What we know about cannabis in the reproductive years

Webinar

March 7, 2018

Funding and support provided from the Public Health Agency of Canada
Nancy Poole - Presenter

Director of the Centre of Excellence for Women’s Health

Prevention Lead for CanFASD Research Network – leading a virtual, national network of researchers, practitioners, policy analysts and birth mothers

Lead on several pan Canadian projects on trauma, gender and substance use with governments and addictions agencies

http://bccewh.bc.ca/
PANELISTS

Karen Mason
Manager, Family Treatment Centre - Prince Albert

Bev Drew, FASD Prevention Coordinator with the Saskatchewan Prevention Institute.
• What we know about cannabis in the reproductive years
• Implications for prevention messages - examples of resources
• Promising practices in brief support - examples from panelists
What we know about the health effects of cannabis

For Best Start/Health Nexus CEWH researchers reviewed the literature on the effects of cannabis in the perinatal period

- Natalie Hemsing, MA
- Lorraine Greaves, PhD
- Nancy Poole, PhD
- Rose Schmidt, MPH

Methods

- 2007-2017
- Medline; CINAHL
  - fertility
  - pregnancy
  - birth outcomes
  - breastfeeding
  - child development
  - parenting
- n= 60 articles

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<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Significant Association</th>
<th>No Significant Association</th>
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<tbody>
<tr>
<td>Maternal asthma</td>
<td>Chabarria et al 2016</td>
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<tr>
<td>Maternal anemia</td>
<td>Gunn et al 2016</td>
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<tr>
<td>Birth defects</td>
<td>Van Gelder et al 2009</td>
<td>Warshak et al 2015</td>
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<tr>
<td>Study</td>
<td>Findings</td>
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<tr>
<td>Chakraborty et al. 2015 New Zealand</td>
<td>Frequent maternal use associated with better global motion perception</td>
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<tr>
<td>El Marroun et al. 2010 Holland: Gen. R</td>
<td>No association with cognitive function/behaviour problems age 3</td>
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<tr>
<td>Day et al. 2011; Goldschmidt et al 2004, 2008; Sonon et al 2015; Wilford et al 2010 USA: MHPDC</td>
<td>First trimester heavy use associated with subtle deficits in verbal reasoning scores at age 6</td>
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<td></td>
<td>Offspring of heavier users more likely to report delinquent behavior at age 14</td>
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<td>Subtle negative effects on school performance</td>
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<td></td>
<td>Subtle deficits in visual–motor coordination</td>
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<tr>
<td>Smith et al. 2006; 2016 Canada: OPPS</td>
<td>No differences on visuospatial task performance; observed differences in neural functioning/ blood flow on fMRI</td>
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<tr>
<td>Teyhan et al. 2017 Australia</td>
<td>Maternal &amp; paternal use not associated with educational attainment</td>
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<tr>
<td>Zammit et al. 2009 UK</td>
<td>Maternal use not associated with psychotic symptoms at age 12</td>
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Breastfeeding

- In animal studies, inhibits lactation
- Systematic review (Ordean 2014)
  - One study reported infant development delays at year 1.
  - One study reported no effect on weaning, growth, mental or motor development
- confounded by prenatal use

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Parenting

- Prevention of accidental use by children
- Qualitative study: parental cannabis use, perceptions of benefits and harm, and harm reduction strategies (Donoghue 2015)
  - Parents reported no adverse impacts on parenting
  - Yet, children’s awareness of use and access occurred earlier than parents thought
  - Harm reduction strategies parents used: being discreet, using less potent strains, prioritizing family & work, not mixing with tobacco
Methodological Challenges

- Confounding factors
  - Tobacco, alcohol, other substances
  - Socio-demographics
- Small samples of women who use prenatally
- Clinical trials unethical
- Self-report
- Lack of data on quantity, potency, method of ingestion
- Interpreting animal studies
MIXED evidence for association with decreased birth weight

MODERATE evidence of association with reduced cognitive function in exposed offspring

SUBSTANTIAL evidence of an association with lower birth weight

INSUFFICIENT evidence of an association with later outcomes in the offspring (e.g., SIDS, cognition/academic achievement, and later substance use).

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IMPLICATIONS FOR MESSAGING
The CanFASD Prevention Network Action Team uses this framework as a foundation

LEVEL 1
Broad awareness building and health promotion efforts

LEVEL 2
Discussion of alcohol use and related risks with all those of childbearing years and their support networks

LEVEL 3
Specialized, holistic support of pregnant women with alcohol and other health/social problems

LEVEL 4
Postpartum support for new mothers and support for child assessment and development

SUPPORTIVE ALCOHOL POLICY

Centre of Excellence for Women’s Health

Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives
2016 review of public health agency websites found messaging on cannabis & pregnancy from 1 federal agency and 10 state agencies (Jarlenski et al 2017)
- adverse health effects
- few addressed scientific uncertainty
- < half provided resources

Limited messaging may reflect challenges with the evidence
**Marijuana Use While Pregnant**

Know how marijuana use can affect pregnant women and their babies.

What you eat or smoke while pregnant can reach your baby. You're probably aware that eating vegetables can help your baby's development. And in the same way, using marijuana can harm your baby. It may have a long-term impact on your child's ability to learn.

If you are pregnant and have been using marijuana, talk to your doctor to get the support you need to make the healthiest choice. Your doctor can help connect you with treatments that are confidential and nonjudgmental.

**Passes Through to Baby.**

- There is no known safe amount of marijuana use while pregnant. That's because, no matter how it's used (smoked, eaten, etc.), THC (Tetrahydrocannabinol, the chemical that makes you *high*) gets passed to your baby.

- Secondhand smoke from marijuana can also be harmful because it has many of the same cancer-causing chemicals as tobacco smoke.

**Brings You a Bundle of Joy.**

- Good to Know

To learn more, visit GoodToKnowColorado.com/Baby.

**Brings on a Bundle of Questions.**
Some Canadian examples

Risks of Cannabis on Fertility, Pregnancy, Breastfeeding and Parenting

Effects of Cannabis Use during Pregnancy

Cannabis Use During Pregnancy

The Canadian government plans to legalize cannabis by July 1, 2016. With the impending legalization of cannabis, it is important to note that the legal use of cannabis does not necessarily make it safe. There is no known safe amount of cannabis use during pregnancy.

Currently, there is limited Canadian data about the prevalence of cannabis use during pregnancy. Canadian use among women in Canada is on the rise, with approximately 11% of women using marijuana during pregnancy reporting cannabis use in the past year (Health Canada, 2013). Cannabis use is higher among younger women, 25-29 years age 20-29 years reported past year use. It is estimated that about 3% of pregnancies are planned during pregnancy, though it is not known what percentage use cannabis specifically.

Research on cannabis use during pregnancy demonstrates some potential negative outcomes associated with heavy use (one or more joints per day). Cannabis use during pregnancy may:

- Affect the ability to become pregnant as a result of changes in the menstrual cycle for women and lower sperm count and poorer sperm quality in men.
- Increase risk of preterm birth.
- Lead to lower birth weight of the baby.
- Be associated with longer-term developmental effects in children, adolescents, and adults including decreases in memory function, attention, learning, and problem-solving skills, and increases in hyperactive behavior.

It is important to note that most of the current research evidence presents few studies where cannabis use was administered by smoking. Little is known about exposure through other routes of use. Current evidence is also limited by small sample size, the presence of confounding factors, and small sample of women who use cannabis appropriately. While research is needed, both in quantity and quality to provide for specific advice on cannabis use during pregnancy.

For more information about cannabis use during pregnancy, please visit: [http://bccewh.bc.ca](http://bccewh.bc.ca)

For more information about the Canada FASD Research Network, including other policy documents, FASD and substance use during pregnancy, please visit: [www.canfasd.ca](http://www.canfasd.ca)

Women and Cannabis

Cannabis and Pregnancy

- Using cannabis while pregnant may affect the foetus. Until more is known about the short and long-term effects of cannabis on the foetus, babies and young children, it is recommended that women who are planning a pregnancy, are pregnant, or are breastfeeding, avoid use of cannabis.

- Women should talk to their healthcare providers about the benefits of using cannabis for medical purposes during the potential risk to you and your baby.

- Women and their health providers should be aware of the potential risks of cannabis use during pregnancy.

- Women and their partners should discuss the benefits and risks associated with cannabis use during pregnancy.

Cannabis and Your Health

- Medical marijuana is prescribed to treat health issues such as to reduce pain, nausea, vomiting, and other symptoms associated with HIV/AIDS and multiple sclerosis.

- Symptoms of withdrawal from cannabis, if they occur, are usually mild and may involve sleep disturbances, irritability, and loss of appetite.

- Regular cannabis use can be associated with smooth, gentle use of the drug.

- Quitting smoking, or using non-smokable forms of cannabis, helps to reduce withdrawal symptoms.

- Some research suggests that cannabis use can affect sleep and the timing of your menstrual cycle.

For more information, please visit: [http://bccewh.bc.ca](http://bccewh.bc.ca)

Additional Resources

- [Cannabis and Pregnancy](http://bccewh.bc.ca)
- [Women and Cannabis](http://bccewh.bc.ca)

Until more is known about the short and long-term effects of cannabis on fetuses, babies and young children, it is safest to avoid using cannabis while pregnant.
To inform messaging - further research needed

- amount, frequency, potency, method of ingestion, timing
- medical/therapeutic use; low to moderate use
- paternal cannabis use
- corroborate self-report with biomarkers
- cannabis use alone; pooling data

http://bccewish.bc.ca/
Summary regarding messaging

- Given evidence gaps and unknown risks, the safest approach is to support women & their partners not to use cannabis when trying to conceive, during pregnancy and breastfeeding & to take precautions while parenting
- Unbiased education & messaging
- Non-judgmental: identification of use & support
  - Beginning in preconception
  - Reduce stigma & increase opportunities for dialogue
  - Address co-use with tobacco, alcohol
- Holistic support
- Discuss risks & benefits regarding medicinal use
- Safe storage, parenting, driving

http://bccewh.bc.ca/
We summarized the evidence related to harmful effects of these 4 substances - for women in general, in pregnancy, when breastfeeding and when parenting. downloadable from http://bcczewh.bc.ca
IMPLICATIONS FOR SUPPORT

Women Centred
Respect women’s context, pressures and goals when delivering care

Harm Reducing
Support women to improve their overall health by reducing tobacco use, improving nutrition, escaping violence, facing stigma, etc

Trauma Informed
Recognize that experiences of trauma and violence are strongly associated with smoking

Equity Informed
Help women address barriers to health such as poverty, low literacy and inadequate support

4 Principles for Practice
Brief support on cannabis

- From our work on other substances we already know some strategies regarding brief support
- Centre of Excellence is doing a national project about brief support on alcohol, tobacco, cannabis and prescription opioids
- Financial support from the Public Health Agency of Canada
Goal

To inspire and facilitate health and social care providers to incorporate brief intervention on alcohol (and tobacco, cannabis and prescription opioids) in their daily practice with girls, women and their partners, in order to promote women’s and men’s health, and prevent FASD.
Professionals engaged in 13 Regional meetings

1. Midwives
2. Nurses
3. Physicians
4. Pregnancy outreach workers
5. Sexual health workers
6. Substance use service providers
7. Violence against women service providers
8. Indigenous service providers

1. Vancouver
2. Edmonton
3. Saskatoon
4. Winnipeg
5. Thunder Bay
6. Toronto
7. Halifax
8. Moncton
9. Charlottetown
10. St John’s
11. Whitehorse
12. Yellowknife
13. Iqaluit
We identified, and summarized available academic evidence, tools and best practices related to the effects of, and how to do brief intervention on, legal substances.

We created summaries of evidence for brief intervention by profession (soon to be released).

Annotated bibliography of articles on 4 levels of FASD prevention, published annually, downloadable from www.canfasd.ca

Alberta Health Services
Brief support

Two recent articles


Pregnancy outreach - Multi-service programs serving pregnant women at risk

- **Women-centred** – women set their own goals for service
- **Harm reduction** – focus on minimizing harm and promoting safety
- **Trauma informed** - appreciating that many women have experienced serious trauma
- **Culturally grounded** – employing cultural programming and approaches & appreciating the multi-generational impacts of colonization
- **Relational** – focus on safe, respectful, non-judgmental, least intrusive relationships, and trusting relationships with providers
- **Kindness; compassion**
- **Interdisciplinary; developmental lens** – addressing women’s and children’s needs holistically

Approaches being studied in multi-site evaluation led by Deborah Rutman, Carol Hubberstey, Marilyn Van Bibber, Nancy Poole and Rose Schmidt.

8 programs across Canada including the Mothering Project in Winnipeg and Raising Hope in Regina.

http://bccewh.bc.ca/
Lessons from programs serving pregnant women - 6 common elements of their approaches

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<tr>
<th>OUTREACH</th>
<th>PRACTICAL SUPPORT</th>
<th>HARM REDUCTION</th>
<th>INTEGRATED</th>
<th>MOTHER + CHILD = SUCCESS</th>
<th>TRAUMA + SAFETY</th>
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<td>Outreach services work with women where they are - on the streets, in their homes, in the hospital. Outreach provides flexibility for service providers in how they work with women. They can accompany women to appointments, share information informally, and help overcome barriers like lack of transportation and distrust of formal settings.</td>
<td>Without practical support, women cannot succeed in meeting other goals like reducing or stopping their substance use or learning parenting skills. Food vouchers, free prenatal vitamins, socks, bus tickets, and support in finding housing are just a few things that meet women’s immediate needs.</td>
<td>A harm reduction approach means that abstinence is just one possible goal for women and that care and support do not require women to address their substance use issues until they are ready. Harm reduction allows for flexible, respectful, and non-judgmental approaches to engaging with and caring for women and their children.</td>
<td>Studies have shown that women who use substances have difficulties accessing services that meet their needs. An integrated “one stop shop” model recognizes that no single service provider or agency can meet the often complex needs of women and that formal and non-traditional partnerships are required (e.g., between child-focused and adult-focused services).</td>
<td>All these programs view the needs of women and the needs of fetus/children as being linked. Programs that focus only on women’s health or only on child health miss a big part of the picture. Approaches that view women’s substance use outcomes, child development outcomes, and parenting outcomes as linked lead to success.</td>
<td>Substance use is often tied to women’s experiences of violence and trauma as well as histories of colonization and migration. Attention to issues of empowerment, trust and safety, cultural awareness, and social justice have shaped the development and success of these programs.</td>
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Victimized or Validated?
Responses to Substance-Using Pregnant Women
LORRAINE GREEVES AND NANCY POOLE

Les femmes qui utilisent des substances nocives dans leur gravidité sont soumises à une stigmatisation en provenance du secteur de la santé publique. On a l'impression que c'est la société et les droits du bien-être qui sont priorisés, et non la santé de la femme. Les auteures présentent une politique et un traitement qui valident la vie, la santé et le bien-être de l'enfant.

Substance use among pregnant women is a major public health problem in Canada. Some studies estimate that approximately 20-30 per cent of pregnant women in Canada during their last pregnancy. These are likely underestimates, as surveys may miss accessing women facing serious health, economic, housing, and other social problems. In addition, the significant societal stigma regarding pregnant women's use of alcohol, drugs, and tobacco may also prevent some women from identifying use of any of these substances, even in the context of a survey.

Pregnant women who use substances are under considerable scrutiny in Canadian society. Analysis of public discourse regarding pregnant women primarily in "scientific" often leads to seeing them as entirely responsible for their situation and any potential damage to their fetus. In recent years this perspective has been evident across sectors: in legal cases, policies, media headlines, and treatment approaches. This perspective reflects a set of attitudes and practices that often push substance-using pregnant women aside, and sometimes contribute to conflict with those of the fetus or child. It also affects the way programs have been developed for pregnant women.

Trauma-Informed Practice Principle: SAFETY

What does this principle look like "in action"?
What are we already doing to create a culture of physical, emotional, and cultural safety for clients and staff? What else can we be doing?

Discussion Questions to Get Started

1. What are your clients' first point of contact with your program, e.g., phone messages, outreach workers, receptionist? What strategies for creating a welcoming and safe environment already exist? What else can you do?

2. Physical, cultural, and emotional safety for both clients and staff should be considered together. For example, what are your program's policies about lights and locks? What might be comfortable and safe for one person might be restrictive or triggering for another?

3. Take a walk through the waiting area, the reception area, group spaces, and interview rooms at your organization. Do they increase feelings of safety for both clients and staff? What are your clients' perspectives on your organization's physical spaces?

Funding for the Trauma-Informed Practice Guide is provided in part by the Government of Canada through Social Sciences and Humanities Research Canada and the Centre of Excellence for Women's Health.

http://bccewh.bc.ca/
Holistic wellness oriented approaches addressing TRC Call to Action #33
Important to create a network of people who are offering respectful support – including child welfare

COLLEEN REID, LORRAINE GREAVES & NANCY POOLE
British Columbia Centre of Excellence for Women’s Health

Good, bad, thwarted or addicted? Discourses of substance-using mothers

Abstract
In this paper we examined discourses of mothers. Focus groups were conducted at two different times with diverse women who identified as mothers with substance use. Real scenarios were presented to the participants and they were sought about how the women within the scenarios would act and the actions taken by legal, media, and social agencies. Through the use of three lenses – rights, risks, and recovery – we identified four major discourses in the participants’ talk: ‘good mother’, ‘bad mother’, ‘thwarted mother’ and ‘addicted mother’. These discourses revealed the multiple and at times contradictory ways that these women made sense of their lives. Within all of the discourses, the importance of providing a stable and loving child bond and the importance of providing care and support for mothers with substance-use problems were central. These discourses highlighted the challenges of negotiating the attitudes, practices and stigmas of being a substance-using mother while trying to do the right thing for their children.

Key words: child welfare, discourse analysis, health policy, mothering/motherhood, substance use

Collaboration Between Addiction Treatment and Child Welfare Fields: Opportunities in a Canadian Context

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http://bccewh.bc.ca/
SUMMARY AND DISCUSSION OF SUPPORT WITH PANELISTS

Karen Mason
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Bev Drew, FASD Prevention Coordinator with the Saskatchewan Prevention Institute.
Website: Dialogue to Action project

Blog: Girls Women Alcohol and Pregnancy
https://fasdprevention.wordpress.com/

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References

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