2022; Drugs and Lactation Database - Methamphetamines, 2024). If a client occasionally uses methamphetamine, it is advised that they abstain from breastfeeding for 48-100 hours (72 hours average) (AWOHNN, 2022; Drugs and Lactation Database - Methmphetamines, 2024; Goyer et al., 2022). Advise the client to have enough breastmilk stored to feed their infant during the period of abstinence and support them to continue to pump and discard their milk regularly to manage their milk supply.

4.13.3 Antineoplastics (Chemotherapy, etc.)

4.13.3(a) Most antineoplastics are not compatible with breastfeeding. It is recommended that the client speak to their care team about the safety of their antineoplastics regime and breastfeeding.

4.13.3(b) Most breastfeeding parents who work with antineoplastics are at minimal risk as long as workplace precautions maintained. Recommend that the client speak with their employer about

reducing their contact with antineoplastics with no known safe level of exposure (Centers for Disease Control and Prevention [CDC], 2024a).

4.13.4 Benzodiazepines

4.13.4(a) When breastfeeding, it is best to take as low as possible of a dose of benzodiazepines to maintain health and wellbeing of the breastfeeding parent. Health care providers should review safety of benzodiazepines while breastfeeding, as some options with a shorter half-life are safer e.g., Lorazepam (Drugs and Lactation Database - Lorazepam, 2024).

4.13.4(b) Monitor infants for sedation, feeding issues, and poor weight gain (Drugs and Lactation Database - Lorazepam, 2024).

4.13.4(c) Due to serious health complications clients should avoid stopping use of benzodiazepines suddenly (Goyer et al., 2022). The healthcare provider should support the client to reduce usage safely.

4.13.5 Caffeine

4.13.5(a) Caffeine can be passed to an infant through breastmilk and has a greater impact on premature infants or infants under the age of 6 months (Nathoo et al., 2021).

4.13.5(b) It is recommended that up to 200mg - 300 mg of caffeine per day is safe (Nathoo et al., 2021, Goyer et al., 2022). This equates to about 237ml (8oz) of coffee per day. Note that varying amounts of caffeine are found in teas, energy drinks, chocolate, and some medications (Nathoo et al., 2021).

4.13.6 Cannabis

4.13.6(a) Information on cannabis use and breastfeeding is limited and contradictory. As such, it is recommended that cannabis use in any form (ingestion and smoking/vaping) be stopped while breastfeeding (AWHONN, 2022; Barry, 2021; Drugs and Lactation Database - Cannabis, 2024, Goyer et al., 2022; Nathoo et al., 2021; CDC, 2024b).

4.13.6(b) The active ingredient in cannabis, tetrahydrocannabinol (THC), may be found in breastmilk for a range of 6 days to more than 6 weeks and research at this time cannot rule out long-term impacts of exposure on an infant's health and development (Drugs and Lactation Database - Cannabis, 2024).

4.13.6(c) Cannabis should not be smoked/vaped by anyone anywhere near an infant, due to health concerns related to exposure to second/third hand smoke and an increased risk of sudden infant death syndrome (Drugs and Lactation Database - Cannabis, 2024).

4.13.6(d) If a client chooses to continue using cannabis while breastfeeding, talk with the client about harm reduction methods, such as ensuring they have pumped and stored a safe supply for their infant, pumping and dumping after consumption, and reducing second/third hand smoke exposure of the infant (Goyer et al., 2022; Drugs and Lactation Database - Cannabis, 2024).

4.13.7 Cocaine

4.13.7(a) Cocaine use is contraindicated with breastfeeding due to high concentrations of the substance being passed through breastmilk (Goyer et al.,2022; Drugs and Lactation Database - Cocaine, 2024). Newborns are "extremely sensitive to cocaine because they have not yet developed the enzyme that inactivates it and serious adverse reactions have been reported" (Drugs and Lactation Database – Cocaine, 2024).

4.13.7(b) Smoking crack may also expose the infant to second/third hand smoke (Drugs and Lactation Database, 2024). Advise the client or anyone else to smoke outside/away from the infant.

4.13.7(c) For clients who occasionally use cocaine, it is recommended that they abstain from breastfeeding for 24 hours after use (Goyer et al., 2022; Drugs and Lactation Database - Cocaine, 2024). Advise the client to have enough breastmilk stored to feed their infant during the period of abstinence and that they should continue to pump and discard their milk regularly to manage their milk supply.

4.13.8 Inhalants

4.13.8(a) There is limited information on inhalant use and breastfeeding, therefore breastfeeding and use of inhalants is contraindicated.

4.13.9 Iodide 131

4.13.9(a) When possible, an alternative to Iodide 131 is given to a breastfeeding parent. If Iodide 131 is required for care, breastfeeding should be stopped permanently, if the dose is equal to or greater than 0.01 MBq (Drugs and Lactation Database – Sodium Iodide 131, 2024).

4.13.9(b) Breastfeeding parents who work with radioactive materials need to take precautions to reduce exposure. Recommend that the client to speak with their employer to help reduce risk of exposure (CDC, 2024a).

4.13.10 Ketamine

4.13.10(a) Ketamine is found in low levels in breastmilk and its oral bioavailability is low, indicating a low risk to breastfed infants. Until further information is made available, careful monitoring of the infant for sedation, poor feeding, and weight gain is recommended (Drugs and Lactation Database - Ketamine, 2023).

4.13.11 Lysergic Acid Diethylamide (LSD)

4.13.11(a) LSD use has not been well studied in the breastfeeding population. For a healthy adult it can take on average 2 days to eliminate LSD from the body (Organization of Teratology Information Specialists [OTIS], 2024). It is recommended that breastfeeding is avoided during LSD use.

4.13.12 Nicotine/Tobacco

4.13.12(a) Tobacco is not a contraindication to breastfeeding, but it should be limited, and harm reduction practices implemented (AWOHNN, 2022). Cigarettes and vaping products contain harmful substances,

in addition to nicotine, that may be passed through breastmilk or inhaled by the infant (AWOHNN 2022; Goyer et al., 2022).

4.13.12(b) Some have recommended use of nicotine replacement products to support smoking cessation while breastfeeding (Drugs and Medication Database - Nicotine, 2023). Whereas these products reduce the impact of second/third hand smoke, nicotine still passes into breastmilk. This is notable as there is some evidence in animal studies that nicotine may increase risk of SIDS (Drugs and Medication Database - Nicotine, 2023).

4.13.12(c) Nicotine exposure in pregnancy and after birth are both major risk factors of SIDS (Moon et al., 2022). If a client chooses to smoke/vape in pregnancy or after the birth support should be offered in harm reduction strategies.

4.13.13 Opioids – Maintenance Therapy Programs

4.13.13(a) Clients on stable doses of methadone and buprenorphine, regardless of the amount, should continue to breastfeed as concentrations of the substances are at low levels in breastmilk (Goyer et al., 2022,). See Resource 6.1 - Eat Sleep Console provincial clinical guideline.

4.13.13(b) Support clients to remain in maintenance therapy programs throughout the perinatal period.

4.13.14 Opioids – Other (Codeine, Morphine, Fentanyl and Heroin)

4.13.14(a) Pregnant people who have opioid use disorder are encouraged to participate in an opioid maintenance therapy program (Lacaze-Masmonteil & O'Flaherty, 2018), as opioid treatment medications are safe to use while breastfeeding (Goyer et al., 2022) and have been shown to reduce withdrawal symptoms in newborns.

4.13.14(b) It is recommended to avoid opioids/narcotic analgesics (codeine, morphine, fentanyl, etc.) while breastfeeding, due to drowsiness and central nervous system depression in the infant (Drugs and Lactation Database - Codeine, 2023; Drugs and Lactation Database - Morphine, 2024; Drugs and Lactation Database -

Fentanyl, 2024). If pain management is needed, it is recommended to use medications other than opioids, when possible (Drugs and Lactation Database - Codeine, 2023; Drugs and Lactation Database - Morphine, 2024; Drugs and Lactation Database - Fentanyl, 2024).

4.13.14(c) Heroin is contraindicated with breastfeeding due to exposure risk to the infant via breastmilk and due to unknown contaminants, that may be harmful (Drugs and Lactation Database - Heroin, 2024).

4.13.15 Phencyclidine (PCP)

4.13.15(a) PCP is contraindicated with breastfeeding because little is known about its absorption into breastmilk or effect on the infant (Drugs and Lactation Database - Phencyclidine, 2023).

4.13.16 Psilocybin (Magic Mushrooms)

4.13.16(a) Psilocybin use during breastfeeding has not been studied, therefore it is contraindicated while breastfeeding (OTIS, 2023).

4.13.17 Selective Serotonin Reuptake Inhibitors (SSRIs)

4.13.17(a) SSRIs used to treat depression are safe to take while breastfeeding (Drugs and Lactation Database – Citalopram, 2024; Drugs and Lactation Database – Escitalopram, 2024).

4.13.17(b) Birth parents taking SSRIs may benefit from additional breastfeeding support due to increased risk of difficulties breastfeeding (Drugs and Lactation Database – Citalopram, 2024; Drugs and Lactation Database – Escitalopram, 2024). The reason(s) for increased breastfeeding difficulties in individuals requiring SSRIs is unknown, however, it may be attributed to the illness itself and not the medication.

4.13.18 Viaderm KC (triamcinolone)

4.13.18(a) Viaderm is a commonly prescribed topical medication used to repair damaged/sore nipples. Viaderm contains triamcinolone, a corticosteroid. Caution should be used when applying Viaderm due

to the risk of ingestion of triamcinolone by the infant. The nipples should be washed prior to breastfeeding (regardless of the time elapsed) (Drugs and Lactation Database – Triamcinolone, 2024).

4.13.18(b) The client should be cautioned that Viaderm, or any topical corticosteroid, should be used only in the short term as long-term use may cause thinning of the skin.

5.0. Procedure

5.1. Not Applicable

6.0. Resources

6.1. Shared Health, Provincial Clinical Guideline: Eat Sleep Console

6.2. Drugs and Lactation Database

6.3. Safe Sleeping for Your Baby

6.4. Doorways to Conversation: Brief Intervention on Substance Use with Girls and Women

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9.0. Appendix A – Stigmatizing Language

Best Practices to Avoid Using Stigmatizing Language

Don't Use	Do Use	Why
"addict" *"abuser"* *"junkie"*	*"person who uses heroin"* *"person with cocaine use disorder"*	*Using "person-first" language demonstrates that you value the person, and are not defining them by their drug use.*
"got clean"	*"no longer uses drugs"*	*"Clean," although a positive word, implies that when someone is using they are "dirty."*
"addicted newborn" *"born addicted"*	*"newborn opioid withdrawal (NOW)"* *"baby with prenatal cannabis exposure"*	*Infants are not addicted; they have prenatal substance exposure and/or physiological dependence.*
"medication replacement therapy (MRT)" *"medication assisted therapy (MAT)"*	*"opioid agonist therapy (OAT)"* *"medication for opioid use disorder (MOUD)"* *"medication for alcohol use disorder"*	*These categories are value-neutral and precise.* *When discussing a specific medication, refer to it by both its generic and brand names.*

Note. From *Pregnancy and substance use: A harm reduction toolkit*, by Goyer, E., Kurzer-Yashin, D., & Sue, K., 2022, National Harm Reduction Coalition & Academy of Perinatal Harm Reduction. In the public domain.

10.0. Appendix B – Substance Use and Breastfeeding Traffic Light

Substances in green **may be used** while breastfeeding or expressing milk. The newborn should be observed for Neonatal Abstinence Syndrome (NAS) and the Eat Sleep Console model of care implemented in acute care facilities.

Reference	Substance	Consideration
4.13.2	Amphetamines (prescribed for ADHD or narcolepsy)	• Support milk production
4.13.4	Benzodiazepines (short half-life): Lorazepam	• Patient should not stop taking without discussing with prescriber"
4.13.5	Caffeine	• Reduce caffeine exposure of the breastfeeding parent.
4.13.10	Ketamine	
4.13.13	Opioids: Buprenorphine, Methadone, & Suboxone (prescribed)	
4.13.17	Selective Serotonin Reuptake Inhibitors (SSRIs): Citalopram	• Provide proactive breastfeeding support due to increased risk of breastfeeding difficulties.

Substances in yellow may be **used with caution** while breastfeeding or expressing milk. Harm reduction strategies should be encouraged.

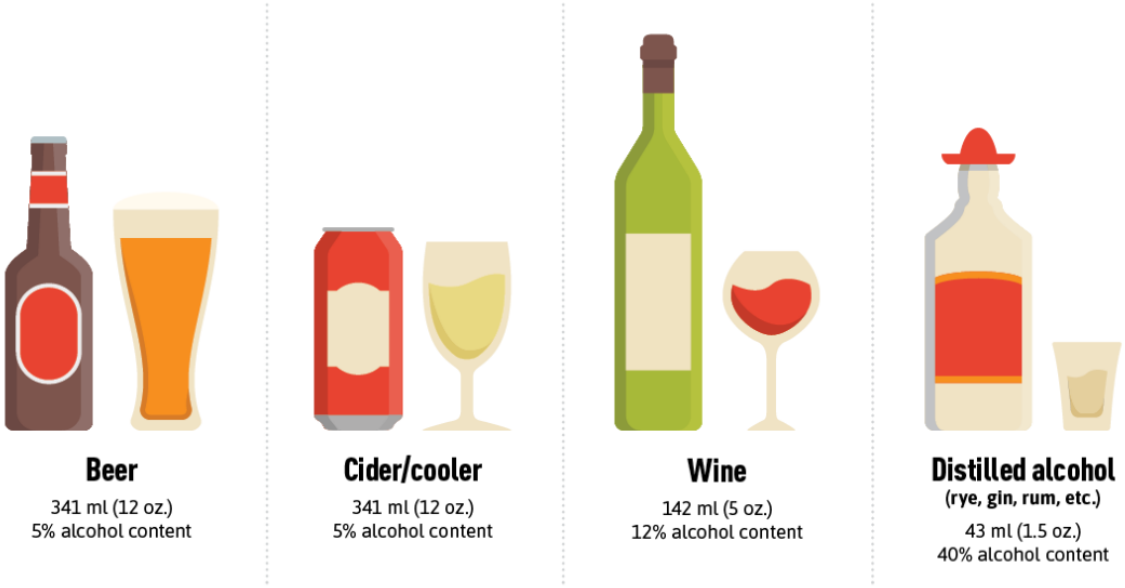
Reference	Substance	Consideration
4.13.1	Alcohol	
4.13.4	Benzodiazepines: Long-half life	• a shorter half-life reduces risk
4.13.6	Cannabis	
4.13.12	Nicotine/Tobacco	
4.13.18	Viaderm	• Should be washed off prior to breastfeeding (regardless of time elapsed) • Avoid long term use

Breastfeeding and newborn consumption of expressed breastmilk **should be avoided** due to the risk of contamination in unregulated substances and due to high levels of the substance being found in the breastmilk.

Reference	Substance	Information
4.13.2	Amphetamines: Misuse or methamphetamine	• Contraindicated in all forms. • 48-100 hour (72-hour average) clearance from breastmilk.
4.13.3	Antineoplastic (Chemotherapies)	• Speak with healthcare team as to safety of specific antineoplastic.
4.13.7	Cocaine	• Contraindicated in all forms. • 24-hour clearance from breastmilk.
4.11.2	Illicit Substance Use	• Contraindicated in all forms.
4.13.8	Inhalants	• Contraindicated in all forms.
4.13.9	Iodide 131	• Contraindicated in all forms.
4.13.11	Lysergic Acid Diethylamide (LSD)	• Contraindicated in all forms.
4.13.14	Opioids – Misuse, Codeine, Morphine, Fentanyl, Heroin	• Support client to access opioid maintenance therapy programs. • Heroin is contraindicated in all forms.
4.13.15	Phencyclidine (PCP)	• Contraindicated in all forms.
4.11.1	Poly-Substance Use	• Generally contraindicated. • Harm reduction may be possible on a case-by-case basis.
4.13.16	Psilocybin (Magic Mushrooms)	• Contraindicated in all forms.

11.0. Appendix C - Standard Alcohol Drink Sizes

Each of the below are considered one standard alcohol drink size.



Note. From *Low-risk alcohol drinking guidelines*, by Government of Canada, 2021. In the public domain.