CANNABIS USE IN THE PERINATAL PERIOD

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Acknowledgements

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Thank you to my family - my mom who was also psychiatrist and inspired my original interest, my husband and kids for supporting me so I can do this work, and my dad for so many things and especially for cooking dinner!

Thank you to my patients for trusting me to care for them and being my greatest teachers always.

OBJECTIVES

- Participants will be able to describe the current state of perinatal cannabis use.
- Participants will be able to discuss how to screen for and evaluate patients for cannabis use disorder (CUD).
- Participants will be able to summarize evidence-based interventions to manage CUD in perinatal period.

Cannabis in Perinatal Period

US prevalence

~7%

of pregnant women — more than doubled over the past two decades

Highest state-level prevalence

26%

of pregnant persons, in some states

Perceived risk

~70%

of women see little or no risk in weekly use during pregnancy

1 **Race / ethnicity**
Use was higher* among of people other race/ethnicity, **38.9%**, compared to use among White people, **17.1%**
p = 0.017

2 **Age**
33.3% of 18–24 year olds — highest use vs. **0.5%** of those ≥ 40 — lowest
p = 0.014

3 **Education**
Highest rates among those who did not complete high school, **41.7%**
p = 0.001

Only 15.3% of all respondents received counseling on cannabis use during pregnancy

Sources: Volkow et al., 2019; Corsi et al., 2019; Ko et al., 2015; Roberson et al., 2014; Westfall et al., 2006; Dickson et al., 2018; Wen et al., 2019; Ramseyer, et al. 2026*;*

CANNABIS IN THE CURRENT MOMENT

1

Rapid expansion of availability

Both in the types of products and in access to them

2

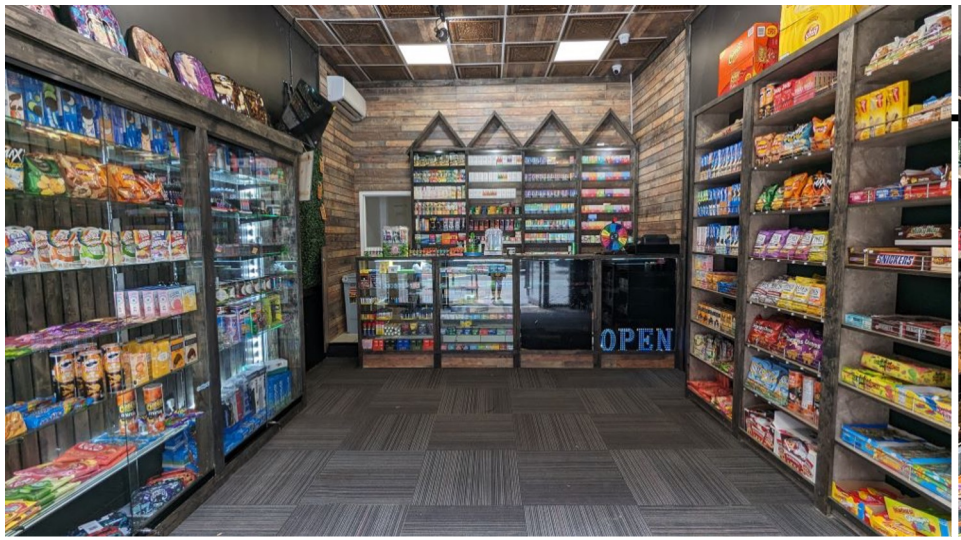
Driven by policy change

Decriminalization, legalization and COMMERCIALIZATION

3

Proliferation of information

Ever more sources of claims about cannabis and THC-infused products

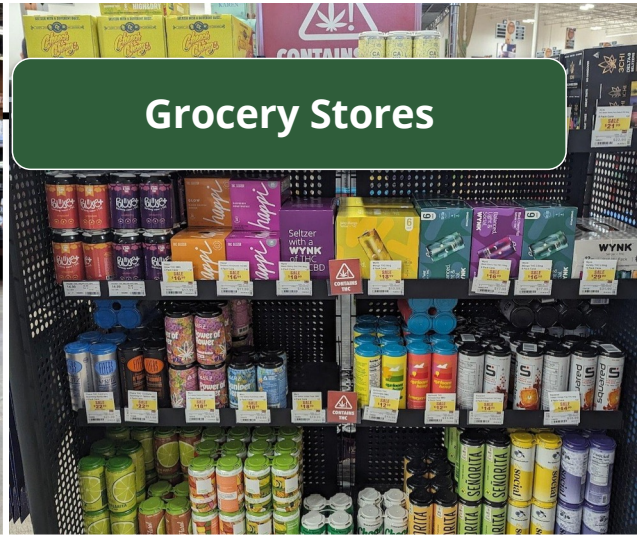


Smoke Shops

Dispensaries


THC


MARKET
BOOZE-FREE • HEMP-DERIVED
FREE SAMPLES!


Grocery Stores


THC BEVERAGES
New!
• DELTA-9 THC derived from hemp
• CHECK DOSAGE and start small
• LEGAL in Illinois
• EFFECTS VARY by person


THC
INFUSED


Nectar

WORDS MATTER:
CANNABIS VS. MARIJUANA

The choice to use "marijuana" over "cannabis" was intentional.

We must be intentional in our word choice, as well.

“MARIJUANA” IN THE US LEGAL SYSTEM

1937
Marihuana Tax Act

- Effectively criminalized cannabis nationwide.
- Held unconstitutional in 1969.

1970
Controlled Substances Act

- Nixon's Shafer Commission created to establish the dangers of cannabis.
- Cannabis classed Schedule I — no accepted medical use; ranked above cocaine and meth.

1994
“Broken Window” Policing, NYC

- NYPD arrested people for minor infractions to improve “quality of life.”
- Public-view cannabis arrests rose from 3,000 (1994) to over 50,000 (2000).
- 84% of those arrested were Black or Hispanic.

These laws were not built on scientific evidence. They were used to control minoritized groups by linking them to illegal substance use — and the stigma they created still shapes perceptions today.

IN THEIR OWN WORDS

> *"There are 100,000 total **marijuana** smokers in the US, and most are **Negroes, Hispanics, Filipinos**, and entertainers. Their Satanic music, jazz and swing, results from marijuana use. This marijuana causes white women to seek sexual relations with Negroes, entertainers, and others."*
>
> **— Harry Anslinger, first director of the Federal Bureau of Narcotics, 1930**

> *"We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the **hippies** with **marijuana** and **blacks** with **heroin**, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. **Did we know we were lying about the drugs? Of course we did**."*
>
> **— John Ehrlichman, senior advisor to President Nixon, 1970**

Taylor, 2023; Solomon, 2020

The inheritance of this history is barrier to disclosure

Why many pregnant persons cannot be forthcoming with providers about cannabis use

1. **Social stigma**
2. **Racism**
3. **Fear of legal consequences**
4. **Child protective services involvement**
5. **Loss of custody**

↓

As a result, many pregnant persons cannot be forthcoming with health care providers regarding their cannabis use.

REASONS CITED FOR CONTINUED USE

NOTE

- Most people who use THC in pregnancy were using pre-pregnancy
- Most are making efforts to change/reduce use

- Manage pregnancy-related conditions
  - Nausea and vomiting
  - Poor appetite, and fatigue
  - Stress
  - Pain management
- Manage mental health conditions
- Social connection and practices
- Perception that it is not a risk to the fetus or the pregnancy
- Perception that it is safer than alcohol or psych meds
- Perception that legalization connotes lower risks have been established

Gesterling et al 2021

CHOICES ABOUT FORMS USED

"I went from mostly smoking blunts [before pregnancy to only smoking cannabis in pregnancy] ... My midwife did let me know... smoke in general, and inhaling even vape, wasn't always ideal. I cut back a lot on smoking... and [used] edibles more [while] being pregnant...Obviously, I wasn't going to smoke tobacco while being pregnant. I knew that wouldn't be safe."

"The only thing [healthcare clinicians] will say is no tobacco... that told me bongs, pipes, papers, the hemp wraps...teas, ...edibles [were all safe to use]... that's six different ways off the top of my head that you can do [cannabis] naturally...it was all a matter of me finding a way that works for me... I didn't like the way the edibles made me feel because it's a way longer high... it lasts for up to eight hours. That's a whole day. [LAUGHS] I don't need that [when] I'm pregnant...I need [cannabis] for me. I don't need my kid to be high."

"I chose to consume edibles instead of smoking because I know that smoking ... doesn't have a positive effect on pregnancy or just your health in general. That's why I decided to do edibles... while I'm pregnant... But my friend who is a nurse [said] choosing edibles has more of an effect on your body. So that's why she chose to smoke. And this is why I would like to know more about it, because I would like to choose an option ... that would have the least effect on the baby."

Gould et al. 2024

Perceived risk of cannabis use in pregnancy is falling

How pregnant women perceive the safety of cannabis use

3×

increase in women perceiving no or only slight risk from general cannabis use from 2005 to 2015

pregnant and nonpregnant women who used cannabis recently perceived slight or no risk

Safety judged by comparison, not evidence

Vs. tobacco and alcohol

Women knew the established risks of prenatal tobacco and alcohol use, and judged cannabis against that benchmark

"No evidence" read as "no risk"

Limited research on prenatal marijuana was often interpreted as proof of safety, rather than an open question

Vs. prescribed medications

Cannabis was frequently perceived as safer than prescription drugs for managing pregnancy symptoms

The primary perceived risk of marijuana use in pregnancy was legal — not medical.

Sources: Jarlenski et al., 2017; Ko et al., 2015; Chang et al., 2019; Mamluk et al., 2017; Popova et al., 2017; Dietz et al., 2010; USDHHS, 2014

Perceived safety of cannabis use

Patient perceptions behind cannabis use in pregnancy

“My only safe option”

Patients described fearing the effects of pharmaceuticals on their developing baby, and believed cannabis was their only safe option (Barbosa-Leiker et al., 2020)

“It’s natural”

Cannabis was seen as a “natural” substance and therefore assumed safer than pharmaceuticals — even though tobacco, also natural, was acknowledged as risky (Chang et al., 2019)

Deliberate, monitored use

Use was not haphazard — patients frequently reevaluated their symptoms and need for treatment throughout the pregnancy (Barbosa-Leiker et al., 2020)

“Not a hard drug”

Compared with substances like methamphetamines or heroin, cannabis was judged safer simply for not being a “hard drug” (Chang et al., 2019)

Sources: Barbosa-Leiker et al., 2020; Chang et al., 2019

Challenges to Cannabis Use Research

Retrospective cohort studies offer strong statistical power from large samples, and the ability to stratify or control for confounding factors.

Recall & self-report bias

Reliance on self-reported cannabis use risks underreporting, which can bias findings toward a null result.

Potency & route differences

Cannabis potency varies widely, and pharmacokinetics differ by route of consumption, complicating comparisons across studies.

Polysubstance confounding

Inadequate control for concurrent tobacco or other substance use can overestimate cannabis's effects — e.g., some studies link low birth weight to combined tobacco + cannabis use, while others find it independent of tobacco.

Dose and timing uncertainty

It remains unclear whether adverse outcomes depend on dose, frequency, or timing of exposure during pregnancy.

Much of today's longitudinal data comes from the 1980s–90s, when cannabis was far less potent — and the clinical significance of neurologic deficits in exposed children remains poorly understood.

Gesterling et al 2021

Risks to Pregnancy and Contradictory Findings

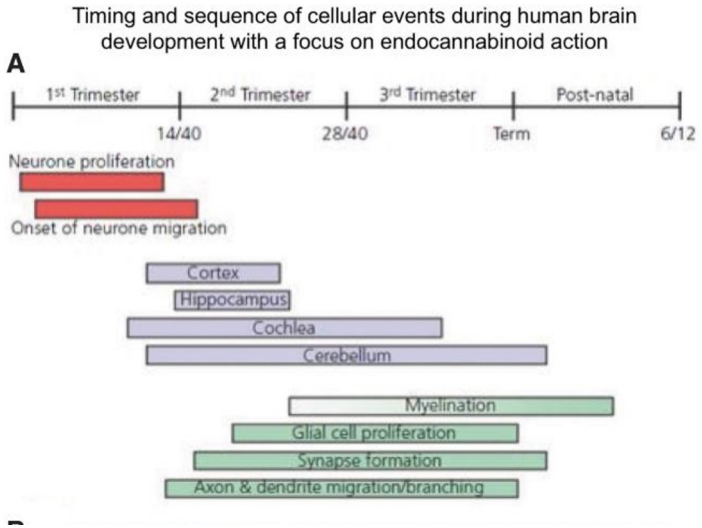
- 2016 systematic analysis and meta-analysis (31 studies; n = 124,867 nonusers, n = 7851 cannabis users)
- Cannabis was **not an independent risk factor** for adverse neonatal and perinatal outcomes after adjusting for other variables, including tobacco use.
  - **Low birth weight** (aOR 1.16; 95% CI, 0.98-1.37)
  - **Preterm birth** (aOR 1.08; 95% CI, 0.82-1.43).
- Increased frequency of cannabis use **was associated with increased risk for**
  - **Low birth weight** (11.2% vs 6.7%; relative risk [RR], 1.90; 95% CI, 1.44-2.45)
  - **Preterm birth** (10.4% vs 5.7%; RR, 2.04; 95% CI, 1.32-3.17),

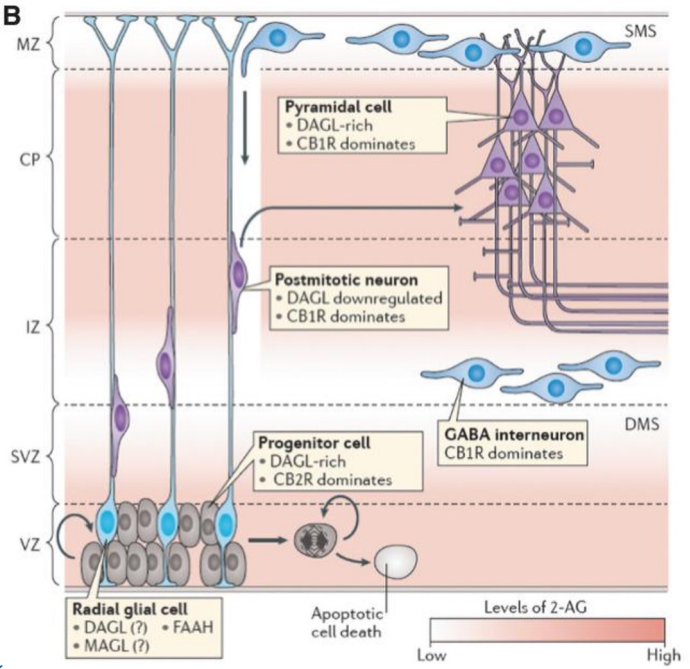
Gesterling et al 2021

FIRST TRIMESTER EXPOSURE TO CANNABIS

- THC easily crosses the placental barrier and can build-up in the fetal tissues
- The endocannabinoid system is implicated in placental implantation and placental cell proliferation
  - Exposure to THC can disrupt this process and potentially lead to miscarriages and IUGR
- The endocannabinoid system is also important for neuronal development
  - THC binds to cannabinoid receptors and has been found to disrupt this process in mouse models and also fetal brain studies
  - May lead to problems in brain development in children whose parents used THC in pregnancy

Gesterling et al 2021





Cannabis Cannabinoid Res.
2021 Oct 13;6(5):381–388. doi: 10.1089/can.2021.0096

Physiological Rules of Endocannabinoid Action During Fetal and Neonatal Brain Development

Tibor Harkany [1,2,*], Valentina Cinquina [1]

Research Findings in Cognitive and Behavioral Development

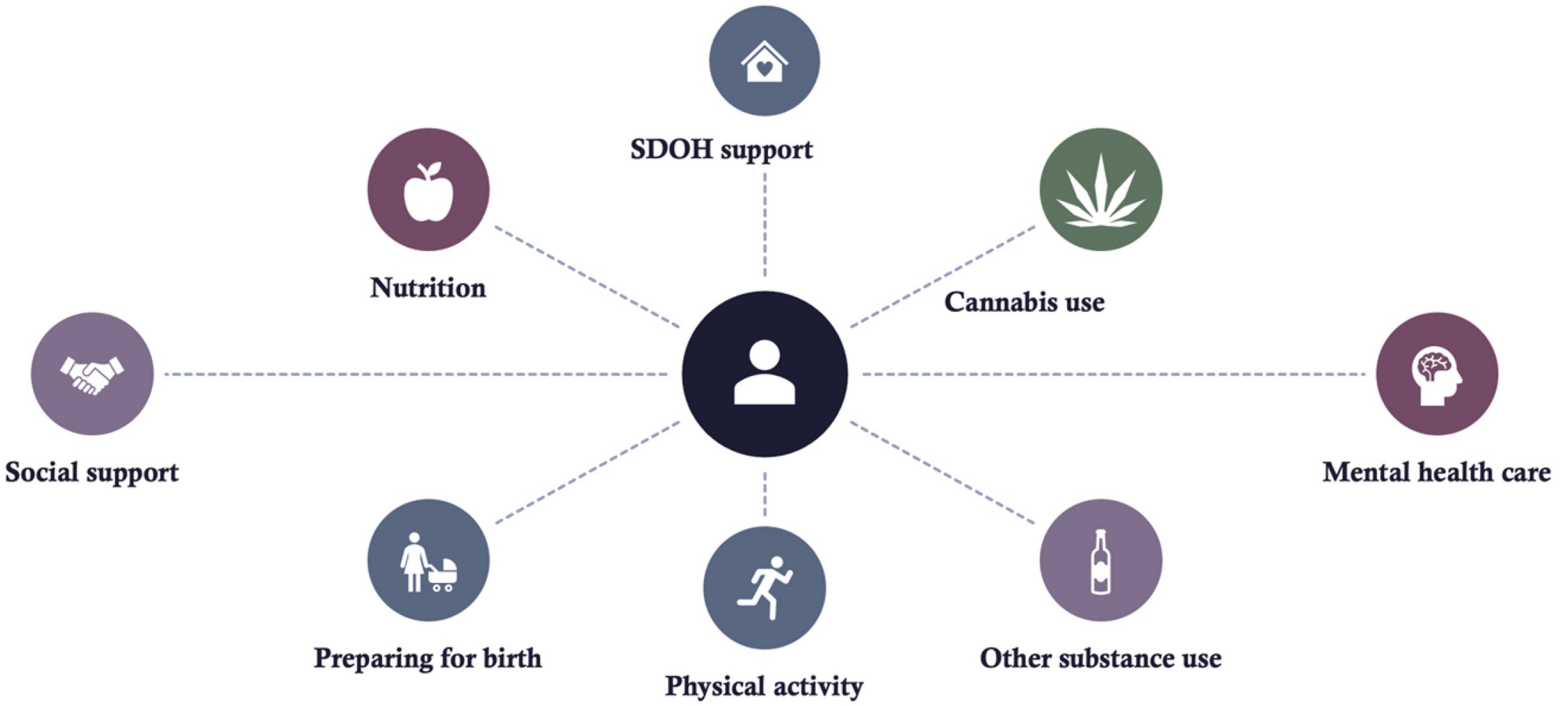
- Human longitudinal studies of cannabis-exposed offspring
  - Deficits in cognition (Fried et al., 1998), executive functioning (Smith et al., 2016), and working memory (Fried and Watkinson, 1990).
- Cross-sectional retrospective studies
  - Impaired memory, impulse control, problem solving, and quantitative reasoning (Sharapova et al., 2018), as well as alterations in emotional reactivity and increased symptoms of affective disorders (De Moraes Barros et al., 2006; Fried and Makin, 1987; Leech et al., 2006; Lester and Dreher, 1989).
- A 2019 review[25] of historical and contemporary literature
  - Exposed preschoolers can exhibit difficulty with attention, memory, and verbal processing, and as they progress to school age are more likely to exhibit increased impulsivity and hyperactivity.
  - Long-term such as decrease in executive functioning skills and an increase in rates of depression, anxiety, and aggressive behavior.[27]

Weimar et al, 2020

Contradictory Findings

- 2020 literature review by Joseph and Vettraino
  - There have been no consistent findings regarding cognition and school performance
- 2020 systematic and critical review by Torres et al.,
  - No clinically significant cognitive deficits in individuals from birth to 22 years with prenatal cannabis exposure compared with nonexposed individuals,
  - Inclusion criterion was prenatal cocaine exposure, with cannabis exposure as a covariate.
- Smid et al, followed children exposed to THC in utero until 60months of age
  - No difference between exposed and unexposed in child IQ at 60 months of age.
  - Cannabis exposure between 8 and 20 weeks gestation was associated with higher Conners attention scores at 48 months of age.
  - Both groups' median T score was within the average range 40–59 (16–83 percentile) which is associated with average levels of attention concern for the child's age and sex.
  - Confounders of lead levels, alcohol exposure, PCB exposure were not collected in their study.

Torres et al, 2020 Smid et al, 2022.


SDOH support
Nutrition
Cannabis use
Social support
Mental health care
Preparing for birth
Physical activity
Other substance use

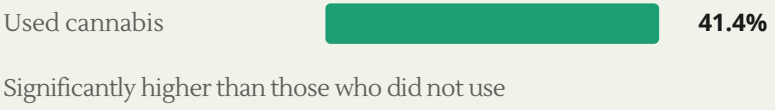
Gaps in Medical Professional Discussion of Cannabis

How clinical counseling reaches patients, and what actually drives them to change their use patterns

Received counseling on cannabis use

p = 0.003

Interested in more information



Significantly higher than those who did not use

p < 0.001

Abstinence-only messaging from clinicians can isolate patients — pushing them toward anecdotal, non-evidence-based information from friends, family, or the internet instead.

Impact of Medical Discussion of Cannabis

27% cited a doctor's recommendation as their motivation to stop or reduce using

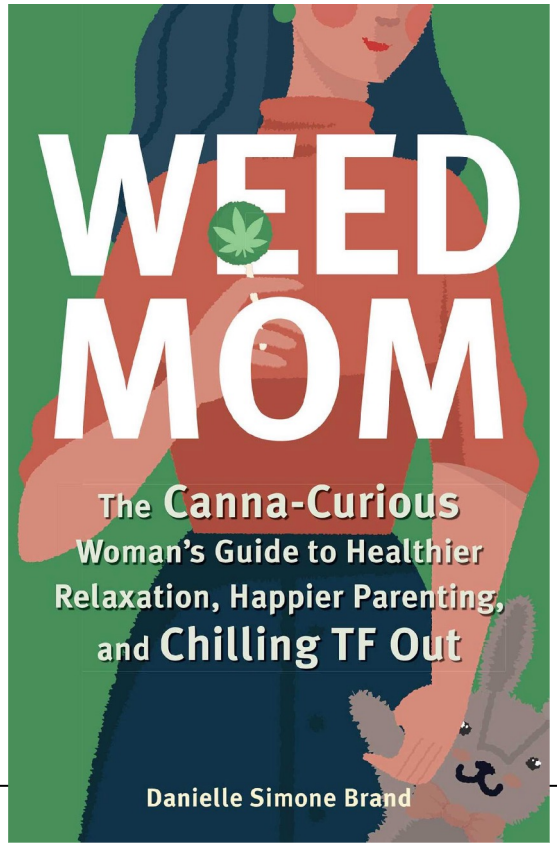
74% cited avoiding being a "bad example" as their motivation to stop using

Sources: Ramseyer et al., 2026; Gould et al., 2024; Mark et al., 2017

WHO FILLS THESE GAPS?

SELF-HELP


GANJA
MAMA
GROUPS


WEED
MOM
The Canna-Curious
Woman's Guide to Healthier
Relaxation, Happier Parenting,
and Chilling TF Out
Danielle Simone Brand


SUPPORT • EMPOWER • ELEVATE
good moms
smoke too
Canna Moms
KC
support group
TALK • RANT • TRADE • ADVICE • CONNECT
WEEKLY MEET UPS & PLAY DATES
RAISING TINY HUMANS & HIGH STANDARDS

What budtenders tell pregnant customers

Findings from a “mystery caller” study of Colorado dispensaries (Dickson et al., 2018)

Researchers posed as pregnant customers and called 400 registered Colorado dispensaries, asking a standardized set of questions about pregnancy-related nausea.

65%

of budtender responses were based on personal opinion, not research or clinical guidance

36%

of budtenders stated outright that cannabis use is safe during pregnancy

69%

recommended specific cannabis products for morning sickness

A clear lack of understanding of cannabinoid effects emerged — responses ranged from firm claims that cannabis is safe for both mother and baby to simply suggesting the caller “try different doses.”

Sources: Dickson et al., 2018

Steering patients away from their doctors

The most alarming trend in budtender advice (Dickson et al., 2018)

When asked directly, many budtenders discouraged pregnant customers from contacting their physician about cannabis use — while a few encouraged it, others expressed open distrust of doctors.

What budtenders actually said:

"Find a physician who is pro-cannabis."

"Avoid physicians — they're only pushing pills."

"The research is propaganda."

"If it's safe for cancer, it must be safe in pregnancy too."

Sources: Dickson et al., 2018

Regulating Dispensary Advice in Pregnancy

Canada's mandatory training vs. Colorado's unregulated dispensaries

Canada — mandatory training (n=456)		Colorado — no regulation	
93%	recommended against cannabis use	**69%**	recommended cannabis products
3.7%	based recommendation on personal opinion	**65%**	based recommendation on personal opinion
99.5%	deferred to the health care provider (89.9% unprompted + 9.6% prompted)	**—**	no comparable deferral requirement or practice

No US oversight board holds budtenders accountable for medical misinformation, and no state with legal cannabis restricts what medical advice they can give.

Sources: Vastis et al., 2020; Dickson et al., 2018

Mandatory warning signs – Unintended Consequences

Effect of MWS-cannabis policies on birth outcomes in Washington (Roberts et al., 2022)

Difference-in-differences comparison: Washington vs. nearby states legalizing cannabis (AK, CA, NV), with states still criminalizing it (ID, MT, WY) as a secondary check.

Birthweight

−7.03 g

95% CI: −10.06, −4.00

p = 0.005 — significant

Low birthweight

+0.3%

95% CI: 0.0, 0.6

p = 0.041 — significant

Gestation

−0.014 wks

95% CI: −0.038, 0.010

p = 0.168 — not significant

Preterm birth

+0.2%

95% CI: −0.2, 0.7

p = 0.202 — not significant

As with MWS-alcohol, enacting MWS-cannabis is linked to worse birth outcomes — the idea that these signs offer a public health benefit is not evidence-based.

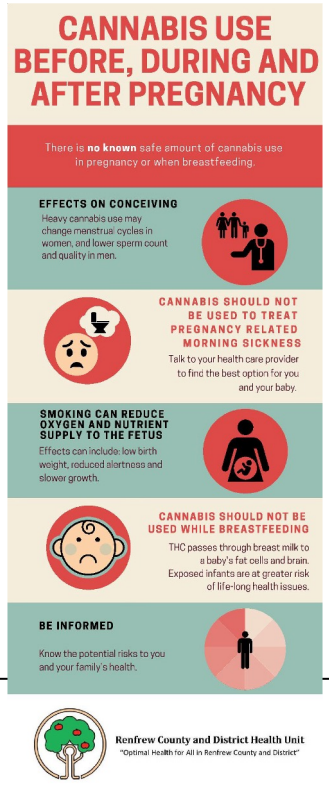
These policies may increase pregnant people's fear of judgment and punishment — leading them to avoid prenatal care altogether.

Source: Roberts et al., 2022

HOW CAN MEDICAL PROVIDERS JOIN THE CONVERSATION?

Setting the stage…

IMAGINE IF YOUR DOCTOR'S OFFICE HAD THESE SIGNS:



What if it was something more like this…

Your Pregnancy and Substance Use

4 Things you can do to improve your health and lower your risk for complications

Get Prenatal Care

Start early. Go to all your visits. Empower yourself with information so you can make smart decisions. Build relationships with providers who understand Substance Use Disorders (SUDs) and know how to help. Partner with them to reach your goals. But remember, you do not need to be abstinent from substance use to get care. Go now.

B'more for Healthy Babies
Every baby counts on you
www.healthybabiesbaltimore.com

Academy of Perinatal Harm Reduction
www.perinatalharmreduction.org

https://www.healthybabiesbaltimore-providers.com/resource-library

Reduce Your Use

There are simple things you can do to limit the harm substances might do.

- Use fewer substances
- Use smaller amounts
- Use less often
- Learn how to use safer

Reducing or quitting smoking is a good place to start. Set your goals, then ask for help.
One of the best things you can do is to stop using alcohol. We know that even small amounts are risky. And when combined with benzos and opioids, alcohol can kill.

Take Good Care of Yourself

You deserve a healthy pregnancy & childbirth.

- Eat healthy and take your prenatal vitamins
- Find the right balance of rest and exercise
- Surround yourself with people who care

Your Health Matters

Academy of Perinatal Harm Reduction

www.perinatalharmreduction.org

National Perinatal Association

www.nationalperinatal.org

ACOG CLINICAL CONSENSUS NO. 10: CANNABIS USE DURING PREGNANCY AND LACTATION

1

Educate

Educate all patients — pre-pregnancy through postpartum — on cannabis risks. No medical indication supports use in pregnancy or postpartum.

2

Know the stakes

Understand the legal and social consequences of positive screens, including CPS involvement — and work to address inequities in these systems.

3

Screen universally

Screen all patients using interview, self-report, or validated tools. Biologic testing should not be used for screening.

4

Advise cessation

Advise cessation in pregnancy and lactation — but continued use is not a contraindication to breastfeeding, which should not be discouraged.

5

Support behavior change

Consider motivational interviewing, social determinants of health, and barriers to cessation to guide intervention strategies.

6

Offer support tools

Consider home visits, psycho-behavioral strategies, or text-message interventions to reduce use and support newborn health.

https://journals.lww.com/greenjournal/fulltext/2025/10000/acog_clinical_consensus_no__10__cannabis_use.23.aspx

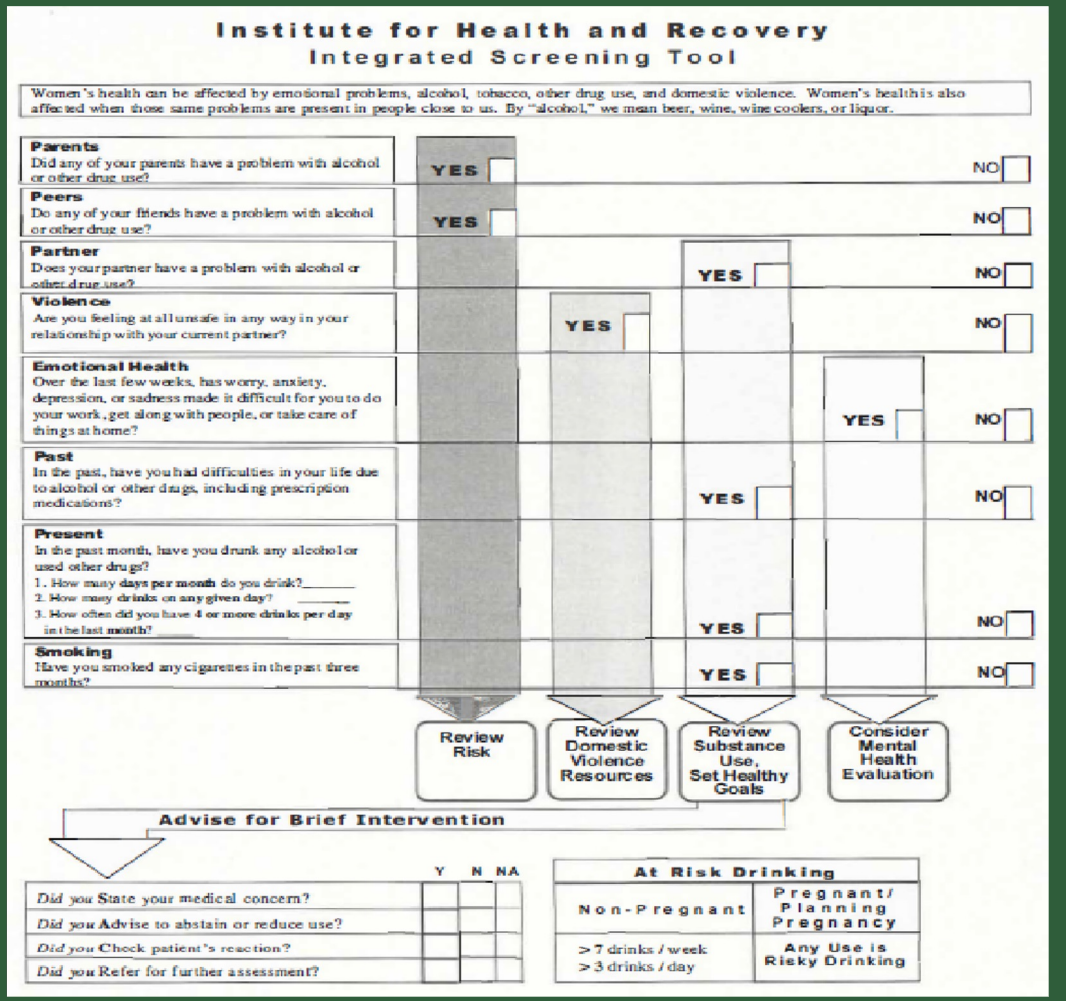
5 P'S SCREENING

5Ps =
Parents, **P**eers, **P**artner,
Past, **P**resent

- Also includes questions about violence, emotional health,

and smoking

- Brief interventions noted
  - Did you state your medical concern?
  - Did you advise to abstain or reduce use?
  - Did you check your patient's reaction?
  - Did you refer for further assessment?
- Also screens for at-risk drinking
- ONLY a SCREENING TEST —
  - Assessment still needed to diagnose SUD



Institute for Health and Recovery
Integrated Screening Tool

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women's health is also affected when those same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.

Parents Did any of your parents have a problem with alcohol or other drug use?	YES ☐	NO ☐
Peers Do any of your friends have a problem with alcohol or other drug use?	YES ☐	NO ☐
Partner Does your partner have a problem with alcohol or other drug use?	YES ☐	NO ☐
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?	YES ☐	NO ☐
Emotional Health Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?	YES ☐	NO ☐
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	YES ☐	NO ☐
Present In the past month, have you drunk any alcohol or used other drugs? 1. How many **days per month** do you drink?_____ 2. How many **drinks** on any given day? _____ 3. How often did you have **4 or more drinks per day** in the last month?	YES ☐	NO ☐
Smoking Have you smoked any cigarettes in the past three months?	YES ☐	NO ☐

Review Risk | Review Domestic Violence Resources | Review Substance Use, Set Healthy Goals | Consider Mental Health Evaluation

Advise for Brief Intervention

	Y	N	NA
Did you State your medical concern?			
Did you Advise to abstain or reduce use?			
Did you Check patient's reaction?			
Did you Refer for further assessment?			

At Risk Drinking	
Non-Pregnant	Pregnant/ Planning Pregnancy
>7 drinks / week >3 drinks / day	Any Use is Risky Drinking

URINE TOXICOLOGY TESTING

- Complicated decision on whether use UTT when working with people who use drugs
- Due to legal context particularly in minoritized population testing can be very damaging to postpartum people and their children's lives
- Research has shown that testing of black and other minoritized persons were more likely be tested with UTT and faced more punitive outcomes due to this testing
- Considerations of what testing communicates to the patient about trust in to them are also important
- Results of UTT without chromatography confirmation
- If UTT is performed, you must use informed consent prior to testing a person's body fluid
- Patient request for monitoring of progress of reduction of use would be a valid reason to test

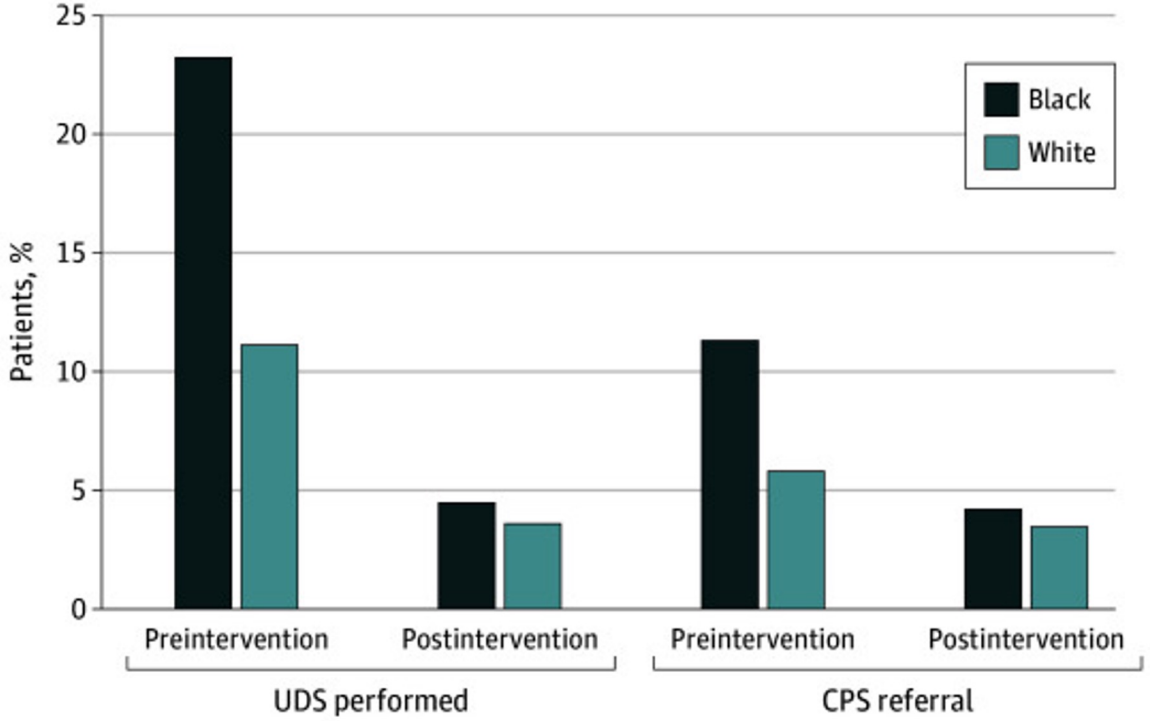
It is important to be cognizant of the effects of structural racism and explicit or implicit biases on the approach, testing, and consequences regarding cannabis use in pregnancy and reporting to child welfare services.

Levy et al., 2025; Terplan et al., 2023; Azzimi et al., 2025;

Figure. Urine Drug Screening (UDS) and Child Protective Service (CPS) Reporting by Race in the Preintervention and Postintervention Time Frames.

Intervention =

1. Isolated cannabis use was removed as reason to perform UDS
2. No prenatal care was reason for UDS, not not insufficient
3. Mandatory electronic CDS tool required clinician to enter reason for UDS ordering



https://pmc.ncbi.nlm.nih.gov/articles/PMC11915058/

Azzimi et al, 2025

Mandatory Supporting Framework

A concept developed by families impacted by family separation and CPS intervention. Popularized in particular by JMACforFamilies who put together a training to help providers enact this framework.

https://jmacforfamilies.org/mandated-supporting

Image was created by Erika Goyer and Jacqueline Tynan and I for a presentation we gave at PSI Annual 2026 in LA

Step 1: Be Curious.

APPROACH TO DISCUSSIONS ABOUT CANNABIS USE

- Medical professionals have a crucial role to play in understanding patient cannabis use
- At all times, maintain a **non-judgmental** and **curious** stance
- Communicate **respect for the patient's perspective** through words and actions.
- Make it clear that we value their knowledge around their use and their own life.
- Educate ourselves on newest findings and trends around cannabis/THC-products
- Maintain patient's **overall health as top priority**
- Avoid prohibition mindset, which tends to stifle disclosure of use & engagement in treatment
- **Be frank and explicit** about what we know and don't know about risks and benefits of cannabis use
- Be mindful of messaging, documents, patient information displayed in your office

ASSESSING CANNABIS USE

- As always in medicine, start with a **thorough history** using empathic listening and open ended questions
- Include both **historical and current** use in your inquiry
- Get into the weeds; as an opportunity to **learn more details** of how the person is using cannabis
- Ask about **other substances** (caffeine, tobacco, alcohol, benzodiazepine, opioids, stimulants, kratom, hallucinogens, other herbal supplements and functional medicine prescriptions, products purchased at gas stations)
- Evaluate impact on patient's life to determine if patient has cannabis use disorder (**CUD) using DSM-V Criteria**
- **This is not a one and done discussion**, the more you meet the person, the more you learn

Cannabis Use Continuum

A Continuum of Use

Occasional
A few times a year; small amounts

Intermittent
Monthly to weekly; moderate amounts

Regular
Several times a week; higher potency

Daily / Heavy
Multiple times daily; high-THC concentrates

Not everyone who uses cannabis has a use disorder — just as not everyone who drinks has alcohol use disorder. Ongoing use in pregnancy does **not, by itself, connote a disorder**.

KEY DEFINITION

Cannabis Use Disorder (CUD)

A DSM-5 diagnosis — requires continued use despite negative consequences

Four domains are assessed

- **Impaired Control**
- **Social Impairment**
- **Risky Use**
- **Pharmacologic Criteria**

DISCUSS STATED REASONS FOR ONGOING USE and ELABORATE ALTERNATIVES

- Nausea and vomiting
- Mental health concerns
  - Anxiety
  - Depression
  - PTSD/Trauma related symptoms
- Insomnia
- Stress and need to find ways to unwind
- Cannabis Use Disorder

Brief Interventions

B'more for Healthy Babies
Every baby counts on you
www.healthybabiesbaltimore.com

Build trust and support change by using these strategies to guide discussions about cannabis use in pregn

How to Start

Open the door with curiosity and empathy, and affirm honesty

> ***"My patients share many different reasons why they use cannabis. Will you tell me why you use it?"***
> ***"Thank you for trusting me with that. I know it is not always easy to talk about."***

What to Share

When it feels right, ask permission:

> ***"Would it be okay if I shared what we know about cannabis use in pregnancy?"***

Any form of cannabis — smoked, vaped, edible, or oils — may be able to harm a baby. No amount has been proven safe during pregnancy or while breastfeeding.

Cannabis use is linked to low birth weight, developmental concerns, and later challenges with attention and behavior.

Keep cannabis products, including edibles that resemble snacks or candy, locked away and out of children's sight and reach. Use child-resistant packaging and avoid consuming around children.

Meeting Patients Where They Are

Patients may not feel ready to stop, and that is okay — you are planting seeds for future change.
Encourage them to make small changes, for example:

> ***"It sounds like cannabis helps you with [nausea, stress, sleep]. At the same time, I hear how much you want your baby to be healthy. How do you see those fitting together?"***
>
> ***If stopping feels too hard, are there smaller changes that feel possible, like cutting back or avoiding use around your baby?"***

Closing with Care

End the visit in partnership and reassurance, not pressure:

> ***"Would it be okay if we revisit this at your next visit? In the meantime, I can connect you with resources that may help."***
>
> ***"You are not alone in this. I am here to support you in making the choices that feel best for you and your baby."***

By approaching patients with empathy, sharing clear information, and offering safe alternatives, you are building trust and supporting families in moments of vulnerability.

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TREATMENT FOR CANNABIS USE DISORDER

- Non-pharmacologic approaches
  - Cognitive behavioral therapy (CBT)
  - Motivational interviewing (MI) See slides by B'more for Healthy Babies
  - Motivational enhancement therapy + cognitive behavioral therapy (MET-CBT)
- No FDA Approved Medications for treatment of CUD
- Off Label Medications Used
  - Mirtazapine – used to treat nausea, insomnia, appetite loss, and anxiety associated with cannabis withdrawal – data supports use in this way
  - N-acetyl cysteine – data no longer supports use of this medication
  - Gabapentin – current data does not support use in pregnancy of this med for CUD

Groff et al, 2023

A Special Note on Nausea

Widely used for pregnancy nausea — but the evidence tells a mixed story

One-third of online media on prenatal cannabis mentions treating nausea, and Colorado dispensary staff often recommended it — yet no study has shown cannabis actually treats nausea and vomiting of pregnancy.

Perceived as effective

65% of pregnant women in a British Columbia survey used cannabis to treat nausea

93% of those users rated cannabis "effective" for their symptoms (BC, Canada)

Evidence raises doubt

A North Carolina case report linked cannabis to cannabinoid hyperemesis syndrome, which may itself contribute to nausea and vomiting.

A Hawai'i study found cannabis users were more likely to report severe nausea, with a significant link between severe nausea and pre-pregnancy cannabis use.

Cannabis use was typically a regular pre-pregnancy habit, and more than half of users continued past the first trimester — when nausea is usually worst. Nausea may be worsened for patients with THC use hx due to their attempts to decrease use, and may also be related to their THC use.

Sources: Jarlenski et al., 2018; Dickson et al., 2018; Westfall et al., 2006; Lambert et al., 2016; Roberson et al., 2014

Does THC pass into human milk?

Does THC pass into human milk?

Onset
1 hour after consumption, THC levels peak in human milk

Elimination
4 hours after consumption, THC levels 4 hours return to their baseline
24 hours of abstention can reduce THC levels to undetectable users^

Regular users
6 weeks, THC has been reported at low levels in human milk of abstention

How much THC is a nursing infant exposed to in human milk?

Cannabis, only 1-5% is available through oral consumption,

Infants are exposed to a dose at least >100 times less the consumed by the lactating parent

RID 2.5% has been calculated to be 2.5% (Less than 10% considered acceptable)

No known negative consequences – which does not mean no risks exist

CANNABIS USE AND BREASTFEEDING

*Obstetrician–gynecologists and other obstetric health care professionals **should** advise cessation of cannabis use during pregnancy and lactation. However, continued cannabis use is not a contraindication to breastfeeding, and breastfeeding should not be discouraged.*

Wynmore, et al. 2021; Bertrand, et al. 2018;

Conclusions

- Cannabis use is rising especially for people of reproductive age
- Decriminalization, legalization and commercialization of THC products is playing role
- Decrease perception of risk about use of THC/cannabis in pregnancy is occurring
- Most people using THC/cannabis in pregnancy were using before pregnancy
- Most are attempting to change their pattern of use and decreasing use
- Risks to the pregnancy and fetus do exist, but quantifying this rigorously has been a challenge
- Drastic and prohibitory signs and messages are not beneficial and increase use
- Using Harm Reduction approaches and focusing on addressing managing THC/cannabis use as part of maximizing health in general is important

Continuing Education – Learner Notification

DBI Perinatal Mental Health Training Series: Aug. 12, 2026 – Cannabis Use in the Perinatal Period

Notice of Requirement for Successful Completion

Participants may earn CE credit for this activity by attending the entire education session and completing the required evaluation. Instructions for claiming CE credit, including the attendance code, will be provided at the conclusion of the activity.

Physicians: Children's National Hospital designates this live activity for a maximum of **1.0 *AMA PRA Category 1 Credits™*** for physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Psychologists: Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs. Children's National Hospital designates this live activity for a maximum of ***1.0 CE credits*** (Instructional Level: Intermediate Learning).

Social Workers: As a Jointly Accredited Organization, Children's National Hospital is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive **1.0 general** continuing education credits.

Relevant Financial Relationships

The planning committee and presenters have no relevant financial relationships with ineligible companies.

Financial and In-Kind Commercial Support

No financial nor in-kind commercial support was received for this education activity.

JOINTLY ACCREDITED PROVIDER™ INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, Children's National Hospital is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. Children's National Hospital Accreditation Provider# 4008362.

Children's National

How to Claim CE Credit for Cannabis Use in the Perinatal Period

1. Submit the **attendance code SOHHOH** by Oct. 11, 2026
   - Texting to **301-273-7643**, or
   - Entering **online** at ce.childrensnational.org/code
2. Complete the Evaluation
3. Download CE Certificate

Credit may be claimed up to 60 days from the date of the live event.

Creating a CE Learner Account

(First-Time Users)

To claim continuing education (CE) credit, you must have a CE Learner Account.

Steps to Create Your Account:

1. Visit ce.childrensnational.org
2. Click "**Sign In**" in the upper right-hand corner
3. Select one option:
   - **Single Sign-On** (Children's National employees), or
   - **Create a Guest Account** (non–Children's National participants)
4. Complete all required profile fields (marked with a red asterisk)
5. Click "**Create New Account**" to finish

Important: Register Your Mobile Number *(Required to link your attendance code)*

1. From **My Account**, select the **Edit** tab
2. Click the **Mobile** tab
3. Enter your **mobile phone number** *(numbers only—no dashes, parentheses, or spaces)*
4. Click **Save**

Email any questions to ce@childrensnational.org