

# Alcohol Use in Pregnancy:

## Clinical Quick Reference for Health Care Providers

### Core Messages

- No safe amount or safe timing of alcohol use in pregnancy has been established.
- Alcohol crosses the placenta and can affect fetal development at any stage.
- Fetal Alcohol Spectrum Disorder (FASD) is preventable.

### SCREEN UNIVERSALLY

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#### When to Screen

- First prenatal visit
- Once per trimester
- 6-week postpartum visit
- Infant well-baby visits

#### Validated Tools

- T-ACE
- TWEAK
- AUDIT-C

### NORMALIZE DISCLOSURE

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*“Many people drink before knowing they’re pregnant. Can you tell me about your experience with alcohol?”*

### HEALTH RISKS OF PRENATAL ALCOHOL EXPOSURE

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#### Maternal

- Miscarriage, stillbirth
- Placental abruption
- Preterm labour and delivery
- Nutritional deficiencies (folate, thiamine)
- Worsening depression/anxiety

#### Fetal

- Fetal growth restriction
- Prematurity
- Congenital anomalies (craniofacial, cardiac, renal)
- CNS disruption
- FASD (sole known cause)

#### Neonatal & Child

- Feeding and sleep difficulties
- Developmental delays
- ADHD-like symptoms
- Increased SIDS risk
- Academic challenges
- Mental health disorders

## BRIEF INTERVENTION (5-15 Minutes Works)

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Use **Motivational Interviewing (MI)**

### 5As Framework

1. **Ask** about use
2. **Advise** no safe amount
3. **Assess** readiness to change
4. **Assist** with plan/support
5. **Arrange** follow-up

Key principles:

- Non-judgmental tone
- Support autonomy
- Reinforce small progress

## WHEN TO REFER

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Refer to addiction or perinatal mental health services if:

- Moderate-severe alcohol use
- Suspected Alcohol Use Disorder (AUD)
- Withdrawal symptoms
- Polysubstance use
- Significant psychiatric comorbidity

Engage multidisciplinary care:

- Addiction medicine
- Mental health services
- Social work
- IPV and housing supports
- Peer support

## ALCOHOL WITHDRAWAL (Emergency)

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- Assess for tremors, seizures, autonomic instability
- Hospital-based benzodiazepine management if needed
- Start thiamine before alcohol reduction

## HARM REDUCTION

(If Immediate Abstinence Not Possible)

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Abstinence is safest.

If patient cannot stop immediately:

- Reduce frequency/quantity
- Avoid binge drinking ( $\geq 4$  drinks per occasion)
- Increase follow-up
- Address trauma, safety, housing

Harm reduction maintains engagement in care.

## POSTPARTUM CARE

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Relapse risk: **60-70% within 6-12 months**

Continue screening and support at:

- 6-week postpartum visit
- Infant visits
- Mental health follow-ups

Screen for:

- Postpartum depression
- Anxiety
- IPV
- Social isolation

## ALCOHOL AND BREASTFEEDING

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- Alcohol passes into breast milk at blood-level concentrations
- Peak levels at 30-60 minutes
- Delay breastfeeding ~2 hours per standard drink
- Chronic/heavy use contraindicated

Abstinence remains safest.

## CLINICAL APPROACH

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- Screen everyone (not risk-based only)
- Use trauma-informed, culturally safe care
- Avoid punitive language
- Document supportive interventions
- Prioritize engagement over surveillance

## KEY TAKEAWAYS

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- Universal screening is essential.
- Brief interventions are effective.
- Integrated addiction + mental health care improves outcomes.
- Postpartum follow-up is critical.
- FASD is preventable.