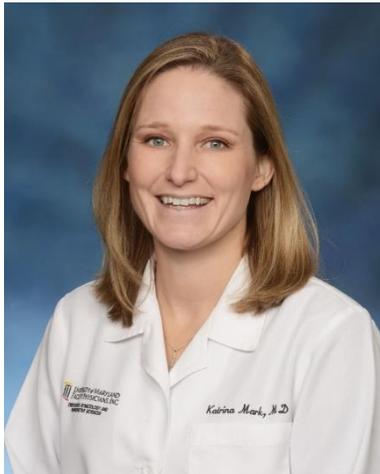


Cannabis Use in Pregnancy: Approaches to Counseling

November 2nd, 2021



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and Reproductive Sciences, University of
Maryland School of Medicine

Maryland Addiction Consultation Service for Maternal Opioid Misuse (MACS for MOMs)

Provides support to maternal health providers and their practices in addressing the needs of their pregnant and postpartum patients with substance use disorders (SUD), particularly opioid use disorder (OUD).

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and pregnancy
- Assistance with addiction and behavioral health resources and referrals
- MACS for MOMs TeleECHO Clinics: collaborative medical education through didactic presentations and case-based learning

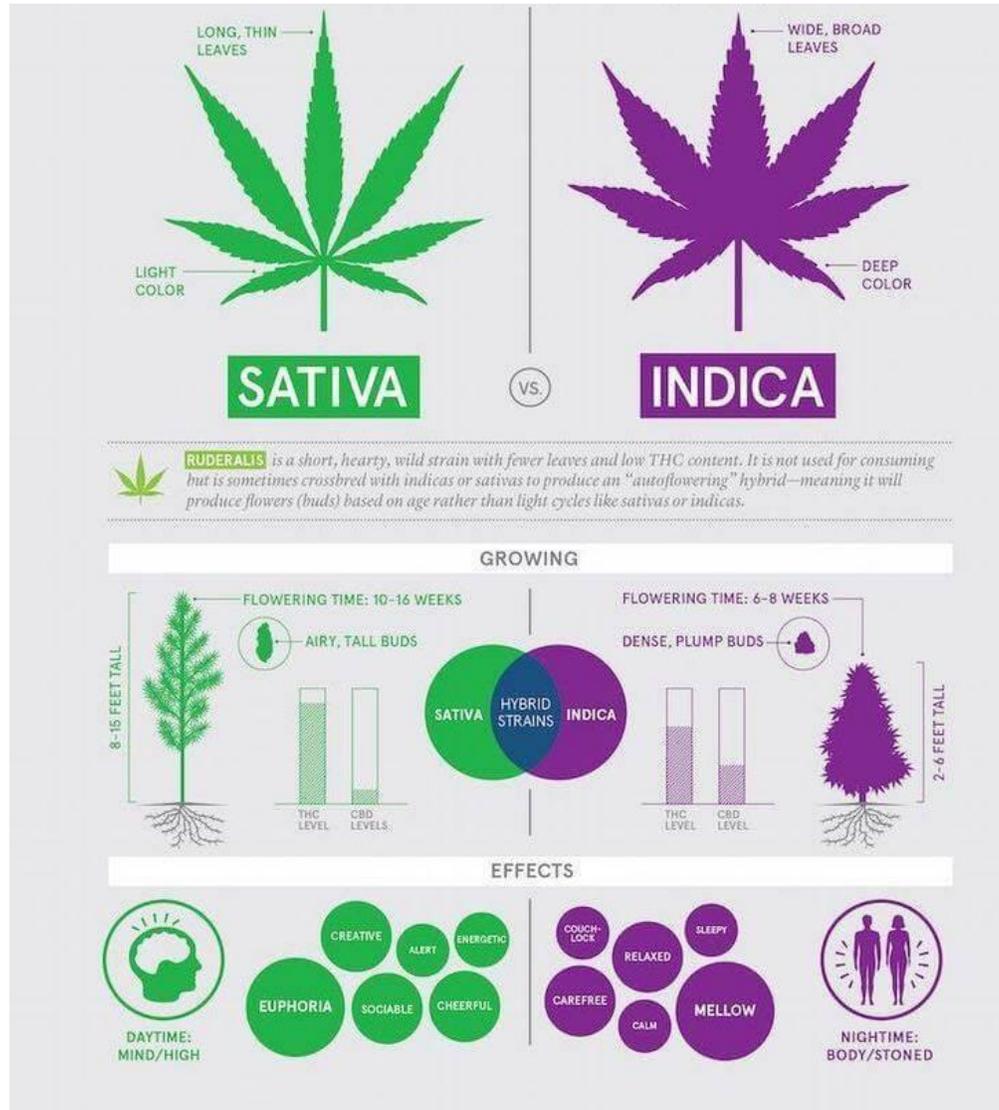
Disclosures

I have no disclosures

Overview

- Epidemiology
- Screening
- Risks
- Medicinal use
- Recommendations/Interventions
- Breastfeeding





Routes of administration



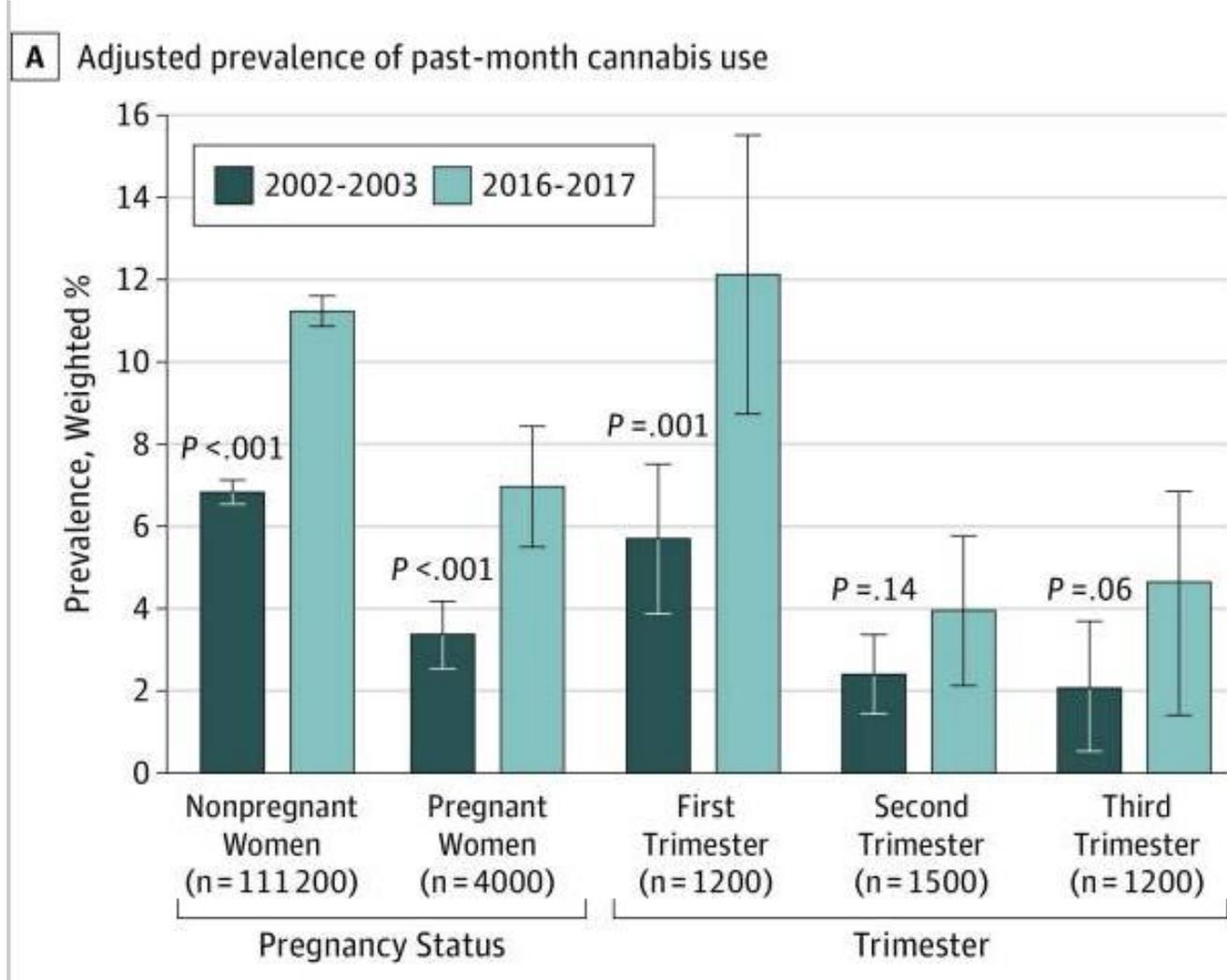
Routes of administration

Table 1. Usual Mode of Marijuana Consumption Among 1467 and 3177 Colorado High School Students Reporting Past 30-Day Marijuana Use in 2015 and 2017

Students With Any Past 30-d Use	Weighted Prevalence (95% CI)		Crude Prevalence Ratio (95% CI) ^{a,b}	P Value	Adjusted Prevalence Ratio (95% CI) ^{a,b}	P Value
	2015	2017				
Smoked	86.8 (84.0-89.6)	77.8 (74.7-80.9)	0.90 (0.85-0.94)	<.001	0.89 (0.84-0.94)	<.001
Ingested	2.1 (1.1-3.1)	9.8 (7.7-11.8)	4.59 (2.71-7.72)	<.001	4.55 (2.68-7.74)	<.001
Vaporized	5.1 (3.1-7.1)	4.0 (2.8-5.3)	0.79 (0.48-1.30)	.36	0.78 (0.47-1.28)	.32
Dabbed	4.3 (2.6-6.1)	7.6 (5.9-9.3)	1.77 (1.12-2.80)	.02	1.94 (1.25-3.01)	.003
Other	1.7 (0.4-2.9)	0.8 (0.4-1.2)	0.46 (0.19-1.14)	.09	0.42 (0.17-1.07)	.07

^a The year 2015 is the reference category.

^b Adjusted for race/ethnicity, sex, and grade.



Not your mom's pot

ElSohly et al.

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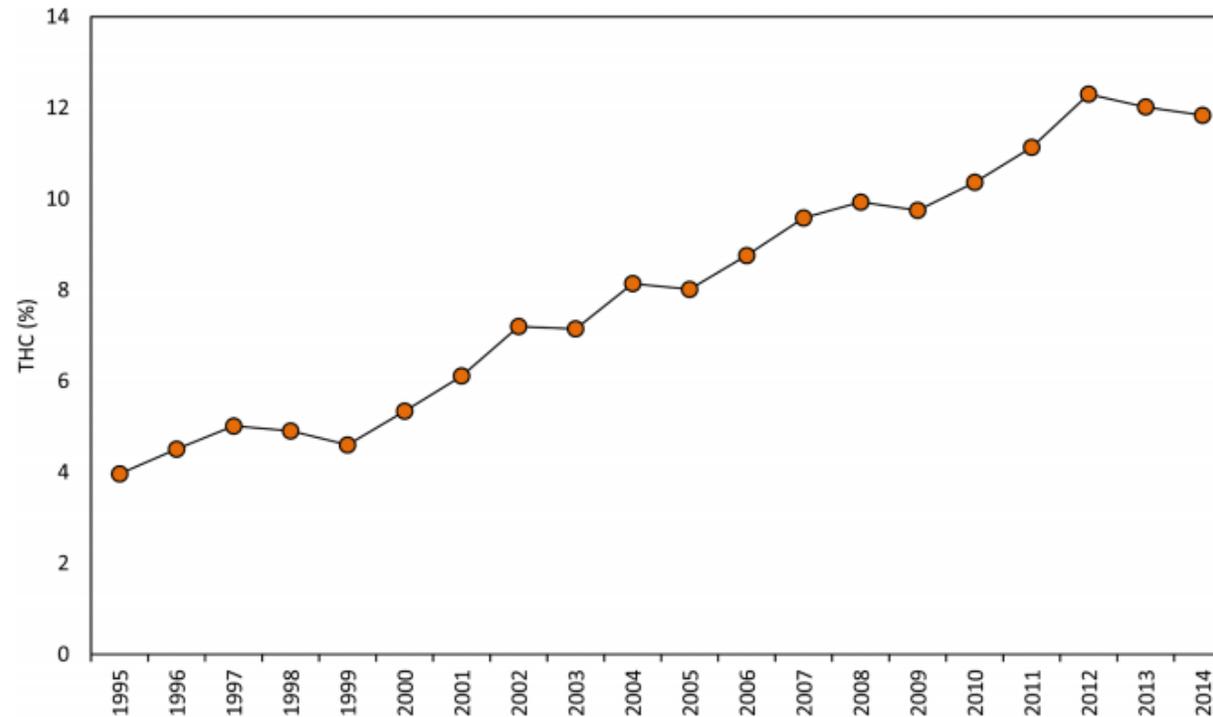
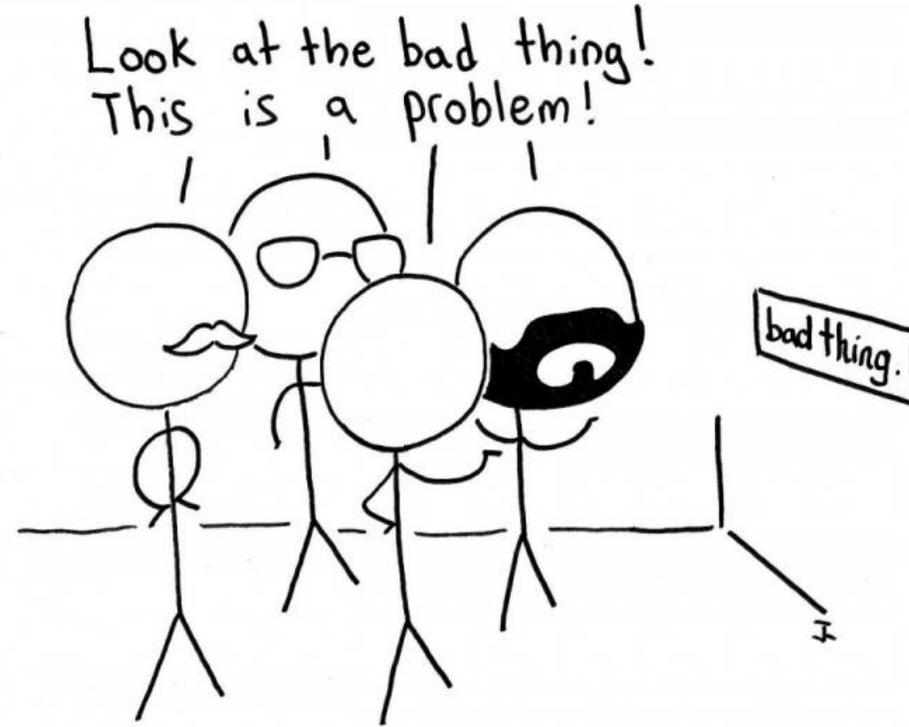


Figure 1.
Average Δ^9 -tetrahydrocannabinol (Δ^9 -THC) concentration of DEA specimens by year, 1995 – 2014.

Biol Psych 2017



Universal Screening: ACOG Recommendations

Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman.

Screening based only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcome can lead to missed cases, stereotyping and stigma.



Accuracy of Three Screening Tools for Prenatal Substance Use

Victoria H. Coleman-Cowger, PhD, Emmanuel A. Oga, MD, MPH, Erica N. Peters, PhD, Kathleen E. Trocin, MPH, Bartosz Koszowski, PharmD, PhD, and Katrina Mark, MD

Table 3. Validity Indices for the 4P's Plus, NIDA Quick Screen, and SURP-P

	4 P's Plus	NIDA Quick Screen ASSIST	SURP-P
Sensitivity*	91.2 (85.7–95.1)	83.5 (76.8–89.0)	93.1 (88.0–96.5)
Specificity*	28.6 (23.7–33.9)	80.8 (76.0–85.0)	21.0 (16.7–25.9)
Positive predictive value*	39.0 (34.0–44.1)	68.4 (61.3–74.9)	37.0 (32.3–41.9)
Negative predictive value*	86.7 (78.6–92.5)	90.8 (86.8–93.9)	85.9 (76.2–92.7)
Sensitivity†	94.7 (88.5–97.4)	85.4 (76.4–89.5)	95.4 (90.7–98.4)
Specificity†	28.7 (23.8–33.6)	76.1 (71.4–80.6)	21.1 (17.3–26.1)
Positive predictive value†	32.6 (28.9–38.8)	56.4 (50.1–64.4)	30.6 (27.3–36.5)
Negative predictive value†	93.6 (85.7–96.7)	93.5 (88.8–95.2)	92.7 (84.8–97.3)
Sensitivity‡	90.2 (84.5–93.8)	79.7 (71.2–84.2)	92.4 (87.6–95.8)
Specificity‡	29.6 (24.4–35.2)	82.8 (78.1–87.1)	21.8 (17.4–27.2)
Positive predictive value‡	44.1 (39.7–50.0)	74.0 (67.8–80.4)	42.0 (38.0–47.9)
Negative predictive value‡	83.0 (73.4–88.9)	86.9 (81.3–89.7)	82.3 (72.1–90.0)

Data are % (95% CI).

* Reference standard: hair test results.

† Reference standard: urine test results.

‡ Reference standard: hair and urine test results combined; positive on either urine or hair sample testing.

The 5Ps Prenatal Substance Abuse Screen For Alcohol and Drugs

The 5Ps* is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women's *parents, peers, partner*, during her *pregnancy* and in her *past*. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are *confidential*.
- A single "YES" to any of these questions indicates further assessment is needed.

1. Did any of your *Parents* have problems with alcohol or drug use?
 No Yes
2. Do any of your friends (*Peers*) have problems with alcohol or drug use?
 No Yes
3. Does your *Partner* have a problem with alcohol or drug use?
 No Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)
 No Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)
 No Yes

Information/Feedback

23% of providers did not acknowledge positive screen
48% of providers did not provide specific counseling
70% of counseling time spent on punitive counseling
African Americans 10x more likely to receive punitive counseling



"I'm right there in the room, and no one even acknowledges me."



Reproductive Health

Pregnant Women's Access to Information About Perinatal Marijuana Use: A Qualitative Study



Marian Jarlenski, PhD, MPH^{a,*}, Jill A. Tarr, LCSW, ACSW^b, Cynthia L. Holland, MPH^b,
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Article history: Received 22 October 2015; Received in revised form 16 March 2016; Accepted 24 March 2016

ABSTRACT

Background: Marijuana is the most commonly used illicit substance in pregnancy. Little is known about how pregnant women who use marijuana obtain and understand information about perinatal marijuana use. We conducted a qualitative study among pregnant women who had used marijuana to understand their information-seeking patterns and perceptions of usefulness of available information about perinatal marijuana use.

Study Design: We conducted semistructured interviews with 26 pregnant women who were receiving prenatal care and who either disclosed marijuana use or had urine samples testing positive for marijuana. Interviews assessed women's sources of information about risks of perinatal marijuana use and perceptions regarding the usefulness of such information. Interview data were coded independently by two coders who iteratively refined the codes and reviewed transcripts for themes.

Results: Commonly reported sources of information about perinatal marijuana use included Internet searching and anecdotal experiences or advice from family or friends. Few women reported receiving helpful information from a health care provider or social worker. Women perceived a lack of evidence about harms of perinatal marijuana use, and reported being dissatisfied with the quality of information. Most women said they desired information about the effects of perinatal marijuana use on infant health.

Report little receipt of concrete information from providers

From social workers – receive info primarily regarding child welfare

“The only thing they’re telling me about marijuana is: ‘Just don’t do it.’ They’re not telling me: ‘Don’t do it because this could happen, that could happen, your baby could have this’... Right now, I don’t feel like they are really concerned”.

Why are providers resistant to screening and/or counseling about cannabis use in pregnancy?

Methodological Issues

How is exposure defined?

If public health concern is cannabis exposure in utero – assessment by L+D toxicology testing insufficient – biases results away from the null

What are outcomes? Are they the outcomes of public health interest or ones of convenience?

Surrogate endpoints (birth outcomes)

Multiple endpoints (OPPS >4000 outcomes, N=120)

What is comparison group? What is best comparison group?

If using medicinally (i.e. NV), the comparison group is a woman with an untreated NV or who is prescribed traditional anti-emetics, NOT a woman without NV

Methodologic issues

Publication bias against the null for illicit substances

Licit versus illicit substances

Prescription drugs use more of an “innocent until proven guilty” approach

This study also warns that expanding legalization may increase perception of safety of marijuana “without data to assure safety.” This warning creates the false impression that other substances prescribed to and commonly taken by pregnant women have been studied and that their safety is assured.²

Lusero, Obstet Gynecol 2018

Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?

Ashley H. Schempf and Donna M. Strobino

ABSTRACT Prenatal drug use is commonly associated with adverse birth outcomes, yet no studies have controlled for a comprehensive set of associated social, psychosocial, behavioral, and biomedical risk factors. We examined the degree to which adverse birth outcomes associated with drug use are due to the drugs versus surrounding factors. Data are from a clinical sample of low-income women who delivered at Johns Hopkins Hospital between 1995 and 1996 ($n=808$). Use of marijuana, cocaine, and opiates was determined by self-report, medical record, and urine toxicology screens at delivery. Information on various social, psychosocial, behavioral, and biomedical risk factors was gathered from a postpartum interview or the medical record. Multivariable regression models of birth outcomes (continuous birth weight and low birth weight ([LBW] <2,500 g) were used to assess the effect of drug use independent of associated factors. In unadjusted results, all types of drug use were related to birth weight decrements and increased odds of LBW. However, only the effect of cocaine on continuous birth weight remained significant after adjusting for all associated factors (-142 g, $p=0.05$). No drug was significantly related to LBW in fully adjusted models. About 70% of the unadjusted effect of cocaine use on continuous birth weight was explained by surrounding psychosocial and behavioral factors, particularly smoking and stress. Most of the unadjusted effects of opiate use were explained by smoking and lack of early prenatal care. Thus, prevention efforts that aim to improve newborn health must also address the surrounding context in which drug use frequently occurs.

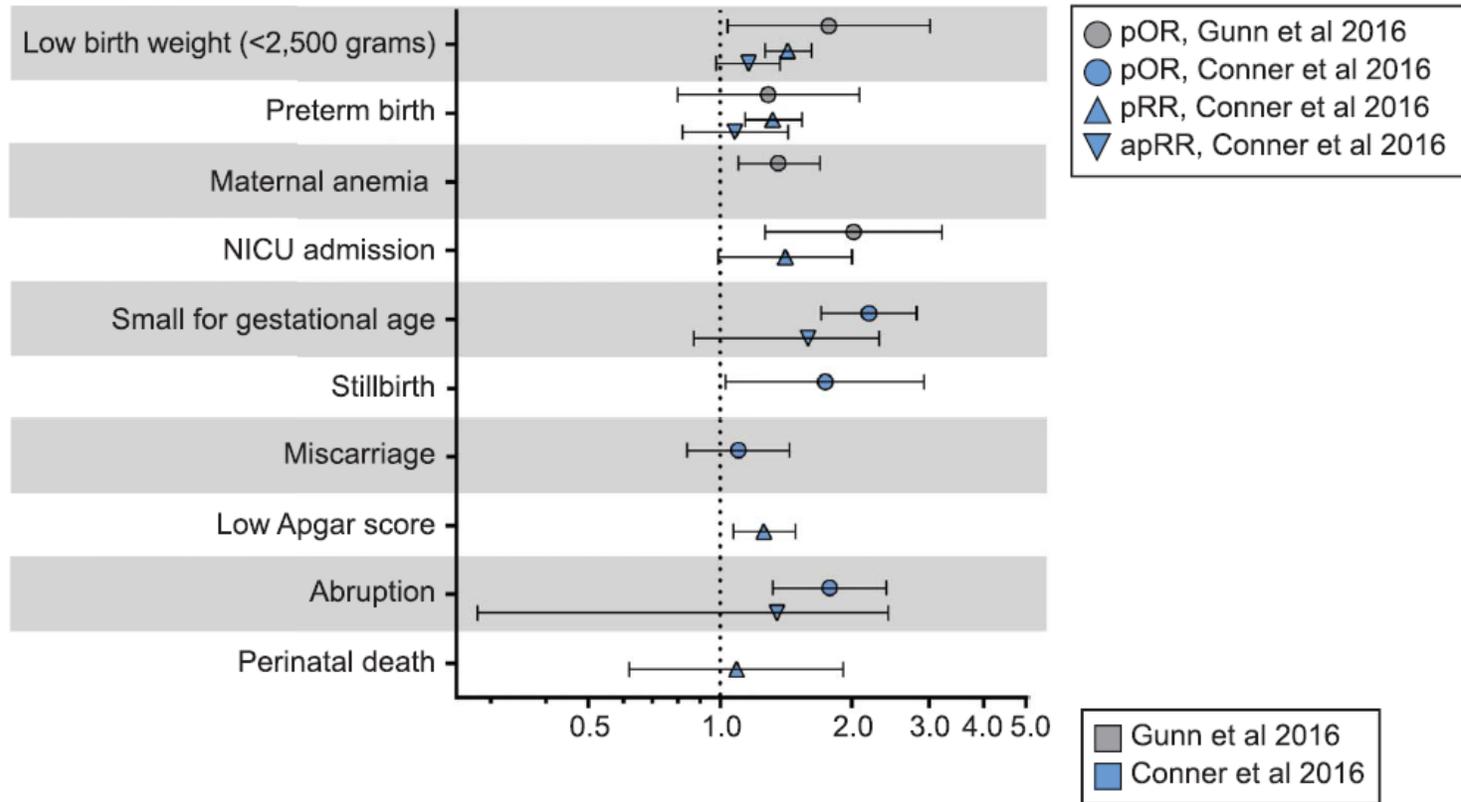
KEYWORDS Illicit drugs, Psychosocial factors, Pregnancy, Birth weight, Low birth weight

The Measurement of Context

In spite of our own biases as physicians, we must acknowledge that women may be knowingly choosing cannabis over conventional medications for several reasons. We must also recognize that women may be electing to use cannabis as the lesser evil or doing so to preserve sobriety from other bona fide, harmful substances such as alcohol or opioids.⁵ Moreover, treating women who use cannabis like criminals could have negative repercussions if they forgo the prenatal care known to improve fetal-maternal outcomes.

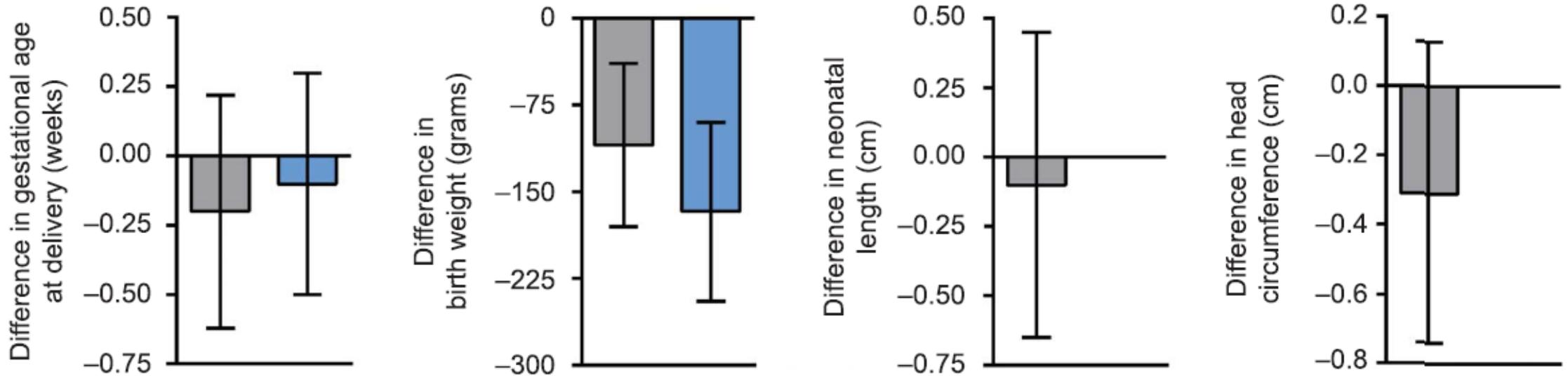
Providing Feedback: *What ARE the risks?*

Known risks of marijuana in pregnancy



Metz, Obstet Gynecol
2018

Risks of in utero exposure



Metz, Obstet Gynecol 2018

Table 1. Summary of Longitudinal Human Studies Evaluating Effect of Prenatal Marijuana Use on Neurobehavioral Outcomes

Study Setting	Population	Major Findings ^{1,49}
Ottawa Prenatal Prospective Study (N=698) ⁵⁰ Ottawa, Canada, 1978	Middle-income, predominantly Caucasian	Younger than age 4 y: no differences in behavior, intellect, visual perception, language, attention, or memory Age 4–8 y: worse performance on tasks related to visual perception, language comprehension, attention, and memory Age 9–12 y: no difference in global IQ, performance on visual tasks, impulse control
Maternal Health Practices and Child Development Study (N=564), ⁵¹ Pittsburgh, Pennsylvania, 1982	Low-income, predominantly African American	Age 3 y: no differences in intelligence testing Age 6 y: decreased verbal reasoning among offspring with exposure to 1 or more joints/d in the 1st trimester Age 10 y: decreased attention, more hyperactivity and impulsivity, worse academic performance when exposed in the 1st and 3rd trimesters Age 14 y: lower scores in reading, math, and spelling, especially with 1st-trimester exposure
Generation R Study (N=9,778) ⁵² Rotterdam, Netherlands, 2001	Higher socioeconomic status, multiethnic	Age 18 mo: higher aggression scores in exposed girls, but not boys Age 3 y: no differences in behavior Ongoing follow-up planned into adulthood for children born April 2002–January 2006

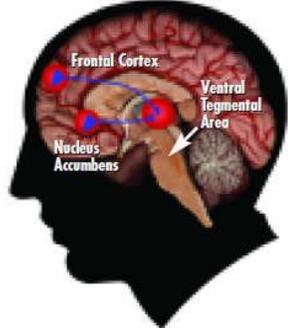
IQ = Intelligence quotient

Prenatal exposure: Dopamine receptors

Dose dependent relationship between cannabis and dopamine receptors (D2) in brains of second trimester human fetuses

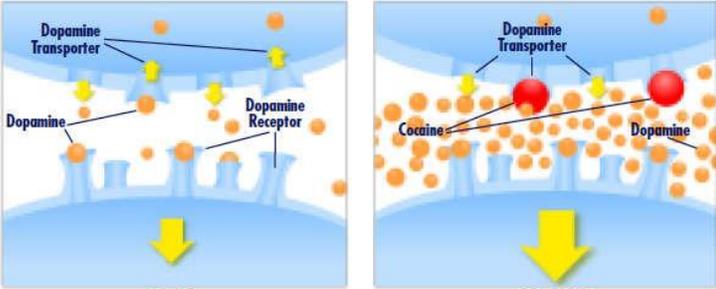
DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways

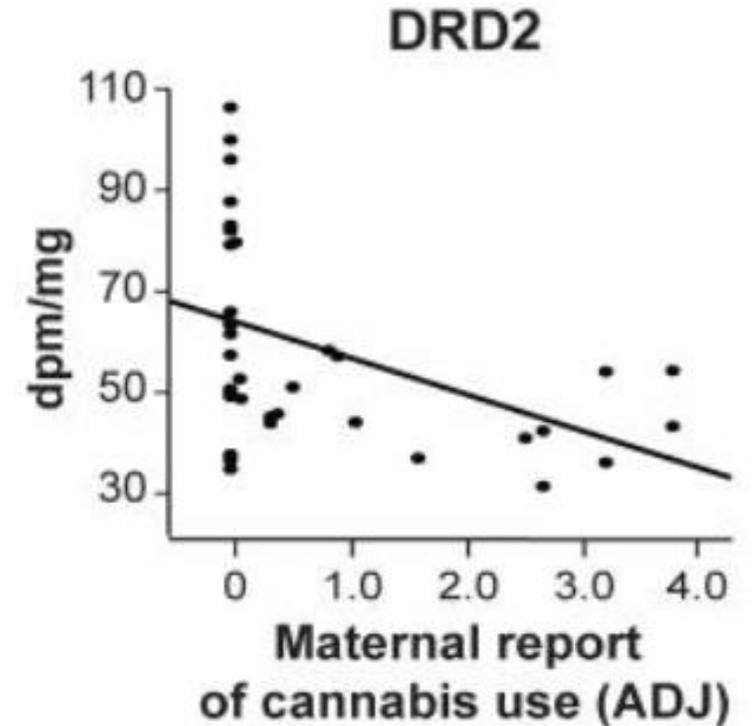


These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine



Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.



DiNieri, Biol Psychiatry 2011

Marijuana: Health Risks

Addiction/Use disorder

9% of users

1 in 6 adolescents

Impaired driving

Relationship between THC level and impairment

Respiratory

inflammation of large airways,

increased airway resistance

lung hyperinflation

Volkow, NEJM 2014

Maternal Effects

- Decreased attention
- Decreased concentration
- Decreased speed of information processing
- Decreased memory
- Decreased associative learning



Volkow, NEJM 2014
Scott, JAMA 2018

Maternal Effects

Cannabis associated psychosis

Contaminating substances

Pulmonary effects

Acute bronchodilation

Longterm can cause airway obstruction



Maternal Effects

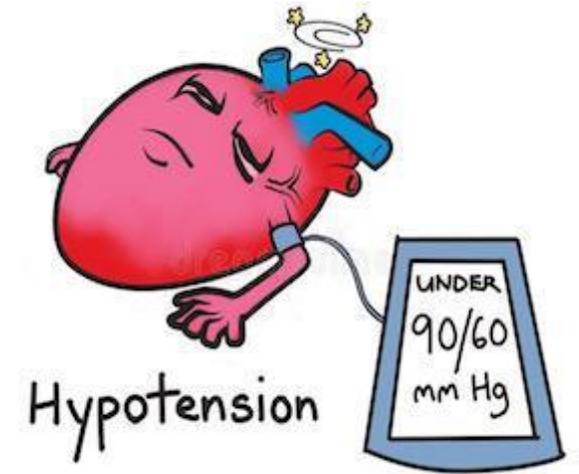
Vasodilation

Tachycardia

Orthostatic hypotension

Increased cardiac output with no increased BP

Increased risk of MI



Possible explanations for continued use

Women don't understand/believe the risks

Women understand the risks but cannot quit (= CUD)

Women understand the risks but chose not to quit because the benefits of their use outweigh these risks

- may include medical marijuana use

NSDUH 2013-2018	Non-pregnant women		Pregnant women	
	% (95% CI)	OR	% (95% CI)	OR (95% CI)
Past month cannabis use	11.19% (10.90, 11.50)**	Ref.	4.77% (3.95, 5.59)**	0.40 (0.33, 0.48)
Past year medical use only	7.50% (6.81, 8.19)*	Ref.	14.06% (5.56, 22.56)*	2.02 (1.00, 4.08)
Cannabis Use Disorder (CUD)	12.95% (12.31, 13.59)**	Ref.	18.86% (12.93, 24.78)**	1.56 (1.06, 2.31)
Self-reported need for treatment	0.33% (0.19, 0.48)**	Ref.	2.19% (0.00, 4.91)**	6.57 (1.71, 25.30)
Past Year Treatment Receipt				
For any substance	9.05% (7.06, 11.04)	Ref.	9.03% (2.54, 15.53)	1.00 (0.44, 2.26)
For cannabis	4.26% (2.81, 5.72)	Ref.	6.20% (1.57, 10.83)	1.48 (0.62, 3.57)

DSM-5 diagnostic criteria for cannabis use disorder

A problematic pattern of cannabis use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1) Cannabis is often taken in larger amounts or over a longer period than was intended.
2) There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
3) A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.
4) Craving, or a strong desire or urge to use cannabis.
5) Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
6) Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
7) Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
8) Recurrent cannabis use in situations in which it is physically hazardous.
9) Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis.
10) Tolerance, as defined by either of the following:
a) A need for markedly increased amounts of cannabis to achieve intoxication or desired effect.
b) Markedly diminished effect with continued use of the same amount of cannabis.
11) Withdrawal, as manifested by either of the following:
a) The characteristic withdrawal syndrome for cannabis.
b) Cannabis (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.
<i>Specify if:</i>
In early remission: After full criteria for cannabis use disorder were previously met, none of the criteria for cannabis use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use cannabis," may be present).
In sustained remission: After full criteria for cannabis use disorder were previously met, none of the criteria for cannabis use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use cannabis," may be present).
<i>Specify if:</i>
In a controlled environment: In a controlled environment: This additional specifier is used if the individual is in an environment where access to cannabis is restricted.
<i>Specify current severity:</i>
Mild: Presence of 2 to 3 symptoms.
Moderate: Presence of 4 to 5 symptoms.
Severe: Presence of 6 or more symptoms.

Treatment for CUD:

Cognitive Behavioral Therapy
(CBT)

Motivational Enhancement
Therapy (MET)

History

NOW SHE
CAN COOK
BREAKFAST
AGAIN



... WHEN YOU PRESCRIBE NEW
MORNIDINETM
(BRAND OF PIPAMAZINE)

A new drug with specific effectiveness in relieving vomiting of pregnancy. Mornidine eliminates the ordeal of morning sickness.

With its selective action on the vomiting center, or the medullary chemoreceptor "trigger zone," Mornidine possesses the advantages of the phenothiazine drugs without unwanted tranquilizing activity.

Doses of 5 to 10 mg., repeated at intervals of six to eight hours, provide excellent relief all day. In patients who are unable to retain oral medication when first seen, Mornidine may be administered intramuscularly in doses of 5 mg. (1 cc.).

Mornidine is supplied as tablets of 5 mg. and as ampule of 5 mg. (1 cc.).

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in ALL pregnancies . . .

95 per cent live delivery with **desPLEX**
in one series of 1200 patients*—
— bigger and stronger babies, too.**

No gastric or other side effects with **desPLEX**
— in either high or low dosage^{3,4,5}

(Each **desPLEX** tablet starts with 25 mg. of diethylstilbestrol, U.S.P., which is then ultramicrozoned to smooth and accelerate absorption and activity. A portion of this ultramicrozoned diethylstilbestrol is even included in the tablet coating to assure prompt help in emergencies. **desPLEX** tablets also contain vitamin C and certain members of the vitamin B complex to aid detoxification in pregnancy and the effectuation of estrogen.)

For further data and a generous trial supply of **desPLEX**, write to:
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- REFERENCES
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GRANT CHEMICAL COMPANY, INC., Brooklyn 26, N.Y.

History

Zofran[®] BIRTH DEFECT
WARNING!

Did you take **ZOFRAN** while **pregnant**
AND was your child born with a **heart**
defect, cleft palate, cleft lip or another
birth defect?



COMMENT & RESPONSE

Why Pregnant Women May Justifiably Choose to Use Cannabis

To the Editor We read with interest a Research Letter by Young-

The implicit idea that naïve, pregnant, cannabis-using women require education is pejorative and paternalistic. Perhaps these women recognize that with no federal standing, quality medical research cannot be conducted on cannabis. Gold-standard randomized clinical trials are effectively illegal. What data we do have on cannabis does not show definitive harm.

Takakuwa, JAMA 2018

Medicinal Use

The Good (possible health indications)

Glaucoma

Nausea

AIDS associated anorexia and wasting syndrome

Chronic pain

Inflammation

Multiple Sclerosis

Epilepsy

Anxiety

PTSD

Sleep disturbances

Spasticity

Volkow, NEJM 2014
Nat Acad Sci Report, 2018

Medical marijuana: Pain

Dosing

most studies use 1-10% THC

highest in studies with chronic users is typically 12.5%, higher doses cause discontinuation due to side effects

average dose advertised at medical dispensaries is 13% and goes as high as 37% (Romero-Sandoval)

Most evidence is for neuropathic pain

Romero-Sandoval, Pharmacotherapy 2018

Nausea and vomiting in pregnancy

Table.

Adjusted Odds for Marijuana Use Among Females Undergoing Screening in the First Trimester of Pregnancy^a

NVP Category	No. (%) of Participants (n = 220 510)	Marijuana Use	
		aOR (95% CI)	P Value
None	181 679 (82.4)	1 [Reference]	NA
Mild	33 691 (15.3)	2.37 (2.17-2.59)	<.001
Severe	5140 (2.3)	3.80 (3.19-4.52)	<.001

Abbreviations: aOR, adjusted odds ratio; NA, not applicable; NVP, nausea and vomiting in pregnancy.

^aAnalyses are controlled for standard covariates based on prior literature and availability in electronic health records, including age group, race/ethnicity, median neighborhood household income, year, and self-reported marijuana use in the year before pregnancy. The median sample size across years was 27 017 (range, 26 451-28 149).

Young-Wolff, JAMA
 2018

Marijuana for NVP

83.1% of medical marijuana dispensaries recommend use for morning sickness

Thus far all evidence is self reported

Confounded by when use began

Cannabis hyperemesis syndrome

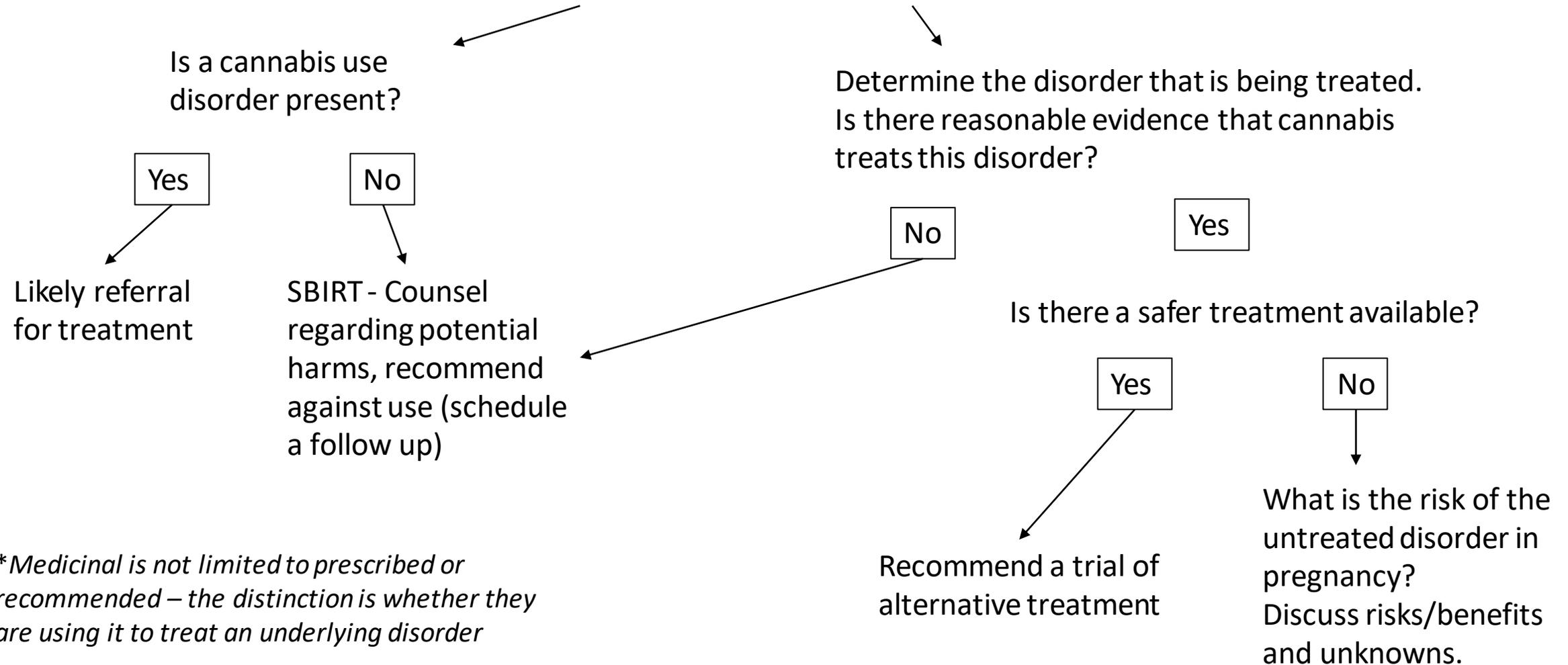
Withdrawal symptoms

Dickinson, Obstet Gynecol 2018
Schmid, Arch Obstet Gynecol 2011

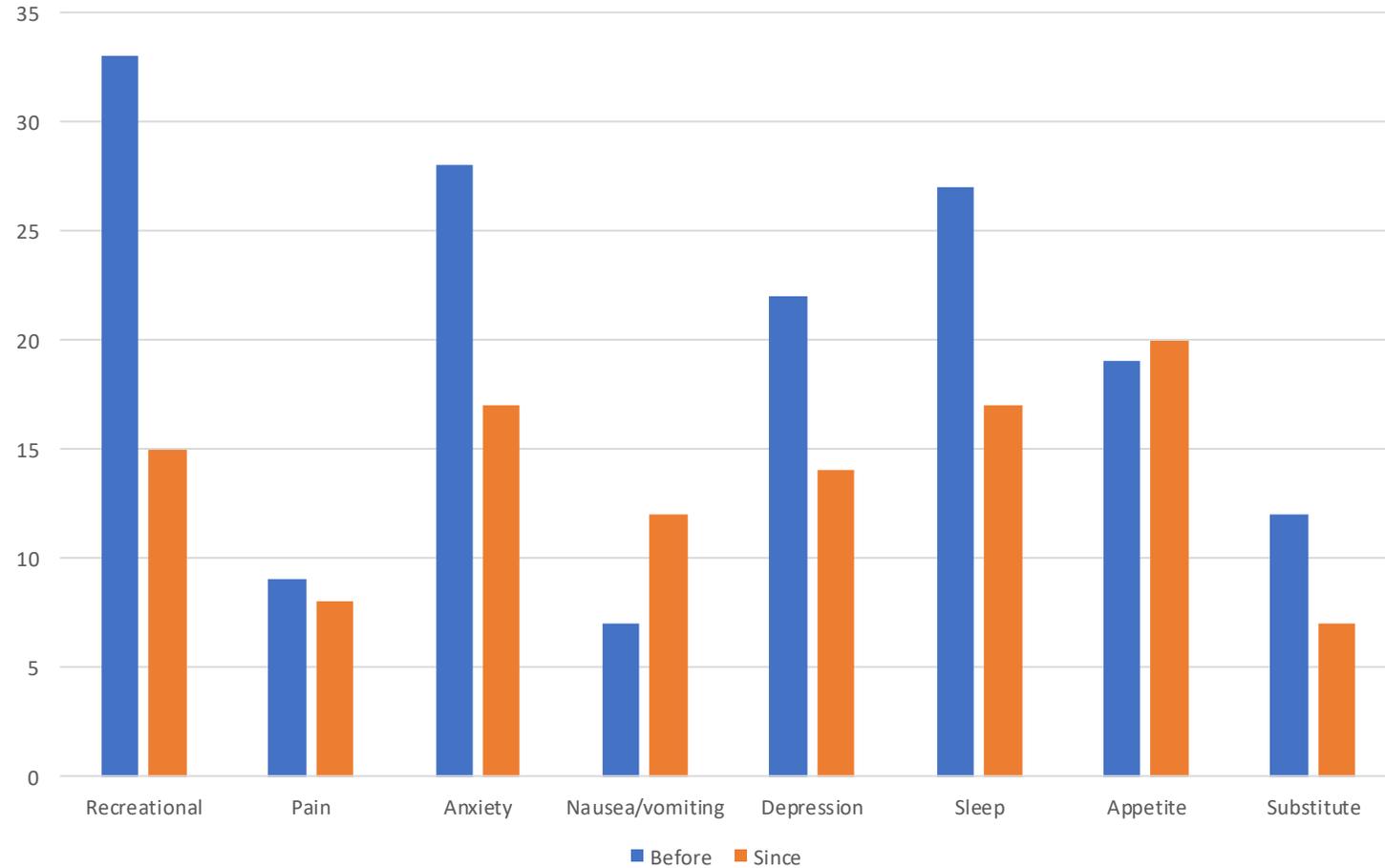
Table 2 Rome IV criteria for cannabis hyperemesis syndrome

Required criteria [8]	Comments
<ol style="list-style-type: none"> 1. Symptoms present for past 3 months (with onset at least 6 months prior) 2. Stereotypical episodes lasting <1 week 3. At least 3 episodes in last 1 year and 2 episodes in last 6 months (occurring at least 1 week apart) 4. No vomiting between episodes. Milder symptoms can be present during this. <p>All these criteria should be associated with chronic use of cannabis and stop after its cessation</p>	<p>Definition of chronic use needs more elaboration</p> <p>Cessation of cannabis use needs to be defined for an exact period</p>

Recreational or Medicinal*?



**Medicinal is not limited to prescribed or recommended – the distinction is whether they are using it to treat an underlying disorder*



Brief Intervention

Understand the patient's views

Identify pros and cons. Summarize.

Give information/feedback

Ask permission to give feedback: “Is it okay if we review some of the health risks?”

Do not assume that they don't know anything: “Tell me what you know about the health risks of X”

Assess/enhance motivation to change

Assess readiness to change: “Given what we've been discussing, tell me how you feel about your use”

“Is there anything that would change the way that you feel about your use?”

Identify goals and develop discrepancies between goals and behaviors

Give advice and negotiate goal

Review concerns, give recommendations

Negotiate a goal: “What are your goals for your use? If you don't feel ready to stop, are there any changes

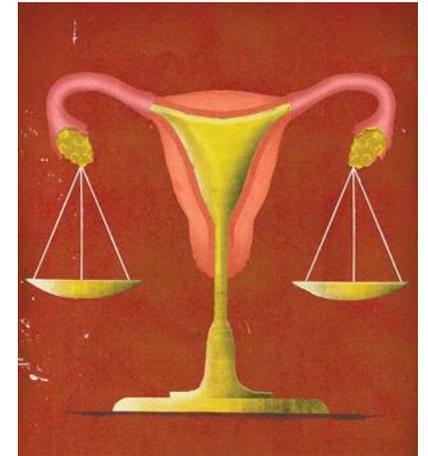
that you would be interested in making?”

Set up follow up

“Would it be okay if we set up an appointment in 2 weeks to check back in?”

Information/Feedback

- Unbias facts
- Admit when harm is unclear/unknown
- Provide information in non-judgmental way
- Do not focus counseling on legality of substance



Motivational Interviewing Strategies

Express Empathy

Meet them where they are.

“It sounds like you have been struggling with this...”

“I would like to hear more about your experience...”

Develop Discrepancy

Highlight their priorities, then help them see the differences between their priorities and their actions.

“You’ve told me that keeping custody of your baby is the most important thing to you. How does your cannabis use fit into that plan?”

Roll with Resistance

View the person as your dance partner, not your wrestling opponent

“It sounds like you’ve tried before and this hasn’t worked for you...”

“Is there anything that you think would help you make this change?”

Support Self-Efficacy

“What do you think is the first step that you could take toward change?”

Marijuana and breastfeeding

THC can transfer into breastmilk

Concentrations 0.4-8.7% of maternal ingested dose

Average 2.5%

Oral bioavailability different than inhaled (4-12% v 30%)

No studies on infant absorption

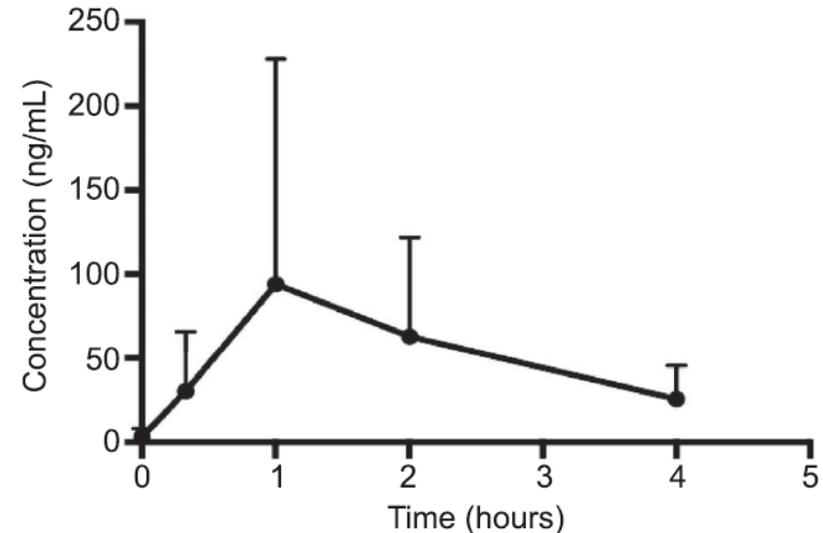


Fig. 4. Mean concentration–time profile of delta-9-tetrahydrocannabinol in human milk (mean±standard deviation, n=8). Reprinted from Baker T, Datta P, Rewers-Felkins K, Thompson H, Kallem RR, Hale TW. Transfer of inhaled cannabis into human breast milk. *Obstet Gynecol* 2018;131:783–788.

Metz and Borgelt. Marijuana Use in Pregnancy. Obstet Gynecol

Baker, *Obstet Gynecol* 2018
McGilveray, *Pain Res Manag* 2005

Recommendations

AAP: “Street drugs such as PCP, cocaine and cannabis can be detected in human breastmilk and their use by breastfeeding mothers is of concern, particularly in relation to the infant’s long-term neurodevelopment, and are thus contraindicated”



- **“Maternal substance abuse is not a categorical contraindication to breastfeeding.”**

Bertrand, Pediatrics 2018

SUMMARY

Cannabis use in pregnancy is common

Universal screening in pregnancy is recommended

Acknowledging a positive screen and providing medically relevant information is critical

A pregnant person's reasons for use should be elicited in order to tailor counseling

Refer for substance use counseling when Cannabis Use Disorder is identified

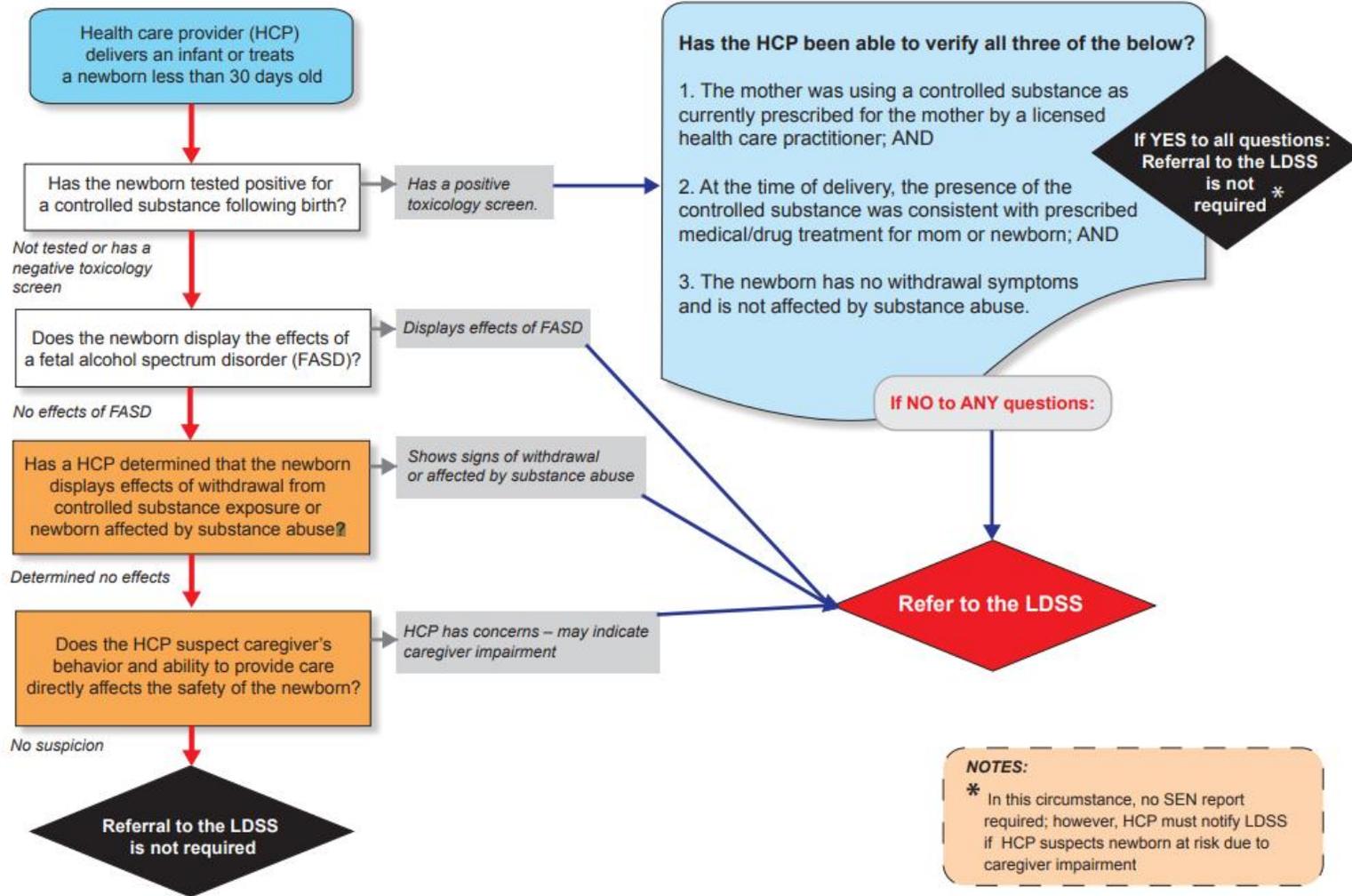
When use is medical, seek alternative treatments and consider risk of untreated disorder



A well-educated mind will always
have more questions than answers.

— *Helen Keller* —

AZ QUOTES



DHS/SSA/2105 11/18

Maryland Addiction Consultation Service for Maternal Opioid Misuse (MACS for MOMs)

Provides support to maternal health providers and their practices in addressing the needs of their pregnant and postpartum patients with substance use disorders (SUD), particularly opioid use disorder (OUD).

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and pregnancy
- Assistance with addiction and behavioral health resources and referrals
- MACS for MOMs TeleECHO Clinics: collaborative medical education through didactic presentations and case-based learning