Summary of Recommendations

RECOMMENDATIONS SIDE-BY-SIDE

SOGC Guideline No. 405 (2020)	BC Pregnancy Supplement (2020)	Updates from the Canadian Alcohol and Pregnancy Committee (2023)
Risks of Alcohol		
SUMMARY STATEMENTS GRADE ratings in parentheses 1. Alcohol is a known teratogen (high). 2. The current evidence cannot establish a safe threshold for alcohol consumption in pregnancy (high). 3. Abstaining from alcohol during pregnancy is the safest option (high). 4. Abstaining from alcohol while breastfeeding is the safest option (high).	Annual alcohol use screening for all patients of childbearing capacity should include education on Canada's Low-Risk Alcohol Drinking Guidelines and the risks of alcohol use during pregnancy.	The Canadian Low Risk Drinking Guidelines (2011) have been replaced by Canada's Guidance on Alcohol and Health (2023), which has updated definitions for low-risk drinking. Discuss updated guidelines with all patients of childbearing capacity. Discuss the risks associated with drinking and becoming pregnant and explore birth control options for people of childbearing capacity. When working with Indigenous Peoples and other groups, cultural safety and humility is integral. Clinicians should be aware of the role of colonization and settler introduction of alcohol to Indigenous Communities and recognize the ongoing discrimination in the health system toward Indigenous people, specifically regarding alcohol. Sensitivity towards other cultures and their historical context and norms related to alcohol is important.
Screening, Brief Intervention, and Diagnosis		
Every clinical encounter is an opportunity to discuss alcohol use. All women of child-bearing age should be periodically screened for problematic alcohol use. Screening, brief intervention, and referral to treatment can be brief or in depth depending on the context. Health care providers should incorporate screening for problematic alcohol use into routine women's health screening and information sharing and include screening, brief intervention, and referral to treatment where needed (strong, high). --- All pregnant women should be questioned about alcohol use by asking a single question (in a non-judgmental way) to determine use. If women consume alcohol, one of the following screening tools should be used: AUDIT-C or T-ACE, or another evidence-based screening tool available in the provincial/territorial prenatal record. If women consume alcohol, pattern of use should be established to screen for binge drinking (strong, high).	Healthcare providers should screen pregnant and post-partum patients for alcohol use at the earliest opportunity. Screening should be repeated routinely throughout pregnancy and post-partum.	All patients of childbearing capacity should be screened for alcohol use early and regularly. Partners of patients of childbearing capacity should also be screened for high-risk drinking or alcohol use disorder. Partner abstinence has been shown to support conception and a healthy environment for the pregnancy. See alcohol and fertility handout for more information. See screening and treatment pathway.

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Screening, Brief Intervention, and Diagnosis, continued		
If screening identifies an alcohol use disorder, brief intervention should be provided at the same time screening is completed (strong, high). --- Health care providers should be knowledgeable on providing brief interventions and be aware of referral pathways (strong, moderate)	All pregnant and post-partum patients who screen positive for alcohol use should receive brief counselling intervention and advice for discontinuing alcohol use.	Brief intervention should be provided if any amount of alcohol is used in pregnancy or during lactation. See the overview of the 5As model of brief intervention in pregnancy and more detailed guidance here. In the “assist” stage of brief interventions, consider a holistic and relational approach that seeks to balance physical, spiritual, mental, and emotional wellness. While this aligns with Indigenous views of wellness, this is beneficial for all clients. A motivational-interviewing style has been shown to be effective and also aligns with cultural safety principles of respect, autonomy, and empowerment.
Brief interventions and, if needed, coordinated referral and follow-up should accompany screening for alcohol use. A non-judgmental, supportive approach is important to encourage disclosure of alcohol use and accessing of services (strong, high).	All pregnant and post-partum patients with AUD* should be offered, or referred to, appropriate treatment interventions and support services.	*See AUD diagnosis page for details. People with AUD are likely to have experienced trauma and stigma. It is especially important to respect the individual and their authority over their health and healing journey. See Trauma-Informed Practice Guide. See the treatment page for an overview of treatment options and planning considerations. Support clients to set self-identified and realistic goals (e.g., reducing binge drinking).
When a maternal alcohol use disorder is diagnosed*, it should be documented in the infant’s medical record after delivery (strong, low). Carers should be encouraged to discuss in utero alcohol exposure with their child’s health care provider (strong, low).		*See AUD diagnosis page for details.
Women need to be able to participate in brief interventions and treatment without undue risk of loss of child custody; where universal screening and brief interventions are implemented, policies must be aligned so that support and treatment can be encouraged by providers and accessed by women without fear (appropriate attention must still be given to the safety of the child) (strong, moderate).		The Government of Canada has an in-depth overview of provincial and territorial child protection legislation and policy on their website. The best interests of Indigenous children are protected by a 2019 federal law that authorizes Indigenous governing bodies to provide child and family services.

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Withdrawal Management		
	Where possible, alcohol withdrawal management for pregnant patients should be conducted in inpatient settings where patients can receive symptom-triggered treatment with close monitoring of withdrawal symptoms.	If inpatient withdrawal management is not an option, then outpatient treatment with close monitoring may be offered. See outpatient withdrawal management resource. When using CIWA-Ar to monitor withdrawal symptoms, note that some symptoms of alcohol withdrawal are also associated with pregnancy (e.g., nausea, vomiting, sweat, or anxiety).
	Clinicians should consider the use of the Prediction of Alcohol Withdrawal Severity Scale (PAWSS), in combination with best clinical judgement, to select the appropriate withdrawal management pharmacotherapy based on the risk of severe complications of withdrawal. --- Pregnant patients who develop alcohol withdrawal symptoms should be offered pharmacotherapy for alcohol withdrawal management. A. Gabapentin may be offered to pregnant patients at low risk of severe complications of withdrawal (PAWSS<4). B. Benzodiazepines are recommended for patients at high risk of severe complications of withdrawal (PAWSS>4).	See withdrawal medication table for detailed information.
	All pregnant and post-partum patients who undergo withdrawal management should be connected to continuing AUD care.	

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Ongoing Care		
If a woman continues to use alcohol during pregnancy, harm reduction, treatment, and social support strategies should be encouraged (strong, high). --- Specialized, community-based interventions need to be available and accessible to women with problematic drinking and related health and social concerns (strong, moderate).	All pregnant and post-partum patients with AUD should be offered, or referred to, psychosocial treatment interventions. --- Healthcare providers should consider offering pharmacotherapy with naltrexone, acamprosate, or gabapentin to prevent relapse to alcohol use in pregnant patients with moderate to severe AUD.	Social conditions should be explored and both partners or other support people should be included in treatment, if appropriate. Clinicians should strive to offer culturally safe and trauma-informed services to all clients and offer cultural practices and services to Indigenous clients as part of their care. See medication table for detailed information on selecting medications.
Post-partum Considerations		
	Healthcare providers should facilitate rooming in and encourage skin-to-skin contact to promote parent-neonate bonding and, in turn, improve maternal and neonatal outcomes.	
	Nursing parents should be strongly encouraged to discontinue alcohol use while lactating. Patients who continue using alcohol during this period should receive advice and support to reduce drinking and schedule feeding and alcohol use to ensure alcohol is eliminated from breastmilk by the time of feeding or storage of milk.	Refer patients to the Breast/Chestfeeding Calculator to determine how long to wait after consuming alcohol, before a nursing session.
	For patients who are stable on AUD pharmacotherapy (i.e., naltrexone, acamprosate, or gabapentin), decisions regarding breastfeeding should be made on a case-by-case basis with the knowledge and involvement of the patient. The possible neonatal risks of these medications should be weighed against the well-established benefits of breastfeeding for mother and neonate.	See medication table for detailed information. Providers should thoroughly explain benefits and risks to the patient. Decisions should involve the patient's preference and consent.