

Section 5: Facilitating Treatment for Alcohol Use and Use Disorders

Alcohol use during pregnancy is the leading cause of preventable birth defects in the United States. Despite this, more than 10% of pregnant women ages 18-44 report alcohol use, and at least 3% report binge drinking (defined as more than 3 drinks at one time) during the past month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013; SAMHSA, 2014). Because alcohol metabolites are not included in most standard urine toxicology tests, alcohol is sometimes also used without being detected by women who are in treatment for other substance use.

Alcohol is a teratogen, and its use during pregnancy is associated with fetal alcohol spectrum disorders (FASD), a term which includes a range of alcohol related effects on the brain, heart, and central nervous system, resulting in characteristic facial features, cardiac anomalies, and impaired growth, through more subtle learning, communication, and behavior problems. The most severe form of FASD, Fetal Alcohol Syndrome (FAS), is associated with higher doses of prenatal alcohol exposure, and includes the presence of congenital anomalies and lifelong neurodevelopmental impairment (Popova, et al 2017). As many as 5% of children in the United States may be affected by FASD (March of Dimes, 2017). The prevalence of the more severe manifestation of prenatal alcohol exposure, FAS, is thought to impact between 30-39 per 10,000 individuals in the United States (Popova, et al, 2017).

There is no safe amount of alcohol use during pregnancy, and no safe period for exposure. However, the effects of alcohol on the fetus are dependent on the timing, frequency and amount of exposure (Association of Reproductive Health Professionals [AHRP], 2015). Therefore, although the goal of prenatal intervention for alcohol use must be complete abstinence, reducing use is preferable to continuing at the same level (ARHP, 2015). Because alcohol use is so harmful to fetal growth and development, screening, early identification and intervention is critical. Women who cannot stop drinking alcohol should be referred for specialty care for substance use.

In Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants, SAMHSA endorses parallel management of alcohol withdrawal during pregnancy with that of the non-pregnant patient. Behavioral health interventions and peer support are

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the most widely used approaches for nonpregnant patients but must be used in conjunction with pharmacologic management of withdrawal when that is indicated (SAMHSA, 2018). Evidence is extremely limited regarding the safety of pharmacologic agents (disulfiram, naltrexone, acamprosate, or gabapentin) for the long term treatment of alcohol use disorder during pregnancy (SAMHSA, 2018).

Many women discontinue alcohol use during pregnancy, but resume postpartum, often with similar harmful use patterns. Therefore, a history of moderate to heavy pre-pregnancy use requires brief intervention and education *even when women are not drinking during pregnancy*. Alcohol also transfers readily into breastmilk. Levels in breastmilk parallel maternal serum levels, with peak levels at 30-60 minutes, or longer if taken with food (Academy for Breastfeeding Medicine, 2015; LactMed, 2017). Alcohol suppresses milk ejection, and nursing after use can decrease the quantity of milk the infant receives. Although occasional use is not considered harmful, the impact of daily alcohol use, especially at moderate to heavy levels (>1 drink/day) is not well understood, but may impact sleep and early psychomotor development. Based on the pharmokinetics of alcohol, women who wish to avoid alcohol exposure for their infants should delay breastfeeding until 2-2.5 hours after drinking 1 standard drink, increasing the time before resuming breastfeeding by the same amount for each additional drink (LactMed, 2017).

Screening and Diagnosis of Alcohol Use and Use Disorder

1. Screening for alcohol use in pregnancy

All pregnant women should be screened for drug and alcohol use at the first prenatal visit and subsequently (WHO, 2014). Screening should utilize a validated screening instrument (ACOG, 2012) and positive screens followed by brief interventions to determine a woman's use pattern, motivation, and level of need for alcohol treatment services.

All healthcare professionals should feel empowered to respond to disclosure of prenatal drug or alcohol use with concern and assist women to obtain further evaluation and/or treatment. Providers should be sensitive to the prevalence of trauma history, particularly childhood sexual and physical abuse among women with alcohol use disorders.

Screening using a validated screening instrument (examples below), followed by a respectful conversation is the optimal approach to identify harmful alcohol use prior to and during pregnancy. Alcohol use is rarely detected in standard urine toxicology tests. The AUDIT-C, TWEAK and T-ACE are

brief alcohol screening tools validated for use with pregnant women, and the ASSIST, 4Ps Plus and Substance Use Screening Tool are valid screening tools for both alcohol and drug use during pregnancy (WHO, 2014).

2. Criteria for a presumed diagnosis of alcohol use disorder

• DSM-V Definition of Alcohol Use Disorder:

"A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period." (American Psychiatric Association, 2013)

• The following checklist can be used to determine whether diagnostic criteria are present for Alcohol Use Disorder:

DSM-5 Diagnostic Criteria	Present	Comments	
1. Alcohol is often taken in larger amounts or over			
a longer period than was intended.			
2. There is a persistent desire or unsuccessful			
efforts to cut down or control alcohol use.			
3. A great deal of time is spent in activities			
necessary to obtain alcohol, use alcohol, or			
recover from its effects.			
4. Craving, or a strong desire or urge to use			
alcohol.			
5. Recurrent alcohol use resulting in a failure to			
fulfill major role obligations at work, school, or			
home.			

6. Continued alcohol use despite having persistent		
or recurrent social or interpersonal problems		
caused or exacerbated by the effects of alcohol.		
7. Important social, occupational, or recreational		
activities are given up or reduced because of		
alcohol use.		
8. Recurrent alcohol use in situations in which it is		
physically hazardous.		
[For example: this criterion would be fulfilled if a		
woman regularly operated a motor vehicle while		
intoxicated]		
9. Continued alcohol use despite knowledge of		
having a persistent or recurrent physical or		
psychological problem that is likely to have been		
caused or exacerbated by the substance.		
[For example: this criterion would be fulfilled if a		
woman is aware of the teratogenic effects of		
alcohol and continues to drink]		
10. Tolerance, as defined by either of the		
following:		
a. A need for markedly increased amounts of		
alcohol to achieve intoxication or desired effect.		
b. A markedly diminished effect with continued		
use of the same amount of alcohol		
[Note that a person can have an alcohol use		
disorder even in the absence of tolerance or		
withdrawal symptoms]		

11. Withdrawal, as manifested by either of the		
following:		
a. The characteristic alcohol withdrawal syndrome.		
b. Alcohol (or a closely related substance such as		
benzodiazepines) is taken to relieve or avoid		
withdrawal symptoms.		

• The severity of Alcohol Use Disorder can be estimated from this table, using the levels described below:

Mild (ICD-10 CM code F10.10): Presence of 2–3 symptoms

Moderate (ICD-10 CM code F10.20): Presence of 4–5 symptoms

Severe (ICD-10 CM code F10.20): Presence of 6 or more symptoms

3. Toxicology tests for alcohol

The standard rapid test for alcohol intoxication is the breathalyzer, which detects the presence of ethanol. Most health care settings do not utilize this technology. Urine can be tested for the presence of two alcohol metabolites, <u>ethyl glucuronide</u> and <u>ethyl sulfate</u>, which can detect alcohol use for several days after its complete elimination from the body (detection window from 30-110 hours, based on quantity of use (Helander, et al, 2009; Wurst, et al, 2003)

Gamma-glutamyl transferase is often used as a screening serum test for heavy alcohol use although it can be elevated with other forms of liver damage ((<u>https://www.mayomedicallaboratories.com/test-catalog/Clinical+and+Interpretive/8677</u>).

4. Alcohol Withdrawal

The majority of pregnant women who use alcohol are not physiologically dependent, meaning that they may not experience tolerance or withdrawal. However, physiologic dependence and subsequent withdrawal from alcohol can result from heavy and prolonged alcohol use. Withdrawal symptoms usually occur within several hours to a few days after cessation or significant reduction of alcohol use

(American Psychiatric Association,2013). **Unlike opioid withdrawal, alcohol withdrawal can be fatal if untreated.** SAMHSA's *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* endorses use of the same management approach for alcohol withdrawal during pregnancy as for the non-pregnant patient (SAMHSA, 2018)

Characteristic symptoms of alcohol withdrawal* include:

- Autonomic hyperactivity (sweating, pulse < 100 bpm)
- Hand tremor
- Insomnia
- Nausea/vomiting
- Transient visual, tactile, or auditory hallucinations or illusions
- Psychomotor agitation
- Anxiety
- Generalized tonic-clonic seizures
- May include confusion or delirium (Delirium Tremens or "DTs")

*symptoms of benzodiazepine withdrawal may be very similar to alcohol withdrawal

The <u>Clinical Institute Withdrawal Assessment for Alcohol Scale</u> (CIWA-Ar) or other similar standardized assessments are used to assess the severity of alcohol withdrawal. Scores <10 on the CIWA do not generally require medication to prevent escalation. If alcohol withdrawal is suspected in a pregnant or postpartum patient, immediate consultation and stabilization is required. The CIWA-Ar can be accessed from: <u>https://www.merckmanuals.com/medical-calculators/CIWA.htm</u>

Benzodiazepines can and should be used for the treatment of alcohol withdrawal during pregnancy, as the risks of untreated alcohol withdrawal exceed the risks of short term use of benzodiazepines.

5. Levels of Care for the treatment of Alcohol Use Disorders

The National Institute for Alcohol Abuse and Alcoholism maintains a treatment navigator to assist patients in finding the right level of treatment near their home communities:

https://alcoholtreatment.niaaa.nih.gov/

Treatment for alcohol use disorders during pregnancy may require varying levels of intensity and duration. If physiologic dependence and risk for withdrawal is suspected, acute hospitalization with addiction medicine, psychiatric, and/or maternal-fetal medicine consultation is necessary.

Residential Treatment Programs

Substance use treatment programs which offer daily treatment in a residential setting. Residential programs may or may not be gender-specific. A few residential programs are also equipped to accommodate children whose mothers are seeking treatment. Access to gender-specific residential programs varies widely by region. Many programs may not accept pregnant women, and many do not allow children to accompany their mothers.

Intensive Outpatient Programs

Intensive Outpatient Treatment usually consists of 9 hours of treatment for substance use disorders split between 3 days per week, although programs vary.

Mutual Aid Groups

Alcoholics Anonymous (AA) and other 12-step programs provide peer support for people who wish to decrease or stop alcohol use. Twelve step programs, in combination with treatment by health professionals, are very effective in helping to maintain day to day sobriety. Many people utilize mutual aid groups as their main recovery support for alcohol use disorders.

Medication Assisted Treatment for Alcohol Use Disorders

Medication assisted treatment for alcohol use disorders includes three medications approved by the U.S. Food and Drug Administration: acamprosate, disulfiram, and naltrexone. <u>None of these medications are currently</u> <u>recommended for use in pregnancy</u>; however, there is emerging evidence supporting the safety of naltrexone for the treatment of *opioid* use disorder during pregnancy, which may support its use for perinatal alcohol use in the future (see Jones, et al, 2013). The use of benzodiazepines as "maintenance treatment" for alcohol use disorders is not supported by evidence and is not recommended.

Additional information about levels of treatment for alcohol use disorders may be obtained from:

https://pubs.niaaa.nih.gov/publications/Treatment/treatment.htm#chapter04

6. Choosing the right level of care

Severity of use, presence or absence of physiologic dependence, availability of treatment, financial resources, health insurance status, conflicting responsibilities and personal preference are all factors which will inform the level of care chosen by a pregnant woman in need of treatment for alcohol use disorder. Most women are highly motivated to seek treatment during pregnancy, and a shared decision making approach is appropriate to facilitate engagement. The following simple algorithm outlines several key steps in this discussion.

Algorithm for discussing levels of care during pregnancy (BH= Behavioral Health clinician)



Additional Provider Resources about prenatal alcohol use and FASD

Substance Abuse and Mental Health Services Administration: Treatment Improvement Protocols

- Addressing Fetal Alcohol Spectrum Disorders (FASD). Accessed from: https://store.samhsa.gov/shin/content//SMA13-4803/SMA13-4803.pdf
- National Organization on Fetal Alcohol Syndrome: <u>https://www.nofas.org/</u>
- Public awareness fact sheet on FAS from NOFAS: <u>https://www.nofas.org/wp-</u> content/uploads/2014/08/Fact-sheet-what-everyone-should-know old chart-new-chart1.pdf

The Arc: Fetal Alcohol Spectrum Disorders Prevention Project:

- Provider training opportunities on FASD <u>http://www.thearc.org/FASD-Prevention-Project/training/webinar-archive</u>
- Summary of current knowledge about the impact of alcohol use during pregnancy: <u>http://www.thearc.org/document.doc?id=5011</u>
- Association of Reproductive Health Professionals: Fetal Alcohol Spectrum Disorders Consensus Meeting, Meeting Report 2015: <u>http://www.thearc.org/file/FASD-Consensus-Meeting-Report---FINAL-VERSION.pdf</u>
- Evidence-based "Choices" curriculum for FASD prevention: *free from CDC:* https://www.cdc.gov/ncbddd/fasd/documents/facilitatorguide.pdf

Additional Patient Resources about prenatal alcohol use and FASD

Centers for Disease Control information and infographics:

- <u>https://www.cdc.gov/ncbddd/fasd/alcohol-use.html</u>
- <u>https://www.cdc.gov/vitalsigns/fasd/index.html</u>
- <u>https://www.cdc.gov/vitalsigns/fasd/infographic.html/#graphic1</u>

Free to download:

- "Think before you drink" https://www.cdc.gov/ncbddd/fasd/documents/ThinkBeforeYouDrinkbrochure.pdf
- "An alcohol-free pregnancy is the best choice for your baby" <u>https://www.cdc.gov/ncbddd/fasd/documents/FASDBrochure_final.pdf</u>
- "Alcohol use in pregnancy" (fact sheet): <u>https://www.cdc.gov/ncbddd/fasd/documents/fasd_alcoholuse.pdf</u>
- Order free fact sheets for patients from CDC: <u>https://www.cdc.gov/ncbddd/fasd/factsheets.html</u>
- March of Dimes: <u>https://www.marchofdimes.org/pregnancy/alcohol-during-pregnancy.aspx</u>

- <u>https://www.marchofdimes.org/complications/fetal-alcohol-spectrum-disorders.aspx</u>
- National Organization on Fetal Alcohol Syndrome: <u>https://www.nofas.org/wp-</u> <u>content/uploads/2014/05/Facts-prevention.pdf</u>
- The Arc: <u>http://www.thearc.org/learn-about/fasd</u>

Consent to share information with Treatment Providers

Once a patient has been referred for treatment, consent to share information between members of the care team is essential. Additional federal rules protect the privacy and confidentiality of substance use treatment records.

- A summary of these rules and sample consent form may be accessed from PCSS-MAT and the American Osteopathic Academy of Addiction Medicine: <u>http://c.ymcdn.com/sites/www.aoaam.org/resource/resmgr/Clinical_Tools/Sample_Consent_fo</u> <u>r_release_o.pdf</u>
- A fillable electronic version of the same form is available through PCSS-MAT: https://www.pdffiller.com/en/project/88623518.htm?f_hash=f7ab01&reload=true