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Prenatal Counseling and Marijuana; Professional Challenges to the Nurse-Patient Relationship

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PRENATAL COUNSELING AND MARIJUANA; PROFESSIONAL CHALLENGES TO THE NURSE-PATIENT RELATIONSHIP

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Abstract

Prenatal counseling is imperative to ensure a safe and healthy pregnancy. With the recent change in legal status regarding marijuana in the United States, challenges for counseling have arose. It is important that healthcare providers are screening women for marijuana use during their prenatal visits, in order to initiate the proper counseling needed for their patients. Considering that THC, the main component in marijuana, can enter the fetal brain, it is crucial for healthcare providers to educate pregnant women on the effects that it can cause to their child.

A systematic review of the literature was done using CINAHL database to identify the needs of pregnant women and the challenges to healthcare providers pertaining to marijuana use. The results of these studies showed that there are barriers related to counseling—how counseling is initiated, the quality of information provided by the healthcare team, and the perception of counseling. Counseling is not always initiated by the provider, whether they feel the patient is not using or because they do not want to deal with the legal and ethical issues of the situation if they are using. The information provided by the healthcare team lacks detail and quality, due to limited amount of research on the topic. Healthcare providers admit that they do not know what to tell their patients about marijuana use during pregnancy. Counseling did differ depending on whether the patient disclosed current or past marijuana use, which is why women fear telling their healthcare providers. More research must be done regarding how marijuana may affect the fetus and newborn. This information needs to be provided to obstetric healthcare workers, so that they can pass it on to their patients.

Key words: [marijuana, pregnancy, counseling]

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Marijuana drug use is very common in the United States. The general public has become increasingly accepting of recreational and medicinal marijuana use and therefore, it has become more prevalent. Current estimates of the prevalence of marijuana use during pregnancy range from 2% to 5% with estimates as high as 15% to 28% among young urban and socioeconomically disadvantaged women (Harris & Okorie, 2017). Pregnant women are encouraged to avoid any substances that may cause potential harm to their baby during their pregnancy.

Research on how marijuana can affect the fetus must be done in order to inform expectant mothers and the healthcare team responsible for their care. Knowing whether a pregnant woman is using marijuana is important because any substance that is able to cross the placenta can affect the fetus. By screening pregnant women for drug use, healthcare providers are able to provide proper counseling to their patients. There currently are barriers to the mother-healthcare provider relationship related to marijuana use, as the legality of this substance is unfolding.

Background

Marijuana is the most commonly used drug during pregnancy in the United States (Holland, et al., 2016). As the change in legal status has occurred in some states, many people seem to dismiss the fact that they are using a drug that can cause potential harm. Use by women of childbearing age and those who are already pregnant, cause specific concern.

Marijuana is illegal at the federal level and remains classified as a Schedule I substance under the Controlled Substance Act. This means that it is considered to have a

high potential for dependency and no accepted medical use (National Conference of State Legislatures, 2020).

Each state has their own laws regarding marijuana, and many states have legalized it for medicinal as well as recreational use (Substance Abuse and Mental Health Services Administration, 2019). There are also some states that have decriminalized marijuana. Decriminalization means that if found with marijuana, the person is charged with a non-criminal violation rather than a criminal penalty.

State legalization of marijuana first began in 1996, with California allowing medical marijuana use. Many states followed suit. In 2012, Colorado and Washington were the first states to legalize recreational marijuana. Now there are 46 states that have legalized medical marijuana use and ten states, plus Washington D.C., that have legalized recreational marijuana use. See Figure 1. The states where marijuana use has not been finalized on the state level are Idaho, Kansas, Nebraska, and South Dakota (Royal CBD, 2020).

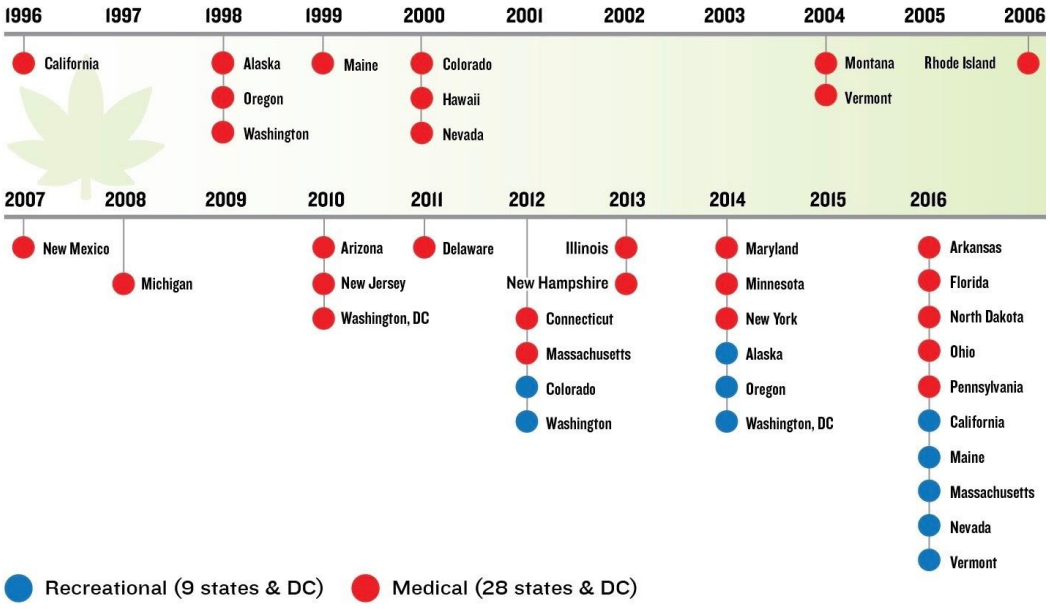

Figure 1; Timeline of marijuana legalization by state (Trumble, 2016).

With the broadening public acceptance regarding marijuana use, it is imperative to understand how to optimize counseling for women using marijuana during pregnancy (Holland, et al., 2016). Despite the fact that it is still federally illegal and a Schedule I substance, many people are using it legally within their state. The legality of marijuana is a factor in how women's healthcare professionals provide counseling, since it can cause confusion and conflict.

The FDA strongly advises against tetrahydrocannabinol (THC), and marijuana in any form during pregnancy or while breastfeeding (U.S. Food & Drug Administration, 2019). Marijuana is composed of over 100 different chemicals. Marijuana's active ingredient of THC is believed to cause the risks that healthcare professionals are concerned about.

THC is the primary psychoactive compound in marijuana that is responsible for the drug's effects of drowsiness, altered mood, hallucinations, memory, and motor control. There are also anti-inflammatory and antiemetic properties in the THC, which lead to its use as treatment for pain and nausea (Fantasia, 2017). Some pregnant women have been using marijuana to combat the morning sickness that they experience during pregnancy.

The U.S Surgeon General advises that the use of marijuana during pregnancy may affect fetal development. Compounds in marijuana cross the placenta during pregnancy and are present in the breast milk that the mother provides to the newborn for nourishment. THC can affect the fetal brain resulting in low birthweight, premature birth, or even potential stillbirth. THC can affect a newborn's brain development and result in

hyperactivity, poor cognitive function, and other long-term consequences (U.S. Food & Drug Administration, 2019).

The aim of this systematic review is to identify the current state of marijuana counseling from the perspective of both pregnant women and healthcare providers, in order to bridge the gap between healthcare providers information on the topic and women's needs on the topic.

Methods

A systematic review of the literature was performed to identify the needs of pregnant women and the challenges to healthcare providers pertaining to marijuana use. Exploration of what is already known about the use of the drug, what risk factors there are when taking the drug while pregnant, and how health care professionals can educate women about the risks of marijuana use during pregnancy was considered when identifying articles.

The database Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus with Full Text was used. A Boolean search was conducted using the key words, "recreational marijuana use pregnancy", "prenatal marijuana use counseling", "perinatal marijuana use counseling", and "marijuana screening pregnancy". The search was narrowed from 2015-2019. See Figure 2.

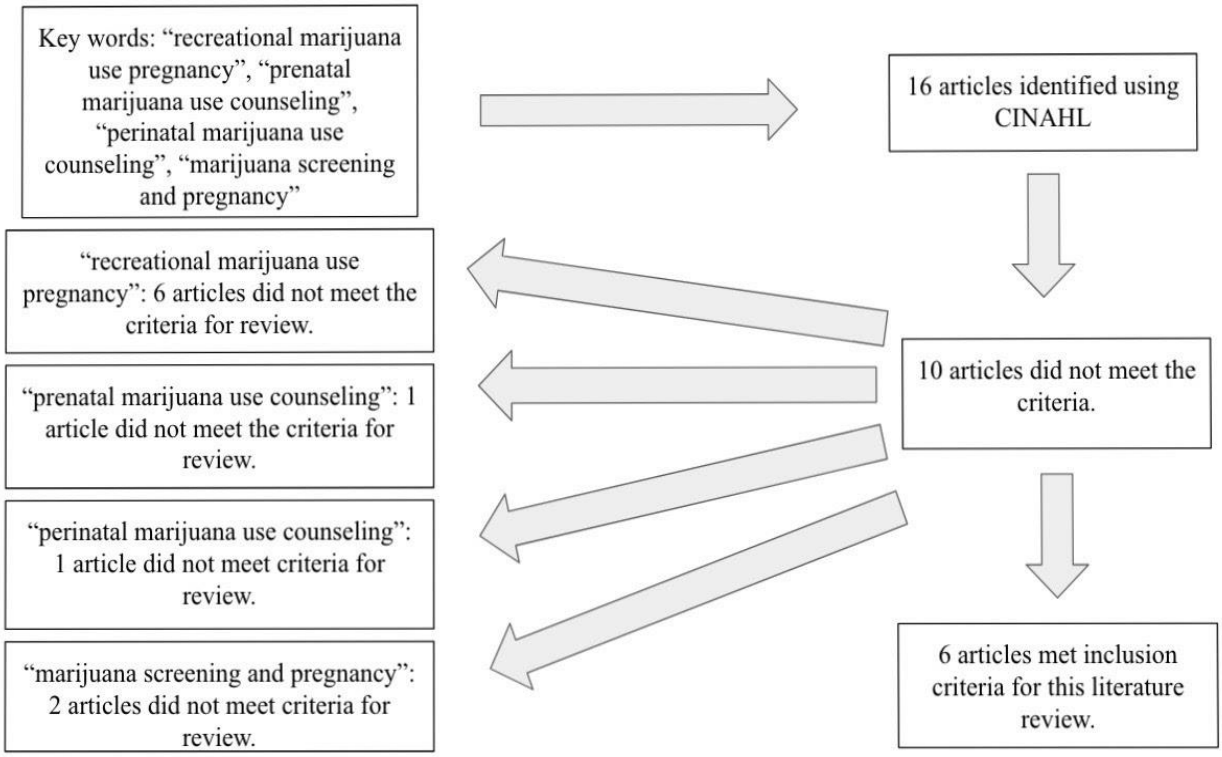

Figure 2; Keyword article search process.

Results

Six studies met the criteria of identifying the needs of the pregnant women and the challenges that healthcare providers face while dealing with marijuana use during pregnancy. Within the six articles, three major themes were identified; how counseling is initiated; the quality of information provided by the healthcare team; and the perception of counseling.

How Counseling is Initiated

Every healthcare provider should be implementing counseling for women on the use of drugs during their first prenatal visit. Counseling should be initiated during the first prenatal visit, so all women know how to go about handling their individual situation regarding marijuana use. Healthcare providers should be screening all mothers at their

first prenatal visit for illicit drug use, however this is not always the case. Counseling is the key aspect in determining care and safety of the mother and baby. It is important to identify women who use substances prenatally in order to link women to treatment resources and improve both pregnancy and neonatal birth outcomes (Klawans, et al., 2019).

Despite the fact that the American College of Obstetricians and Gynecologists advocate for universal screening, there appears to be no universal standard for prenatal substance use screening. This is due to the cost, legal ramifications in many states with regard to child abuse and child custody, and the potential that women who test positive may no longer feel comfortable seeking prenatal care (Klawans, et al., 2019). The typical screening methods to determine prenatal illicit drug use include self-reporting and urine drug screenings. However, self-reporting has shown to be less effective once a patient is pregnant due to the fact that women fear the judgement they might receive if they do disclose their drug use.

If healthcare providers do not initiate counseling, then patients are not gaining anything from them or the visit. They are not receiving the quality care that they need and deserve. However, if providers do initiate counseling based on bias or their perception of the person, this may also lead to ineffective care. A provider should not suspect that someone is using illicit drugs based on their socioeconomic status, age, race, or ethnicity. This may cause a patient to feel uncomfortable with the provider, feeling that they do not trust them—and possibly stopping them from seeking prenatal care. A provider must remain open-minded when talking with patients because patients may be influenced by the providers' overall interaction style or communication elements used when discussing

other topics (Chang, et al., 2017). Some providers even find discomfort with counseling due to the fact that they fear what the women may say about drug use. Providers also fear that they might alienate the woman, or that they lack the ability to treat the women or offer referral sources (Harris & Okorie, 2017).

Quality of Information Provided by Healthcare Team

Information about marijuana use during pregnancy is needed to help these mothers make an educated decision about what they should do regarding the use of marijuana. Although providers agree that it is their job to provide teaching to their patients, they also express that there is not enough research on the topic of marijuana during pregnancy. Since they feel as though they do not have enough information, they often do not give any information about it to their patients or focus on more harmful drugs to avoid (Jarlenski, Tarr, Holland, Farrell, & Chang, 2016).

There is a lack of both detail and quality in the information patients have found or received regarding marijuana use during pregnancy. This can be the result of a lack of research on the topic.

Although women should be able to receive information from their obstetric provider, many women reported conducting Internet searches to gather their information about whether they should use marijuana during their pregnancy.

Although the Internet can be a viable source for information, there is not always accurate information on the Internet. This can cause confusion for women who are seeking help about whether marijuana is harmful during pregnancy or not. Women also expressed that they compared information that they found on the Internet to personal experience or experience from their family or friends. Some sources from the Internet

said prenatal marijuana use was harmful, but they knew someone who did use marijuana during their pregnancy and their baby had no adverse effects (Jarlenski, Tarr, Holland, Farrell, & Chang, 2016). Women wanted information regarding prenatal marijuana use from their health care providers and other members of the healthcare team, but they did not receive much information at all. It was clear that there was a lack of evidence being provided to the patients regarding prenatal marijuana use.

Rather than specifically providing risks associated with marijuana, providers compared marijuana use to other substances during pregnancy. Broad and general risks were used, rather than engaging in a discussion and referring these women to treatment (Jarlenski, Tarr, Holland, Farrell, & Chang, 2016). This may be due to the fact that providers frankly do not know much about the effects of marijuana or that other illicit drugs like cocaine or opiates take priority over marijuana. One provider even said, “I don’t think we really know what marijuana does in pregnancy. So, I think that’s a harder one to counsel people about”. Another provider expressed that they avoid the topic simply because the data is not good enough in order for them to even provide them counseling about it (Holland, et al., 2016).

Women’s healthcare providers must educate themselves either by seeking continuing education and/or consultation with experts in the substance abuse field (Harris & Okorie, 2017). Pregnant women need quality information regarding marijuana use during pregnancy because they want to do whatever is best for the health of their baby. Many reported that by far, the most important factor to women was their infant’s health (Jarlenski, Tarr, Holland, Farrell, & Chang, 2016).

Perception of Counseling

Counseling did differ slightly depending on whether the patient disclosed current, past, or undetermined timing of last use of marijuana (Holland, et al., 2016). This shows that providers are showing bias when they provide counseling to their patients, even if they think that they are not.

The need for counseling must be counterbalanced by what the healthcare provider can deliver. Healthcare counseling should be driven by the needs of pregnant women who use marijuana.

Many women feared the perception of their drug use by their healthcare providers which may contribute to the fact that they did not want to disclose their marijuana use to them. They also feared the type of counseling that they would receive if they did disclose this information. Healthcare providers must be nonjudgmental and open to their patients, in order for their patients to feel comfortable disclosing information about themselves to them. Establishing trust in the provider-patient relationship is key to giving the best care possible.

Many providers focus on the legal and ethical issues when women disclose drug use to them, rather than counseling them on how to get help. Some states have severe social and legal consequences including potential loss of child custody (Klawans, et al., 2019). This is why some providers did not even initiate counseling or ask their patients if they use marijuana—because they do not want to be in the legal and ethical dilemmas. Some providers even used “scare tactics”, about involving child protective services, as a motivator to get their patients to stop using prenatal marijuana (Holland, et al., 2016). Many women however, were aware of these issues as well. Pregnant women who are

using illicit drugs worry about stigma and judgement that inhibits their willingness to disclose or seek treatment. They described feeling embarrassed and guilty about their illicit drug use, and fearing imprisonment, prosecution, or losing custody of their child/children (Chang, et al., 2017).

The focus on legal issues was also the case for many social workers. One common experience was that social workers focused on child welfare agencies' potential involvement after delivery, rather than providing resources to help women stop using marijuana during pregnancy (Jarlenski, Tarr, Holland, Farrell, & Chang, 2016). Women look to social workers for advice and help regarding certain situations--and these women felt as though the social workers failed them.

Discussion

The research shows that there are challenges on both sides of the situation with pregnant women and healthcare providers. Women fear disclosing marijuana use to their obstetric providers due to the repercussions and judgement from them. Healthcare providers have a lack of scientific evidence on the subject of marijuana use during pregnancy, which interferes with quality care given to their patients. These patients need information on the matter of marijuana use during their pregnancy while healthcare providers are conflicted because of their obligation to give information according to their state laws.

Patients do not always feel that their providers are doing a good job with counseling and education about marijuana use during pregnancy. Providers have admitted that this is true due to the lack of research and knowledge on the subject, as well as the legal issues.

There is a discrepancy in what should be happening versus what is actually happening in the healthcare industry regarding prenatal marijuana use. Providers should be screening every patient on their first prenatal visit for drug use and advise them against the use of any substances. This, however, is not happening. In order to prevent potential harm to the fetus, healthcare professionals must rethink how they are providing marijuana counseling to pregnant women. Healthcare providers must remain professional and non-judgmental in order for women to disclose their use, so that they can provide appropriate counseling.

The quality of information regarding marijuana use during pregnancy lacks scientific evidence due to the fact that there is not enough research. This explains why some providers avoid counseling with their patients because they do not know what to tell them. Even though there is a lack of information about the effects of marijuana use on the fetus during pregnancy, providers must still address it. If a provider does not address it, then women may interpret the missing information the wrong way. These pregnant women may perceive that the lack of counseling about discontinuation or the lack of education on marijuana use on the infant indicates that use during pregnancy would not negatively affect the fetus (Harris & Okorie, 2017).

Limitations

Determining counseling about marijuana during pregnancy has many limitations. There was only one database used to gather articles—CINAHL Plus with Full Text. There is little evidence to support any claims that marijuana may or may not affect the fetus and newborn because it is unethical to conduct these studies on pregnant women. There is also little research done on the topic since it has recently increased in popularity,

due to the legalization. The six articles used focused on one main study. These results only showed outcomes in one part of the United States, which may not reflect how counseling is handled in other parts of the country.

Conclusion

More research must be done regarding how marijuana may affect the fetus and newborn. This information needs to be provided to obstetric healthcare workers, so that they can pass it on to their patients. Women's healthcare organizations, including the U.S. Women's Health Alliance and The American Congress of Obstetrics and Gynecologists (ACOG), must step up to obtain the information needed. Interdisciplinary research is warranted to reach this goal.

Healthcare providers need to find better ways to help women with the subject of using marijuana while pregnant, with the information that they currently have. It is important that healthcare providers and other members of the healthcare team become educated on the effects of marijuana in order to provide the best care for their patients. As marijuana for medicinal and recreational purposes continues to grow along with its acceptability by the general public, women's health nurses will increasingly encounter women who have past or current history of use (Harris & Okorie, 2017).

Members of the healthcare team, as well as social workers, should know the legal aspects of marijuana in their state. Healthcare workers must evaluate their own opinions on prenatal marijuana use and remain non-judgmental when discussing it with their patients. Nurses and healthcare providers should engage in discussion that, "should include education about marijuana use, counseling techniques for cessation of use, and useful community resources for advocacy and support" (Harris & Okorie, 2017). The

most important aspect of this is to help women have healthy newborns and give their child the best care possible.

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