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# Cannabis Use During Pregnancy: Exploring Mental Health Implications and Intervention Gaps

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## Introduction

- Cannabis is the most widely used drug during pregnancy [3] (self-reported use is 5% and up to 28% in socioeconomically disadvantaged groups) [2], with usage being highest in the first trimester.[1]
  - As cannabis is federally illegal, there is limited and unclear research regarding its effects during pregnancy.[11]

- Due to stigma and a lack of information from providers, pregnant individuals rely on peers and online sources for information and recommendations.[6,7]
  - In a study of 400 Colorado dispensaries, 69% recommended cannabis to treat morning sickness in the first trimester.[5]

- The American College of Obstetrician-Gynecologists (ACOG) recommends universal screening through validated tools and interviews, rather than drugs screening.[1]
  - Reports of positive drug tests disproportionately affect Black and minority women.
  - Focus on risk-reducing strategies, rather than penalizing patients.

- Focus question: In what ways does maternal mental health influence perinatal cannabis use, and what gaps in clinical interventions exist to address this issue?

## Methods

- Conducted a literature review of 11 articles from PubMed and 2 articles from ACOG.

- Inclusion criteria: articles published in the last 10 years addressing cannabis use in pregnant people, and its relation to mental health and/or provider interventions.
  - 12/13 articles were published in the last 5 years.

- Focused on reasons for self-medication, maternal mental health, and provider challenges.

## Results

- Common reasons for perinatal cannabis usage included symptom relief, anxiety/stress, and believing it is more effective and safe than prescription medicine. [7]
  - Cannabis withdrawal syndrome can mimic pregnancy symptoms, such as morning sickness.[3]

- All major classes of mental health disorders were significantly linked to past-year cannabis use in pregnant people.[4]
  - **Anxiety disorders: aOR = 1.90** [13]
  - **Depressive disorders: aOR = 2.25** [13]
  - Incidence of cannabis use disorder was 5.3% or 19% of all pregnant cannabis users (n=227).[9]

- There are 3 decision frameworks that motivate limiting or abstaining for perinatal cannabis usage.[6]

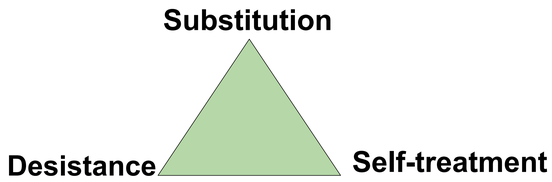


Figure 1: Decision Types for Perinatal Cannabis Usage

## Intervention Gaps

- Increased screening is needed throughout pregnancy and the first postpartum year.[4]
  - Interventions require a multidisciplinary approach.[3]

- Clinicians' uncertainty about cannabis safety and counselling strategies is a barrier to effective care.
  - When patients disclosed marijuana use, obstetric providers responded in about half of the encounters, primarily addressing legal and procedural issues rather than discussing health or medical consequences.[6,10]

## Conclusions

- Public health messaging and clinician awareness are needed to counter misinformation from online sources and dispensaries.

- Greater education and training is needed for providers to adopt strategies that focus on harm reduction, trauma-informed care, and motivational interviewing.
  - Emphasize reducing stigma, understanding patient's social context, and helping patients create individualized goals that support withdrawal and promote alternative treatment options.
  - Identify trauma history, mental health history, and substance use history in early pregnancy.

- Further research is needed to examine how providers can effectively engage and counsel patients on perinatal cannabis usage as well as alternative treatment options for symptom relief.

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