NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Substance Use Disorders
Alcohol Use Disorder
Progressive Case Conference
Facilitator's Guide

Contributors
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Session
Sessions are typically designed to last 90 minutes but can be modified for a longer or shorter session by either presenting both or one of the cases. During the session, the cases will be distributed to trainees and will be read along by a resident volunteer. The entire group will then discuss the case as well as formulate the diagnosis and treatment approach based on facilitator guided questions. This session can be run by a single facilitator who oversees the entire group.

Learning Objectives
1. Describe the DSM-5 diagnostic criteria for alcohol use disorder (AUD)
2. Explain the risks of alcohol use in pregnancy and lactation
3. Discuss treatment options for AUD in pregnancy
4. Describe the management of alcohol withdrawal in pregnancy
5. Discuss considerations related to child protection reporting of alcohol use in pregnancy

Part 1:

You are working in an integrated care setting in the OB clinic at your institution. You receive a call from a certified nurse midwife at the clinic. She is requesting a curbside on a patient who she saw in clinic earlier in the day. She tells you that the patient, Jessica, is a 24 year old G2P1 female who presents for her first OB appointment at 24 weeks pregnant. According to the midwife, Jessica reported that she discovered she was pregnant by a home pregnancy test after missing her monthly menstrual cycle. She had planned to seek routine prenatal treatment earlier on in the course of her pregnancy but felt ashamed because she had planned to quit drinking alcohol though has been unable to do so. She repeatedly stated," I just thought I would be able to get my drinking under control." Her continued inability to decrease her intake has led to her feeling increasingly ashamed. She was initially ambivalent about the pregnancy and has since decided that she is excited about the baby though is very anxious and concerned about her inability to stop drinking alcohol. She now realizes that she can't do this on her own and comes to the midwife seeking assistance, in addition to routine prenatal care.

1) Does this patient have Alcohol Use Disorder?
   -DSM-5 criteria for Alcohol Use Disorder:
   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.
9) Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
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.
11) Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal) b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.
-Characterize as
-Mild: The presence of two to three of the above symptoms
-Moderate: The presence of four to five of the above symptoms
-Severe: The presence of six or more of the above symptoms.

2) What additional historical information do you want to know before making recommendations?
-Gathering an SUD History:
Amount she is currently drinking, pattern of alcohol use before finding out she was pregnant, problems related to drinking, history of withdrawal symptoms (including complicated withdrawal), use of any other concurrent substances, periods of abstinence and how she was able to maintain abstinence, how she did in prior pregnancy, comorbid psychiatric disorders, family history, support system, history of trauma/abuse and current risk for trauma/abuse, check the Prescription Drug Monitoring Program, Collateral from PCP or other providers if available

3) What objective data (labs, Physical exam) would you like to check?
-Physical signs of withdrawal, intoxication or stigmata for chronic ETOH use:
Vital Signs and Physical exam: note flushing, diaphoresis, tremor, sequelae of liver disease
-Labs: Urine Drug test, Pregnancy test, CBC, BMP, LFTs

4) The provider asks if she should report this patient to child protective services for lack of prenatal care and drinking. How would you counsel this provider?
-In most states, child protection reports cannot be made during pregnancy unless concerns are present regarding other children in a woman's care
- Fear of child protection involvement can lead to delays in seeking prenatal care or difficulty sharing difficulties with substance use with health care providers; a non-judgmental stance is key!
-Women with SUD in pregnancy may present for care later in pregnancy due to factors such as higher rates of unplanned/unexpected pregnancy, shame and guilt, and fear of stigma, intimate partner violence, or lack of resources
- Focusing on engagement in care, treatment alliance, and working together toward shared goals may enhance a woman's ability to parent safely

Part 2:

Upon further questioning, the midwife reports that Jessica has struggled with alcohol use since age 18. Jessica reports that she started drinking alcohol at this age following a rape by a family member. She began using alcohol as a way to "forget about the pain." Her use escalated quickly, and she reports a history of frequent blackouts, 3 DUIs (for which her driver's license has subsequently been revoked), and inability to maintain a job due to her drinking. She reports that she was drinking a fifth of a gallon of whiskey per day prior to finding out she was pregnant. Since she found out she was pregnant, she has cut down, and reports current use of approximately 2 shots of whiskey per

day plus a 6-pack of beer. She denies other substances other than cigarettes, around one pack per day. She denies any history of complicated withdrawal (seizures or delirium tremens). She reports that her longest period of abstinence from alcohol was when she was pregnant with her first child, who is now 3 years old. She was able to quit drinking during this pregnancy but quickly resumed following the pregnancy. Her 3 year old daughter is currently living with her older sister, as placed by child protective services, due to a house fire during which she was found to be intoxicated, though she has regular supervised visits. When asked what helped her to maintain her sobriety from alcohol during the time that she was pregnant previously, she says that her mother was a major source of support and she been living with her mother during the time. She denies seeking treatment during this period and says that she was able to do it on her own with the support of her mother. She is frustrated with herself that she has been unable to quit this pregnancy. She notes that her mother died a year and a half ago and this was a major loss. She reports domestic violence in her current relationship with a man, who is the father of her baby. She describes symptoms consistent with PTSD. She denies any passive death wish, suicidal ideation, and homicidal ideation. She reports a family history of addiction issues (alcohol primarily), and is unable to identify anyone who is supportive of her since her mother passed away. Vital signs are within normal limits, and she does not exhibit flushing, diaphoresis, tremor, or sequelae of liver disease on exam.

1) What should the midwife tell the patient about the risks of her drinking during pregnancy?
-Risk of untreated psychiatric comorbidity
-Maternal risks of ETOH – withdrawal, which can be life threatening and complicate delivery; Risks of intoxication – violence, injury
-Trauma-related sequalae (trauma risk even higher while pregnant, poor prenatal care, poorer outcomes in baby)
-Fetal alcohol spectrum disorders: ETOH doesn't produce a single abnormality but cluster of nonspecific defects: Birthweight and length, head circumference, dysmorphic facial features (smooth flattened philtrum, thin upper lip, microcephaly, short palpebral fissures)
-In addition to fetal alcohol syndrome, ETOH associated with neurodevelopmental delays and CNS deficits
-Fetal/neonatal intoxication and potential for neonatal withdrawal
-Information about risks of alcohol use in pregnancy needs to be balanced with a message of hope for the future. Each day she does not drink is a way to reduce risk to herself and to her pregnancy. She can recover with support.

2) The midwife asks "How do I get her to stop?"
-Motivational Interviewing:

How much do you want to stop drinking? Rate this from 1-10; How confident are you in your ability to stop drinking? Rate from 1-10. What made you select than number? What would need to happen for you to select a higher number? (Goal is to get the patient to generate this content)

3) What treatment do you recommend?
-Management of withdrawal in pregnancy:
If at risk for alcohol withdrawal based on pattern of use and past withdrawal symptoms, treat with a benzodiazepine taper
Lorazepam is preferred over other benzodiazepines ***(link with module for benzodiazepine use in pregnancy)***
If misusing benzodiazepines, manage taper with same medication being abused
Limited data regarding the impact of alcohol or benzodiazepine withdrawal on pregnancy
Setting for withdrawal management individually determined based on obstetric status, gestational age, medical and psychiatric comorbidity. Some women may need inpatient monitoring.
-Treat co-occurring psychiatric issues if present
-Encourage and support smoking cessation
-Engage with domestic violence advocate
-Regular follow with OB – encourage provider to continue to provide care whether or not patient engages in treatment or achieves sobriety – women with substance use disorders in pregnancy often fear judgment

or harsh criticism from providers and need to know that providers will care for them unconditionally. A trauma-informed approach to care can help with engagement.
-Limited data on medications used for relapse prevention during pregnancy:
***Naltrexone** - emerging data for use in pregnancy, few small studies mostly in OUD - no adverse birth outcomes*
***Disulfiram (Antabuse)** - not recommended for use in pregnancy due to data re: fetal malformation and risk of severe reaction with ETOH use*
***Acamprosate (Campral)** - no human pregnancy data*
-Psychosocial treatments such as peer supports, counseling, or recovery housing should be offered concurrently. Substance use disorder treatment programs specifically designed for pregnant women should be offered if available.

Part 3:

You are now working on the psychiatry consult service at your institution's women's hospital. Jessica presents to the hospital at 34 weeks and 3 days for cramping and contractions. She was evaluated by the OB team and determined not to be in labor, but to have pyelonephritis. She is being treated appropriately for this. You receive a consult from the OB team for assistance with evaluation for alcohol withdrawal and treatment recommendations. You go to see Jessica, and she reports that she did not follow-up with recommended treatment and was lost to follow-up, despite efforts by her midwife and social worker at the clinic to reach out. She feels even more guilty now than she did before, and repeatedly states, "I just couldn't get it together." There was continued violence in her relationship with her partner as well as a host of other stressors, including financial issues. Her prenatal care was therefore very limited. She reports that she was able to cut out whiskey on her own but has continued to drink 6 beers daily throughout her pregnancy and has continued to smoke cigarettes. She denies any physical symptoms of withdrawal at time of admission and vital signs and exam are unremarkable.

1) What treatment do you recommend at this point?
-Monitor symptoms with an alcohol withdrawal scale such as the Clinical Institute Withdrawal Assessment (CIWA) scale, using lorazepam to manage withdrawal symptoms. Depending on level of symptoms a lorazepam taper and/or assessment-based dosing can be used
-Urine drug screen; BAC (blood alcohol content)

2) How would you prepare this patient for the delivery and the postpartum period?
-Again, motivational interviewing approach to her substance use
-Recommend follow-up treatment- outpatient vs intensive outpatient vs residential care, ideally in a program tailored to the needs of pregnant and parenting women
-Address safety planning – counsel on child protective service reporting requirements
-Evaluate for psychiatric comorbidities and counsel on the risk for postpartum emotional complications, for which she is at elevated risk
- Engage with neonatology to counsel patient on likely delivery conditions, newborn care

3) How would this case be different if Jessica were also concurrently using benzodiazepines and heroin?
-Need to concurrently treat these conditions; ***(link with module for benzodiazepine use in pregnancy; link with module for opioid use disorder in pregnancy);*** *note increased risk for respiratory depression with concurrent benzodiazepine/alcohol and opioid use; as always, use motivational interviewing*

Part 4:

A. The decision to proceed with delivery is made at 34 weeks and 6 days given continued poorly controlled blood pressure and subsequent fetal distress. The baby goes to the neonatal intensive care unit for monitoring and is treated appropriately and has been placed in foster care by child protective services. While seen in the postpartum ward, Jessica continues to voice feeling very ashamed and guilty about the situation, and reports that she is now motivated to engage in treatment given that she wants to do anything it takes to return baby to her custody. She is in agreement with attending an intensive outpatient program for the treatment of her alcohol use disorder.

1) How would you counsel her with respect to her desire to continue breastfeeding?
-Breastfeeding is recommended in women who are in treatment and abstaining from other substances – institutions often develop policies about how to define sobriety (time course, requirements for toxicology testing). Child protection may or may not allow her to pump breastmilk for her infant not in her custody.
-Benefits of breastfeeding especially with respect to attachment, soothing of baby who may have withdrawal symptoms
-Caution if baby is removed from mother's care as child protection may not allow contact or use of expressed milk

B. Following several months of treatment, she is scheduled with you at your institution's psychiatry clinic. She is thrilled to report to you that she has abstained from using alcohol and her baby is now back in her custody at age 4 months. She has broken up with her boyfriend, obtained a protective order and is living in a shelter for women who are survivors of intimate partner violence. She continues to smoke cigarettes, although is open to discussing tobacco cessation strategies. **See Tobacco Use Self-Study for more information.**

1) What can you recommend to the patient regarding longer term treatment?
-Women with severe SUD are at elevated risk for postpartum relapse, and this risk is highest in the 6-12 months PP. Recommend engagement in treatment and maintaining treatment supports during this time
-Women with SUD are at higher risk for postpartum/perinatal mood episodes and should be monitored at an early postpartum visit and frequently thereafter
-Women with SUD should be engaged in dyadic therapy and parenting support
-She should be offered support with tobacco cessation, including medication treatment if desired

References

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