Can Moms Who Had a Transplant Breastfeed While Taking Tacrolimus?

By LauraAnne Hirschler, BS, OMS4 with help from Casey Rosen-Carole, MD, MPH, MSEd, FABM and Rogelio Perez-D'Gregorio, MD, MS

As an infant, I received the gift of life in the form of a liver transplant. Growing up, I remember taking a multitude of medications that just became part of my daily life. As the years went on, my immune system became stronger, the transplant check-ups became farther and farther in between. As the years went by, I found myself taking an extremely low dose of one immunosuppressant called tacrolimus. Inspired by my personal journey as a transplant patient, I went to medical school with a passion to care for patients as my healthcare providers had cared for me. During my training as a physician, I began to become interested in how the medicines that a person needs to take can impact pregnancy and breastfeeding.

With this interest in women's health, I pursued a rotation in Breastfeeding and Lactation Medicine. I worked alongside an amazing team of lactation specialists to help patients achieve their breastfeeding goals. I reviewed the medications that new moms were prescribed to make sure that they would address the medical needs of the mom and also have the lowest risk of impacting their developing baby. With a desire for a family of my own, I wanted to learn more about taking tacrolimus while breastfeeding. I saw firsthand how beneficial breastfeeding was and wondered if taking this medication multiple times per day would pose any risk for my developing baby. Would I ever be able to breastfeed?

Tacrolimus (Prograf®, Envarsus®, Astagraf®) is a medicine used by people who have had a transplant, like liver, kidney, or heart transplants. It helps prevent the body from rejecting the new organ. It's usually taken as a pill, but it can also be taken as an IV, as a liquid, or applied to the skin for conditions like eczema.

I found that research studies have shown promising evidence that breastfeeding while taking tacrolimus is most likely not of concern for breastfed children. One study looked at a mom who took tacrolimus twice a day. After one dose, scientists checked her breast milk and found a very small amount of tacrolimus in the milk. The amount was much lower than what is given directly to babies who need the medication.

One study involved a breastfeeding heart transplant patient who took tacrolimus throughout her pregnancy and after birth. When her baby turned one month old, tacrolimus blood levels were measured in both mom and baby. This baby's tacrolimus levels were extremely low.

Another study examined three exclusively breastfed infants and one partially breastfed infant whose mothers took oral tacrolimus. Researchers measured tacrolimus amounts in these infants between age of 15-27 days of life. None of the babies had detectable tacrolimus levels in their blood.

One of the largest studies was performed by the National Transplantation Pregnancy Registry. It looked at 68 mothers who had liver or kidney transplants. The study followed 83 babies, some for as long as 16 years. None of the babies had medical problems related to their mother's use of tacrolimus.

Tacrolimus is also used in cream form for conditions like eczema. The good news is that the risk of this cream affecting a breastfeeding baby is very low because only a small amount of the cream enters the mom's body. However, if the

cream is applied to the nipple, it should be cleaned off before the baby nurses. If a topical nipple treatment is needed, some experts recommend pimecrolimus cream over tacrolimus because it does not contain paraffin. Other treatments such as hydrocortisone ointments are better studied and are usually used first.

Breastfeeding while taking tacrolimus has been shown to be a low risk for breastfed babies. Since breast milk has many health benefits for babies, healthcare providers recommend moms who are taking tacrolimus breastfeed their babies. As with any health condition, a discussion with your healthcare provider is needed to weigh risks and benefits to determine the right choice for your family.

After learning more about the safety of breastfeeding while taking tacrolimus, I feel empowered and encouraged to breastfeed my future children, especially since breastmilk is so healthy and nourishing for babies.

References/Resources

- https://www.ncbi.nlm.nih.gov/books/NBK544318/#:~:text=Tacrolimus%20is%20a%20medication%20used,calcineurin%2Dinhibitor%20class%20of%20medications
- https://www.ncbi.nlm.nih.gov/books/NBK501104/
- https://pmc.ncbi.nlm.nih.gov/articles/PMC3613954/
- https://www.halesmeds.com/monographs/61433?q=tacrolimus
- https://www.halesmeds.com/monographs/61171?q=hydrocortison

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By Lynn Martinez, Teratogen Information Specialist, MotherToBaby Utah

"O.K., so I can't look at pizza the same way. Saltine crackers seem to be my go-to snack for sustenance and don't even SAY the word 'curry!' Oh no, I said it… Please excuse me while I hurl," said Nicole, 34, who's pregnant with her second child.

For many of the moms I counseled as a teratogen information specialist with the international non-profit, MotherToBaby, this is part of the reality of becoming a mom – nausea and vomiting of pregnancy (NVP). Yes, it's a real diagnosis. "Please help me! Can I take something to help this nausea?" is usually the caller's desperate question following her description of how she'd rather swim with sharks than accidentally catching a whiff of chicken tikka masala.

Nausea and vomiting of pregnancy (NVP) affects most pregnant women, whether it's their first pregnancy or a subsequent one. For nearly a third it can be serious enough to disrupt their usual lives and routines. In the past, it has too often been discounted, but now more health care providers are willing to take it seriously and treat their patients. One of the drugs I get asked about more and more often recently is ondansetron, or Zofran, as it's more commonly known.

Ondansetron is FDA-approved for use with nausea and vomiting in non-pregnant patients, but has been found to be effective for and used increasingly to treat NVP. Early studies demonstrated no increased fetal risk with its use. Two later studies found very small associations with oral clefting (cleft lip and or palate). Oral clefting defects are very common, so associations with exposures are more likely to be coincidental. These studies have not conclusively shown ondansetron to cause clefting or any other defect. More recent research continues to be reassuring. Therefore, it is unlikely the drug needs to be avoided during pregnancy

Other drugs to treat NVP have also been shown not to be a problem for the baby. The combination of doxylamine and vitamin B6 has been used for many years and is effective for many women. This combination is now available in the newly-marketed Diclegis. Ginger, whether in its raw form or in tablets, also works well for some expectant moms.

"So there are options?" exclaimed Nicole. "Thank goodness! Is it appropriate to ask my older child to work with daddy to get me some medication for nausea this Mother's Day – instead of flowers?" she giggled.

For some women the nausea and vomiting subside greatly after the first trimester, but for those who need extra support with some treatment, encourage the moms-to-be in your life to consult their health care providers for options. And, whatever you do, do not, I REPEAT, do NOT show up with a potpourri basket for mom coupled with freshly-made Panang curry this Mother's Day.

Lynn Martinez is a retired Teratogen Information Specialist. Lynn has traveled around the Utah educating doctors, nurse midwives, pharmacists and others over the past three decades.

Questions? Call 866.626.6847 | Text 855.999.3525 | Email or Chat at MotherToBaby.org.

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"I'm worried. I can't sleep. It's anxiety." The message came through from Natalie a few minutes after I had logged onto our live chat service at MotherToBaby.org. "I'm 14 weeks pregnant and concerned about taking a SSRI" she continued. As a Teratogen Information Specialist, I answer questions about exposures during pregnancy and breastfeeding on a daily basis, and I was happy to chat with Natalie about this topic.

Natalie had just returned from a visit to her OB/GYN's office where she was diagnosed with anxiety. She had shared with her doctor that she was having trouble eating and sleeping, and was experiencing racing thoughts and constant worry about the future. Natalie's OB/GYN was concerned that what she was describing was more than the typical pregnancy concerns that many women have. She recommended that Natalie start on an SSRI to help manage her symptoms.

Natalie knew she needed to do something to deal with her anxiety, but she was reluctant to take any medication. "I've read online that SSRIs can cause the baby to experience withdrawal symptoms, and I would never want to do anything to hurt my baby!" she quickly typed. "Instead of taking this medication, would it be better for me to just suffer through the next 26 weeks so my baby will be born ok?"

Natalie's question was not uncommon. Here in the United States, anxiety affects about 6.8 million adults, and women are twice as likely as men to have this mood disorder. Furthermore, about 6% of women will develop anxiety at some point during their pregnancy. Non-medication approaches may be an effective first-line treatment for certain individuals. Some women benefit from daily meditation or exercise. For others, opening up to a friend or attending talk therapy sessions may help. Natalie had tried all of these options in her first trimester, and unfortunately her anxiety was getting worse.

I knew Natalie wanted a quick answer to her question about withdrawal, but I told her that first it was important for us to review just how necessary it was for her to treat her mood disorder. I applauded Natalie for recognizing the symptoms of anxiety, and having an honest conversation with her doctor about how she was feeling. Next, I let her know that many women think that suffering through these feelings during pregnancy may be the best option. However, we know that anxiety can actually cause problems on its own when left untreated. Studies have identified an increased risk for preterm birth (baby born before 37 weeks) and low birth weight when women do not properly treat their anxiety during pregnancy. Women with untreated anxiety may also have more trouble bonding with their baby both during pregnancy and after delivery. Lastly, a personal history of anxiety prior to or during pregnancy is a known risk factor for developing a serious mood disorder after giving birth.

Natalie completely understood the importance of weighing the risks vs. the benefits. Her niece had been born premature and she has seen firsthand just how scary that experience was for her sister. She agreed that treating her anxiety was important.

Natalie's doctor had recommended that she start on sertraline (Zoloft), which belongs to a class of medications known as selective serotonin reuptake inhibitors, or SSRIs. Other medications in this class include citalopram (Celexa), fluoxetine (Prozac), and paroxetine (Paxil), to name a few. The SSRIs are well studied, which means that we have a

good idea of what the effects might be when a woman takes one of these medications during pregnancy. Withdrawal (also known as neonatal adaptation syndrome) is one of those known effects.

Babies of women who are taking an SSRI at the time of delivery may have some difficulties in the first few days of life. Reported symptoms include jitteriness, increased muscle tone, irritability, constant crying, changes in sleeping patterns, tremors, difficulty eating, and problems with breathing. Not every baby will experience these symptoms. For the SSRI medications, it is estimated that 10-30% of babies will be affected.

Some babies with symptoms of withdrawal may need to spend time in the neonatal intensive care unit (NICU) to receive additional care. However, in most cases the symptoms are mild and go away within two weeks. Reassuringly, there does not seem to be a dose-response relationship, which means that women who need a higher amount of medication to manage their anxiety are not expected to have babies who are at a higher risk for withdrawal.

“I feel so much better after chatting with you, and I really feel like this withdrawal issue can be managed if I plan ahead” Natalie said. “I think it’s going to be in my baby’s best interest for me to start taking this medication as soon as possible to get my anxiety under control.” I was glad that Natalie had reached out to chat with us about this issue. It can be a complex topic, but certainly not an uncommon one. Now armed with the most current information available, Natalie can make the best choice for her and her baby

References:

• U.S. anxiety stats: https://www.womenshealth.gov/mental-health/illnesses/generalized-anxiety-disorder.html
• Pregnancy anxiety stats: http://www.postpartum.net/learn-more/anxiety-during-pregnancy-postpartum/
• Postpartum Anxiety: https://www.anxiety.org/postpartum-anxiety-risk-factors
• Medications used to treat anxiety: https://adaa.org/finding-help/treatment/medication

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Can Moms Who Had a Transplant Breastfeed

While Taking Tacrolimus?

“I am so overwhelmed with all information available online nowadays about pregnancy and having a baby, I don’t know how to know what is best for me and my pregnancy!” shared Michelle, who was 15 weeks into her first pregnancy. Not only has the first trimester been full of morning sickness, but she has been obsessed with reading all the latest advice regarding healthy pregnancies and newborn care. This led Michelle to reach out to MotherToBaby’s confidential and free text service asking about prenatal vitamins, but she also wanted to know what other resources were available for first time parents.

As a MotherToBaby specialist, I knew the perfect resource to direct Michelle to: Nurse-Family Partnership. Elly Yost, a nurse practitioner with over 35 years of experience explains how this evidence-based, community health program can help first-time moms and their children affected by social and economic inequality.

Moms enrolled in the Nurse-Family Partnership program benefit by getting the care and support they need in order to have a healthy pregnancy. At the same time, families develop a close relationship with the nurse who becomes a trusted resource they can rely on for advice on everything from safely caring for their child to taking steps to provide a stable, secure future for their new family. Find out more about Nurse-Family Partnership here.

Q: What does the relationship look like between an NFP nurse and parent-to-be?

Elly: The relationship between an NFP nurse and a parent-to-be is built on trust and support. We prioritize the client as the expert in their own life, ensuring that their desires and needs guide our approach to supporting a healthy pregnancy. Our role is to meet them where they are and provide the tailored support to navigate this transformative journey effectively.

Q: What health benefits might a person experience from participating in the NFP Program?

Elly: Participating in NFP can yield a range of health benefits for first-time parents. Through regular health assessments conducted by a registered nurse (RN), participants receive personalized health screenings aimed at promoting overall wellness. This holistic approach not only addresses the immediate health needs of the parent but also extends to the well-being of their child. By closely monitoring factors such as blood pressure and weight gain, NFP nurses work with expectant mothers to identify and understand potential danger signs, such as swelling or headaches, that may indicate underlying health concerns.

Recognizing that pregnant women are the experts on their own bodies, NFP empowers them with knowledge and support to recognize and address anything that seems concerning. We learn about each person’s health history to customize care to their needs.

NFP nurses also regularly check on the baby's growth and development after birth by measuring length, weight, and head circumference, along with developmental milestones using Ages and Stages Questionnaires®. We look at what the parent and child need emotionally and socially, understanding how their health is linked and creating a caring environment for them to bond.

Q: Why does the Nurse-Family Partnership model work?

Elly: The NFP model is proven to work because it prioritizes the needs and desires of the parents it serves. By adhering to client-centered principles, we believe in listening to each first-time mom we work with because we know she's the one who knows her life best. We've seen that even small changes can lead to big, positive results, so we focus on finding solutions together.

One big part of what we do is making sure moms feel heard and supported. We talk with them about how they're feeling during pregnancy, understanding that it's normal to have all kinds of emotions during this time. We're here to offer guidance and reassurance, helping them navigate any worries they might have.

Our team of RNs is crucial to our work. With their education and experience, they provide moms with the best information and support possible. They're here to make sure every mom gets the care and guidance she deserves on her journey.

Q: How long does the relationship between the NFP and the family last?

Elly: Something unique about the role of an NFP nurse in the partnership with moms is the duration of the relationship. Families have the freedom to stay connected with their NFP nurse until their child turns two. This extended period allows for a deep and meaningful relationship to develop between the nurse and the parents, fostering trust, support, and continuity of care throughout the critical early stages of the child's development. This extended duration underscores the uniqueness of the bond formed within the NFP partnership, reflecting a commitment to long-term support and empowerment for both the parents and their child.

Q: How does the role of an NFP nurse change after a baby is born?

Elly: After a baby is born, NFP nurses adjust their role to support the special bond between the mother and her newborn. While the basics of care stay the same, the focus now extends to the dyad and family unit. The nurse's attention is directed towards both the individual needs of the mother, developmental milestones, well-being of the newborn, and the family.

Despite this adjustment, the core role of the nurse as a source of guidance, advocacy, and support for the mother persists, ensuring that she continues to receive personalized care and attention throughout her journey into motherhood.

Q: How do NFP nurses support first time parents' mental health?

Elly: NFP nurses play a crucial role in supporting the mental health of first-time parents through a combination of clinical expertise, compassionate care, and advocacy. From a clinical perspective, nurses conduct thorough assessments for depression and anxiety. Additionally, nurses assess the temperament and emotions of mothers, providing tailored support and referrals based on individual needs and preferences.

What sets NFP nurses apart is their dedication to building trusting relationships and providing personalized care. They invest time in getting to know each client, fostering a supportive environment where parents feel comfortable expressing their concerns and emotions. This level of care and observation allows nurses to offer not only clinical support but also emotional reassurance and guidance.

NFP nurses also act as advocates, guiding parents through the healthcare system and connecting them with resources for mental well-being. By addressing both the clinical and emotional aspects of mental health, NFP nurses empower first-time parents to navigate the challenges of parenthood with strength and confidence.

Q: What would you like to see improved about the current state of pregnancy and/or post-birth care?

Elly: I think one area for improvement in current pregnancy and post-birth care is the practice of listening and truly hearing the experiences and concerns of expectant and new parents. For example, the 'Hear Her' campaign by CDC highlights the importance of this simple yet profound concept: actively listening to pregnant and postpartum people and believing them.

By taking the time to genuinely hear and understand the needs and perspectives of clients, healthcare providers can foster trust, enhance communication, and deliver more patient-centered care. Empowering women to share their stories and validating their experiences can lead to improved outcomes and a more supportive healthcare environment for all.

Q: What is additional guidance you would give a first-time parent?

Elly: Additional guidance I would offer to first-time parents is simple yet powerful: You're doing a great job! Love for your child is the cornerstone of effective parenting. Embrace the idea of 'good enough parenting,' where you do your best without feeling pressured by unrealistic standards. In a world full of advice and expectations, what matters most to your child is your love and care. Trust your instincts, show them love, and believe in your ability to navigate parenthood's journey. If you are a first-time mom who is 28 weeks pregnant or less, you can find a free, personal NFP nurse in your area here.

NFP Is Here For You!

After sharing the resources of NFP with Michelle, she texted back the next day saying “Thank you! I read through their website and this is exactly what I need to make me feel confident in my decisions during the rest of my pregnancy and have someone to help me during the early days of parenthood. I already enrolled in the program and hope to get started soon.” It is so lovely to hear that NFP was exactly what Michelle needed, and I hope that she and other first-time parents continue to benefit from this resource for years to come.

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“This is my first child, and I don’t know what to do!” exclaimed Lyndsay, a newly pregnant woman when I answered MotherToBaby’s free and confidential helpline. Lyndsay explained that she is taking several medications and was concerned about their potential effects on her unborn baby. She is currently very new to recovery from cocaine and opioid use disorder. She is taking buprenorphine and naloxone for the opioid use disorder, along with baclofen and n-acetylcysteine (NAC) for cocaine cravings. Her medication regimen also includes aripiprazole, escitalopram, bupropion and mirtazapine for depression, mood stabilization and insomnia.

“This combination has been working well for me,” she explained. “Having that said, I wonder if the treatments are increasing my chances for pregnancy complications or birth defects in my baby?” She wondered if she would be better off getting off the buprenorphine and naloxone now.

In preparing to answer her concerns, I reached out to Ellen Kolomeyer, PhD, PMH-C, a licensed clinical psychologist certified in perinatal mental health, who is part of the National Maternal Mental Health Hotline team to assist us in providing the best answers about recovery treatment while pregnant. The National Maternal Mental Health Hotline provides 24/7 support to pregnant and postpartum individuals experiencing challenges with mood and anxiety, as well as their support women and loved ones through its phone and text line 1-833-TLC-MAMA.

Q: How common is it for a woman in recovery and who is also pregnant to be treating an opioid use disorder with medications?

According to the Centers for Disease Control and Prevention (CDC), about 7% of pregnant women used opioids during pregnancy, with one in five of those women reporting that they misused opioids during pregnancy. But, only about half of the pregnant women who use opioids during pregnancy are in recovery, so it is wonderful that Lyndsay is reaching out to learn how to best care for herself and her baby. I hope her story shows that it is possible to get help and have a healthy pregnancy.

Q: What treatments can be used?

When a pregnant woman is dealing with opioid addiction, healthcare providers often prescribe medicines like methadone and buprenorphine. It is best if treatment starts before someone gets pregnant to help both the mother and baby stay healthy. But sometimes, people face challenges that make it hard to get treatment. These can be personal issues like having a tough time managing feelings or problems with relationships. There can also be unfair judgments from others about drug addiction that make it harder for people to seek help. Besides giving medicine, it is also important to get help for mental health. This means talking to a counselor or therapist about the things that might be causing someone to use drugs in the first place.

Q: Is discontinuing treatment while pregnant recommended? Why or why not?

It is important to know that stopping opioid use suddenly during pregnancy can be dangerous for both the pregnant woman and the baby. Managing opioid use with medication is a better way to stay healthy and reduce the risk of going back to using drugs. So, it is best to keep taking the medication rather than stopping it while pregnant. It is crucial to talk with a healthcare provider before making any decisions about treatment.

Q: Should a pregnant woman expect her healthcare provider to start or stop medications or switch to alternatives?

Each pregnancy is different, so there is no one answer that fits everyone. Depending on the situation, a pregnant woman might start, stop, or switch medications. It is common for healthcare providers to talk about medications, like methadone https://mothertobaby.org/fact-sheets/methadone/ or buprenorphine, https://mothertobaby.org/fact-sheets/buprenorphine/ and suggest starting them if needed. Sometimes, providers might think about changing to a different medication but they will carefully consider the risks and benefits. It is best to see a healthcare provider who knows how to give the right recommendations for pregnant women.

Q: What can a pregnant woman do to advocate for herself in this scenario?

Pregnant women who are struggling with opioid use often face challenges in getting the right information and help. Even though there can be judgment from others, pregnant individuals can benefit from speaking up for themselves.

One important way to do this is to understand the reasons behind the problems they are facing and to talk about their goals.

Research shows that many people turn to drugs because of past trauma, not having enough support or money, dealing with bad feelings, and having tough relationships, among other reasons. By thinking about their own situation and struggles, individuals can work to address the main issues they're facing.

I want every pregnant woman in this situation to know that they can still have a good relationship with their baby and take care of their baby's needs. It is a good idea to find a healthcare provider who knows a lot about opioid use disorder to get the right support. Building a strong support system could be the key to making a big change and getting better.

There are some great ways that pregnant women recovering from opioid use disorder can build their support system. Talking through personal hardships in support groups, with home visitors, with a counselor, or with a therapist can help build the tools and confidence you need to learn how to advocate for yourself and your baby with medical providers.

Q: What is the best way that a pregnant woman can share her questions and concerns with their Obstetric provider?

To make sure you get the best support, it is helpful to find a healthcare provider who knows about substance use issues. One great way for a pregnant woman to talk about their questions and worries with their OB is to write them down before an appointment and bring the list with them. As the pregnancy progresses, working together with the provider to plan for labor, delivery, and postpartum care can get the parent-to-be ready for what is ahead at each stage. I suggest asking your obstetric provider to be open and share information throughout the process so that there are fewer surprises when it is time for the birth, after-birth care, and taking care of the newborn.

Q: After delivery, what does a typical newborn period look like for the parent(s) and baby?

It is common for babies to experience withdrawal symptoms from medications used to treat opioid addiction (also called neonatal abstinence syndrome), but this should not stop a healthcare provider from prescribing the medications or pregnant women from taking them. After the baby is born, parents should team up with their baby's healthcare provider to keep an eye on the newborn and get help when needed. It is important for parents to be involved in their baby's care and spend time bonding with them. If parents feel they are not getting these chances, they can speak up and ask for them.

Withdrawal symptoms in a baby are treatable, but some babies need to be monitored extra closely and around the clock. It can also be helpful to prepare ahead of time and learn if it is possible that your baby might go to the Neonatal Intensive Care Unit (NICU) instead of staying in the recovery room with you. While unexpected things can happen in any pregnancy and birth, you could ask your providers ahead of time whether they think there is a reason your baby might go to the NICU and what you might expect. For example, you might want to know how long your baby could be in the NICU and make a plan for advocating to still be able to see, touch, and care for your baby as often as possible during your baby's medical care.

Q: Can you share recommended resources?

There are widely available, free, and confidential programs, resources, and provider directories that anyone can access

including the following:

- National Maternal Mental Health Hotline provides 24/7 support to pregnant and postpartum individuals experiencing challenges with mood and anxiety, as well as their support persons and loved ones. Call or text 1-833-TLC-MAMA.
- MotherToBaby provides information about exposures, like medications and diseases, during pregnancy and while breastfeeding through its free phone service 866-626-6847, text 855-999-3525, email and live chat via MotherToBaby.org.
- Substance Abuse and Mental Health Services Administration (SAMHSA) offers a directory to find medical providers who specialize in treating opioid use disorders. Locate a practitioner here. SAMHSA also provides a National Helpline that can provide treatment referral and information 24/7. Call 1-800-662-HELP.
- Postpartum Support International HelpLine provides basic information, support, and resources for pregnant, postpartum, and parenting individuals and their support persons and loved ones. This line is not 24/7 but messages are returned daily. Call or text 1-800-944-4773.
- Postpartum Support International Provider Directory lists medical and mental healthcare professionals who are specially certified to care for pregnant and postpartum individuals. Access the directory here.
- The Suicide and Crisis Lifeline is available 24/7 by calling or texting 988.
- Circle of Security is an evidence-based program that helps parents build secure parent-child relationships, effectively meet babies' needs, and help parents break cycles from their own childhoods that they do not wish to carry over to their children. Learn more here and a Circle of Security Parent Educator here.

We had just shared a lot of information with Lyndsay. She was relieved to hear that her recovery treatment was going to allow her to stay well in pregnancy and give her the best chance to have a healthy baby. "I feel like I have a better idea of what questions I need to ask my OB and pediatrician," she told us. "I feel less alone in this now and it looks like there are places I can go to get more information too."

References:

MotherToBaby Blog: "Dear Opioid-Addicted Moms-To-Be, We are Here for You"

Centers for Disease Control and Prevention. (2022). ***About opioid use during pregnancy***.

Centers for Disease Control and Prevention. (2022). ***Treatment for opioid use disorder before, during, and after pregnancy***.

Gerdts-Andresen, T. (2021). Circle of security-parenting: a systematic review of effectiveness when using the parent training Programme with multi-problem families. ***Nordic Journal of Social Research***, ***12***(1), 1-26.

Henry, M. C., Sanjuan, P. M., Stone, L. C., Cairo, G. F., Lohr-Valdez, A., & Leeman, L. M. (2021). Alcohol and other substance use disorder recovery during pregnancy among patients with posttraumatic stress disorder symptoms: A qualitative study. ***Drug and Alcohol Dependence Reports***, 1, 100013.

Horton, E., & Murray, C. (2015). A quantitative exploratory evaluation of the circle of security-parenting program with mothers in residential substance-abuse treatment. ***Infant mental health journal***, ***36***(3), 320-336.

Substance Abuse and Mental Health Services Administration. (2018). Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants. ***Vol HHS Publication No.(SMA) 18-5054***.

Substance Abuse and Mental Health Services Administration. (2024). Evidence-based, whole-person care for pregnant women who have opioid use disorder. SAMHSA Advisory. https://store.samhsa.gov/sites/default/files/whole-person-care-pregnant-people-oud-pep23-02-01-002.pdf

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