

Clinical and Legal Considerations Regarding Breastfeeding on Psychiatric Units

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Women in the postpartum period are at especially high risk of developing psychiatric disorders, and in severe cases, they may require inpatient psychiatric hospitalization. Because of the lack of specialized units for peripartum mothers in the United States, this treatment is usually relegated to general inpatient psychiatric units. Despite the clear benefit of breastfeeding for both mother and child, lactation can be a barrier to placement on a general inpatient psychiatric unit and often is not supported during the hospital stay. Limiting access to inpatient psychiatric care for postpartum mothers with mental illness could be considered sex discrimination under the Affordable Care Act (ACA) because of failure to accommodate lactation. With improvements in education and accommodations around breastfeeding, general inpatient psychiatric units could provide appropriate care for this population.

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From a psychiatric perspective, pregnancy and the postpartum period are times of exceptionally high risk in a woman's life. In the postpartum period, mothers may experience a range of psychiatric disorders including depression, obsessive compulsive disorder, and postpartum psychosis. In fact, eighty-five percent of postpartum women have a mood disturbance of some kind when those who experience the

baby blues (depressive symptoms that resolve within a few weeks after delivery) are included.¹ Fisher *et al.*² estimated the prevalence of common perinatal mental disorders to be 16 percent antenatally and 20 percent postnatally in low- and lower-middle-income countries, while Gavin *et al.*,³ focusing on high-income countries, estimated that up to 20 percent of women have a depressive episode during the first three months postpartum. Immigrant women are at especially high risk; one meta-analysis estimated them to be twice as likely as their nonimmigrant counterparts to experience postpartum depressive symptoms.⁴

Postpartum psychiatric disorders can have significant and lasting consequences for both mother and infant. Mothers with untreated postpartum depression have increased risk of depressive episodes in the future.⁵ They also engage in unsafe behaviors such as smoking and risky alcohol consumption at higher rates.⁵ Infants of mothers with postpartum depression may have physical consequences reflected in anthropometric scores (low birth weight, decreased length at birth), as well as sleep, motor, social,

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cognitive, language, and behavioral problems.⁵ Infants born to depressed mothers are more likely to exhibit difficult temperaments, have higher internalizing behaviors, and exhibit less mature regulatory behaviors.⁵ Mother-infant bonding is also negatively affected when mothers experience postpartum depression.⁶ Children of mothers with untreated mood disorders after pregnancy are more likely both to have decreased stature and to be obese at preschool age.^{7,8} In adolescence, these children tend to have greater difficulty with regulating emotion and adjusting to social situations.⁹ Therefore, treating maternal mental illness is of paramount importance to not only the mother, but also to the child and family.

Postpartum mothers experiencing acute symptoms of mental illness may be at risk for harming themselves and their child. Suicide is the leading cause of death in depressed postpartum women, accounting for one-fifth of all postpartum deaths.¹⁰ Compared with suicide attempts by other women, suicide attempts by postpartum mothers more often involve violent, irreversible methods, such as self-incineration and jumping from heights.¹¹ An especially serious potential consequence of untreated postpartum psychiatric illness is infanticide (murder of one's infant), which is much more common among mothers with postpartum psychosis, though rates of this rare event vary across studies.^{12,13} Depressive symptoms, command auditory hallucinations, and lack of treatment may exacerbate the risk of infanticide.¹³⁻¹⁵ Depressed mothers more frequently have thoughts of harming their young child than mothers without depression.¹⁶

Postpartum mental disorders can range from mild to functionally incapacitating, requiring immediate hospital-level treatment. This paper focuses on the mothers who, because of the gravity of their illness, require inpatient psychiatric hospitalization for safety and stabilization.

Peripartum Inpatient Psychiatric Treatment

For women who are significantly incapacitated by psychosis, mania, or depression, with suicidality, violence risk, or grave disability, the appropriate level of care is often inpatient psychiatric treatment. Internationally, the preferred treatment setting for women requiring psychiatric hospitalization in the postpartum period is a mother-infant joint unit.¹⁷ As these are generally unavailable in the United States,

the next best option is a standard mental health inpatient setting.¹⁷

The co-admission of infants with mothers requiring inpatient psychiatric treatment was pioneered in 1948 in Surrey, England.¹⁸ It has since spread to facilities in Canada, Australia, New Zealand, Sri Lanka, India, and across Europe and the United Kingdom.¹⁹ Since at least 1992, the UK National Institute for Health and Clinical Excellence (NICE) clinical guidelines recommend peripartum women who require hospitalization for a mental disorder should be admitted with their infants to a specialized mother-baby unit (MBU), which is an inpatient psychiatry service with multidisciplinary staff who can care for both mothers and babies.²⁰ According to the NICE guidelines, these specialized units should provide six mother-baby beds for a population that has 15,000 deliveries per year. They also advocate that MBUs be connected to specialized perinatal community mental health teams to provide seamless continuity of care.²⁰ At MBUs, breastfeeding is encouraged.²⁰ Mothers are provided dyadic psychotherapy and psychoeducation about peripartum mental health, and their families are provided support with counseling and social services when needed.²¹ A study considering patients admitted to a mother-baby unit in India showed that 37 percent of patients experienced disrupted breastfeeding on admission, but 86 percent of those patients with disrupted breastfeeding were able to restore breastfeeding by discharge.¹⁹ This particular unit provided breastfeeding education with specific guidance about psychiatric medications and the use of breast pumps, as well as access to lactation consultants.¹⁹

Compared to other high-income countries, there has been a historical and persistent resistance to the adoption of MBUs in the United States.²² Staff anxiety, cost constraints, legal risk, pediatric concerns, and risk of injury to the infant are cited as concerns.^{21,22} Instead of receiving specialized treatment, most postpartum mothers in the United States who need inpatient care are thus admitted to a general psychiatric inpatient unit.³

There are two perinatal psychiatric units in the United States: at University of North Carolina (UNC) at Chapel Hill and at Zucker Hillside Hospital in Long Island, NY.^{23,24} UNC's perinatal unit, the first in the United States, includes five inpatient beds. Infants are encouraged to be present, but, unlike in most mother-baby units worldwide, they

are not allowed to stay overnight.²³ Patients are provided space to nurse, hospital-grade breast pumps, access to lactation consultation, refrigeration and freezer storage for breast milk, and therapeutic groups geared to the postpartum period, including attachment therapy and peripartum yoga.²³

Breastfeeding in the Postpartum Period

One important reason to have dedicated perinatal psychiatry units is to support women who choose to breastfeed. Breastfeeding has profound effects for both mothers and infants. Although the neuroendocrine link between breastfeeding and depression has yet to be demonstrated, breastfeeding appears to help ameliorate both acute and long-term symptoms of postpartum depression.^{25,26} Compared with their nonbreastfeeding counterparts, women who breastfeed exhibit an attenuated response to stress, better sleep patterns, and a decrease in depressive symptoms.^{27–29} For infants, breastfeeding reduces the risk of obesity, allergies, type-1 diabetes, upper respiratory infections, otitis media, gastrointestinal infection, sudden infant death syndrome, leukemia, and celiac and inflammatory bowel diseases.^{30,31} Recognizing these benefits, the American Academy of Pediatrics recommends that women exclusively breastfeed for six months postpartum.³¹

According to the 2018 CDC Breastfeeding Report Card, 83 percent of women initiate breastfeeding after childbirth, yet only one in four of those women exclusively breastfeed by six months.³² Challenging experiences can discourage mothers from initiating breastfeeding or continuing for recommended durations.³³ Women who are breastfeeding benefit from support, accommodations, and coaching.³² One of the U.S. Department of Health and Human Service's public health goals, as detailed in Healthy People 2020, is to increase the number of health care facilities where babies are born that provide recommended lactation care for mothers and babies.³⁴

In 1991, WHO and UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) to implement practices that protect and promote breastfeeding in hospitals globally.³⁵ It was initiated following UNICEF's Innocenti Declaration, which established that, "as a global goal for optimal maternal and child health and nutrition, all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breastmilk up to 4-6 months of age."³⁶ The BFHI outlines ten evidence-based

practices shown to promote the initiation and duration of breastfeeding in hospitals immediately after delivery.^{35,37} They include: preparing a breastfeeding policy that is communicated to all health care staff; training health care staff in skills necessary for implementing policy; instructing mothers on initiating and maintaining lactation; and providing facilities for mothers to bond with infants for as much time as possible. In a systematic review of 58 studies surveying hospitals internationally, Pérez-Escamilla and colleagues³⁷ reported a dose-response relationship between the number of BFHI steps adopted by hospitals and outcomes such as initiation of breastfeeding, exclusive breastfeeding at hospital discharge, and duration of breastfeeding. While these interventions are geared for obstetrics units in hospitals, some interventions can be applied to women who are in the postpartum period on acute psychiatric units.

Challenges on Inpatient Psychiatric Units

Given the benefits of breastfeeding for both mother and baby, it is striking that breast pumping and breastfeeding are frequently not permitted on psychiatric units.^{21,38–39} Anecdotally, breast pumping is often disallowed on psychiatric units, and reasons given to justify such policies include the ligature risk in electric breast pumps and a lack of adequate infrastructure, such as a space for pumping or electric outlets. It is also common for postpartum mothers not to be able to breastfeed their infants on adult inpatient psychiatric units; reasons cited include potential risk to the infant from other patients on the unit, the need for increased staff to supervise breastfeeding, and the need for a space that ensures privacy.⁴⁰ Postpartum mothers in need of acute psychiatric care therefore risk not being able to pump or breastfeed, which could lead to a physiologic cessation of lactation and subsequent inability to breastfeed their infants entirely.²¹ This is often a source of grief and loss and may negatively affect attachment.^{21,38}

Some mothers who need inpatient level of care refuse it because of their beliefs about the importance of breastfeeding. One mother wrote, "I was so depressed I felt like my breastmilk was the only thing that I had left to give my baby. Being separated from her only added to my feelings of guilt, anxiety, and being an 'unfit' mother. It was only when I couldn't eat enough to produce milk that I agreed to go into the hospital" (Ref. 21, p 483).

Legal Analysis

As noted above, lactation may present an obstacle to a mother's admission to a general inpatient psychiatric unit. Once it is determined that a breastfeeding mother in need of acute psychiatric treatment will require an inpatient level of care (either voluntarily or involuntarily), specific units might deny her admission because of anticipated difficulties accommodating breastfeeding and related safety concerns. We sought to understand the lack of inpatient psychiatric care allowing breastfeeding within the legal framework of discrimination. Searches of legal databases identified no case law on the subject of breastfeeding on inpatient psychiatric units. Thus, we based our analysis on the interpretation of discrimination under federal civil rights law as applied to the Affordable Care Act (ACA).

Limiting a mother's access to inpatient psychiatric care either by denying admission to a specific unit based on lactation status or disallowing breastfeeding or pumping on the unit may constitute sex discrimination. We base this assertion on Section 1557 of the Affordable Care Act (ACA) of 2010 that prohibits most health programs from discriminating against patients on the basis of sex. Whether or not discrimination related to a woman's lactation status constitutes sex discrimination has recently been heavily litigated in other domains, predominantly employment law. In fact, cases brought in which employers have allegedly discriminated against lactating women increased eight-fold between 1996 and 2006.⁴¹ The related case law demonstrates that within the sphere of employment law, discrimination based on lactation constitutes sex discrimination, and this same logic may apply to the ACA.

Sex Discrimination in Employment Law

The Civil Rights Act of 1964, which generally prohibited discrimination in public places, included Title VII, which specifically prohibited employment discrimination based on sex among other aspects of a person's identity including race, color, religion, and national origin.⁴² The Pregnancy Discrimination Act (PDA) of 1978 amended Title VII of the Civil Rights Act of 1964 to make clear that sex discrimination included discrimination based on pregnancy, childbirth, and related medical conditions.⁴³

Whether or not lactation is a "related medical condition" has been the focus of litigation. In 2013, in

Equal Employment Opportunity Commission (EEOC) v. Houston Funding II, LLC, the U.S. Court of Appeals for the Fifth Circuit determined that lactation constitutes a related medical condition under the PDA.⁴⁴ In that case, firing a woman because she asked if she could pump breastmilk at work was an example of unlawful sex discrimination. Similarly, three years later, in the case of *Allen-Brown v. District of Columbia*, a federal district court ruled that a patrol officer experienced sex discrimination when her request for limited-duty based on her lactation status was denied because lactation is a "related medical condition" to pregnancy.⁴⁵

The Affordable Care Act

The Affordable Care Act (ACA) is a federal statute enacted in 2010 with the goal of expanding health insurance availability. Section 1557 of the ACA is the nondiscrimination provision of this statute, and it "prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities" (Ref. 46, Title I, § 1557) This applies to all individuals participating in any health program that has received any funding from the U.S. Department of Health and Human Services (HHS), any health program administered by HHS, and all health insurance marketplaces and the plans offered by the issuers that take place in these marketplaces.⁴⁶ Thus, Section 1557 of the ACA applies to the vast majority of hospitals and institutions providing medical care.

Section 1557 specifies that sex discrimination includes discrimination based on an individual's sex, pregnancy, childbirth and related medical conditions, gender identity, and sex stereotyping. The ACA clearly intends to protect lactation in general. First, Section 2713 of the ACA requires health insurance support for breastfeeding pump rental and breastfeeding education (Ref. 46, Title I, § 2713). Second, Section 4207 amends the Fair Labor Standards Act (1938) to require employers to provide reasonable break time as well as a place other than a bathroom for employees to express milk for one year after childbirth (Ref. 46, Title I, § 4207). The ACA itself does not comment on what constitutes a "related medical condition" to pregnancy and childbirth. Since lactation has been defined as a "related medical condition" in federal cases related to civil rights actions in the area of employment law,

one might expect that the ACA would follow a similar standard.

Section 1557 of the ACA came under scrutiny in 2016 when a group of religiously affiliated health care organizations filed a lawsuit against the federal government to challenge the prohibition of sex discrimination against patients seeking transgender or reproductive care. The U.S. District Court for the Northern District of Texas issued an opinion in *Franciscan Alliance v. Burwell* (2016) which blocked the enforcement of prohibitions against discrimination on the basis of gender identity and pregnancy termination. This did not, however, affect the prohibition of discrimination on the basis of sex in all other regards (including pregnancy, childbirth, and related medical conditions).⁴⁷ *Franciscan Alliance v. Burwell* has gone through a series of appeals, but at the time of this writing, discrimination on the basis of pregnancy, childbirth, and related medical conditions remains prohibited.⁴⁸

State Law

Breastfeeding is widely protected by state law. All 50 states have laws protecting a woman's right to breastfeed in public places. Thirty-one states exempt breastfeeding from public indecency laws; 32 states have laws protecting breastfeeding in the workplace, and 19 states exempt those who are lactating from jury duty or allow jury duty to be postponed.⁴⁹ Many states offer unique protections for breastfeeding, perhaps most notably New York, which issued a Breastfeeding Mothers Bill of Rights in 2009 and requires that this document be posted in maternal health care facilities. Included in this document is the provision that, if a mother or baby is re-hospitalized in a maternal health facility after the delivery, "the hospital will make every effort to continue to support breastfeeding, and to provide hospital-grade electric pumps and rooming-in facilities" (Ref. 50, Section 2). While breastfeeding is widely protected on the state level, especially within the employment sphere, the protection of patients' breastfeeding within the health care setting is not uniformly codified.

Some states also protect breastfeeding in correctional settings. New York law "allows a child under one year of age to accompany the mother to a correctional facility if the mother is breastfeeding at the time she is committed."⁴⁹ Washington requires that mothers who are incarcerated have access to

midwifery or doula services, including breastfeeding assistance.⁴⁹ Although breastfeeding for postpartum women is often not accommodated in correctional systems, recent literature has highlighted this as problematic and has focused on barriers to breastfeeding in this population as well as potential ways of supporting breastfeeding for women in prisons.⁵¹ Furthermore, recent prescribing recommendations for women include recommendations about medications for lactating mothers in prison.⁵² Both specific state laws and medical literature have conceptualized how to protect lactation in the prison setting, and this sets an example for the protection of breastfeeding in other confined spaces, such as inpatient psychiatric units.

Health Care Regulation

Sex discrimination in the health care setting also may jeopardize a hospital's accreditation. For example, the Joint Commission, which provides accreditation for hospitals and other health care organizations, explicitly prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.⁵³ Thus, hospitals could potentially risk their accreditation by limiting access to breastfeeding or pumping on inpatient psychiatric units.

Recommendations

Ideally, the number of specialized perinatal psychiatric beds in the United States would increase, however we appreciate the complex challenges associated with that proposal. Thus, we provide recommendations for how administrators and clinicians working with general psychiatric inpatient units may increase their knowledge about breastfeeding and their ability to accommodate breastfeeding women seeking admission while acknowledging the unique logistical concerns that may arise when making these decisions.

Education

We recommend educating all individuals associated with the operation of general inpatient psychiatric units about the topic of breastfeeding. One essential message would be that breastfeeding positively affects the health of postpartum women and their infants in the short and long term.²⁵⁻²⁹ We also

recommend emphasizing that limiting mothers' access to breastfeeding or pumping on inpatient psychiatric services likely constitutes sex discrimination. With knowledge about the benefits of breastfeeding and the risks of not supporting it, hospitals might make an effort to admit and accommodate breastfeeding mothers on their inpatient psychiatric units. We recommend establishing a policy regarding admission and accommodation of breastfeeding mothers and training all relevant staff to implement this policy.

Accommodations

When proper accommodations are made and careful attention is paid to the pharmacological management of postpartum mothers receiving inpatient psychiatric care, breastfeeding during psychiatric hospitalization may be possible. For example, in one study of mothers with postpartum psychosis in an Australian mother-baby unit, 36 percent were breastfeeding upon discharge.⁵⁴

We make the following recommendations for the management of breastfeeding mothers on general inpatient psychiatric units. Where possible, we recommend that mothers work with a reproductive or perinatal psychiatrist to jointly select a reasonable treatment plan, considering the nuances of medication safety in lactation. In the absence of access to these specialists, general psychiatrists may consult free online resources such as The LactMed Database operated by the National Library of Medicine or Massachusetts General Hospital Center for Women's Mental Health Reproductive Psychiatry Resource and Information Center.^{55,56} While a full discussion of medications in breastfeeding is outside of the scope of this article, various psychiatric medications can be safely used in breastfeeding when the benefits outweigh the potential risks. Misinformation about the safety of psychiatric medications in breastfeeding can contribute to both discontinuation of treatment and early cessation of breastfeeding.⁵⁷

In terms of logistical considerations, lactating patients could be assigned to single rooms when possible, although the unavailability of a single room should not be a barrier to admission. When a single room is not available, private spaces on the unit could be offered for the patient to use during scheduled pumping or nursing sessions. Adequate staffing to supervise pumping or feeding is essential to ensure safety. Other potential accommodations include

access to medical grade pumping equipment, lactation consultants, dieticians, and refrigeration capabilities for milk storage.

Finally, a thorough risk assessment of the mother and an appraisal of the unit's milieu should be conducted. In the Royal College of Psychiatrists' recent Standards for Inpatient Perinatal Mental Health Services, they recommend mother-baby units in the United Kingdom assess the mother's risk to themselves, the baby, and others; the support and supervision required to care for themselves and the baby; mode of infant feeding (breast versus bottle); substance use; elopement risk; sexual vulnerability; and domestic violence.⁵⁸ They also recommend safety reassessments weekly, and more frequently if there is a change in the mother's mental status or if the mother is acutely ill.⁵⁸ While a guideline for the specialized postpartum safety assessment on general inpatient psychiatric units in the United States is outside the scope of this article, we suggest that in addition to a general risk assessment, the evaluation of a postpartum mother should address the safety of breast pumping as well as the safety of visitation with her infant. Breast pumping is likely safer in many cases. If it is deemed safe for an infant to come to a supervised visiting area on the unit, extended and flexible visiting hours and adequate staffing for supervision of feeding are recommended.

Conclusion

The protection of breastfeeding is important for the physical and psychiatric health of mothers and children alike. In the United States, a mother in need of inpatient psychiatric treatment may not be able to breastfeed her infant or be able to pump while hospitalized. If the hospitalization is voluntary, the mother may decline admission due to fear of losing her ability to breastfeed. If the mother is involuntarily admitted, she may lose the ability to breastfeed entirely. Complex factors, including risk of harm to self or the infant, contribute to hospital and administration decisions about how to accommodate or limit mothers' lactation on inpatient psychiatric units. If these risks are not evident, and a mother is declined admission to a psychiatric unit based upon her lactation status alone, this may constitute sex discrimination as defined by Section 1557 of the Affordable Care Act. We recommend continued education about the benefits of breastfeeding and consultation with perinatal specialists with the creation of a multi-disciplinary

treatment plan for a breastfeeding mother seeking inpatient psychiatric admission. The treatment plan should explicitly consider and address the mother's lactation status. Breastfeeding mothers on inpatient psychiatric units are likely to preserve lactation when accommodations for expressing milk and specialized pharmacologic assessments are available. Hopefully, our medical systems can recognize the legal, ethical, and clinical importance of access to appropriate specialized treatment for postpartum mothers with mental illness, whose care affects not only them but also their children and families.

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