Welcome & Introductions

CANNABIS USE IN THE PERINATAL PERIOD

Chris Dorval MSW, LICSW LCDP, LCDCS, is a nationally recognized speaker, trainer and clinical consultant in the areas of addiction, trauma, and men's health, as well as, the Clinical Director of Ocean State Recovery Center in Johnston, Rhode Island. A Licensed Independent Clinical Social Worker (LICSW), Licensed Drug and Alcohol Counselor (LADC), and a Licensed Chemical Dependency Clinical Supervisor (LCDCS), Chris graduated from Rhode Island College with a Bachelor's degree in Psychology and a Master's degree in Clinical Social Work (MSW). Chris is an adjunct faculty at Rhode Island College in the School of Social Work, and has been a frequent guest lecturer on addiction, trauma and men's health at Rhode Island College in the Political Science department, Nursing, and Psychology department, as well as, Brown University in both Warren Alpert Medical School and School of Public Health. Chris is on faculty for the Addiction Technology Transfer Center (ATTC) in connection with the Substance Abuse and Mental Health Services Administration (SAMHSA).

Anupriya Gogne, MD, is an Attending Psychiatrist at Women & Infants Hospital Center for Women's Behavioral Health. A graduate of Vardham Mahavir Medical College in New Delhi, India, where she also completed an internship, Dr. Gogne completed a residency at State University of New York Downstate Medical Center and a fellowship in addiction psychiatry at the New York University School of Medicine and in reproductive psychiatry at Women & Infants Hospital/Brown University. Dr. Gogne is an adult psychiatrist with training in addiction psychiatry and women's mental health. She has a special interest in working with women presenting with both addiction and psychiatric issues, and also has experience with treatment of trauma and dialectical behavior therapy.

RI MomsPRN
Maternal Psychiatry Resource Network

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE

Women & Infants

Available Perinatal Behavioral Heath Teleconsultation Services for Providers

RI MomsPRN **401-430-2800**

Secure Email:
RIMomsPRN@CareNE.org

A FREE PSYCHIATRIC TELECONSULTATION SERVICE FOR HEALTHCARE WORKERS

Clinical Consultation (Psychiatrist and Psychologist)

- Same-day, provider-to-provider psychiatric teleconsultation services
- Diagnostic support
- Treatment planning
- Medication and dosage recommendations

Resource and Referral (Social worker)

- Call intake and triage
- Make connections to treatment and support services
- Schedule provider teleconsultation with perinatal behavioral health experts

Margaret Howard, PhD

Zobeida "Zee' Diaz, MD

Anupriya Gogne, MD

Eva Ray, LCSW

- Healthcare providers can call the RI MomsPRN line at **401-430-2800**, Monday-Friday, 8 a.m. – 4 p.m., to speak with clinician about patient needs and/or concerns. The line does not provide direct treatment or prescribe medications and is not a crisis line.

Learn More: www.womenandinfants.org/ri-momsprn

Women & Infants

Working with Pre-contemplative or Contemplative Cannabis Use in Expecting Parents

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What is addiction anyway?

Short Definition of Addiction: *(American Society of Addiction Medicine, 2011)*

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response.

Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

What about cannabis?

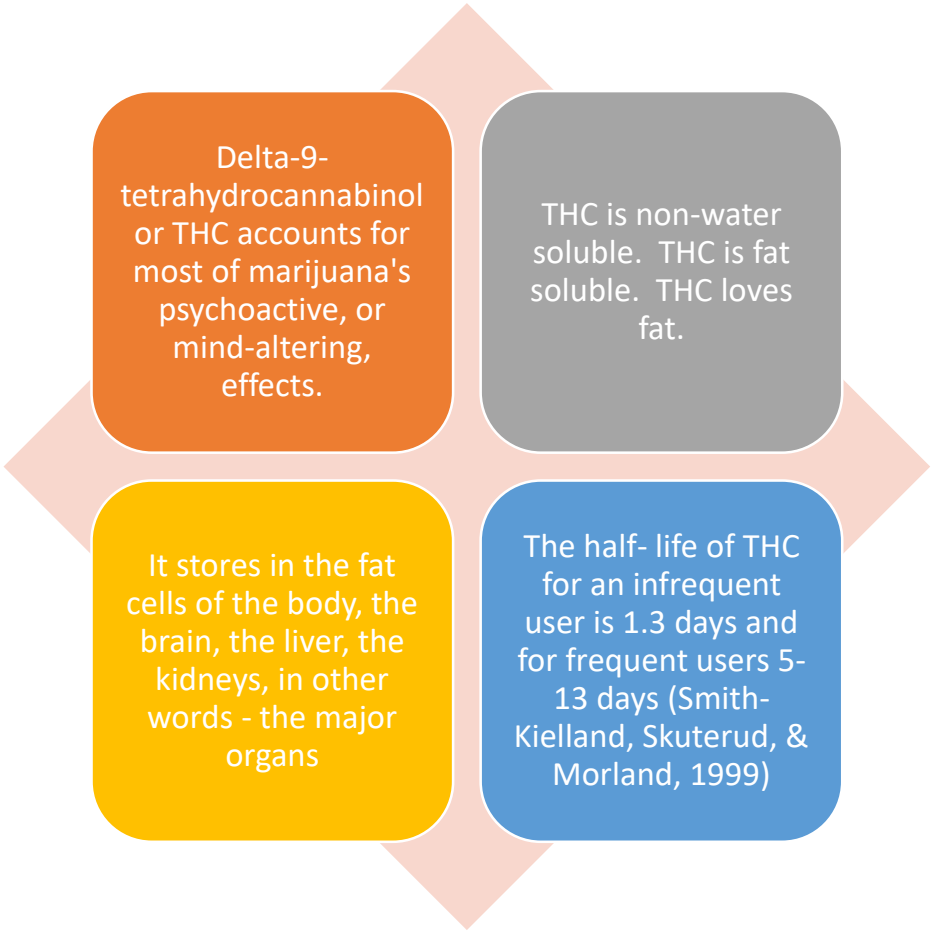
Cannabis Use

- Cannabis can be addictive
- According to The National Institute on Drug Abuse (NIDA) 9% of marijuana users will become addicted to it…roughly 1 in 11
- That number increases to 17% for those who start using before age 16… roughly 1 in 6
- Among daily marijuana 25-50 % become addicted.

Characteristics of Addiction- Cannabis

- Compulsive marijuana-seeking behavior
- A pattern of self-destructive behavior due to weed use
- Failure to fulfill major life obligations at work, home or school because of pot use
- Marijuana use continues in spite of recurring negative consequences, including legal consequences
- Weed use continues in spite of recurring social or interpersonal problems caused by or made worse by drug use
- Marijuana is used in dangerous situations

Cannabinoid System

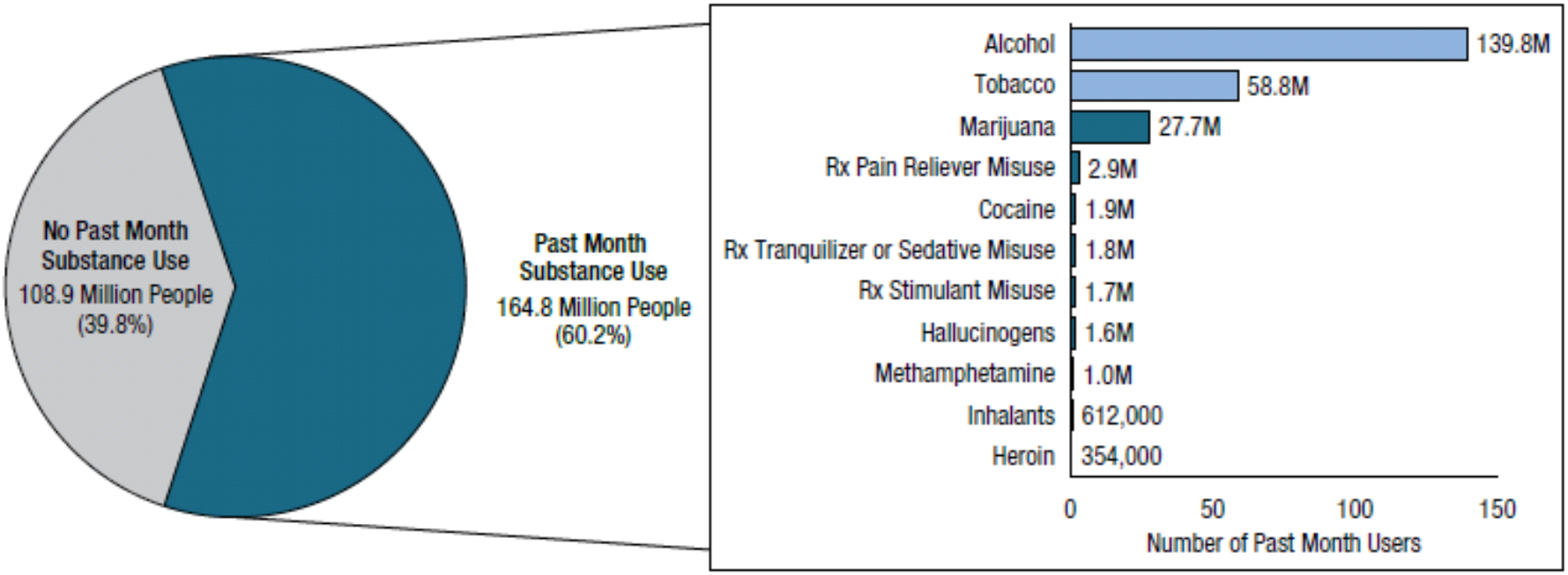


Health Consequences of Substance Use

- Cancer
  - Breast
  - Throat
  - Mouth
  - Esophagus
  - Liver
- Accidents/Injury
- Pancreatitis
- HIV/AIDS
- Osteoporosis
- Renal disease
- Fetal Alcohol Spectrum Disorders
- Cardiovascular disease
  - Stroke
  - Cardiomyopathy
  - Arryrithmias
- Hypertension
- Diabetes Mellitus
- Hepatitis C
- Overdose
- Depression
- Liver disease
  - Fibrosis
  - Cirrhosis
- Alcoholic hepatitis

Source: UpToDate 2015 Mukamal KJ. *Overview of the risks and benefits of alcohol consumption .*
Up To Date 2015. Weaver MF, Jarvis MAE. *Substance use disorder: Principles for recognition and assessment in general medical care.*
http://pubs.niaaa.nih.gov/publications/Hangovers/beyondHangovers.pdf

Figure 1. Past Month Substance Use among People Aged 12 or Older: 2018

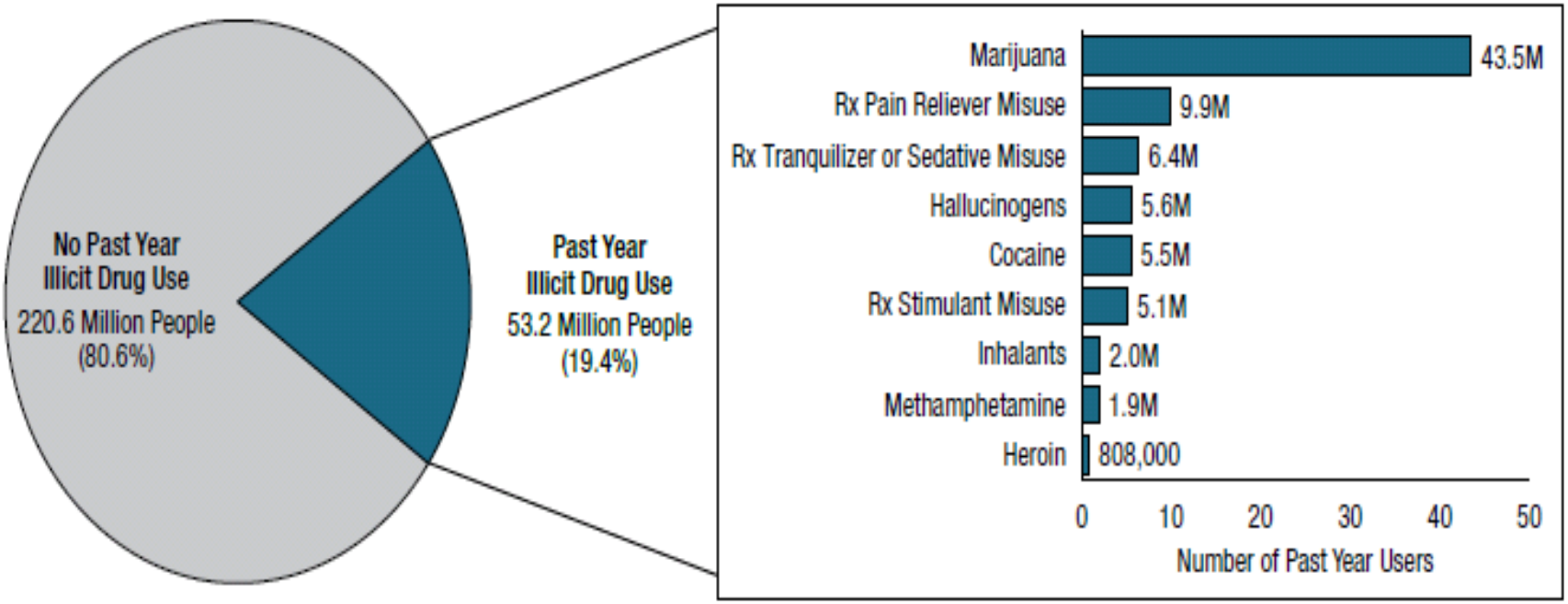


Rx = prescription.

Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used more than one type of substance in the past month.

Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health

Figure 10. Past Year Illicit Drug Use among People Aged 12 or Older: 2018



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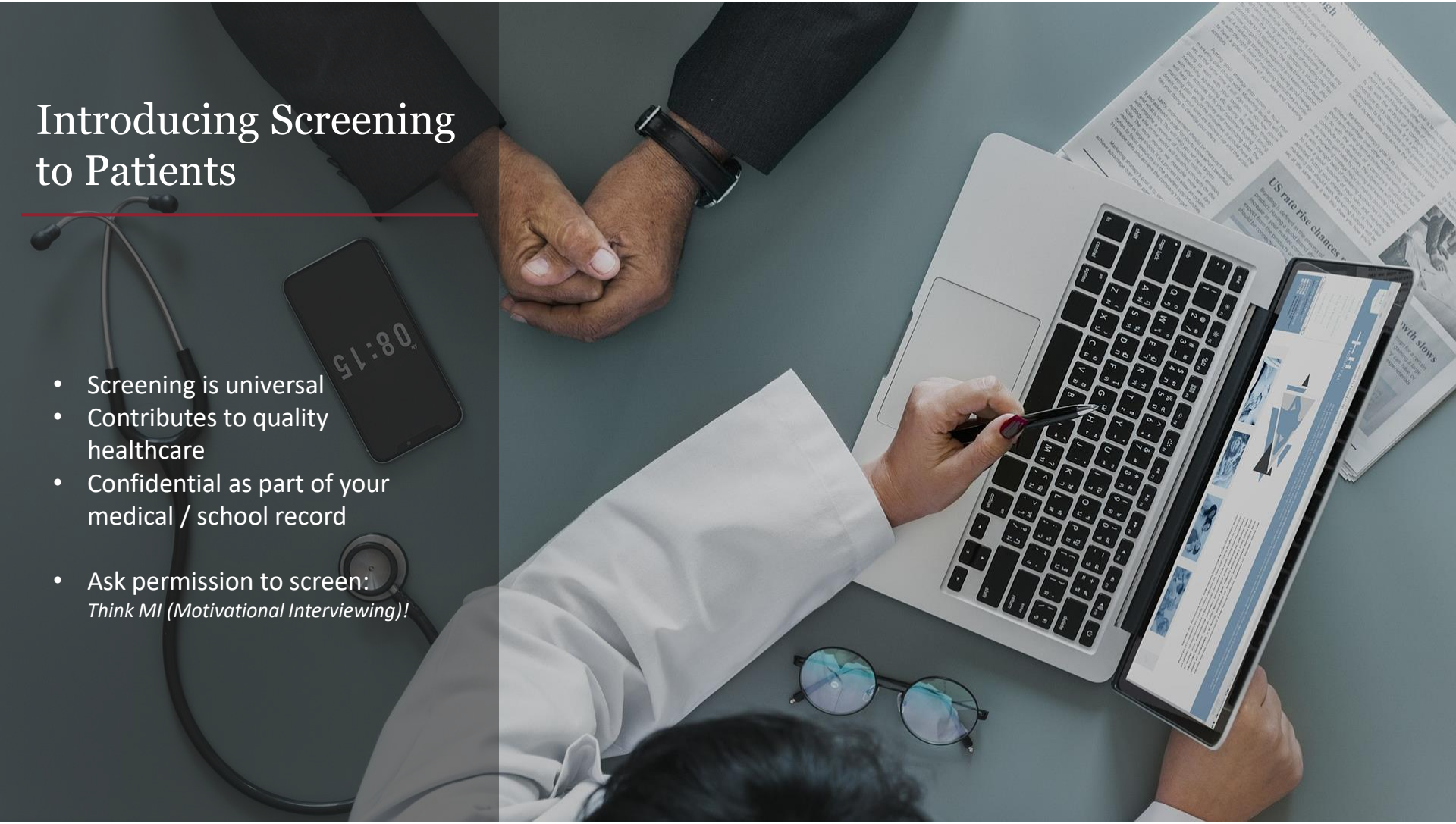
Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health

Introducing Screening to Patients



- Screening is universal
- Contributes to quality healthcare
- Confidential as part of your medical / school record

- Ask permission to screen:
  Think MI (Motivational Interviewing)!

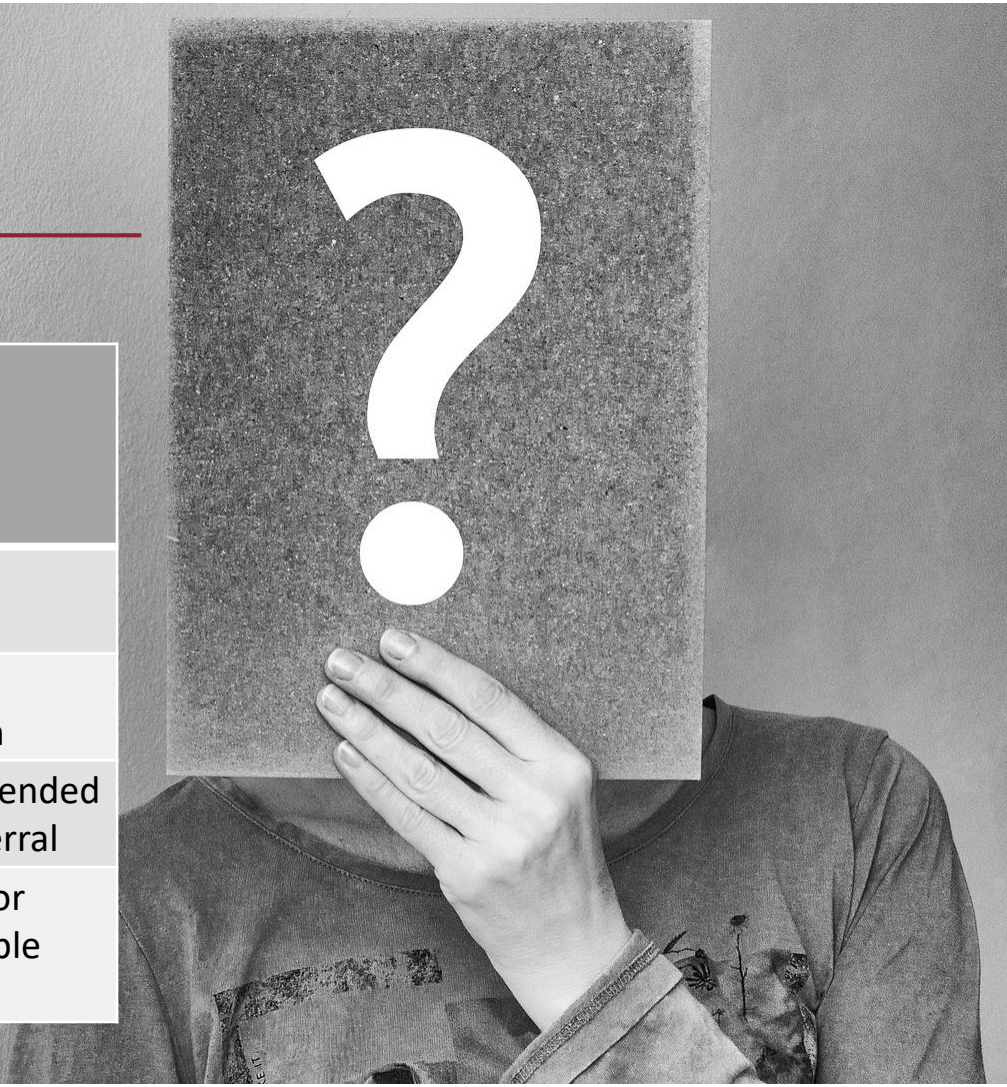
DAST-10

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you unable to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?

DAST-10 Translating Scores into Practice

Add 1 point for each "yes"

Positive DAST score	Degree of Problems Related to Drug Abuse	Recommendation
2	Low	Brief Intervention
3-5	Moderate	Brief Intervention & Extended Intervention
6-8	Substantial	Brief Intervention, Extended Intervention, and Referral
9-10	Severe	Referral to specialist for assessment and possible treatment

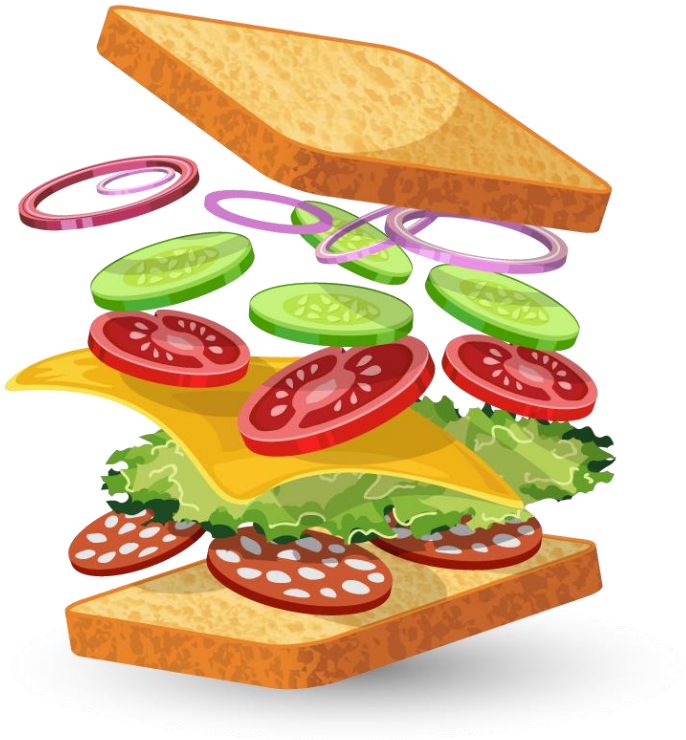


Motivational Interviewing (MI): A Review

- Patient-centered
- Goal-directed (behavior change)
- Helps to resolve ambivalence

A-C-E

- Affirms patient's autonomy
- Collaboration between patient and provider
- Evokes patient's own motivation and reasons for change



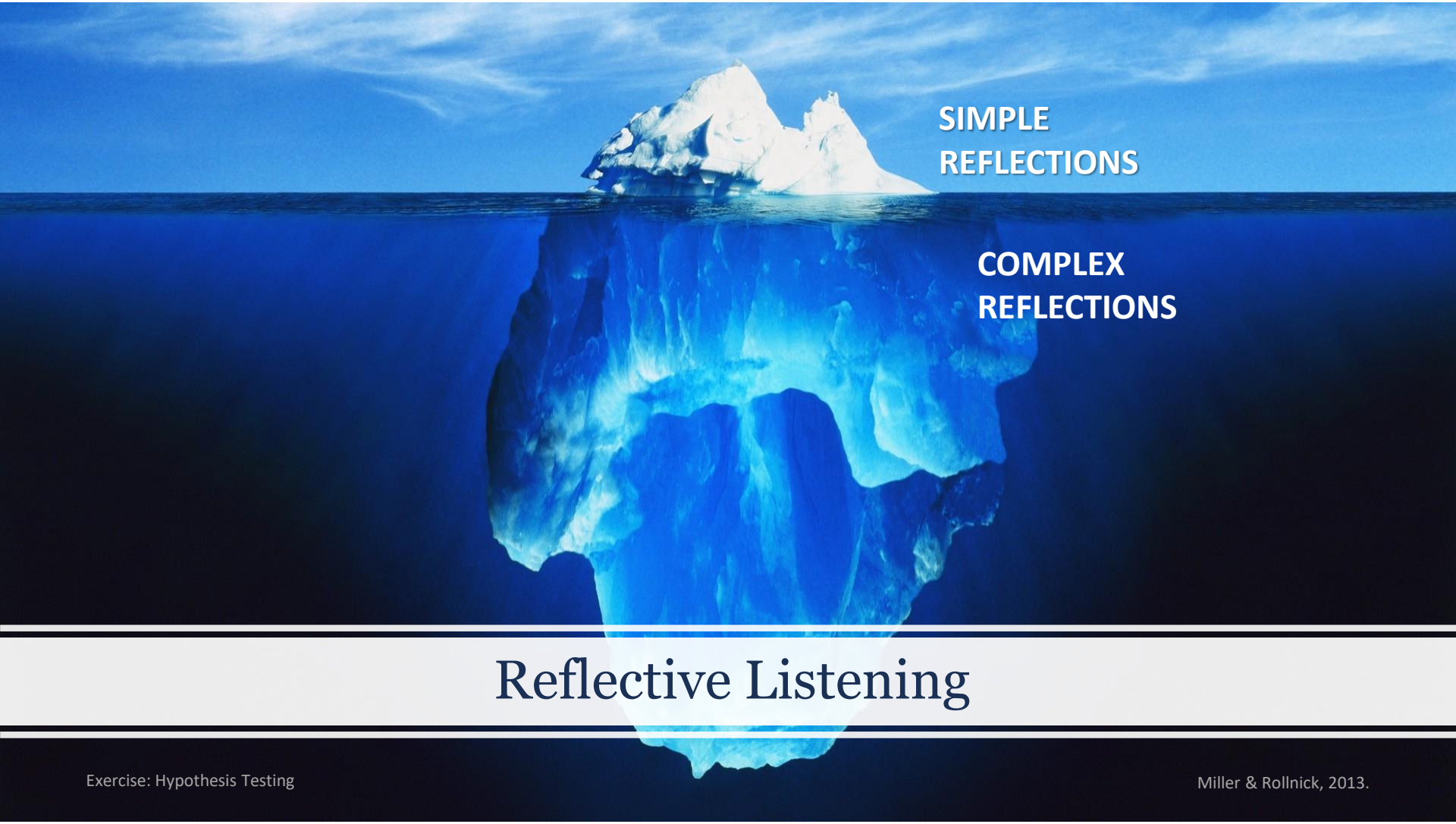
Giving Feedback & Advice:
The MI Sandwich

- Ask Permission
  - *"Is it OK if I share with you what is considered high risk drinking according to research studies?"*
- Give Information or Feedback
- Ask for Response
  - *"What do you make of that?"*

Key MI Communication Skills:

O.A.R.S.

- Open Questions
- Affirmations
- Reflections
- Summaries



Reflective Listening

Exercise: Hypothesis Testing

Miller & Rollnick, 2013.

Change Talk

- Statements about change
- Linked to a specific behavior
- Typically comes from patient
- Phrased in the present tense

Desire	• I want to…
Ability	• I could or might be able to…
Reasons	• Things would be better if I …
Need	• I really should…
Commitment	• I am ready to…
Steps	• This week I started…

Source: Rosengren, 2009.

Brief Negotiated Interview

An evidence-based algorithm that provides a structured format for using motivational interviewing skills in the context of clinical care

Things to Note about the BNI

- Follows a scripted approach
- BNI is the skeleton, but you bring it to life!
- Not always linear; might need to adapt process as situation unfolds
- While ideal, it might not be possible to complete each step at every encounter

What is Pushback?

- Absence of collaboration between two people
- Normal part of adolescence and change process
- Product of interpersonal dynamics
- Cue to try something different (reflections)
- Less resistance → more likely to change

GOAL: Not to eliminate pushback, but to *minimize it*.

Tips to Decrease Patient Pushback

1. Don’t try to convince them that they have a problem.
2. Don’t argue about the benefits of change.
3. Don’t tell them *how* they should change.
4. Don’t warn them of the consequences of not changing.

Brief Negotiated Interview (BNI)

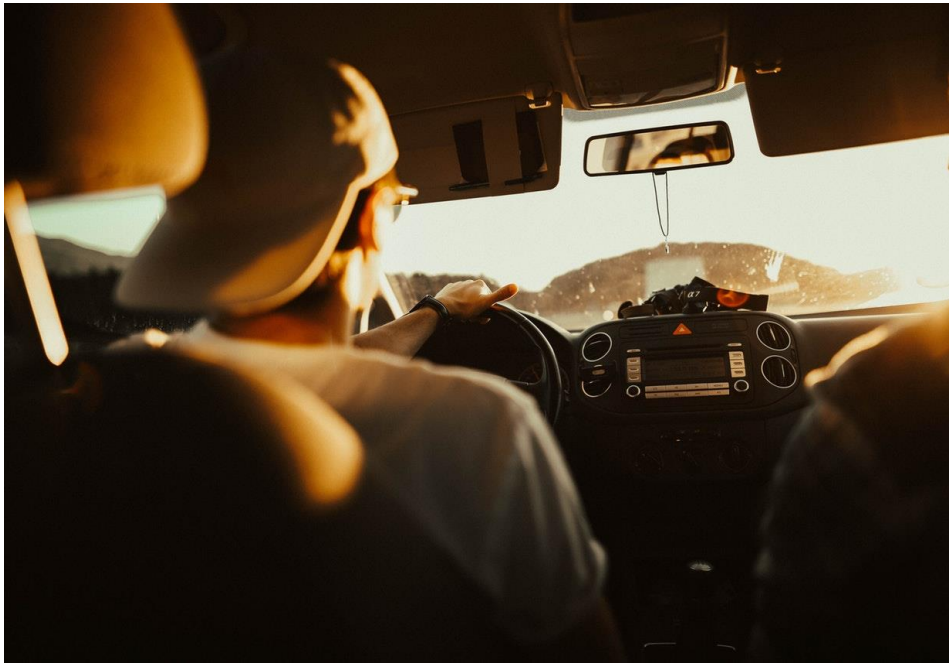
*Patient Voice and **Choice***

Guiding, not directing

Avoid the “righting reflex”

Patient as decision maker

They’re in the driver’s seat



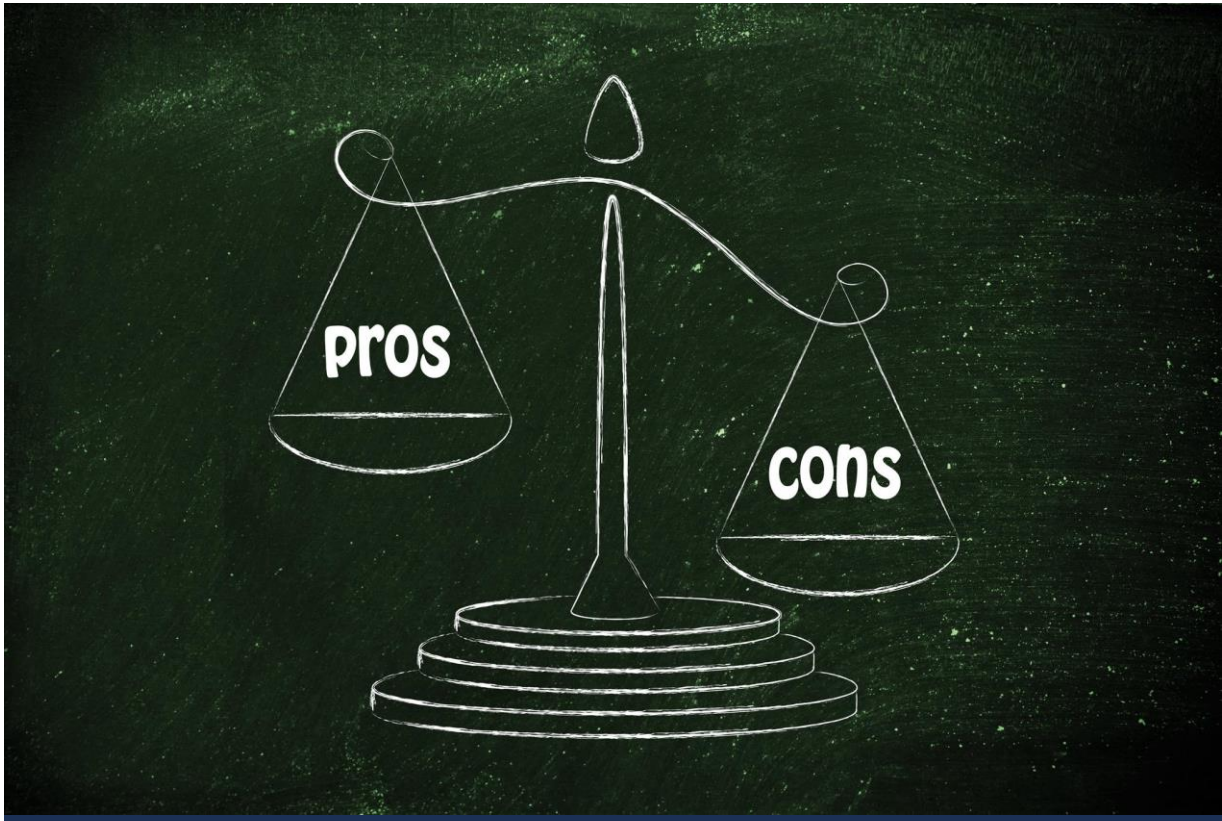
Step 1:

Build Rapport/ Engagement

- Before we start, I'd like to know more about you. Would you mind telling me a little bit about yourself?
- What is a typical day like for you?
- How does your [x] use fit in?

Step 2:
Pros and Cons

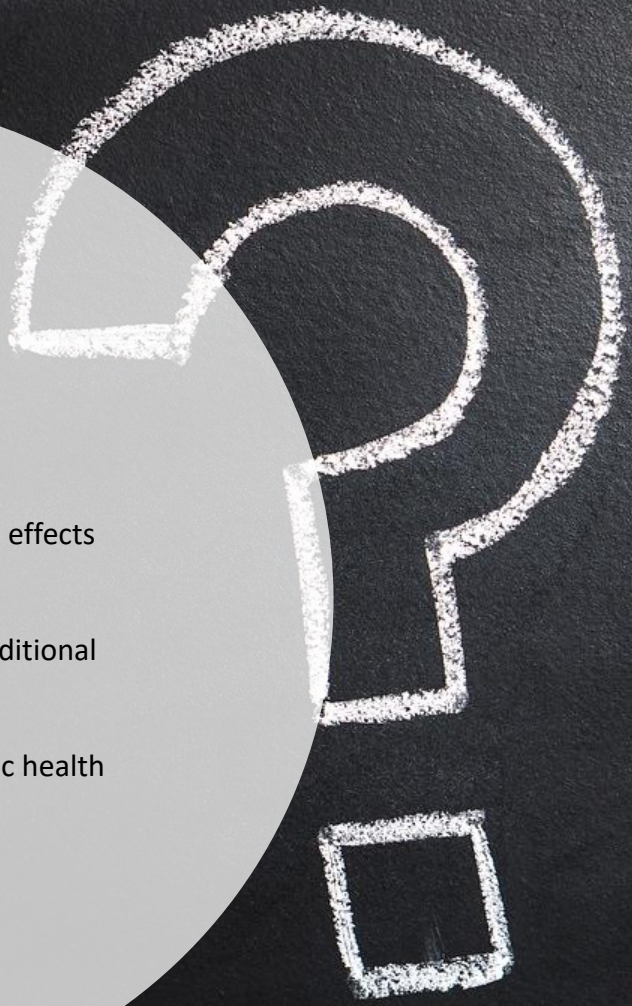
- I'd like to understand more about your [X] use.
- What do you enjoy about [X]? What else?
- What do you enjoy less or regret about your [X] use? What else?
    - **If NO cons: Explore problems mentioned in screening.**
    - *"You mentioned … Can you tell me more about that situation?"*
- So, on the one hand you said [PROS], and on the other hand you said [CONS].



- Explore PROS and CONS
- Use reflective listening
- Summarize

Step 3:
Feedback

- What do you know about the health effects and/or risks of [X]?
- Would you mind if I shared some additional information with you?
- Provide 1-2 salient substance specific health effects/risks.
- What are your thoughts on that?



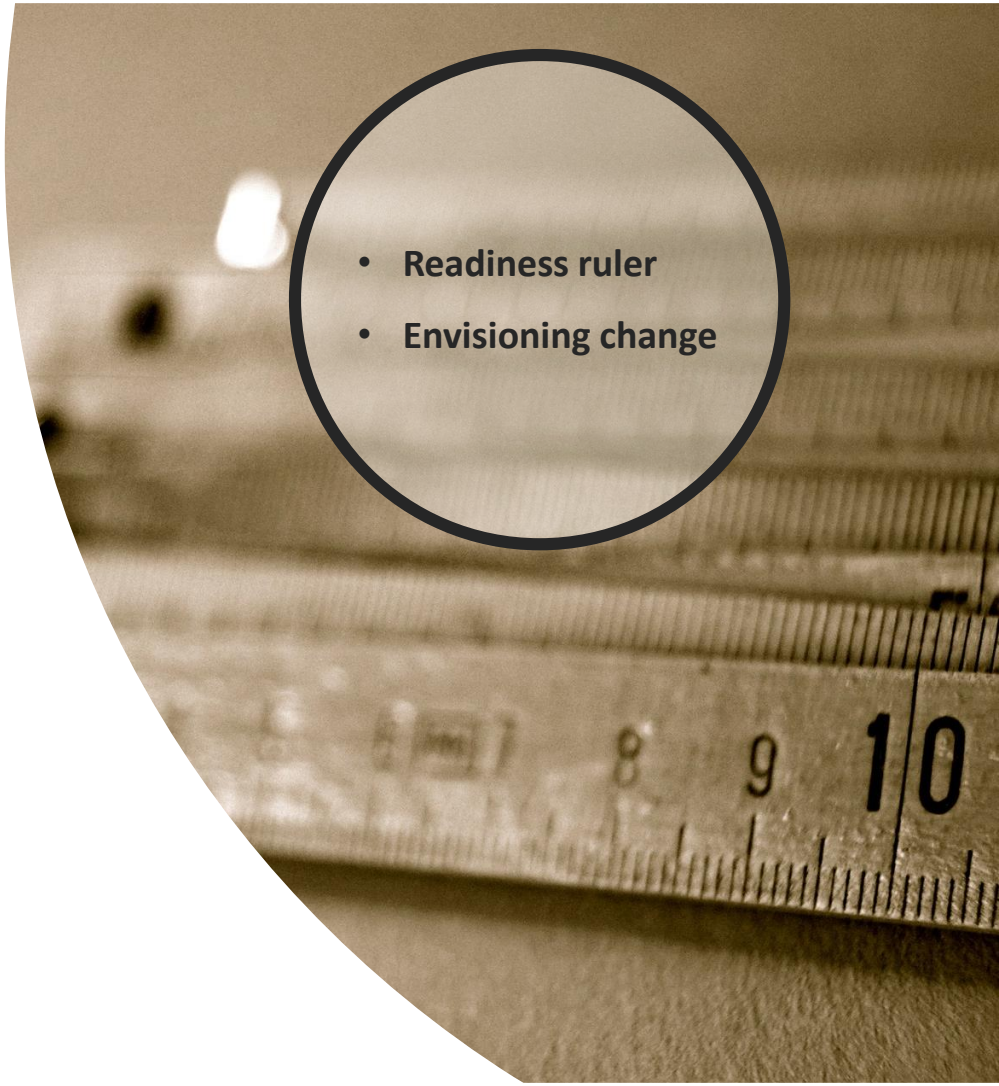
- Ask permission
- Provide information
- Elicit response

Step 4:

Readiness Ruler

1	2	3	4	5	6	7	8	9	10

- To help me understand how you feel about making a change in your [X] use, [*show readiness ruler*]…
- On a scale of 1-10, how ready are you to change **any** aspect related to your [X] use?
- Why did you choose a [X] and not a **lower** number like a 1 or 2?
    - If they choose "0": What would need to happen in your life to consider making a change?



- **Develop plan**
- **Assess confidence**
- **Explore challenges**
- **Summarize**
- **Thank client**

Step 5:
Action Plan

- What are you willing to do for now to be safe and healthy?...What else?
- On a scale of 1-10, how confident (1-10) are you that you could do that?
- Why did you choose a [X] and not a **lower** number like a 1 or 2?
- What are some challenges to reaching your goal?
- Let me summarize what we've been discussing, and you let me know if there's anything you want to add…[*review action plan*]
- **Thanks for being so open with me today!**

Confidence Scale

- Assesses client's confidence
- Identifies potential barriers
  - *"What would you need to change for you to feel more confident?"*
- Can discuss previous successes to build confidence
  - *"What changes have you made in your life?"*
  - *"How did you accomplish that change?"*

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Cannabis Use in the Perinatal Period

Anupriya Gogne MBBS, MD
Attending Psychiatrist
Director, Moms MATTER
Women and Infants Hospital

Women & Infants | A MEMBER OF Care New England

OVERVIEW

- Introduction
- Epidemiology
- Research Data in Pregnancy
- Updated Policies at WIH
- Treatment
- Transference/Countertransference
- Take Home Points

Introduction

- Cannabis has been used medicinally as early as 2737 BCE
- Indications for Medicinal Cannabis Use in Women:
  - Migraines
  - Menstrual cramps
  - Labor pains
  - Induction of labor
- Indicated for intractable pain, cancer related nausea and cachexia
- Criminalization in 1937, Schedule 1 drug (federally)

Epidemiology

- Cannabis is the most widely used illicit drug in the world
- In the US- Cannabis is the most pervasively used illicit substance among individuals who are 12 years of age or older
- US National Survey on Drug Use and Health:
  - 32% of individuals aged 18–25 have used cannabis within the past year
  - 19% have used in the past month
- 9.5% of reproductive aged women reporting past month use (SAMHSA, 2015), max. use during 18-25 yoa

Epidemiology

- Pregnancy:
  - Pregnant women report less cannabis use (4.5% overall) compared with non-pregnant women
  - Use decreases markedly through pregnancy (Mark et al., 2016 and SAMHSA, 2015)
  - 2–5% of women use cannabis during pregnancy (ACOG)
  - Pregnant cannabis users more likely to:
    - Report daily use (16.2% vs 12.8%)
    - Meet criteria for a CUD (18.1% vs 11.4%)
  - Use increases among socioeconomically disadvantaged women in urban areas
    - Frequency of use during pregnancy is estimated to be 15%-28%

Research Data in Pregnancy

- Difficulties with perinatal research:
  - Ethical
  - Multiple confounding factors (Socio-economic, untreated psychiatric illness)
  - Polysubstance use (Tobacco)
  - Variable potency of the drug
  - Variable frequency of use and routes of administration
  - No regulations/monitoring or dosing schedules
  - Research based on cannabis exposures in the 1980s, 90s--> not reflective of contemporary potency of cannabis (6-7 x 70s)

Reasons for Cannabis Use

- Clinically, most common stated reasons for MJ use during Pregnancy:
  - Nausea/HG
  - Low appetite/Inadequate weight gain as per gestational age
  - Insomnia
  - Anxiety/psychological distress
  - Pain- “Medical MJ”

Adverse Obstetric Outcomes

- Risk of adverse fetal effects d/t:
  - Cannabis is highly lipid soluble
  - Readily crosses the placenta and BBB
  - Metabolites accumulate in fetal brain, adipose tissue:
    - MJ can alter the fetal endogenous cannabinoid signaling system even at early embryonic stages
    - Concern for infant neurodevelopment
- Most published studies report *inconsistent* results for outcomes of fetal growth, rates of stillbirth, PTL

Contd.

- Congenital malformations:
  - Maternal and paternal cannabis use increased risk for VSD, Epstein's anomaly, gastroschisis
  - Neurodevelopmental effects:
    - Impaired EF- difficulty organizing, cognitive processing, affective regulation
    - Ottowa Prenatal Prospective Study:
      - Prospective study
      - 300 white, middle class, low risk women, self-reported using at least 6 joints per week during pregnancy
      - Infants followed throughout childhood
      - These children presented with a range of developmental issues at various age
      - Ate age 4 years, showed significantly lower scores on several verbal and memory subscales

Cannabis Use during Lactation

- Lipophilic properties of cannabis→ Transfer into breastmilk
- At low maternal weight-adjusted dose (or RID)
  - 0.8% transferred to infant
  - In heavy users can be higher (Milk-to-maternal cannabinoid plasma ratio 8:1)
- Additionally, the oral bioavailability of THC is only 2–14% (in adult studies)
- Hence, the actual amount transferred is even lower

Contd.

- Infants have additional exposure through passive inhalation
- Concerns for effects of both smoke and THC through inhalation→ Limited data
- One study reported daily infant exposure to cannabis via breastmilk associated with a decrease in motor development at 1 year of age *(result confounded by 1st trimester cannabis exposure)*

Data from Colorado

- Medical cannabis was legalized in Colorado in 2001
- In 2012, voters legalized recreational marijuana
- Sales of recreational marijuana increased steadily
- In 2014, the total revenue from medical and recreational cannabis taxes and fees was >$67 million
- In 2015, it was >$130 million, showing a *steady increase in sales and consumption*

Contd.

- Tessa L. Crume et al. Cannabis Use During the Perinatal Period in a State With Legalized Recreational and Medical Marijuana: The Association Between Maternal Characteristics, Breastfeeding Patterns, and Neonatal Outcomes (J Pediatr 2018;197:90-6)
  - Prevalence of maternal cannabis use during pregnancy and early postnatal period
  - 2 year data from the Colorado Pregnancy Risk Assessment Monitoring System (PRAMS)
  - Trimester-specific prenatal cannabis examined
  - Maternal demographic characteristics, selected risk factors, breastfeeding initiation and duration, pregnancy intendedness accounted for

Table V. Relationship between prenatal cannabis use and neonatal birth outcomes—PRAMS, Colorado, 2014-2015*

	Model 1†			Model 2‡		
Neonatal birth outcomes	OR§	95% CI	*P* value	OR	95% CI	*P* value
LBW (<2500 g)	1.8	1.3-2.4	**.0008¶**	1.5	1.1-2.1	**.02****
Small for gestational age	1.7	1.1-2.6	**.03****	1.3	0.8-2.2	0.3
Infant admission to NICU	1.0	0.6-1.7	0.9	1.0	0.6-1.7	1.0
Preterm birth (<37 wk)	1.3	0.8-2.1	0.2	1.3	0.8-2.1	0.2

Dependent variable infant complications (yes/no).
Boldface indicates statistical significance.
*$P < .01$.

- Self-reported prevalence of cannabis use at any time during pregnancy= 5.7 ± 0.5%
- Prevalence of early postnatal cannabis use among women who breastfed was 5.0% (95% CI, 4.1%-6.2%)
- Prenatal cannabis use associated with 50% increased likelihood of LBW ***independent of maternal age, race/ ethnicity, level of education, and tobacco use during pregnancy (OR, 1.5; 95% CI, 1.1-2.1; P = .02)***
- Small for gestational age, preterm birth, and neonatal intensive care unit admission NOT associated with prenatal cannabis use, independent of prenatal tobacco use
- Higher levels of use amongst women of younger age, lower guidance and socioeconomic status

Other studies..

- Torri D. Metz, et al. Maternal marijuana use, adverse pregnancy outcomes, and neonatal morbidity. (Am J Obstet Gynecol 2017;217:478.e1-8)
  - Maternal MJ use not associated with a composite of small for gestational age, spontaneous preterm birth, or hypertensive disorders of pregnancy
  - After adjustment for tobacco, race, other illicit drug use, MJ use was ***still associated with composite neonatal morbidity or death***

Contd.

- Pregnant Women's Current and Intended Cannabis Use in Relation to Their Views Toward Legalization and Knowledge of Potential Harm. Katrina Mark, MD et al. (J Addict Med 2017;11: 211–216)
  - Voluntary, anonymous survey distributed to a convenience sample of pregnant women presenting for prenatal care at an outpatient university clinic
  - 35% of women reported using cannabis at the time of diagnosis of pregnancy
  - 34%of those women continued to use
  - 70% believed that cannabis could be harmful to a pregnancy
  - 59% believed that cannabis should be legalized in some form
  - 10% reported that they would use cannabis more during pregnancy if it were legalized
  - Those who continued to use cannabis during pregnancy were less likely than those who quit to believe that cannabis use could be harmful during pregnancy ($P<0.001$)
  - Most common motivation for quitting was to avoid being a bad example (74%)
  - 27% listed a doctor's recommendation as a motivation to quit

Psychiatric Outcomes *(Are psych meds any safer than MJ in pregnancy?)*

- No ***scientific data*** supporting use of cannabis to medicate anxiety/depression/PTSD
- Studies show worsened baseline anxiety, ADHD, motivation, social withdrawal with long term Cannabis use
- Unreliable source→ lacing, high potency, synthetic MJ→ Unknown risk
- Risk vs. Benefit does not support use

If there is no conclusive data, then why is assumed to be a risk to use?

- Substantial conflicting data and beliefs regarding negative and positive effects of cannabis use
- Cannabis has not been shown to be ***harmless*** during pregnancy and breastfeeding
- Given this unknown risk, ACOG recommends not using cannabis while trying to get pregnant or during pregnancy
- Safe resources- lacing/potency is 6-7 times since the 70s

- *Medical Card for marijuana, will they test the baby?*

Ethical/Legal Discussions

- *How does smoking something "natural" harm my baby?*
  - Make it a scientific discussion, NOT moralistic or legal
  - Validate inconsistencies of data and unpredictable risks
  - Educate about safety of resources
  - Post-partum implications:
    - Navigating through complex legal systems→ difficult communication (prepare and practice in the weeks leading to delivery)
    - Separation from the baby→ worsening of psychological distress
    - Prolonged separation from the baby→ attachment problems both for mother and the growing child
    - Coordination with the OB/medical team/SW/CM/DCYF- advocating for the patient when self advocacy is difficult

WIH Policy

- All pregnant patients expected to deliver at WIH:
  - Provided with information about substance use in pregnancy and breastfeeding during prenatal care
  - Verbally screened for substance use
  - Patients with negative verbal drug screening during pregnancy and upon admission to WIH do NOT require drug testing

Outpatient and LDR

- Obstetrician, midwife, NP provides counseling on ***all*** substance exposures + explain hospital policy
- (+) Verbal screen for *any substance* other than cannabis→ UDS + treatment referral
- An explanation of why UDS is being performed should be discussed with the patient by the ordering provider
- Verbal consent for UDS obtained and documented in the patient's chart

Contd.

- (+) Verbal drug screen MJ only → UDS for MJ within next 5-8 weeks or at the time of the visit (if patient presents > 32 weeks)
- UDS MJ (-) cannabis ***and*** (-) verbal drug screening for cannabis in 3rd trimester ***and*** on admission to LDR→ Neonatal drug testing for cannabis ***not*** indicated
- UDS MJ (+) in third trimester and (+) verbal screen MJ→ Patient declines UDS→ Patient informed of Neonate drug testing after delivery

ED and Inpatient

- Upon admission, verbal screening for non-prescribed substances repeated and documented
- If (+) verbal screen or (+) UDS for any substance during 3rd trimester→ UDS requested
- If (+) verbal screen or (+) UDS only for MJ→ UDS only for MJ requested
- Patient (+) any substance on admission or Patient declines drug testing→ Neonatal testing after delivery→ Neonate (+) for ***any*** illicit substances→ CPS notified

Patients from non WIH prenatal provider

- (-) prenatal record from an outside healthcare system for drug use during pregnancy + (-) verbal screen→ No UDS
- (+) prenatal record from an outside healthcare system for drug use during pregnancy & (+) verbal screen→ UDS
- Patient does not meet the above criteria for drug testing BUT (+) conditions such as PTL, abruption, fetal tachyarrhythmia, altered mental status, hypertensive emergency :
  - Discussion with the primary OB team to consider UDS
  - Decision to perform drug testing based upon the provider's knowledge of past history + clinical presentation

Policy for Breastfeeding

- (+) Verbally screen/UDS for ***only MJ*** and wishes to breastfeed:
  - Breastfeeding can occur and will be supported with standard inpatient procedures (lactation consultant, pump access, etc.)
  - Pediatrics will have a documented discussion regarding the risks and benefits of breastfeeding
  - No prenatal records or no prenatal care received→ UDS

Treatment

- No pharmacological options for reducing cravings
- One study on gabapentin + psychosocial interventions in adolescents
- Treat underlying nausea/insomnia/anxiety/psychiatric illness
- Referrals to higher LOC
- Outpatient follow-up/aftercare planning

Contd.

- Treatment retention is key, especially post-partum

- High risk of relapse:
  - Social triggers
  - Untreated psychiatric illness
  - Use by other family members/friends
  - 6 mo PP/DCYF involvement ends

Controlled Substances in Dual Diagnosis

- Basic concepts:
  - Do NOT prescribe irresponsibly/without close F/up/sole reliance on meds
  - Do NOT be scared to prescribe
    - Latest research in SUD patients with ADHD: SUD patients in FSR (>1 yr sober) can be prescribed stimulants with no heightened risk of relapse
    - Risk of relapse heightened by ***untreated comorbid psychiatric s/s/distress***

- Clinical Practice guidelines:
  - Clarify or confirm diagnosis
  - Trial of Non addictive options
  - If fails/has side effects→ trial of controlled substance with the following structure/Treatment contract:
    - Start with XR formulations
    - More frequent visits until sober > 90 days
    - Random UDS
    - Therapy for healthier attachments: AA/NA/Sponsor/Life Coach
    - Case Management
    - Collaboration of care with other specialties

Psychotherapy

- MI
- CBT
- Modified DBT
- Seeking Safety (group)
- Attachment based interventions

Addiction as an Attachment Disorder

- During developmental years, humans learn to self regulate emotions/behavior through interpersonal relationships
- Humans are social animals; attachment is protective for survival
- Secure attachment mediates emotional regulation both within oneself and in relationships
- Insecure attachment/early life trauma→ Self regulation through social bonds not learnt→ M*aladaptive coping/Reduced Resilience*

- Reinforcing substance→ can serve this regulatory purpose
- Attachment with substance→ Social detachments/isolation (etoh, MJ)
- Abstinence→ marked distress and inability to cope
- If not replaced by social attachments, relapse is likely *(has nothing to do with "willpower")*-mechanisms of change through AA/sponsors etc.

Transference

- Patient:
  - Attachment needs
  - Re-enactment of prior traumatic relationships
  - Maladaptive defenses:
    - Projection, projective identification, denial, dissociation
    - Avoidance
    - Dependency

Counter-transference

- Therapist:
  - Compassion fatigue/burnout
  - Empathy vs. therapeutic neutrality
  - Vicarious trauma
  - Feeling helpless/hopeless
  - Depression/frustration with multiple relapses

How to maintain compassion?

- Pick your battles!
- Balancing provider expectations with patient's
- Sense of Agency vs. Supportive Interventions
- Honesty and making difficult decisions
  - Do not give false reassurances to patient or teams or self
  - Know when to say NO
  - Know when to say YES
  - Involve risk/legal services if in doubt
- Documentation to be thorough and timely but concise

How to prevent burnout?

- Manage expectations from self and patient
  - Realistic goals
  - Small steps
  - Review progress at regular intervals
- You don't have to do this alone
  - Peer supervision and support
  - Work with the teams, delegate and assign roles
- Take a break
  - Find ways to take mental and actual vacations
  - Maintain a sense of humor

Questions

- What if I've tried everything else for my nausea? Best practice support for weaning off when they are experiencing n/v. Legal rights of people who make informed decisions to continue medical cannabis use (medically prescribed prior to pregnancy):
  - Separate legal from medical
  - Evidence base for nausea exists but MJ vs. anti nausea meds (which is a relatively safer option?)
  - Cases of MJ induced Hyperemesis
  - Remeron/gabapentin/Zyprexa as treatment options for nausea, anxiety, insomnia

- Data on CBD products in pregnancy?
  - Saraffpour S et al. **Considerations and Implications of Cannabidiol Use During Pregnancy.** Curr Pain Headache Rep. 2020 Jun 10;24(7):38. doi: 10.1007/s11916-020-00872-w. PMID: 32524214
  - **Findings:**
    - Despite CBD's accessibility, there are limited studies showing its safety during pregnancy
    - Some studies suggest fetal exposure to cannabinoids can reduce proper development of the microbiome
    - May modulate the immune system by altering cytokine levels, affecting apoptosis→ Predisposition to cancers and infections in later life
    - It is anti-angiogenic to human umbilical vein endothelial cells→ decreases angiogenesis→ Placental insufficiency, PEC
    - Dysregulation of certain transporters can result in placental inflammation and potentially reduce the defense mechanism of the placental barrier

Take Home Points

- Safety data of MJ use in Pregnancy/Lactation not as straightforward compared to other substances
- There are many legitimate reasons for MJ use (both in patient perception and scientifically supported uses)
- Ultimate goal is to minimize harm to the *Mother-baby dyad* in its entirety
- Treatment of underlying psychiatric or medical issue is necessary
- Legality or criminalization of use should not be the primary target of medical treatments by physicians *(not cops) Keeping up with the latest research data is key*
- Open-mindedness and acceptance facilitate treatment retention
- Secure attachments might prevent relapse
- Teams more effective than one overwhelmed treatment provider
- Patience, realistic goal-setting, at times even humor can go a long way!

- Thank you


hope


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RI MomsPRN Contact Information

Psychiatric Teleconsultation Line for Providers
Call 401-430-2800 Mon-Fri, 8 am – 4 pm to speak with clinicians from the Center for Women's Behavioral Health about behavioral health needs and/or concerns of pregnant or postpartum patients/clients. Providers can also send a secure email to RIMomsPRN@CareNE.org to request a teleconsultation call-back.
Learn more: www.womenandinfants.org/ri-momsprn

RIDOH Program Contact Information
Jim Beasley, MPA
RI MomsPRN Program Manager
Rhode Island Department of Health
Jim.Beasley@health.ri.gov

RI MomsPRN
Maternal Psychiatry Resource Network

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