

Marijuana Use During Pregnancy

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses

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Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) supports the implementation of legislation, policies, and public health initiatives that help raise awareness, remove stigma, discourage use, and facilitate access to prenatal and maternity care for women who use marijuana during pregnancy. AWHONN also supports ongoing research on the prevalence of use of marijuana during pregnancy and the short- and long-term effects for the woman, fetus, and newborn.

Background

The drug marijuana is derived from the cannabis sativa plant. The leaves and buds of the female plant contain delta 9-tetrahydrocannabinol (THC), a psychoactive chemical (Mehmedic et al., 2010). THC is distributed rapidly to the brain and fat when smoked or ingested and affects the cannabinoid receptors in the brain and body. This chemical alters mood and cognition, indirectly increases dopamine release, and produces psychoactive effects by functioning as a neurotransmitter (National Institute on Drug Abuse, 2018). One hundred years ago, marijuana production and use were not regulated in the United States. However, by the 1930s, use was associated with crime, violence, and socially deviant behavior. With the passage of the Marihuana Tax Act of 1937, the importation, cultivation, possession and/or distribution of marijuana were regulated (U.S. Customs and Border Protection, 2015). By 1970, marijuana (or cannabis) was classified by the federal government as a Schedule I drug: a dangerous substance with a high potential for abuse and no valid medical purpose (Comprehensive Drug Abuse Prevention and Control Act of 1970, 1970; U.S. Drug Enforcement Administration, n.d.). Efforts to decriminalize also began in the 1970s and continue today. Federal child protection legislation implemented to protect fetuses and newborns from exposure to dangerous substances add to the complexity of issues surrounding marijuana use. Marijuana use is still illegal at the federal level in the United States, but it has been legalized for medical and/or recreational use in more than half of the states.

The Child Abuse Prevention and Treatment Act of 1974, passed in 1974, established national child protection standards and specifically addressed the

substance-affected newborn. This act was amended in 2003 by the Keeping Children and Families Safe Act of 2003, and as a result, a state's eligibility for federal Child Abuse Prevention and Treatment Act funds became dependent the adoption of policies and procedures intended to address the needs of substance-exposed infants (Jacobs Institute of Women's Health, 2017). However, the act failed to set forth specific standards for assessment, testing, and reporting for these newborns. This left individual states to interpret the legislation, which resulted in variability in how substance-exposed newborns are identified and what actions are required of health care professionals after identification (Jacobs Institute of Women's Health, 2017). Because of this variability, all health care professionals must be familiar with policies for their states, especially the legal definition of child abuse and mandatory reporting laws concerning child abuse or neglect.

Updates to clinical guidelines and protocols for mandated reporting, screening of newborns, and testing and education for mothers have not kept pace with the movement toward the legalization of marijuana (Krening & Hanson, 2018). State legalization protects adults who use marijuana, but civil legal implications from mandated reporting laws remain, and "discriminatory testing, length of time the drug remains in the system, potential for compromised provider patient relationships, overload of community child protection resources, punitive or legal interventions that may have a negative psychosocial impact on a new family, and the risk for development of community standards of care based on opinion rather than science are just a few of the issues realized after marijuana legalization" (Krening & Hanson, 2018, p. 43).

Research indicates that more women are using marijuana during pregnancy. Based on data from the U.S. National Survey on Drug Use and Health, Brown et al. (2017) reported that among all pregnant women, the adjusted prevalence of past-month marijuana use increased from 2.37% in 2002 to 3.85% in 2014. However, in other studies, self-reported rates were as high as 15% (Passey, Sanson-Fisher, D'Este, & Stirling, 2014) and 48% (Moore et al., 2010). In a recent study conducted in Colorado, a state with legalized medical and recreational marijuana, the self-reported prevalence of cannabis use at any time during



pregnancy was 5.7%, and prenatal cannabis use was found to result in a 50% increased likelihood of low birth weight (Crume et al., 2018). The following factors have been significantly associated with marijuana use during pregnancy: younger age, lower level of education, race/ethnicity, Medicaid as the primary source of insurance, poverty, and nonmarried status (Crume et al., 2018). Pregnant marijuana users were also less likely to have used folic acid before conception and more likely to have used alcohol and tobacco than nonusers (van Gelder et al., 2010). Use by women during pregnancy may become more prevalent as additional states legalize marijuana for medical and recreational use.

In a recent, comprehensive report on the current state of the evidence of the health effects of cannabis and cannabinoids, the Committee on the Health Effects of Marijuana (National Academies of Sciences, Engineering, and Medicine, 2017) reported that “overall, there is substantial evidence of a statistical association between cannabis smoke and lower birth weight, but there is only limited, insufficient, or no evidence in support of any other health endpoint related to prenatal, perinatal, or neonatal outcomes” (p. 261). The committee noted the limitations of the existing studies, including reliance on self-report, small sample sizes, and the presence of other confounding variables such as alcohol and tobacco.

The Role of the Nurse

The nurse should be knowledgeable about relevant, state mandatory reporting laws concerning drug-related child abuse or neglect. The nurse should also be knowledgeable about the potential effects of marijuana on the woman, fetus, and newborn and be able to discuss those risks with the woman and her family members. The American College of Obstetricians and Gynecologists (2017) recommended that “because of concerns regarding impaired neurodevelopment, as well as maternal and fetal exposure to the adverse effects of smoking, women who are pregnant or contemplating pregnancy should be encouraged to discontinue marijuana use” (p. e205). The American Academy of Pediatrics (2012; Ryan, Ammerman, O’Connor, & Committee on Substance Use and Prevention, Section on Breastfeeding, 2018) also discouraged cannabis use during breastfeeding because of concerns with short- and long-term neurobehavioral development in the infant. During the initial prenatal visit and the perinatal period, all women should be asked about their use of marijuana. Those who admit use should be educated regarding the potential adverse effects on their own health and the health of their future or current fetuses and/or newborns and receive information regarding available treatment and community resources.

The nurse should provide evidence-based information and emphasize health promotion, disease prevention, and holistic care. Consistent screening, education, testing, and retesting of pregnant women is imperative and reduces the potential for discriminatory testing. Women should be educated in a non-punitive manner so they do not avoid further prenatal or maternity care in the future.

Policy Considerations

Hospitals should consider foregoing newborn testing when a mother with a history of use has a negative test for THC upon admission for

labor, which may be viewed as punitive. The benefits of breastfeeding are well documented, and women who use marijuana should be encouraged to discontinue use in order to breastfeed.

Laws that criminalize drug use during pregnancy have the potential to deter women from seeking prenatal and maternity care that can provide access to appropriate counseling, referral, and monitoring. Seeking health care for marijuana use during pregnancy should not expose a woman to criminal or civil penalties such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing (Association of Women’s Health, Obstetric and Neonatal Nurses, 2015).

AWHONN supports the implementation of legislation, policies, and public health initiatives that help raise awareness, remove stigma, facilitate access to prenatal and maternity care, and expand research related to marijuana use during pregnancy. Such initiatives include the following:

- Culturally specific public health campaigns that help women and their families to better understand potential effects of marijuana use on the woman, fetus, and newborn.
- Increased access to interventions for use of all substances, including marijuana, that are high-quality, affordable, and logistically feasible, including in the home or integrated into the maternity care setting.
- Removing marijuana from the federal list of controlled substances to allow further research on the prevalence of marijuana use during pregnancy and the short and long-term effects on the woman, fetus and newborn.
- Insurance coverage in public and private plans for marijuana screening and for the full range of effective treatment options.
- Establishment of community networks and community-based partnerships intended to support women during pregnancy and the postpartum period. These should include non-punitive screening programs, education on parenting and marijuana, secondhand smoke, driving and marijuana, safe storage, and accidental ingestion of marijuana and marijuana products.



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