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Cannabis Use During Pregnancy and Lactation

Committee on Clinical Consensus–Obstetrics. This Clinical Consensus was developed by the American College of Obstetricians & Gynecologists' Committee on Clinical Consensus–Obstetrics in collaboration with committee members Amy M. Valent, DO, Melissa L. Russo, MD, and Shari M. Lawson, MD.

SUMMARY

Cannabis refers to all products derived from the plants *Cannabis sativa, Cannabis indica, and Cannabis ruderalis* and is the most commonly used illicit drug under U.S. federal law. With increasing social acceptability, accessibility, and legalization in many states, the prevalence of cannabis use among pregnant and lactating individuals has increased significantly. Substance use in pregnancy, including cannabis use, has been associated with adverse outcomes such as spontaneous preterm birth, low birth weight, and developmental delay. Obstetrician–gynecologists and other obstetric health care professionals should be aware of the possibility of pregnant and lactating patients' use of cannabis and be prepared to counsel and screen all patients and use evidence-based strategies to reduce cannabis use.

BACKGROUND

Purpose

With increasing social acceptability, accessibility, and legalization in many states, cannabis use has increased in the United States, including in pregnant and postpartum individuals. The prevalence of cannabis use among pregnant and lactating individuals ranges from 3.9% to 16.0% (1–4). Among young adults aged 19–22 years, cannabis usage is reported to be as high as 43% (5). There has been an increase in prescriptions for the medical use of cannabis, state legalization of recreational cannabis, and near-universal exposure to cannabis in social and print media. These factors have contributed to increased availability of and familiarity with the drug and the perception that it is safe for use during pregnancy with minimal adverse effects (6–8). A higher prevalence of cannabis use is noted in the first trimester of pregnancy, when many patients report usage to curb pregnancy-related nausea and vomiting (9, 10).

Substance use (including cannabis, opioids, tobacco, and alcohol) in pregnancy has been associated with adverse outcomes such as spontaneous preterm birth, low birth weight, and developmental delay (9, 11–14). This document aims to provide obstetrician–gynecologists and other obstetric health care professionals with evidence-based guidelines for counseling, screening, and strategies to reduce cannabis use in prepregnancy and in pregnant and lactating individuals. This guidance focuses on cannabis use during pregnancy and lactation. For information on the use of cannabis by

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nonpregnant people, see Clinical Consensus No. 7, *The Use of Cannabis for the Management of Pain Associated With Gynecologic Conditions*. For more information on managing opioid, alcohol, and tobacco use in pregnancy, see Committee Opinions No. 711, *Opioid Use and Opioid Use Disorder in Pregnancy*; No. 473, *Substance Abuse Reporting and Pregnancy: the Role of the Obstetrician-Gynecologist*; No. 633, *Alcohol Abuse and Other Substance Use Disorder: Ethical Issues in Obstetric and Gynecologic Practice*; and No. 807, *Tobacco and Nicotine Cessation During Pregnancy*.

Definition

Throughout this document, we intentionally use *cannabis* rather than the colloquial terminology *marijuana*. Cannabis refers to all products derived from the plants *Cannabis sativa, Cannabis indica*, and *Cannabis ruderalis* (15). Two of the main cannabinoids in the plants are tetrahydrocannabinol (THC) and cannabidiol (CBD), with THC being the most potent. THC and CBD may interact with other medications through their inhibition of cytochrome P450 substrates (16). The term *marijuana* has racist and xenophobic undertones associated with its use throughout the 20th century (17, 18). For these reasons, we will refer to cannabis use mainly in this document. Cannabis can be smoked, vaped, taken orally, or mixed with food or beverages. As with tobacco products, cannabis markets have diversified, with a wide range of products at greater potencies, and may refer to cannabis by many different terms (Tables 1 and 2).

Epidemiology

Cannabis is the most commonly used illicit drug under U.S. federal law, with the highest proportion of people who use cannabis being of reproductive age (19). Since Colorado and Washington approved measures for adult use of recreational cannabis, rapid legalization of cannabis has been adopted across the United States for medical, financial, or social justice reasons. Legalization has led to greater retail availability of cannabis, more accessibility, and perceived acceptance of cannabis use in pregnancy and lactation (20).

Cannabis use during pregnancy has increased over the past 20 years with reported rates varying between 3.9% and 22.6% of pregnant individuals in high-income countries (4, 9, 21, 22). The highest frequency of cannabis use during pregnancy is reported in the first trimester and generally declines across gestation (1, 23, 24). Return to use or increased use within 6 to 12 months postpartum is common (25, 26). In a state with recreationally legal cannabis, self-reported cannabis use among pregnant people in the year before and during pregnancy has increased, with the relative rates of daily use rising most rapidly (27, 28). Moreover, THC content in cannabis products has increased in markets by 0.29–0.57% annually, with nearly a fourfold increase since 1995 (29, 30). This is

Table 1. Forms of Cannabis

Form	Description
Cannabinoid	Biologic compounds that act on the endocannabinoid system
Herbal	Dried *Cannabis sativa* leaves and flowers, or buds Most common form Least concentrated (2–5% THC)
Hash "hashish"	Solid or paste (green, yellow, black, brown) Compressing trichomes (resin) from buds Higher concentrations THC
Hash oil	Resin extracted in purest form (oil-like) 50% THC or greater
Synthetic	Synthetically developed to mimic effects of cannabis (interact with the cannabinoid receptor) Commonly liquid, sprayed or dried onto plant material May have increased potency
Slang terms, including but not limited to	Cannabis: 420, Aunt Mary, blunts, cabbage, chronic, cola, creeper, dank, ditch weed, dope, endo, fire, gangster, ganja, gash, grass, hash, herb, joint, marijuana, Mary Jane, pot, reefer, reggie, smoke, trees, tweeds, weed Synthetic: K2, spice, AK-47, Mr. Happy, Scooby Snax, Kush, or Kronic

THC, tetrahydrocannabinol.

Data from: National Institute on Drug Abuse. Synthetic cannabinoids. Accessed April 16, 2024. https://nida.nih.gov/research-topics/synthetic-cannabinoids; Gloss D. An overview of products and bias in research. Neurotherapeutics 2015;12:731–4. doi: 10.1007/s13311-015-0370-x; Drug Enforcement Administration. Drug slang code words. DEA Intelligence Report. Accessed July 21 2025. https://www.dea.gov/sites/default/files/2018-07/DIR-020-17%20Drug%20Slang%20Code%20Words.pdf; *and* American Addiction Centers. Nicknames for marijuana and slang for pot. Accessed July 21, 2025. https://americanaddictioncenters.org/marijuana-rehab/slang-names.

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Table 2. Methods of Cannabis Consumption				
System	**Method**	**Onset**	**Duration**	**Bioavailability**
Pulmonary	Smoking, vaporizing, dabbing	5–10 min	2–4 h	11–45% inhaled CBD 2–56% inhaled THC
Gastrointestinal	Edible, candy, drinks, capsules, baked goods, "cannabutter"	30–180 min	6–8 h	4–20% oral THC 6–33% oral CBD
Skin	Topical: balms, lotions, salves, bath soak, sprays, creams Transdermal: patches, gels	Variable	Variable	Unknown
Mucosal	Oral: drops, tinctures, sprays, lollipops, chewing gum, strips Vaginal: suppository, tampons, oil, wax Rectal: suppository, oil, wax	Variable	Variable	Unknown

THC, tetrahydrocannabinol; CBD, cannabidiol.

Data from: MacCallum CA, Russo EB. Practical considerations in medical cannabis administration and dosing. Eur J Intern Med 2018;49:12–9. doi: 10.1016/j.ejim.2018.01.004; Page RL 2nd, Allen LA, Kloner RA, Carriker CR, Martel C, Morris AA, et al. Medical marijuana, recreational cannabis, and cardiovascular health: a scientific statement from the American Heart Association. Circulation 2020;142:e131–52. doi: 10.1161/CIR.0000000000000883; Chayasirisobhon S. Mechanisms of action and pharmacokinetics of cannabis. Perm J 2020;25:1–3. doi: 10.7812/TPP/19.200; Valiveti S, Hammell DC, Earles DC, Stinchcomb AL. In vitro/in vivo correlation studies for transdermal delta 8-THC development. J Pharm Sci 2004;93:1154–64. doi: 10.1002/jps.20036; Stinchcomb AL, Valiveti S, Hammell DC, Ramsey DR. Human skin permeation of delta8-tetrahydrocannabinol, cannabidiol, and cannabinol. J Pharm Pharmacol 2004;56:291–7. doi: 10.1211/0022357022791; Grotenhermen F. Pharmacokinetics and pharmacodynamics of cannabinoids. Clin Pharmacokinet. 2003;42:327–60. doi: 10.2165/00003088-200342040-00003; *and* Huestis MA. Human cannabinoid pharmacokinetics. Chem Biodivers 2007;4:1770–804. doi: 10.1002/cbdv.200790152.

concerning because pregnant individuals increasingly have greater accessibility, social acceptability, and variable routes of use available to them. It is important to acknowledge that cannabis is not regulated by the U.S. Food and Drug Administration, lacking the oversight and quality assurance of labeled products available on the market (31). Studies investigating products available online have demonstrated that 23–60% of products contained underlabeled or overlabeled concentrations of cannabinoids and that one in five products labeled as CBD-only contained THC (32, 33). Furthermore, cannabis users often have concomitant use of other substances, including tobacco, alcohol, and other illicit drugs that independently have known associated perinatal complications (34–36).

Health Equity

With an increasing number of U.S. states legalizing cannabis use, there are still heterogeneous policies at state and institutional levels regarding cannabis use in pregnancy, drug testing of pregnant individuals and their neonates, and reporting guidelines for exposed neonates to child protection agencies. As a result, there are disproportionate rates of drug testing and mandatory reporting to child protective services in Black and minority birthing individuals and their neonates. Black people and their newborns are more likely to be drug tested in medical settings (37, 38). A recent study at one institution showed that Black and Hispanic pregnant individuals were 4–5 times more likely to have drug testing for an indication other than reported substance use compared with their White counterparts (39). A study of child protective services reporting for prenatal substance use showed that Black women were reported almost five times more than White women, and Black women are unevenly labeled as "drug users" despite similar levels of substance use across groups (40).

With punitive policies regarding substance use in pregnancy, there has not been an improvement in neonatal outcomes. For example, regarding the association of policies on opioid use disorders in pregnancy and neonatal abstinence syndrome, there was no difference in rates neonatal abstinence syndrome when comparing states with mandatory reporting requirements with those without mandatory reporting requirements (41). Additionally, these policies contribute to racial disparities in referrals to child protective services, with disproportionate outcomes in family separation without evidence of benefit and potential for short-term and long-term harm to both parents and children (42, 43).

METHODS

This Clinical Consensus document was developed using an a priori protocol in conjunction with the authors listed above. The a priori protocol was modeled after the

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Clinical Consensus methodology, a full description of which has been published separately (44). The description below is specific to this Clinical Consensus document.

Literature Search

American College of Obstetricians & Gynecologists' (ACOG) medical librarians searched Ovid MEDLINE and PubMed for human-only studies written in English and published between 2000 and September 2022. MeSH terms and keywords can be found in Appendix 1 (available online at http://links.lww.com/AOG/E276). Search terms for racial and ethnic disparities in maternal and fetal outcomes for cannabis use during pregnancy and lactation were incorporated into the literature review, and recommendations were drafted with the intent to promote health equity and reduce these disparities. A bridge literature search was completed in April 2023 and February 2025. Any updated literature was incorporated into the text and recommendations, as appropriate.

Study Selection

Qualifying studies passed both the title and abstract screening and full-text screening and met the following inclusion criteria: conducted in countries ranked very high on the United Nations Human Development Index (45), included female participants, and included all study designs. Studies that passed full-text screening by the authors were included in a summary evidence map (Appendix 2, available online at http://links.lww.com/AOG/E277).

Consensus Voting and Recommendation Development

At a meeting of the Committee on Clinical Consensus–Obstetrics, a quorum of two-thirds of eligible voting members was met and the committee held a formal vote for each proposed recommendation. All recommendation statements met or exceeded the 75% approval threshold required for consensus.

CONSENSUS RECOMMENDATIONS AND DISCUSSION

Screening, Treatment, and Diagnosis

Obstetrician–gynecologists and other obstetric health care professionals should be knowledgeable and educate all individuals presenting for prepregnancy, pregnancy, and postpartum care on specific perinatal and newborn risks of cannabis use in pregnancy and lactation. Obstetrician–gynecologists and other obstetric health care professionals should educate patients that there are no medical indications for cannabis use during pregnancy and the postpartum period.

With cannabis use increasing secondary to legalization, accessibility, and normalization in our society, it is important for obstetric health care professionals to incorporate into their practices universal counseling about the association of cannabis use during pregnancy or lactation with adverse perinatal health outcomes. Obstetrician–gynecologists and other obstetric health care professionals should be knowledgeable and educate all individuals presenting for prepregnancy, pregnancy, and postpartum care on specific perinatal and newborn risks of cannabis use in pregnancy and lactation.

SUMMARY OF CONSENSUS RECOMMENDATIONS

Obstetrician–gynecologists and other obstetric health care professionals **should** be knowledgeable and educate all individuals presenting for prepregnancy, pregnancy, and postpartum care on specific perinatal and newborn risks of cannabis use in pregnancy and lactation. Obstetrician–gynecologists and other obstetric health care professionals **should** educate patients that there are no medical indications for cannabis use during pregnancy and the postpartum period.

Obstetrician–gynecologists and other obstetric health care professionals **should** be aware of procedural, social, and legal consequences of positive screens in their institutions' local policies and jurisdictions, including involvement of child protective services and criminalization. With these considerations, obstetrician–gynecologists and other obstetric health care professionals **should** actively work to address inequities inherent in many existing systems.

Obstetrician–gynecologists and other obstetric health care professionals **should** perform universal screening by interview, self-report, or validated screening tools for cannabis use during the prepregnancy, pregnancy, and postpartum period. Biologic testing **should not** be used as a screening assessment for cannabis use.

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

Obstetrician–gynecologists and other obstetric health care professionals **may** use motivational interviewing, address social determinants of health, and assess barriers to cannabis cessation to guide cessation-intervention strategies.

Obstetrician–gynecologists and other obstetric health care professionals **may** utilize supportive home visits, psychobehavioral strategies, or brief electronic or text messaging interventions to reduce cannabis use in pregnancy and the postpartum period to promote parental and newborn health.

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Some individuals may be hesitant to disclose the use of cannabis secondary to concerns of judgment, stigma, guilt, or potential legal or child welfare implications (46). Furthermore, limiting the discussion of the risks of cannabis to individuals who disclose cannabis use is a missed opportunity. Omission of this counseling may lead to incorrect assumptions that the adverse health outcomes for the neonate related to cannabis use are not significant (47). Obstetric health care professionals should make a point to discuss health concerns regarding cannabis use in pregnancy and lactation, because this information may influence a person's perception of risk and affect their behavior during pregnancy. A person's perception of health risks associated with a specific behavior (eg, cannabis use) may be an important factor in the decision-making process regarding cessation or use during pregnancy.

Studies indicate that there are a variety of reasons pregnant and lactating people may choose to use cannabis, including treating pre-existing conditions or symptoms associated with pregnancy. Some pregnant individuals may view cannabis as an aid to discontinue more harmful substances or as a method to decrease the effects of unmet physical or mental health needs (48). Pregnant individuals have reported that cannabis use helps with symptom management of pre-existing conditions such as anxiety, depression, insomnia, and chronic pain, and pregnancy-related symptoms such as nausea and vomiting, weight gain, pain, and stress (49, 50). It is important for obstetric health care professionals to inquire, in a nonjudgmental manner, about reasons for cannabis use and to collaborate with patients to identify alternative methods to address any health concerns. Obstetrician–gynecologists and other obstetric health care professionals should educate patients that there are no medical indications for cannabis use during pregnancy and the postpartum period.

Obstetrician–gynecologists and other obstetric health care professionals should be aware of procedural, social, and legal consequences of positive screen results in their institutions' local policies and jurisdictions, including involvement of child protective services and criminalization. With these considerations, obstetrician–gynecologists and other obstetric health care professionals should actively work to address inequities inherent in many existing systems.

Despite legalization in many states across the country, there continues to be a lack of clarity for pregnant and lactating individuals regarding the legal and child protection implications of cannabis use (51). There are inconsistent state and institutional policies about drug testing in pregnant individuals and their newborns and about notifying child protection agencies. There are disparities in practices of drug testing and reporting to child protective services, with Black birthing people and their newborns being more likely to be drug tested in a medical setting and Black newborns being more likely to be reported to child welfare services (52, 53). All pregnant individuals should be counseled about the risks and benefits of drug testing, and informed consent should be obtained before drug testing of the person or their newborn.

Secondary to variability in institutional and state policies regarding drug testing, involvement of child protective services, and legal action for cannabis use during pregnancy, it is important for obstetric health care professionals to familiarize themselves with their own institutional and state policies regarding cannabis use in pregnancy, potential legal ramifications, and reporting duties to child protective services. It is important to be cognizant of the effects of structural racism and explicit or implicit biases on the approach, testing, and consequences regarding cannabis use in pregnancy and reporting to child welfare services. Obstetrician–gynecologists and other obstetric health care professionals should be aware of procedural, social, and legal

Table 3. Screening and Assessment Tools

	Substance Type		Patient Age		Administered by	
Tool	Alcohol	Drugs	Adults	Adolescents	Patient	Clinician
Brief Screener for Alcohol, Tobacco, and Other Drugs (BSTAD)	X	X		X	X	X
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Car, Relax Alone, Forget, Friends, Trouble (CRAFFT)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication and other Substance use (TAPS)	X	X	X		X	X

Adapted from National Institute on Drug Abuse. Screening and assessment tools chart. Accessed April 15, 2024. https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools.

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consequences of positive screen results in their institutions' local policies and jurisdictions, including involvement of child protective services and criminalization. With these considerations, Obstetric health care professionals should actively work to address inequities inherent in many existing systems.

Obstetrician–gynecologists and other obstetric health care professionals should perform universal screening by interview, self-report, or validated screening tools for cannabis use during the prepregnancy, pregnancy and postpartum periods. Biologic testing should not be used as a screening assessment for cannabis use.

The ethical principle of justice can be applied to universal substance use disorder screening because it supports equitable and nondiscriminatory health practices. Substance use disorders affect individuals of all ages from diverse racial and ethnic backgrounds, economic strata, and rural and urban communities. Universal screening of all patients during pregnancy provides a chance for intervention and referral to treatment before delivery (38, 54). Obstetrician–gynecologists and other obstetric health care professionals should perform universal screening by interview, self-report, or validated screening tools for substance use during the prepregnancy, pregnancy, and postpartum periods. Additionally, early screening for substance use offers an opportunity to repeat screening across gestation. Serial screening has demonstrated a several-fold decrease in pregnant individuals screening positive for substance use (54–56).

Universal screening for substance use should rely on validated screening tools for adults (eg, the TAPS [Tobacco Alcohol Prescription medication and other Substance use] tool) or adolescents (eg, S2BI [Screening to Brief Intervention], CRAFFT [Car, Relax, Alone, Forget, Friends, Trouble], 5Ps [Parents, Peers, Partner, Past and Pregnancy]) (57); see Table 3 for examples. Routine use of biological materials (eg, urine, hair) is controversial and strongly discouraged. Biologic testing should not be used as a screening assessment for cannabis use. Drug tests performed on biological materials are not used to detect alcohol or tobacco (both used more prevalently and associated with adverse fetal effects) nor to rule out sporadic use of illicit substances. The window of detection for cannabis use is long, because carboxy-THC (inactive metabolite captured on presumptive immune assays) is highly fat-soluble (urine: 1–30 days, hair: up to 90 days, oral fluid: up to 24 hours, sweat: 7–14 days) and clearance time in pregnancy has not been studied extensively (58).

For terminology of different types of tests to provide information about substance use, there are presumptive (testing with lower sensitivity or specificity or both, which establishes preliminary evidence of drug metabolites in a sample) and definitive (testing with higher sensitivity and specificity to identify drugs and their metabolites in a sample) drug tests (59). Additionally, a positive presumptive or definitive test result does not diagnose a substance use disorder nor detect the severity of use; all positive presumptive test results should be validated by definitive gas or liquid chromatography combined with mass spectrometry, as indicated (54).

Furthermore, toxicology testing with biological materials may have significant social and legal consequences and always should be conducted with the patient's informed consent (55). Guidelines related to reporting positive presumptive or definitive drug test results during pregnancy and postpartum are variably enforced in some jurisdictions and are biased against racial and ethnic minority groups. Black patients screen positive for substance use disorders at the same rate as White patients yet are 4–10 times more likely to have a positive drug screen result reported to child protective services (38, 60). Obstetrician–gynecologists and other obstetric health care professionals should perform universal screening by interview, self-report, or validated screening tools for cannabis use during the prepregnancy, pregnancy, and postpartum periods. Biologic testing should not be used as a screening assessment for cannabis use.

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

Many professional and societal guidelines recommend that pregnant and lactating individuals abstain from cannabis use or at least reduce exposure if abstinence is not possible (5, 61–66). Despite these recommendations, the prevalence of cannabis use remains relatively high, with the highest frequency of cannabis use in pregnancy in the first trimester (10, 24). Moreover, the general perception of cannabis use in pregnancy is that its use has no or low risk of harm and is safer than other illicit substances or medications (8).

Obstetric health care professionals should counsel their patients on the adverse effects of cannabis exposure on their offspring and should advise cessation of cannabis use during pregnancy and lactation. Cannabinoid receptors are present in the fetus as early as 5 weeks. The main psychoactive component of cannabis, THC, is lipid-soluble, can cross the placenta, and can transfer into breast milk (67). Although the concentration of THC through the placenta and breast milk is dependent on several variables (ie, dose consumed, frequency of use, route of administration), the fetal concentration of THC has been reported to be

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approximately 10% of the maternal concentration, and the risk of adverse outcomes increases in a dose-dependent fashion (63, 68).

Cannabis exposure during pregnancy has been associated with low birth weight, small-for-gestational-age neonates, neonatal intensive care unit admission, and perinatal mortality (14, 22). Neonates exposed to cannabinoids in utero also demonstrate altered arousal patterns, regulation, and excitability in the first month of life (69). Prior studies suggest potential risk for postnatal neurocognitive and behavioral dysfunction, including attention deficit disorders, behavioral and short-term memory challenges, and intellectual disabilities. Systematic reviews face challenges in summarizing varying doses, durations, delivery methods, gestational ages, and postnatal exposure of cannabis. This makes it difficult to rigorously quantify the risk of prenatal cannabis exposure on long-term neurocognitive dysfunction (70–78). Independent of tobacco and other drugs, cannabinoid use was associated with diminished cognitive functioning in verbal reasoning, language comprehension, and executive function. Adolescents and adults exposed to cannabinoids prenatally are at increased risk of developing substance use disorder or psychiatric disorders (4, 63).

Cannabis use has been shown to continue or increase during the postpartum period (79). Literature on cannabis use and lactation is limited by study quality and sample size, demanding more studies to focus on determining the short-term and long-term consequences of cannabis use for the infant, with variable approaches to cannabis use in the postpartum period. Considering limited data on the safety of cannabis use during lactation, cannabis use is discouraged. However, it is important to note that breastfeeding has numerous health effects, including decreased rates of infection, asthma, and obesity and improved intellectual development (80–82). Obstetrician–gynecologists and other obstetric health care professionals should advise cessation of cannabis use during pregnancy and lactation. However, continued cannabis use is not a contraindication to breastfeeding, and lactation should be encouraged regardless of cannabis use.

Studies have demonstrated varying education, understanding, and patient communication practices of obstetric health care professionals regarding the potential harms of cannabis use in pregnancy (83, 84). Furthermore, when cannabis use is encountered during patient interactions, the focus has been on the potential legal consequences of use instead of the health implications (85). There is a critical need for more robust human research on perinatal and postpartum cannabis use and adverse outcomes. However, the available animal and human literature demonstrates potential neurodevelopmental consequences with fetal and neonatal cannabis exposure during pregnancy or lactation.

Obstetrician–gynecologists and other obstetric health care professionals may use motivational interviewing, address social determinants of health, and assess barriers to cannabis cessation to guide cessation-intervention strategies.

Motivational interviewing is an effective communication style to assist individuals in committing to making challenging behavioral changes using nonjudgmental and patient-centered approaches. The obstetric health care professional's objective is to determine personal priorities, values, and knowledge to motivate behavioral change intrinsically. In doing so, obstetric health care professionals can individualize risks of cannabis use, identify benefits of cessation, and recognize current and anticipated barriers the patient may face in receiving or continuing treatment. Additionally, social determinants of health are nonmedical factors, such as the systems and conditions in which people are born, grow, work, live, and age, that influence health outcomes, including vulnerability to substance use disorders (86). Identifying protective and risk determinants that influence cannabis use can help strategize interventions designed to promote protective behaviors and reduce risk factors. Robust work among youth populations has demonstrated interventions involving peer networks, family, and community factors to be effective for risk-reducing and preventing cannabis use (87, 88). Family factors such as partner's perception or use of substances are associated with greater cannabis use (89). Conversely, peer disapproval of cannabis use can be a protective factor associated with lower use. Educating and advising cannabis cessation with the patient and their partner or family members may play a positive role in cessation efforts (90).

Often, individuals who use cannabis are more likely to use alcohol, tobacco, or other substances during pregnancy compared with pregnant individuals who do not use cannabis (91). Patients have reported using cannabis during pregnancy to self-treat nausea, stress, and appetite challenges (92–94). In an ancillary study of 9,250 nulliparous pregnancies, higher THC metabolite levels were associated with greater odds of moderate to severe nausea than no THC metabolite detection (adjusted odds ratio 1.6, 95% CI, 1.1–2.2 for a 500 ng/mg Cr THC-COOH increment) (95, 96). Cannabis hyperemesis syndrome is a recognized complication characterized by cyclic episodes of nausea, vomiting, and abdominal pain and is associated with high potency or regular use of cannabis. More than 95% of individuals can achieve complete resolution of symptoms with cannabis cessation. Supportive care measures such as dopamine antagonists, topical capsaicin cream, and intravenous fluid resuscitation have limited evidence but may provide acute symptom relief (95). More commonly, pregnant and postpartum patients report using cannabis to relieve anxiety and stress (97). Therefore,

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determining underlying symptoms that may be driving individuals to self-medicate and proactively treating those symptoms may help with a reduction in or cessation of cannabis use.

Patients may face various obstacles to receiving needed treatment that can include misinformation on the potential risks and harms of cannabis use in pregnancy and lactation, mental health disorders, and lack of social support (98, 99). Cannabis withdrawal syndrome (CWS) is a *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition)–recognized disorder, which is characterized by behavior, emotional, and physical symptoms (eg, irritability, anxiety, decreased appetite, abdominal pain, tremors, headache). It can occur within 24–72 hours after last cannabis use and can continue up to 2 weeks. Because CWS correlates with the quantity of cannabis consumed, obstetric health care professionals should have a higher suspicion for CWS with cannabis consumption greater than 1.5 g/d (inhaled) or using products more than 2–3 times per day (16). Recognizing that withdrawal can be a barrier to successfully achieving cessation may be key to relapse prevention. Obstetrician–gynecologists and other obstetric health care professionals may use motivational interviewing, address social determinants of health, and assess barriers to cannabis cessation to guide cessation-intervention strategies.

Obstetrician–gynecologists and other obstetric health care professionals may utilize supportive home visits, psychobehavioral strategies, or brief electronic or text messaging interventions to reduce cannabis use in pregnancy and the postpartum period to promote parental and newborn health.

Addressing cannabis use disorders within a population is multi-layered and should involve a comprehensive approach (ie, national and local policies, health care systems, community resources, peer and familial support, and individual therapies). Cannabis use disorder is a *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) diagnosis defined as cannabis used in a problem-causing pattern that leads to clinically significant impairment or distress, as manifested by at least two distinguishing symptoms (eg, cannabis is taken in larger amounts or for longer periods than intended; experience of craving; continued cannabis use despite the experience of physical, social, or interpersonal problems caused by cannabis use) occurring within a 12-month period (100). There are no U.S. Food and Drug Administration–approved medications for the treatment of cannabis use disorder. Overall, individual treatment approaches for reducing cannabis use are limited and rates of continued abstinence after treatment and cessation are low (101). However, as seen with tobacco use, adverse outcomes related to cannabis use appear to be dose-dependent. Therefore, strategies that can help with risk reduction, decreasing use, or cessation may provide benefit to lower adverse outcomes.

Obstetric health care professionals may utilize supportive home visits, psychobehavioral strategies, or brief electronic or text messaging interventions to reduce cannabis use in pregnancy and the postpartum period to promote parental and newborn health. Psychobehavioral interventions, including motivational enhancement therapy, cognitive behavioral therapy, or motivational interviewing in conjunction with coping skills training, have been shown to be beneficial in making behavioral changes and reducing cannabis use (102). Integrated substance-use programs and paraprofessional home-visiting interventions have been shown to improve child developmental outcomes, particularly in populations that experience higher health disparities (103, 104). Structured exercise programs, brief text messaging or computer-based motivational interviewing interventions, and strategies focused on quality-of-life improvements have shown potential promise in successfully reducing substance use.

FURTHER RESEARCH

The health effects of legalization, particularly among pregnant and lactating individuals, have been a challenge to quantify due to the heterogeneity of laws, varying cannabis potencies and products on the market, frequency of polysubstance use, and inconsistent adverse outcomes reported in the literature. Even with the medicinal use of cannabis, there is a paucity of data rigorously investigating the safety or efficacy of cannabis use in human pregnant or lactating individuals. Understanding the pathobiology of cannabis use on placental function, fetal growth and development, and the developmental programming of long-term health is critical to provide informed education for obstetric health care professionals and pregnant individuals on the health risks associated with cannabis use. Moreover, robust evidence-based treatment strategies are lacking. Identifying interventions that can lead to a reduction in or cessation of cannabis use in various settings and populations is necessary.

Use of Language

ACOG recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, the authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by the investigators. ACOG's policy on inclusive language can be reviewed at https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

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APPENDICES

1. Literature search strategy: http://links.lww.com/AOG/E276
2. Evidence map: http://links.lww.com/AOG/E277

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