Expanding legalization and increasing social acceptability and accessibility of cannabis may potentially be associated with increased use of cannabis among women of reproductive age. Using repeated cross-sectional data from the Pregnancy Risk Assessment Monitoring System (PRAMS) between 2004 and 2018, Skelton and colleagues\(^1\) compared maternal cannabis use at 2 time points during the preconception, prenatal, and postpartum periods among women living in 2 states that legalized recreational use (Maine and Alaska) and 2 that legalized only medicinal use or decriminalized recreational use (Vermont and New Hampshire). The authors used a difference-in-difference analysis over time, contrasting changes in intervention and comparison states, an important strength compared with earlier studies on this topic. Consistent with prior research, results indicated that the prevalence of cannabis use before and during pregnancy increased over time in both intervention and comparison states. In the 2 states that legalized recreational cannabis use, preconception and postpartum cannabis use, but not prenatal use, increased significantly compared with states that did not legalize recreational use.

However limitations of the study design, most noted by the authors, were that data were available for only 4 states, periods were asynchronous, response rates were low, follow-up periods were short, there was overlapping medical legalization in comparison states, there were differences in the characteristics of women in intervention vs comparison states, and cannabis use was retrospectively self-reported. These design issues limit the ability to generalize results across states legalizing recreational cannabis use and also limit causal interpretation. An earlier study by Skelton et al\(^2\) reported a significantly higher prevalence of prenatal cannabis use among women who lived in states that had legalized cannabis for recreational use, but that study used a single year (2016) of PRAMS data, did not use the difference-in-difference approach, and included a different combination of states.

Increased prevalence of cannabis use among pregnant women in recent years and increasing evidence of associated adverse effects for fetal, neonatal and neurodevelopmental outcomes are cause for substantial concern.\(^3\) The US Surgeon General, American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics advise against cannabis use during pregnancy and lactation. However, pregnant women remain uncertain about the harms of prenatal cannabis use and many seek out anecdotal advice from peers and online communities supportive of cannabis when choosing whether to use (or continue to use) cannabis during pregnancy.\(^4\) Adding to the confusion, many cannabis retailers tout cannabis as a safe, natural, and effective way to manage pregnancy symptoms. In 1 study,\(^5\) 69% of cannabis retailers recommended use for nausea and vomiting during pregnancy in response to a simulated call from a pregnant woman. Many women using cannabis during pregnancy believe that cannabis carries little risk and perceive it as a natural substitute for prescribed medications used to treat mental health and pregnancy-related symptoms.\(^6\)

As legalization of cannabis for recreational use continues to expand across the US, additional research is needed to better understand whether state legalization is associated with increases in prevalence, frequency, or intensity of cannabis use among women before, during, and after pregnancy. Furthermore, legalization has been accompanied by expansion of alternative methods of cannabis administration (eg, high-potency vaping and edibles) and extensive product diversification.
Studies are needed to determine whether pregnant and lactating women switch or add new methods of cannabis administration after legalization and to evaluate the impact of their use. Certain methods of prenatal cannabis administration and product types may be more harmful or associated with greater risk of cannabis use disorder.

Beyond state cannabis policies, local governments in many states can further regulate retail cannabis sales, for example, by limiting retailer density, banning retailers altogether, by requiring prominent pictorial warnings on prenatal use in stores or on advertising, or by limiting product types allowed to be sold. Of note, both states that legalized recreational cannabis in the study by Skelton et al1 (Alaska and Maine) require package warnings about prenatal use (but no minimum font size). Local governments are also allowed to opt out of permitting commercial cannabis sales; thus, the true reach of legalized commercial sale may vary. Where recreational use is legal, better understanding of this geographic patchwork of laws will help determine whether more cautious state and local cannabis regulatory policies protect against prenatal cannabis use and may identify which policies effectively reduce exposure and harms to the offspring of pregnant women (eg, by requiring on-site warnings, more prominent or graphic package warnings, or staff trained to not recommend use during pregnancy).

Although cannabis legalization may be associated with reduced inequities in criminal justice, it may also be associated with worsening of existing health and social disparities in maternal and child health outcomes. Disparities in low birth weight between Black and non-Black infants are well documented. Prenatal cannabis use can potentially exacerbate these disparities. If, like tobacco and alcohol retailers, cannabis retailers open disproportionately or market more intensively in lower-income communities (creating an inequitable distribution of risk factors), disparities in low birth weight may be further exacerbated.

In addition, child welfare laws have not kept up with cannabis legalization. Punitive policies criminalizing prenatal substance use and the underlying discrimination in their implementation may also be associated with increased cannabis-related social inequities. Black women are more likely to be reported to Child Protective Services for prenatal substance use than are White women, even when their substance use status does not differ.7 Immigrants can still be deported for cannabis use or possession because immigration is governed by federal law. Although for a decade, the American College of Obstetricians and Gynecologists has recommended that physicians work with policy makers to repeal punitive policies related to prenatal substance use, many states still consider prenatal use grounds for termination of parental rights. Women in general and Black women in particular may underreport prenatal cannabis use or avoid seeking prenatal care owing to fear of punitive action, leading to worse pregnancy outcomes and missed opportunities for education and linkage to substance use treatment. This is especially likely in states where prenatal substance use is considered to be child abuse and punishable by law. Even when women choose to disclose cannabis use (with legalization, they may feel more comfortable disclosing use to their health care providers during preconception, pregnancy, and lactation), inequities in repercussions for honest disclosure may remain. With cannabis legalization extending across the US, research on the best policies to protect health and social equity and to minimize harm is critical.

As cannabis legalization unfolds and use increases among women of reproductive age, now is the time to reform antiquated policies that criminalize prenatal substance use in favor of focusing on protecting the health of mothers and their children. Improvements in primary prevention and education are vital but also necessary are legal and regulatory policies that protect infants and children, inform women of risks, prohibit health and therapeutic claims for cannabis outside scientific approval processes, and ensure equitable access to supportive and nonpunitive substance use treatment.
REFERENCES