ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

Perinatal Cannabis Use in the Era of Increasing Legalization: Considerations for State MCH Programs

About AMCHP

The Association of Maternal & Child Health Programs is a national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth, and families, including those with special health care needs. AMCHP's members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, and other public health leaders who work with and support state maternal and child health programs.

PERINATAL CANNABIS USE IN THE ERA OF INCREASING LEGALIZATION: CONSIDERATIONS FOR STATE MCH PROGRAMS

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Part 1

Perinatal Cannabis Use Landscape and Implications

INTRODUCTION

Cannabis—or marijuana—is the most commonly used addictive drug after tobacco and alcohol.[1] Among pregnant people, cannabis is the most frequently used federally illicit substance. Approximately 1 in 20 people report using cannabis while pregnant.[2] Prenatal cannabis use is associated with poor health outcomes, including maternal anemia, fetal growth restrictions, stillbirth, preterm birth, low birth weight, and neurodevelopmental deficits affecting memory, learning, and behavior.[3] The effects of prenatal cannabis use can also exacerbate existing health and social disparities among population groups.[4]

Most of the country lives in a jurisdiction where cannabis is legal for medical or recreational use.[5]* With the pace of legalization over the past decade, it is conceivable that in the future, all states will have some degree of cannabis legalization (medicinal, recreational, or both), occurring through legislative policy-making or state ballot initiative efforts.[5]

Due to the rapid pace of legalization, many state health departments and maternal and child health (MCH) programs are increasingly concerned about the use of cannabis by pregnant people and the substance's impact on fetuses and newborns.

This issue brief covers the following topics:

- An overview of the cannabis policy landscape, usage trends, and the potential health impacts of perinatal cannabis use
- The challenges public health leaders face in countering cannabis industry messaging
- The racial equity and legal implications for pregnant people who use cannabis
- State approaches to prevent and reduce perinatal cannabis use
- Recommendations for state MCH programs.

In the era of accelerated cannabis legalization across the country, this brief is a call to action for MCH professionals to be leaders in designing and implementing public health approaches to minimizing the potential harms of perinatal cannabis use.

POLICY LANDSCAPE

The policy landscape for cannabis is changing rapidly. Although cannabis remains illegal at the federal level, many states are decriminalizing cannabis possession and legalizing medical and recreational use. Consequently, there are inconsistencies between federal and state laws, which compromise regulatory oversight and public health messaging.[7]

Several arguments have been articulated against and in support of full cannabis legalization. Legalization opponents cite the health effects of cannabis, including its potentially negative impact on cardiovascular and pulmonary health, cognitive functioning, mental health, and its addictive nature.[8] Advocates argue that legalizing recreational cannabis use would reduce the illicit market, permit cannabis use to be regulated, reduce the costs of enforcing the prohibition

*The term "adult-use" is sometimes used in place of "recreational use" to describe cannabis use by people 21 years old or older in a legal state. Although typically used in reference to cannabis purchased for recreational purposes, the word "adult-use" derives from the notion that not all consumers of a cannabis dispensary are consuming cannabis solely for recreational purposes, but for reasons that go beyond the recreational-medicinal cannabis binary.[6]

of cannabis use, and enable the government to raise revenue by taxing cannabis products.[9] In addition, advocates reason that the criminalization of cannabis is more harmful than legalization, particularly for Black and Latinx communities, because these groups are disparately targeted by law enforcement for cannabis-related offenses.[10-12]

Federal Policy

Cannabis remains illegal under federal law and is a Schedule I controlled substance under the U.S. Controlled Substances Act of 1970. Accordingly, the production, sale, possession, and distribution of cannabis can carry federal fines and imprisonment. The Obama Administration released updated guidance regarding cannabis enforcement through the 2013 Cole memorandum, which was subsequently nullified by the Trump Administration. In 2021, Senate Majority Leader Chuck Schumer released draft legislation, the Cannabis Administration and Opportunity Act, which removes cannabis from the Controlled Substances Act, and lays the groundwork for federal taxation and regulation of the cannabis industry.[7]

State Policy

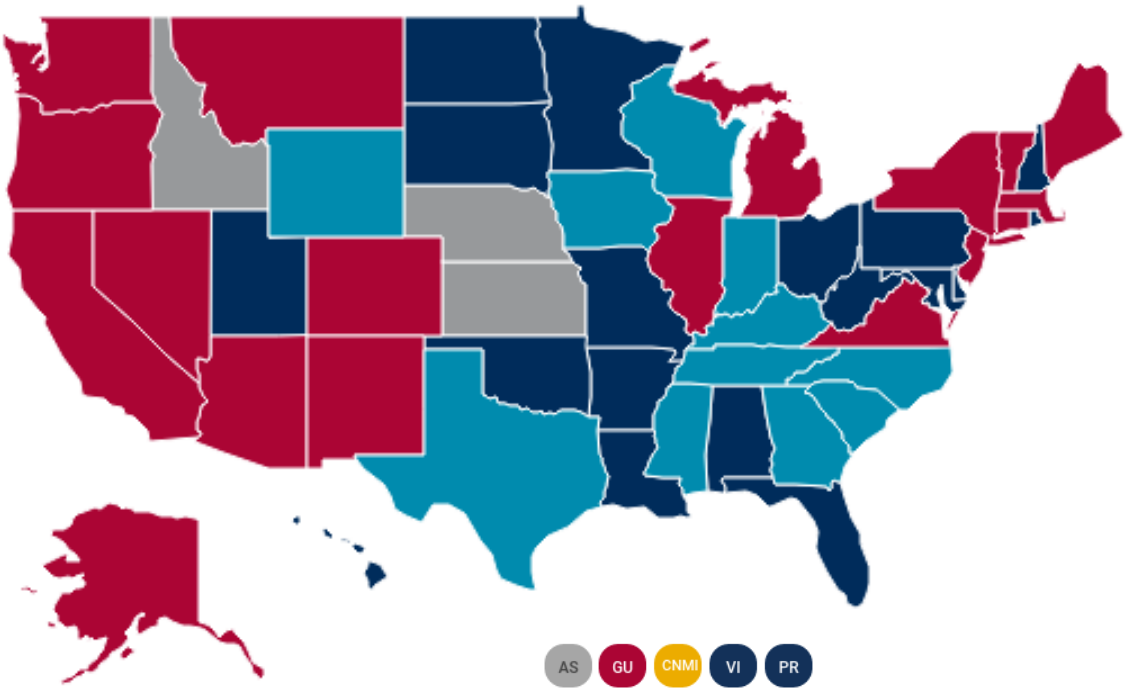
Cannabis policy is primarily a state activity, and laws vary by state and local jurisdiction. Table 1 lists the four main cannabis policy categories.

TABLE 1. Primary State Cannabis Policy Categories

Illegal or no public cannabis access program	Disallows the production, sale, possession, or distribution of cannabis.
Decriminalization	Cannabis remains illegal, but the legal system lowers or deprioritizes enforcement of penalties associated with cannabis possession and casual exchanges (not including sales).[7]
Medical legalization	Medical cannabis laws permit patients to purchase cannabis at dispensaries operating within the state for certified medical use. Physicians can only recommend cannabis for qualifying health conditions, which vary by state.[7] The comprehensiveness of medical cannabis programs also differs by state. For example, Cannabidiol/Low Tetrahydrocannabinol (CBD/Low THC) programs only allow cannabis strains that are low in THC and rich in CBD, which excludes medical conditions that benefit from strains with greater quantities of THC.
Recreational—or adult-use—regulated program	Recreational cannabis laws remove criminal and civil penalties associated with the supply or possession of the substance by adults ages 21 and older.[7] These laws typically allow individuals to grow a small amount of cannabis for personal use. Most states impose at least a 10 percent retail excise tax and prohibit the use of cannabis while operating a motor vehicle.[7]

Eighteen states have legalized recreational use; Colorado and Washington were the first states to legalize recreational use in 2012.[13,14] Most legalization efforts have been advanced via ballot measures.[14] However, the four states that legalized recreational cannabis in 2021—New York, Virginia, New Mexico, and Connecticut—passed the law through the legislature, demonstrating increased political support for full cannabis legalization.[14] Figure 1 categorizes states by the type of state-regulated cannabis program implemented.

FIGURE 1. State Regulated Cannabis Programs [13]



Recreational & medical use regulated program

CBD/Low THC program

No public cannabis access program

Comprehensive medical cannabis program

Recreational use only; no medical regulated program

CANNABIS USAGE TRENDS AMONG PREGNANT PEOPLE

Consistent across studies, cannabis use is defined as any use, recreational or medical. Cannabis usage among adults in the U.S. more than doubled between 2001 and 2013.[15] Approximately 32 million people use cannabis monthly, and 48 million people use it yearly.[16] During the COVID-19 pandemic, the number of cannabis users has increased nationally.[17] A state-specific study found that prenatal cannabis use increased by 25% throughout the COVID-19 pandemic.[18] Notwithstanding the COVID-19 pandemic, the uptick in cannabis usage has been attributed to increased accessibility, more permissive attitudes toward cannabis, and decreased perceived risk.[16,19]

The high prevalence of cannabis usage nationwide warrants attention to the use of cannabis among people in the perinatal period.[20] Cannabis is the most common federally illegal drug used among reproductive-aged, pregnant, and lactating people.[3,21,22] Among pregnant people, the prevalence of past-month cannabis use doubled from 2002–2003 to 2016–2017.[23] For young urban, low socioeconomic pregnant people, usage rates are estimated to be 15 to 28 percent.[24] Moreover, usage rates often rely on self-reporting, which suggests that the rate of cannabis use during the prenatal period is likely an underestimate.

Furthermore, data from a nationally representative sample of women ages 12 to 44 years found that the prevalence of cannabis use was higher in the first trimester (6.44 percent) than the second (3.34 percent) and third trimesters (1.82 percent).[23] Although cannabis use is common when prenatal care begins, most pregnant people stop using it by the time they deliver their baby.[25] Research from Colorado, a state with legalized recreational use, indicated that among cannabis users (past and current) a part of the Women's Infants and Children Program, 35.8 percent said that they had used cannabis at some point during pregnancy, 41 percent had used cannabis since the infant was born, and 18 percent had used cannabis while breastfeeding.[26] The number of birthing persons who report cannabis use in the perinatal period is likely to increase, as additional states legalize recreational cannabis.[27]

CANNABIS USE AND PERINATAL HEALTH

Evidence emerging on the public health impact of cannabis legalization cautions the use of cannabis during pregnancy and lactation.[9,28] The potency of cannabis has increased over time. The concentration of tetrahydrocannabinol (THC), the main psychoactive chemical in cannabis plants, increased three-fold between 1995 and 2014.[29] THC passes through the placenta to the fetus in utero and can be detected in human milk for up to 6 weeks.[27,30]

Exposure to cannabis in the womb can be harmful to a baby's development.[3,31,32] A recent study found that prenatal cannabis use disorder was associated with greater odds of infant mortality, small gestational age, preterm birth, or low birth weight.[33] Maternal cannabis use also increases the risk of neonatal intensive care unit admissions.[34-36] In addition, pregnant people who report cannabis use have increased odds of becoming anemic compared to pregnant people who do not use cannabis.[35]

Current data collection and research methodology have limitations, which include:

- Reporting bias because cannabis use is self-reported
- Difficulty in ascertaining frequency of exposure, concentration, quantity, and duration of cannabis use
- Inability to control for confounding variables (e.g., polysubstance use and income) that are independently associated with adverse maternal and neonatal health outcomes.[35,37,38]

Despite limitations in the research, there is sufficient evidence to conclude that no amount of cannabis use during pregnancy is considered safe. Thus, the American College of Obstetricians and Gynecologists, American Academy of Pediatricians, Association of Women's Health, Obstetric, and Neonatal Nurses, U.S. Surgeon General, Centers for Disease Control and Prevention (CDC), and Substance Abuse and Mental Health Services Administration discourage the use of cannabis by pregnant and lactating people.

CANNABIS INDUSTRY VERSUS PUBLIC HEALTH MESSAGING

The increased legal access to recreational cannabis has allowed the cannabis industry to expand its influence.[7] In 2020, approximately 7,500 cannabis dispensaries were located nationwide.[39] The legal sale of cannabis in the U.S. reached a record high of $17.5 billion in 2020, representing a 46 percent increase from 2019.[40] Most cannabis sales are conducted in the underground economy, where sales are estimated to be more than $100 billion annually.[40]

The cannabis industry invested $4.1 million in marketing and advertising in the U.S. in 2018.[41] Increased media attention—via the Internet and social media in particular—is associated with increased support for recreational cannabis use and legalization.[42] The youth and young adult markets receive the highest levels of advertising exposure.[43] The heightened visibility of cannabis through advertisements contributes to more positive perceptions of recreational cannabis use, reduced perceptions of potential harms, and greater cannabis use.[44-46] Cannabis marketing often cites the presumed health benefits of cannabis.

It is unlawful in all states to provide medical advice or prescribe medication without an active medical license.[47] However, many cannabis dispensaries offer medical advice and recommend cannabis products for health conditions. A study of 146 recreational cannabis retailers in Colorado and Washington found that 61 percent of Colorado dispensaries and 44 percent of Washington dispensaries made health claims to customers about the benefits of cannabis, including treatment of anxiety, depression, insomnia, and pain/inflammation.[48]

Health claims regarding cannabis use and pregnancy

For consumers, confusion abounds regarding the use of both medical and recreational cannabis during pregnancy. Pregnancy-related conditions are not legally approved for medicinal cannabis in any state.[49] However, many states that allow medicinal cannabis do not list pregnancy as a contraindication for recommending or dispensing medicinal cannabis, nor do they require dispensaries to display warnings about possible harms to a fetus or infant.[49]

Colorado Case Study

Unsubstantiated cannabis health claims promoted by dispensaries have become a focus of public health research. In 2017, 400 Colorado cannabis dispensaries were included in a study to determine whether the dispensaries would recommend cannabis to treat pregnancy-related morning sickness. Nearly 70 percent of the retailers surveyed advised treating morning sickness with cannabis products.[50] Most recommendations were based on personal opinion, and 36 percent of respondents stated cannabis use during pregnancy is safe.[50] Only 32 percent of retailers voluntarily recommended discussing cannabis use with a health care provider.[50] Despite the absence of data to support cannabis use during pregnancy, many people who use cannabis while pregnant cite that they use it to remedy morning sickness.[49,51]

Cannabis as a treatment for morning sickness is an example of a false health claim. Table 2 lists other common misconceptions about the health benefits of cannabis for pregnant people and babies, followed by accurate information.

TABLE 2. Cannabis Health Misconceptions in the Perinatal and Postpartum Period

Misconception	Accurate Statement
Cannabis is natural, so it cannot harm the body.	Many natural substances are harmful to human health. Cannabis use is associated with several adverse health outcomes for all people, including pregnant people and infants. In addition, cannabis may be laced with harmful contaminants.
Cannabis is a drug, but it is not addictive like cocaine, heroin, meth, or other illegal substances.	Cannabis is often viewed as a benign, natural substance that is not addictive. However, users can develop cannabis use disorder,[17] which is often characterized by dependence and addiction.[52] Characteristics of cannabis addiction are the inability to stop using, prioritizing use over important aspects of life, and undergoing withdrawal symptoms when not using.[8,52]

TABLE 2 (continued). Cannabis Health Misconceptions in the Perinatal and Postpartum Period

Misconception	Accurate Statement
Cannabis helps prevent morning sickness.	One study of women using cannabis during pregnancy found that 51 percent reported using it to relieve symptoms of morning sickness, including nausea and vomiting.[53] Although THC-based pill medications have been approved to treat nausea and vomiting in patients undergoing cancer chemotherapy,[54] these drugs are not recommended for pregnant people.
Cannabis helps to release breast milk.	No evidence indicates that cannabis use helps release human milk or makes breastfeeding easier. Data do show, however, that cannabis can be transferred to a baby via human milk. For this reason, it is advised that people do not use cannabis while breastfeeding.

RACIAL EQUITY IMPLICATIONS OF THE CRIMINALIZATION OF PREGNANT PEOPLE AND MOTHERS WHO USE DRUGS

History of the racialization of drug use by pregnant people and mothers

The harmful effects of drug-related criminalization on communities of color and the racial inequities in cannabis law enforcement stem from long-standing U.S. drug policy. Initiated in 1971, the national "War on Drugs" advanced a narrative that associated certain racial groups with illicit drug use and assigned greater punishment to drug use associated with Black and Brown people.[55,56] In the 1980s, the War on Drugs sensationalized so-called "crack babies," a term coined from a debunked research study,[57] which suggested that pregnant urban Black women with substance use disorders were recklessly exposing their fetuses to crack cocaine.[58] This led to increased policing and incarceration of Black pregnant people and mothers with prenatal cocaine exposure, often resulting in family separation.[57,59] Since the 1980s, authorities in at least 44 states have sought to hold women criminally accountable for drug use during pregnancy.[60]

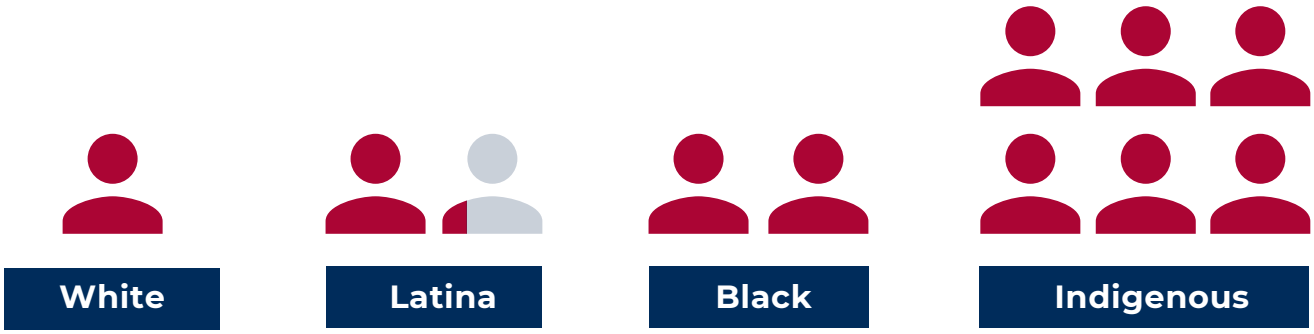
The harmful effects of drug-related criminalization on communities of color and the racial inequities in cannabis law enforcement stem from long-standing U.S. drug policy.

By contrast, today's opioid crisis is frequently associated with white people living in suburban and rural areas.[59,61] The opioid policy climate is less punitive than that which existed in the crack cocaine era of the 1980s. To address the opioid problem, officials often call for lighter sentencing for nonviolent illegal drug offenses and expanded access to addiction treatment.[59,61] White pregnant and pregnant-capable people have disproportionately benefited from this non-punitive, public health approach to opioid use disorders.[62]

Current policy approaches to address cannabis usage disproportionately target Black and Latinx communities via legal drug enforcement and sentencing practices, without consideration of comprehensive public health perspectives.[10-12]

Health consequences of the criminalization of pregnant people and mothers who use drugs

Women, particularly Black, Indigenous, and Latinx women, are disproportionately affected by social stigma and drug law enforcement.[63] Drug use occurs at similar rates across racial groups.[64] Yet, Black women are two times more likely, Latinas 1.2 times more likely, and Indigenous women six times more likely to be criminally prosecuted for drug law violations than white women.[65]



Cannabis legalization will reduce arrests in general, but racially biased mandated reporting laws are still in effect in many states.[66] Therefore, although people of color are no more likely than white people to use illicit drugs during pregnancy, they are far more likely to experience bias within the health care system, be screened for substance use, and be reported to the legal and child welfare systems for substance use than their white counterparts.[67-69]

Social stigma and fear of being reported to law enforcement and the child welfare system discourage pregnant and postpartum people from seeking critical health care, which increases mistrust in the medical system.[70] In addition, there is significant racial bias in reporting,[71,72] and mandated reporting requirements have not been updated at the same rate as cannabis legalization.[66] The American College of Obstetricians and Gynecologists opposes the criminalization of individuals who use drugs during pregnancy and the postpartum period.[73] Ideally, in a trusted patient-provider relationship, the provider can screen the patient for perinatal cannabis use via a conversation and not exercise punitive actions.[73] Testing should be performed with the patient's consent, and a positive test should not be a barrier to care, a disqualifier for coverage under publicly funded programs, or the sole factor in determining whether a family requires separation.[73]

Investments in cannabis harm reduction strategies and plans of safe care with pregnant and parenting people can reduce adverse health outcomes and help maintain autonomy for pregnant and parenting people.[73,74]Also, patients and providers must understand how the decriminalization and legalization of cannabis apply to pregnant people and impacts existing policies (e.g., mandated reporting laws). It is imperative to divert people from the legal and child welfare systems—which have not traditionally prioritized substance use treatment or reproductive justice—and prioritize harm reduction strategies and address the racism inherent in mandatory reporting laws.

Part 2

Perinatal Cannabis Use Prevention Response

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STATE MCH PROGRAM APPROACHES TO PREVENTING PERINATAL CANNABIS USE

State health departments and state MCH programs have experienced successes as well as obstacles to adopting public health approaches to perinatal cannabis use. Qualitative interviews with state MCH program professionals in Colorado, Kansas, Louisiana, Michigan, New Jersey, North Dakota, Oklahoma, and Virginia yielded valuable insights into the policy and program environments related to cannabis legalization at the state and local levels. Data from state health department websites and Title V block grant applications and annual reports supported the state interviews.

State MCH Program Challenges and Limitations

Public health departments and state MCH programs have encountered several challenges to implementing public health measures to address perinatal cannabis use, such as the following:

Generalized cannabis campaigns that do not target perinatal users. Cannabis prevention programs in state health departments have not traditionally prioritized pregnant and postpartum people as a target population.

Prioritization of opioid use within the perinatal population. Skyrocketing opioid use among pregnant people in the last decade has diverted attention from the growing risk of perinatal cannabis use, despite the rapid pace of cannabis legalization.

Lack of awareness among health care providers on cannabis risks and insufficient screening and counseling on perinatal cannabis use. Prenatal care providers need additional support to screen women and effectively communicate the risks of cannabis use during pregnancy.

Lack of coordination between state MCH and behavioral health programs. Efforts to address perinatal cannabis use are more effective when these state agencies collaborate closely.

State Public Health Department and State MCH Program Initiatives

Despite these challenges and limitations, some state public health departments and state MCH programs have launched successful initiatives to target perinatal cannabis use.

Comprehensive Websites and Online Resources

Several states have invested in comprehensive websites specific to cannabis and health. California, Colorado, Connecticut, Illinois, Maine, Oregon, Vermont, and Washington offer extensive information for the public and providers. Many of these states also have specific web pages that address cannabis use during pregnancy.

Educational Materials for Patients and Providers

States have produced public awareness resources to educate pregnant and breastfeeding people about the potential harms of cannabis use. These materials convey the message that no amount of cannabis use is considered safe.

Patient education materials cover a wide range of topics, such as:

- Evidence on the potential harm of cannabis use on the pregnant person, fetus, and newborn
- Debunking cannabis health claims
- Risks of parenting caregiving while using cannabis
- Safe storage tips
- Treatment for cannabis dependency.

FIGURE 2. First Page of a Two-Page Oklahoma Education Material

MARIJUANA: WHAT YOU NEED TO KNOW

Marijuana, which can also be called weed, pot, dope, or cannabis, is the dried flowers and leaves of the cannabis plant. Marijuana is a psychoactive drug that contains close to 500 chemicals, including tetrahydrocannabinol (THC), a mind-altering compound that causes harmful health effects. Over the past few decades, the amount of THC in marijuana has steadily climbed; today's marijuana has three times the concentration of THC compared to 25 years ago.

Q. IS IT POSSIBLE TO "OVERDOSE" OR HAVE A "BAD REACTION" TO MARIJUANA?

A. YES. The signs of using too much marijuana are similar to its typical effects, but more severe. These signs may include extreme confusion, anxiety, paranoia, panic, fast heart rate, delusions or hallucinations, increased blood pressure, and severe nausea or vomiting. In some cases, these reactions can lead to an injury, such as a motor vehicle crash, fall, or poisoning. Eating foods or drinking beverages that contain marijuana increase the risk of poisoning.

Q. IS MARIJUANA ADDICTIVE?

A. YES. Marijuana can be addictive. Some users become dependent and have trouble quitting even if it interferes with their life. Marijuana use disorder is common and can range from mild problematic use to severe addiction.

Q. ISN'T SMOKING MARIJUANA LESS DANGEROUS THAN SMOKING CIGARETTES?

A. NO. Both marijuana and cigarette smoke can be harmful. Marijuana smoke deposits four times more tar in the lungs and contains 50-70% more cancer-causing substances than tobacco smoke does. More research is needed to fully understand the connection between marijuana and long-term effects such as cancer.

Q. IT'S LEGAL IN MANY STATES, SO DOESN'T THAT MEAN MARIJUANA IS SAFE?

A. NO. The fact that it's legal does not mean that it is safe. Marijuana use can have negative and long-term effects, including:

Brain health: Marijuana use at a young age can cause permanent IQ loss; these IQ points do not come back.

Mental health: Studies link marijuana use to depression, anxiety, suicide planning, and psychotic episodes. It is not known, however, if marijuana use is the cause of these conditions.

Athletic performance: Research shows that marijuana affects timing, movement, and coordination, which can harm athletic performance.

Driving: People who drive under the influence of marijuana can experience slower reactions, lane weaving, decreased coordination, and difficulty reacting to signals and sounds on the road.

Baby's health and development: Marijuana use during pregnancy may be associated with fetal growth restriction, premature birth, stillbirth, and problems with brain development. THC and other chemicals can also be passed from a mother to her baby through breast milk.

Daily life: Research shows that people who use marijuana are more likely to have relationship problems, worse educational outcomes, lower career achievement, and reduced life satisfaction.

Provider educational materials focus on the potential health impacts on pregnant people and fetuses, how cannabis may affect children and youth, safe storage, and discussion guides for communicating with patients on cannabis use during perinatal visits. The Colorado Health Department developed comprehensive flyers for pregnant people and providers.

Public health messaging must be effective to counter the cannabis industry's narrative that cannabis is a safe, non-addictive substance. Public health messages should not increase the stigma associated with pregnant people who use drugs, worsen mental health stigma, exacerbate distrust in government and the medical system, discourage people from seeking help, or lead to the unnecessary criminalization of pregnant people.[75,76]

Public health cannabis messaging should focus on:

- Framing cannabis use as a health concern rather than a legal matter
- Promoting both prevention and harm reduction strategies
- Addressing the determinants of mental health and substance use that may increase the likelihood of cannabis dependency[77,78]
- Disseminating accurate and transparent information about the available research on cannabis and its potential harms for MCH populations
- Understanding the socioeconomic and racial equity implications of cannabis messaging
- Avoiding scare tactics, shaming, and stereotyping of perinatal cannabis users
- Making educational materials physically accessible in health and community settings that are frequented by pregnant people and new parents
- Developing material at a literacy level for the general public and in languages represented within the state.

State Campaigns

States have developed innovative cannabis campaigns that target perinatal users. "Let's Talk Cannabis" is the most extensive cannabis campaign that spans California, Illinois, and Vermont. Two other examples include:

- New Hampshire's Today is for Me campaign, which informs pregnant people and pregnant-capable people about the potential harms of alcohol and cannabis
- Vermont's One More Conversation Can Make the Difference initiative, which encourages provider-patient conversations about cannabis.

These campaigns can be effective in cautioning against perinatal cannabis use.

Colorado MCH partnered with the Marijuana Education Program at the Colorado Department of Public Health and Environment to launch a media campaign for pregnant-capable people. This campaign received more than 30 million media impressions on various media channels. Evaluations from the campaign found that English-speaking women of reproductive age in the survey sample demonstrated statistically significant increases in understanding the health effects of cannabis on children and the risks of breastfeeding while using cannabis.[79] Consistent results were found in a second media campaign, Responsibility Grows Here (Figure 3), which Colorado created for young parents (ages 15 to 19).[79]

Public health department cannabis campaigns can also be found in cannabis dispensaries. In addition to public service announcements, the Nevada Department of Health and Human Services developed posters and referral cards on pregnancy and children for all state dispensaries.[80] The effectiveness of promotional materials in dispensaries is unclear because evaluation data are lacking.

Alaska MCH distributed rack cards at no cost to local health centers and Women, Infants, and Children (WIC) sites with the message: "Tobacco, alcohol, and marijuana are legal in Alaska. Legal is not the same as safe."[81] Similarly, Maryland distributes rack cards that communicate the dangers associated with being under the influence of cannabis while caregiving (Figure 4). In North Dakota, the Division of Medical Marijuana in the Department of Health reviews and approves all promotional materials created by dispensaries to ensure that the content does not present false health information, nor target MCH populations.

FIGURE 3. Colorado Responsibility Grows Here Campaign

FIGURE 4. Maryland Rack Cards Adopted by Spokane Regional Health District

Policy

Table 3 describes some effective policy initiatives at the state and local levels that focus on preventing perinatal cannabis use.

TABLE 3. State and Local Policy Initiatives Focused on Perinatal Cannabis Use Prevention

State	Level	Description	Status
Alaska	State	During the state's fiscal year 2020, cannabis revenue funds from the Alaska Office of Substance Misuse and Addiction and Prevention were used to support Screening, Brief Intervention, and Referral to Treatment (SBIRT) and school-based health centers.[81]	In effect since 2020
Delaware	State	Delaware requires all incidents of infants born with substance exposure, including cannabis, to be reported to the state child welfare agency, which develops a plan of safe care and referral to home visiting services.[82]	Passed June 2018
Maine	Local	With technical assistance from the health department, two municipalities in Maine, representing 21,000 people, adopted smoke-free policies that include cannabis.[83]	In effect
Michigan	State	Dispensaries in Michigan are required to include labels warning pregnant and breastfeeding people about the health risks of cannabis use for fetuses and infants.[84]	Passed February 2020
Oregon	State	The Oregon Health Authority requires dispensaries selling to recreational consumers to display public health warnings about keeping these products out of the reach of children and advise pregnant and breastfeeding people not to use cannabis.[85]	In effect since 2015
Washington	State	Washington Initiative 502 broadened the state health department's cannabis program by creating a cannabis use public health hotline to refer people to treatment for substance misuse; by establishing a grant program for local health departments and agencies to develop youth cannabis prevention programs; and by launching a state-wide cannabis media campaign targeting youth and young adults.[86]	Passed November 2012; In effect since July 2015

Cross-Sector Workgroups

Several jurisdictions—such as Colorado, Connecticut, the District of Columbia, Massachusetts, Michigan, New Hampshire, New Jersey, Oregon, and Virginia—have created councils, committees, commissions, and workgroups specific to cannabis use prevention. Often, members of these groups are government officials, public health professionals, health care providers, members of academia, law enforcement, and community members, representing multiple sectors. The workgroups can serve a variety of purposes:

- Approving health-related regulations (e.g., Virginia Cannabis Public Health Advisory Council)
- Reviewing scientific literature and translating scientific information into public health messaging (e.g., Colorado Retail Marijuana Public Health Advisory Committee)
- Enabling communities affected by the War on Drugs to fully participate in the cannabis industry through business, entrepreneurship, and professional development training (e.g., Massachusetts Social Equity Program).

Data Collection for Perinatal Cannabis Use

Insufficient data, especially the lack of disaggregated data, is a significant barrier for jurisdictions aiming to assess the magnitude of perinatal cannabis use and the health and social impacts on the MCH population. Certain states have invested resources to measure perinatal cannabis use through the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a CDC-sponsored surveillance project administered in partnership with state and local health departments. The survey collects jurisdiction-specific, population-based data on maternal health, attitudes, and experiences before pregnancy, during pregnancy, and shortly after giving birth.

TABLE 4. State MCH Data Collection on Perinatal Cannabis Use

PRAMS Supplemental Questionnaire	PRAMS CDC-Developed Standard Questions	PRAMS State-Developed Questions	Other	None
These states added the 12-question Marijuana and Prescription Drug Use questionnaire to their PRAMS survey.	These jurisdictions added at least one of the three CDC- developed and tested cannabis questions to their PRAMS survey.	These states added cannabis questions to their PRAMS surveys that were state developed and tested.	California administers its own PRAMS-like survey, which includes questions about cannabis use.	These states do not include cannabis-specific questions on their PRAMS (or PRAMS-like) surveys.
Alaska Illinois Maine New Jersey New Mexico New York North Dakota Pennsylvania Rhode Island Virginia West Virginia	Arizona District of Columbia Hawaii Indiana Kansas Kentucky Louisiana Michigan Missouri Montana New Hampshire Nevada Oregon Puerto Rico South Dakota Vermont Wisconsin Wyoming Ohio	Colorado Tennessee Washington	California – Maternal Infant Health Assessment	Alabama Arkansas Connecticut Delaware Florida Georgia Idaho Iowa Mariana Islands* Maryland Massachusetts Minnesota Mississippi Nebraska New York New York City North Carolina Northern Texas Utah

*The Northern Mariana Islands PRAMS survey is in dvelopment.

Optional PRAMS questionnaires supplement the regular PRAMS survey and rapidly collect data on emergent topics, such as COVID-19. Since 2017, the CDC has offered states a 12-question PRAMS supplemental questionnaire on marijuana and prescription drug use. Before the PRAMS marijuana supplement was implemented, some states developed their own state-specific, cannabis-related questions, and they continue to include these questions on their PRAMS surveys. The CDC also created three standard questions on cannabis, which states may add to their surveys. Sites are advised to use CDC-developed and tested questions rather than create their own, to ensure similar data are collected across all jurisdictions. In addition, states are encouraged to use supplemental cannabis questions because the core PRAMS survey includes only one reference to cannabis within a polysubstance use question. Table 4 categorizes states by type of cannabis data collection, and Table 5 includes the cannabis-related questions that appear on the core, standard, and supplemental PRAMS surveys.

TABLE 5. CDC Developed and Tested PRAMS Questions

Core question	Marijuana and prescription drug supplement
During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you if you were using drugs such as marijuana, cocaine, crack, or meth? (Y/N)	At any time during the 3 months before you got pregnant OR during your most recent pregnancy, did you use marijuana or hash in any form? (Y/N)
Standard questions During any of the following time periods, did you use marijuana? • During the 12 months before I got pregnant (Y/N) • During my most recent pregnancy (Y/N) • Since my new baby was born (Y/N)	During the 3 months before you got pregnant, about how often did you use marijuana products in an average month?
During the month before you got pregnant, did you use marijuana or hash for any reason? (Y/N)	During your most recent pregnancy, about how often did you use marijuana products in an average month?
During your most recent pregnancy, did you use marijuana or hash for any reason? (Y/N)	During your most recent pregnancy, how did you use marijuana? (e.g., smoked it or ate it)
	Why did you use marijuana products during pregnancy? (e.g., to relieve nausea or pain)
	During any of your prenatal care visits, did a doctor, nurse, or other health care worker do any of the following things? Please include if they asked you on a written form or in a conversation. • Ask me if I was using marijuana (Y/N) • Recommend that I use marijuana for any reason (Y/N) • Advise me not to use marijuana (Y/N) • Advise me not to breastfeed my baby if I was using marijuana (Y/N)
	During any of your prenatal care visits, did a doctor, nurse, or other health care worker refer you to treatment because of drug use (prescribed or non-prescribed drugs)? (Y/N)
	Since your new baby was born, have you used marijuana or hash in any form? (Y/N)
	How long do you think it is necessary for a woman to wait after using marijuana to breastfeed her baby?

States have also utilized the CDC Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS) surveys to collect data on cannabis use among adults and youth. The BRFSS survey includes an optional marijuana module (similar to the PRAMS supplement) that jurisdictions can adopt. Twelve states and Guam implemented the BRFSS marijuana module in 2019.[87] States, such as Maine and Kansas, have developed creative data visualizations and dashboards to share cannabis information with the public.

CONSIDERATIONS FOR STATE MCH PROGRAMS

As more states legalize cannabis for medical and recreational use, perinatal cannabis use will become an increasing concern for state health departments. State MCH programs should consider implementing policies and strategies that promote awareness of the potential harms of cannabis use while people are pregnant and breastfeeding, decrease perinatal cannabis use, and reduce harm. MCH programs should consider the following strategies as they design initiatives to address perinatal cannabis use:

AMCHP Program Level Recommendations

- Enhance public health surveillance by implementing the cannabis and prescription drug use PRAMS supplemental questionnaire to collect cannabis-specific data among the perinatal population.
- Dispel cannabis misconceptions with ethical, evidence-informed, and accessible public health communication materials and campaigns.
- Sponsor educational opportunities for providers, home visitors, and allied health professionals on the health impacts of perinatal cannabis use and effective screening and counseling approaches. Offer continuing education units for provider training.
- Leverage and tailor existing substance use prevention and harm reduction programming for opioid and alcohol use to address perinatal cannabis use.
- Increase peer support by training certified birth doulas to be addiction specialists in the prevention and treatment of perinatal cannabis use.
- Support the availability and accessibility of treatment for cannabis use disorder in perinatal health care and community settings, especially underserved locations.
- Integrate state public health and behavioral health program initiatives for perinatal cannabis use prevention, to improve coordination and leverage resources.

AMCHP Policy Level Recommendations

- States that have legalized cannabis may wish to support efforts that require most or all cannabis tax revenue to be used to develop cannabis oversight and regulation infrastructure and to implement cannabis use prevention and education efforts.
- States that have legalized cannabis may wish to support efforts that require public health department review and approval of dispensary promotional materials and require dispensaries to display warning labels against cannabis use during pregnancy and lactation.
- Extend tobacco smoke-free air restrictions to consistently include smoking and vaporizing cannabis in public places, including indoor and outdoor locations. Ensure that cannabis legalization does not negatively impact existing tobacco control laws.
- Collaborate with the state child welfare agency to refer people to resources and treatment and develop safe plans of care for substance-exposed infants, including those exposed to cannabis.
- Work with law enforcement to develop Safe Harbor laws that protect pregnant people and parents who use cannabis against liability, penalty, or risk of losing custody of their children, if they seek treatment.
- Promote the use of a racial equity lens in perinatal cannabis prevention measures.

Note: Under current federal policy, cannabis remains an illicit substance, and state legalization efforts are in violation of current federal law.

CONCLUSION

As legal access to cannabis increases nationwide, perinatal cannabis use is emerging as a high priority for MCH advocates. However, state MCH programs face formidable obstacles to action, including widespread misinformation about the health consequences of cannabis use, a powerful cannabis industry, and state budgets stretched thin by COVID-19 response efforts and other public health priorities. Additionally, the resolve of MCH programs to address the disparate impact of substance use on families of color is challenged by the racism that continues to influence substance use reporting and criminalization.

MCH programs are well-positioned to address perinatal cannabis use through public education, data collection and monitoring, and policy approaches, as outlined in this report. MCH programs should also leverage their relationships with the behavioral health and child welfare systems, law enforcement, and the health care provider community to ensure that pregnant and postpartum people are connected to appropriate care, and that cannabis addiction is addressed non-punitively, so families remain united. MCH professionals have a proactive role in amplifying public health messaging and ensuring appropriate investments in perinatal cannabis use prevention, within the context of a health and racial equity framework.

RESOURCES

Toolkit and Comprehensive Reports

- California
  Let's Talk Cannabis - Community Toolbox (in Spanish and English)
- Maine
  Marijuana Education Toolkit: Preventing Underage and High Risk Use
- Michigan
  Impact of Recreational Cannabis Legalization in Michigan: A Baseline Report

Educational Information

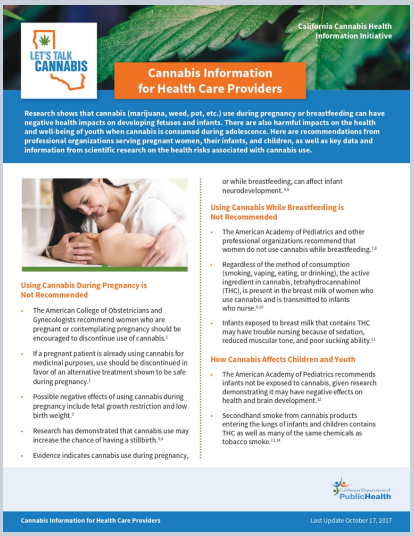
- California
  Pregnant and Breastfeeding Women and Cannabis (in Spanish)
- Colorado
  Marijuana and Your Baby: Overview of Marijuana-Related Concerns in Pregnant/Breastfeeding Women (in seven languages)
- Illinois
  Cannabis and New or Expecting Moms (in English and Spanish)
- Maine
  Is it Safe to Use Marijuana While You are Pregnant or Breastfeeding?
- Oklahoma
  Marijuana and Your Baby
- Oklahoma
  Marijuana: What You Need to Know
- Oregon
  Marijuana is Now Legal in Oregon
- American College of Obstetricians and Gynecologists
  Marijuana and Pregnancy

Educational Information for Providers

- California
  Cannabis Information for Health Care Providers (in Spanish)
- Colorado
  Marijuana: Health Care Provider Resources

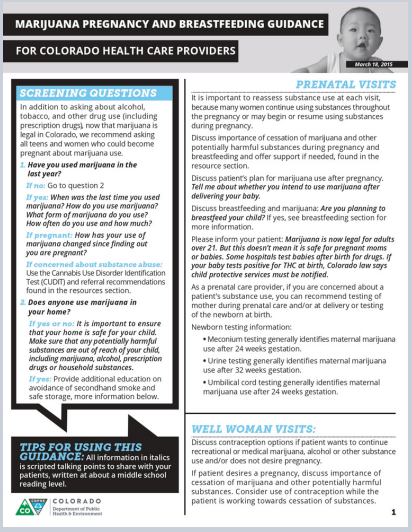
Educational Information for Providers (Continued)

- Colorado
  Marijuana Pregnancy and Breastfeeding for Health Care Providers
- Maine
  Cannabis and Pregnancy: (Resources for Health Care Providers)
- Nevada
  Marijuana Pregnancy and Breastfeeding Guidance for Health Care Providers
- Vermont
  Tips and Tools for the 9+ Month Conversation on Substance Use and Pregnancy



Public Health Campaigns

- Let's Talk Cannabis (developed by the California Department of Public Health; adopted by Illinois and Vermont)
- Colorado
  Responsibility Grows Here



Data and Evidence

- Colorado
  Marijuana Evidence Statements
- U.S. Centers for Disease Control and Prevention
  Cannabis Strategy
- Pregnancy Risk Assessment Monitoring System
  Marijuana and Prescription Drug Supplement
- Pregnancy Risk Assessment Monitoring System
  Phase 8 Standard Questions (marijuana questions: DRUG1 - not listed, DRUG2, DRUG3)

Policy Resources

- Public Health Institute
  Getting it Right from the Start: Advancing Public Health & Equity in Cannabis Policy
- Illinois
  Protecting Public Health and Promoting Equity in Adult-Use Marijuana Legalization in Illinois—Recommendations for Policy Makers

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Association of Maternal & Child Health Programs
1825 K Street NW | Suite 250 | Washington, DC 20006
amchp.org