

Clinical Practice Guideline
for
Smoking Cessation in Pregnancy

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IMPORTANT NOTICE

This guideline is designed to assist health care clinicians in identifying and assisting pregnant women with smoking cessation.

The guideline is not intended to be prescriptive, and the recommendations may not be appropriate for use in all circumstances. The guideline is designed to provide reliable, up-to-date information enabling integration of best evidence, clinicians' judgement and individual choice in arriving at decisions about smoking cessation. Clinical practice guidelines may be considered as generally recommended practice.

The first edition of the Clinical Practice Guideline for Smoking Cessation in Pregnancy was launched in July 2004 and piloted for 12 months at the Mater Mothers' Hospital, Brisbane.

This is the second edition of the Clinical Practice Guideline for Smoking Cessation in Pregnancy, reviewed and updated in August 2005.

This guideline will be updated on or before August 2008.

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FURTHER INFORMATION

For further information about the guideline, please contact:

Centre for Clinical Studies, Mater Health Services

Phone + 61 7 3163 1591

Fax +61 7 3163 1588

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1.0 EXECUTIVE SUMMARY

1.1 Introduction

Although the effectiveness of interventions for smoking cessation in pregnancy is well established and a substantial amount of work has been undertaken in the area of guideline development, best practice has not been implemented across Australia. A recent report from the National Institute of Clinical Studies has highlighted the gap between what is known from the best available research and what is actually done in day-to-day practice for smoking cessation programs in pregnancy ⁽¹⁾.

Through a Service Agreement with Queensland Health, the Centre for Clinical Studies at Mater Health Services has coordinated the development of this guideline to address this issue in Queensland. A pilot project was undertaken at the Mater Mothers' Hospital in Brisbane during 2004 to evaluate the guideline and the implementation strategy for increasing uptake of the guideline recommendations into practice. The results of the evaluation, which includes feedback from antenatal care clinicians and women attending the antenatal clinic, has informed the most recent update of the guideline and will enable consideration by Queensland Health of potential strategies for widespread implementation of the guideline in Queensland maternity hospitals.

1.2 Background and rationale

Cigarette smoking during pregnancy is common. Smoking prevalence in developed countries has been reported to range between 13% to 38% ⁽²⁾. The detrimental effects of cigarette smoking in pregnancy are well known. Adverse pregnancy and infant outcomes are well documented and include: miscarriage, stillbirth, antepartum haemorrhage, preterm premature rupture of membranes, preterm birth, low birth weight (LBW), fetal growth restriction, Sudden Infant Death Syndrome (SIDS) and childhood respiratory and behavioural problems ⁽²⁻⁶⁾.

The effectiveness of smoking cessation interventions for pregnant women in reducing smoking rates, reducing preterm birth and low birth weight is supported by high level evidence ⁽⁷⁾. Despite this evidence and numerous international and national publications recommending best practice, there is a lack of national policy and guidelines regarding smoking cessation interventions in routine antenatal care ⁽⁸⁾ and little uptake into practice ⁽⁹⁾. Few Australian hospitals adopt a systematic approach to identifying pregnant women who smoke or offer advice and assistance to quit ^(8,10). This guideline and the planned implementation project have been developed in an attempt to address this deficiency.

1.3 Purpose and intended audience

The purpose of the guideline is to assist health care clinicians in antenatal clinics and general practices to more effectively identify pregnant women who smoke, assist them to quit smoking and to stay quit. The intended audience are health care clinicians providing routine antenatal care in Queensland public hospitals. The guideline specifically addresses smoking in pregnancy and is intended to complement the Smoking Cessation Guidelines for Australian General Practice ⁽¹¹⁾ and the Smoke Check Program for Indigenous Australians ⁽¹²⁾ initiatives. It is hoped that implementation of the guideline will assist health care providers in addressing this important health care issue resulting in reduced tobacco exposure for mothers and babies and improved health outcomes.

1.4 Methods

The guideline has been prepared according to the National Health and Medical Research Councils' (NHMRC) Guidelines for the Development of Guidelines (NHMRC 1999), which included the establishment of a multidisciplinary state-wide Working Party. The Working Party drew heavily on the National Tobacco Strategy 1999 to 2002-03 occasional paper "Smoking Cessation Interventions: review of evidence and implications for best practice in Health Care Settings" ⁽²⁾. Other major resources included Clinical Practice Guidelines for Health Professionals in the United States ⁽⁴⁾, United Kingdom ⁽¹³⁾, New Zealand ⁽¹⁴⁾ and 3 Centres Consensus ⁽¹⁵⁾.

1.5 Guideline recommendations

The "5As" approach to smoking cessation (Ask, Advise, Assess, Assist, Arrange support) forms the basis of this guideline. Using the 5A's approach women are asked their current smoking status; advised of risks to themselves and their baby; assessed for readiness to quit; offered assistance with quitting and if required support is arranged. To reduce workload in busy hospital antenatal clinics, the guideline recommends a focus on accurate identification of smoking status for all women at the first antenatal booking in visit and subsequently more focussed attention at each antenatal visit for women who are current smokers or who have recently quit (within last 12 months) using the 5A's approach. Due to limited evidence, the guideline does not adequately address the important area of postpartum relapse prevention. As smoking relapse rates are high for women who quit during pregnancy, this issue requires urgent attention.

1.6 Key recommendations for smoking cessation in pregnancy

Recommendation	Level of Evidence	References
<p>Clinic or institutional systems should be developed to enable effective uptake of best practice in smoking cessation in pregnancy including systems which:</p> <ul style="list-style-type: none"> enable easy identification of all pregnant women who are current smokers or recent quitters enable smoking cessation interventions to be incorporated into routine antenatal care address local barriers to the uptake of best practice in smoking cessation promote a total smoke free environment 	<p>B</p> <p>C</p>	(2, 4, 14)
<p>Antenatal health care professionals should be provided with training from expert counsellors on effective strategies to aid quitting, counselling skills and referral agency options for pregnant women.</p>	C	(2)
<p>A women's current smoking status and the smoking cessation support provided should be clearly documented in the woman's Pregnancy Hand Held Record.</p>	C	(2, 4, 14)
<p>All women should be asked their current smoking status at the first antenatal booking visit using a multi-choice approach to questions.</p> <p>The 5A's approach to smoking cessation should be incorporated into routine antenatal care. As a minimum, a brief smoking cessation intervention (lasting approximately 3 to 5 minutes) using the 5A's (Ask, Advise, Assess, Assist and Arrange) framework should be implemented for all pregnant women who are identified as smokers or recent quitters (quit within the last 12 months) at every antenatal visit and continued in the postpartum period.</p> <p>More intensive counselling should be made available to pregnant women to aid a quit attempt and/or prevent relapse eg referral to Quitline.</p> <p>The 5A's approach: Ask: Ask the woman about her smoking status using a multi-choice approach to questions. Advise: Advise the woman of the risks to her baby's health, her own and other family members' health and of the benefits of quitting at any stage during pregnancy. Advice should be given in a clear, non-judgemental, supportive personalised manner. Assess: Assess the woman's readiness to quit or stay quit, to determine the advice and support needed. Assist: Assist the woman with smoking cessation support. Use the stage of 'readiness to quit' to guide the assistance and support provided.</p> <p>Motivation interventions using the 5R's (relevance, risk, rewards, roadblocks and repetition) framework may be utilised to promote the motivation to quit for women not ready to make a quit attempt. Clinicians should use motivational interventions with empathy and understanding promoting the woman's choice and supporting self efficacy.</p> <p>Offer pregnancy specific, culturally appropriate written material on smoking cessation. Offer: <i>Smoking & Pregnancy and Healthy 2 (Baby and You)</i> and/or <i>Smoke Check (for Indigenous women)</i> to all women who are identified as smokers and recent quitters.</p> <p>Arrange: For all women who are ready to quit or who have recently quit offer referral to Quitline: use fax form (07) 3238 4075 and provide phone number 131 848.</p> <p>To enable continuing support for women choosing shared antenatal care with a General Practitioner (GP), information on the woman's current smoking status, readiness to quit, and the support provided at the hospital antenatal clinic should be included in the routine hospital correspondence to the GP.</p>	<p>B</p> <p>A</p> <p>A</p> <p>B</p> <p>B</p> <p>B</p> <p>C</p> <p>A</p> <p>B</p> <p>✓</p>	<p>(2, 4, 14)</p> <p>(2)</p>

Smoking cessation support should be provided to the woman's partner if a smoker. Offer written materials <i>Important News for Fathers Who Smoke and QUIT Because You Can</i> brochures and offer referral to Quitline: using a fax form (07) 3238 4075 and providing the phone number 131 848	B ✓	(4)
Postpartum relapse prevention should commence during the antenatal period and continue after birth of the baby in hospital and in the community at routine postnatal health checks and non routine consultations to health care professionals. Postpartum relapse interventions should follow the 5As approach and include provision of written materials, fax referral to Quitline and advice which reinforces the importance of staying a non smoker including the risks to the baby of passive smoking. Offer the brochure <i>Staying Stopped - remaining a non-smoker after your pregnancy</i> at the 36 week antenatal visit or at delivery prior to discharge home.	B ✓ ✓	(2, 16)
Pharmacological Interventions, such as Nicotine Replacement Therapy, should be only considered when a pregnant woman is otherwise unable to quit and when the likelihood and benefits of quitting outweigh the risks of pharmacotherapy and continuation of smoking.	C	(2, 4, 14)

Definitions for the strength of evidence: This grading system has been adapted from National Tobacco Strategy 1999 to 2002-03 occasional paper "Smoking Cessation Interventions: review of evidence and implications for best practice in Health Care Settings" ⁽²⁾.

- A Multiple well-designed, randomised, controlled trials directly relevant to the recommendation, yielding a consistent pattern of findings.
- B Some evidence from randomised controlled trials, but not optimal. More interpretation of the evidence was needed. For example, there were not many randomised-controlled trials. For trials that did exist results were not consistent or the trials were not directly relevant to the recommendation. They may not have been directly relevant because, for example, the study population was different.
- C NO randomised controlled trials but the issue was important enough to merit a recommendation based on published evidence and expert opinion of review panel (of the National Tobacco Strategy 1999 to 2002-03).
- ✓ Consensus of the Queensland Smoking Cessation Working Party. Insufficient evidence for the interventions in pregnancy and no clear consensus by the expert review panel (of the National Tobacco Strategy 1999 to 2002-03) in relation to pregnancy, however the Working Party thought the issue important enough to merit a recommendation.

2.0 CLINICAL PRACTICE GUIDELINES FOR SMOKING CESSATION IN PREGNANCY

2.1 Introduction

Although the effectiveness of interventions for smoking cessation in pregnancy is well established and a substantial amount of work has been undertaken in the area of guideline development, best practice has not been implemented across Australia. A recent report from the National Institute of Clinical Studies has highlighted the gap between what is known from the best available research and what is actually done in day-to-day practice for smoking cessation programs in pregnancy⁽¹⁾. Pregnancy is seen to be an opportunistic time for women to quit smoking, however few hospitals include smoking cessation advice as part of routine antenatal care^(8,10).

Through a Service Agreement with Queensland Health, the Centre for Clinical Studies at Mater Health Services has coordinated the development of this guideline to address this issue in Queensland. A pilot project was undertaken at the Mater Mothers' Hospital in Brisbane during 2004 to evaluate the guideline and the implementation strategy for increasing uptake of the guideline recommendations into practice. The results of the evaluation, which includes feedback from antenatal care clinicians and women attending the antenatal clinic, has informed the most recent update of the guideline and will enable consideration by Queensland Health of potential strategies for widespread implementation of the guideline in Queensland maternity hospitals.

This guideline has been prepared according to the National Health and Medical Research Councils' (NHMRC) Guidelines for the Development of Guidelines (NHMRC 1999) and is based on the national document, The National Tobacco Strategy 1999 to 2002-03 occasional paper "Smoking Cessation Interventions: review of evidence and implications for best practice in Health Care Settings"⁽²⁾. The "5A's" (Ask, Advise, Assess, Assist and Arrange support) strategy is recommended at each antenatal visit to identify pregnant women who smoke and to offer assistance to stop smoking. The repeated use of this strategy is recommended due to high relapse rates in quitters; inaccurate reporting by women of smoking status and the impact of changed circumstances on women's motivation⁽¹⁵⁾. With consideration of the often heavy workload of clinicians in hospital antenatal clinics, the guideline recommends a focus on accurate identification of smoking status for all women at the first antenatal booking visit and subsequently more focussed attention at each antenatal visit for women who are current smokers or who have recently quit (within last 12 months) only using the 5A's approach. The US Department of Health Guideline suggests that repeated assessment is not necessary for those women who have never smoked or who have not used tobacco for many years and for whom this information is clearly documented in the medical record⁽⁴⁾.

Due to limitations in the currently available evidence, the guideline does not adequately address the important area of postpartum relapse prevention. As smoking relapse rates are high for women who quit during pregnancy, this issue requires urgent attention.

The guideline was intentionally developed to be a concise summary of the best available evidence and readers are referred to the major sources used by the Working Party for further information as follows:

- Miller M, Wood L. National Tobacco Strategy 1999 to 2002-03 occasional paper: Smoking cessation interventions: review of evidence and implications for best practice in health care settings. Canberra: Commonwealth Department of Health and Ageing; 2001.
- Fiore EB, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz ER, et al. Treating Tobacco Use and Dependence. A Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2000.
- West R, McNeill A, Raw M. Smoking cessation guidelines for health professionals: an update. Health Education Authority. Thorax 2000;55 (12):987-99.
- National Advisory Committee on Health and Disability. Guidelines for Smoking Cessation. Wellington, New Zealand: National Health Committee; 2002.
- Three Centres Consensus Guidelines on Antenatal Care Project. Three Centres Consensus Guidelines on Antenatal Care. Victoria, Australia: Three Centres Consensus Guidelines on Antenatal Care Project, Mercy Hospital for Women, Southern Health and Women's & Children's Health; 2001.
- Lumley J, Oliver S, Chamberlain C, Oakley L. Interventions for promoting smoking cessation during pregnancy. In: The Cochrane Library 2005, Issue 3. Wiley Interscience software.

2.2 Purpose of the guideline

The purpose of the guideline is to assist health care clinicians in antenatal clinics and general practices to more effectively identify pregnant women who smoke, assist them to quit smoking and to stay quit.

2.3 Intended audience

The intended audience for the guideline is health care clinicians providing routine antenatal care in Queensland public hospitals. The guideline has been developed to specifically address smoking in pregnancy and is intended to complement the Smoking Cessation Guidelines for Australian General Practice⁽¹¹⁾ and the Smoke Check Program for indigenous Australians⁽¹²⁾.

2.4 Aims of the guideline

It is hoped that implementation of the guideline will assist health care providers in addressing this important health care issue resulting in reduced tobacco exposure for mothers and babies and improved health outcomes.

Specifically the short and longer term aims of the guideline are to:

Short term

- provide a framework for a systematic approach to smoking cessation interventions in pregnancy
- assist health care clinicians to more effectively identify pregnant women who smoke
- assist health care clinicians to more effectively assist pregnant women to quit smoking and stay quit
- permit smoking cessation in pregnancy to be monitored and to provide local feedback.

Longer term

- minimise tobacco exposure to women and babies
- minimise harm caused by passive smoking to newborns
- reduce the long-term health risks for women and babies associated with tobacco use.

2.5 Background

2.5.1 Smoking in pregnancy: the burden of illness

Cigarette smoking during pregnancy is common. Smoking prevalence in developed countries has been reported to range between 13% to 38%⁽²⁾. Adverse pregnancy and infant outcomes are well documented and include: miscarriage, stillbirth, antepartum haemorrhage, preterm premature rupture of membranes, preterm birth, low birth weight (LBW), fetal growth restriction, Sudden Infant Death Syndrome (SIDS) and childhood respiratory and behavioural problems⁽²⁻⁶⁾. Pooled estimates of relative risks for smokers are at least doubled for LBW (RR 2.04) and fetal growth restriction (RR 2.28); a third more likely for preterm delivery (RR 1.34) and almost three times higher for SIDS (RR 2.76). Smoking is associated with around 10% of stillbirths (RR 1.33) and miscarriage (RR 1.36)^(7, 15).

There are marked social differences between women who smoke in pregnancy and those who do not. Continued smoking in pregnancy and high daily consumption show a strong association with social disadvantage, high parity, being without a partner, and low income⁽¹⁴⁾. Although population based data on smoking in pregnancy is limited, it is clear that smoking rates are particularly high in teenagers and Indigenous Australians (approximately 50%-60%)⁽²⁾. A recent analysis of smoking data for women attending antenatal clinic at the Mater Mothers' Hospital, Brisbane revealed that 22% were smokers at the time of the initial booking visit. Of these, approximately 50% smoke greater than 11 cigarettes per day and 40% are teenagers (less than 19 years of age). Other factors associated with smoking in this cohort included low education level (not having finished Grade twelve) and women who were not married or living in a de facto relationship⁽¹⁷⁾.

Whilst 20%-30% of women who become pregnant will quit, there is a high relapse rate during pregnancy and post delivery. Approximately half of women who quit smoking during pregnancy will have started smoking again within 6 months and up to 70% will have recommenced smoking within 12 months^(2, 4). Despite the high relapse rates, smoking cessation programs in pregnancy have been shown to reduce the number of women who smoke in pregnancy and results in health benefits⁽⁷⁾.

2.5.2 Effectiveness of smoking cessation in pregnancy

The effectiveness of smoking cessation interventions in reducing smoking rates in pregnant women, reducing preterm birth and low birth weight is supported by high level evidence ⁽⁷⁾. The Cochrane systematic review on smoking cessation in pregnancy ⁽⁷⁾, identified a total of 44 randomised control trials between 1975 and 1998, involving over 17,000 women testing the effectiveness of smoking cessation interventions during pregnancy. Meta-analysis of 34 trials showed that smoking cessation interventions of various types are effective. A 50% reduction in smoking rates was shown for women who had received some exposure to a smoking cessation intervention (OR 0.53, 95% Confidence Interval (CI) 0.47, 0.60, effect size 6.6%) ⁽⁷⁾. A subgroup analysis showed a reduction in low birthweight (OR 0.80, 95% CI 0.67 to 0.95), preterm birth (OR 0.83, 95% CI 0.69 to 0.99) and an increase in mean birthweight of 28g (95% CI 9 to 49) ⁽⁷⁾. Furthermore, smoking cessation programs in pregnancy have been shown to be cost-effective ⁽¹⁸⁻²¹⁾.

2.5.3 Current policies, protocols and guideline

Despite numerous international and national publications including evidence based best clinical practice recommendations for smoking cessation programs in pregnancy, there has been little uptake of these recommendations into practice ⁽⁹⁾. A review of national policy documents and guidelines on routine pregnancy care failed to find any policies or guidelines which included advice on smoking cessation ⁽⁸⁾. A national consensus conference on smoking and pregnancy held in 1998 made recommendations for the development of guidelines ^(22, 23). However, a later review of protocols for antenatal care in Australian public hospitals and Divisions of General Practice revealed that 90% of protocols did not include written information and advice about smoking cessation. Of the eleven protocols that included smoking cessation only two gave details about how to provide advice and support for quitting ⁽⁸⁾. More recently there has been antenatal guidelines developed by the 3centres collaboration in Victoria, which includes provision of smoking cessation interventions during pregnancy ⁽¹⁵⁾.

2.5.4 Barriers to uptake of guidelines

Whilst most pregnant smokers in Australia are identified through routine antenatal care, only limited numbers of health care providers receive training in quit smoking interventions and therefore feel unable and lack the confidence to counsel smokers ⁽²⁴⁾. A survey of medical and nursing directors of public antenatal clinics in Australia on smoking cessation intervention programs offered to pregnant women identified the following barriers for uptake into practice for clinicians: lack of appropriate training; lack of staff confidence in their ability to counsel smokers; pessimism about the effectiveness of smoking advice; staff being unfamiliar with the role expected of them; competition with existing organisational priorities and lack of institutional policies ⁽²⁴⁾. Similar barriers have been identified by general practitioners ^(25, 26). Locally, Balanda et al (1995) suggest that less than 25% of antenatal clinics in Queensland provide effective cessation programs for smokers.

This guideline and the accompanying implementation project is an attempt to address the current deficiency in best practice for smoking cessation in routine antenatal care in Queensland.

2.6 Recommendations for smoking cessation in pregnancy interventions

2.6.1 Systems for effective uptake of best practice

Clinic or institutional systems should be developed to enable effective uptake of best practice in smoking cessation in pregnancy including systems which:

- enable easy identification of all pregnant women who are smokers or recent quitters
- enable smoking cessation interventions to be incorporated into routine antenatal care
- address local barriers to the uptake of best practice in smoking cessation
- promote a total smoke-free environment

The National Tobacco Strategy 2004-2009 states as one of its policy intentions that all Australian smokers in contact with the health care system are identified and advised to quit ⁽²⁷⁾. The National Tobacco Strategy 1999 to 2002-2003 occasional paper ⁽²⁾ recommends hospital systems be implemented to routinely identify and treat smokers. The paper states that "Hospitals are an ideal setting for smoking cessation interventions because of the opportunities to provide information and advice during patient contact; in relation to admission for smoking related health problems; risks of surgical complications related to smoking and the fact that most

B /
C

hospitals have smoke-free policies". Pregnancy is a highly motivating time for many women to improve health behaviours and pregnant women are seen in hospitals on a regular basis providing an opportune situation to assist and support smokers in quitting smoking. In implementation of best practice, hospitals should consider ways to overcome potential barriers to effective uptake. Hospitals should be encouraged to work towards total smoke-free policies.

2.6.2 Education of health care professionals

Antenatal health care professionals should be provided with training from expert counsellors on effective strategies to aid quitting, counselling skills and referral agency options for pregnant women.

C

The National Tobacco Strategy 1999 to 2002-2003 occasional paper ⁽²⁾ recommends that health professionals have ready access to training and practice guidelines for supporting smokers in quit attempts. Training programs for health professionals should address barriers to implementation and involvement for example:

- *lack of time to carry out the intervention* - brief intervention strategies require only between 3-5 minutes and should be achievable for all women and their partners identified as smokers or recent quitters during routine antenatal visits and referral options for more intensive intervention and follow up i.e. Quitline;
- *lack of confidence in providing the intervention*- training by expert counsellors eg Queensland Cancer Fund;
- *lack of resources*- appropriate resources should be provided including clear clinical practice recommendations and reminders (decision algorithms and documentation systems), written materials for women and advice about available referral options for more intensive intervention and follow up i.e. Quitline.

2.6.3 Documentation

Refer Appendix 1: Smoking assessment and intervention form

C

A woman's current smoking status and the smoking cessation support provided should be clearly documented in the woman's Pregnancy Hand Held Record.

Effective identification and documentation of current or past cigarette smoking is the first step in providing effective interventions for smoking cessation. Documentation of smoking status and readiness to quit assists clinicians in providing appropriate interventions. Adequate documentation results in increased intervention rates ⁽⁴⁾.

2.6.4 Smoking cessation interventions

Refer Appendix 2: Algorithm of Smoking Cessation Interventions in Pregnancy

2.6.4.1 Identification of smoking status

All women should be asked their current smoking status at the first antenatal booking visit using a multi-choice approach to questions.

B

For all women ask "Have you ever smoked?" If the response is "No" record on the Pregnancy Hand Held Record, no further action required. If the response is "Yes" then ask the following and record the response:

"Which of the following statements best describes your cigarette smoking?"

- I smoke daily now, about the same as before finding out I was pregnant
- I smoke daily now, but I have cut down since finding out I was pregnant
- I smoke every once in a while
- I quit since finding out I was pregnant
- I wasn't smoking around the time I found out I was pregnant – I had stopped smoking within the last 12 months
- I wasn't smoking around the time I found out I was pregnant – I had stopped smoking more than 12 months ago.

The use of multiple choice questions is more effective than a simple dichotomous (Yes/No) question, increasing disclosure of tobacco use among pregnant women by as much as 40% ⁽²⁸⁾.

A

2.6.4.2 The 5A's (Ask, Advise, Assist, Assess and Arrange)

The 5A's (Ask, Advise, Assist, Assess and Arrange) approach to smoking cessation should be incorporated into routine antenatal care. As a minimum, a brief smoking cessation intervention (lasting approximately 3 to 5 minutes) using the 5A's (Ask, Advise, Assess, Assist and Arrange) framework should be implemented for all pregnant women who are identified as smokers or recent quitters (quit within the last 12 months) at every antenatal visit and continued in the postpartum period.

The Cochrane systematic review of interventions for promoting smoking cessation during pregnancy shows that brief interventions during pregnancy can double quit rates and prevent relapse among spontaneous quitters, whilst multifaceted interventions (such as multiple contacts, multiple formats with appropriate written resources and follow up) result in a reduction in smoking rates, low birth weight and preterm birth⁽⁷⁾. Whilst greatest benefits to the fetus are realised if mother abstains from smoking throughout pregnancy, there are benefits to quitting at any stage⁽⁴⁾.

Based on National Tobacco Strategy 1999 to 2002-2003 occasional paper, smoking cessation and relapse interventions should be implemented in all maternity care settings as part of routine antenatal care and extended into the postpartum period⁽²⁾. As a minimum, the 5A's (*Ask, Advise, Assess, Assist and Arrange*) approach as a brief clinical intervention (lasting from 3-5 minutes and up to 10 minutes) should be implemented. This intervention involves asking the woman her smoking status; advising of health risks to her and her baby and the benefits of attempting to quit, offering relevant brochures and assistance as required by the woman depending on her stage of readiness to quit; and arranging follow-up.

A

More intensive counselling should be made available to pregnant women to aid a quit attempt or prevent relapse. A referral to Quitline should be offered to all women attempting to quit smoking or who have recently quit smoking.

Women who are preparing to quit or may have recently quit require extra support and assistance in the form of more intensive interventions. Intensive interventions generally take more than 10 minutes and will involve more in depth counselling and offering extended support such as Quitline referral^(2,4).

B

2.6.4.2.1 ASK the woman about her smoking status

Ask the woman about her smoking status using a multi-choice approach to questions at each antenatal visit.

A

2.6.4.2.2 ADVISE the woman of the risks

Advise the woman of the risks to her baby's health, her own and other family members' health and of the benefits of quitting at any stage during pregnancy. Advice should be given in a clear, non-judgemental, supportive, personalised manner.

Advice about the risks should include: the risk of having a stillbirth, preterm birth, growth restricted or with low birth weight baby, the need for admission of the baby to a special/intensive care nursery and the risks associated with passive smoking (environmental smoke) on the infant including Sudden Infant Death Syndrome, respiratory and ear infections, asthma and behavioural problems⁽³⁾.

2.6.4.2.3 ASSESS the woman's readiness to quit or stay quit

B

Assess the woman's readiness to quit or stay quit, to determine the advice and support needed.

Assessing the woman's readiness to quit is a helpful first step in planning care by allowing clinicians to identify smoking cessation support which meets the woman's needs. ^(2, 4) Although there is currently limited information on the effectiveness of this approach for pregnant women, after reviewing the evidence in detail, the Working Party agreed to recommend assessing a woman's readiness to quit as this may increase uptake into practice by providing a clear framework for clinicians.

Examples for questioning readiness to quit or stay quit:

"How do you feel about your smoking?"

"Have you ever tried to quit?"

"Would you have a go at cutting down?"

"Have you thought anymore about smoking since your last visit?"

"Have you had a chance to read the brochures you were given on smoking in pregnancy?"

"Did you find the brochures helpful?"

If referred to Quitline "Did the people from Quitline contact you?"

2.6.4.2.4 ASSIST the woman with smoking cessation support using the stage of 'readiness to quit'

B

Assist the woman with smoking cessation support. Use the stage of 'readiness to quit' to guide the assistance and support provided.

The stages of 'readiness to quit' present specific strategies and interventions to guide clinicians in providing brief interventions ⁽⁴⁾.

Stage 1: For women not interested in quitting

- Use the 5R's (*relevance, risk, rewards, roadblocks and repetition*) approach to motivate a quit attempt (see below: 2.6.5 *Motivational Interventions*)
- Offer written resources, specific to pregnant women eg Brochures: *Smoking & Pregnancy, Healthy 2 (Baby and You), Smoke Check* (for Indigenous women)
Suggested advice: "What I would like you to do is take these brochures with you. I know that you are not interested in quitting at the moment, but in future you might like to think about having a quit attempt".
- Advise that the health care team is available to help when the woman is ready

Stage 2: For women interested in quitting: 'thinking about it'

- Use the 5R's approach to motivate a quit attempt
- Offer written resources, specific to pregnant women eg Brochures: *Smoking & Pregnancy, Healthy 2 (Baby and You), Smoke Check* (for Indigenous women)
- Advise that the health care team is available to help when she is ready
- Offer the woman referral to Quitline; use fax form (07) 3238 4075 and provide phone number 131 848

Stage 3: For women interested in quitting: 'preparing to quit'

- Confirm with the woman, which pregnant specific written resources have been given, and offer further brochures as needed eg Brochures: *Smoking & Pregnancy, Healthy 2 (Baby and You), Smoke Check* (for Indigenous women)
- Offer the woman referral to Quitline; use fax form (07) 3238 4075 and provide phone number 131 848
- Discuss supports available: social supports (help the woman to develop social support for her attempt to quit) and nicotine replacement therapy (NRT) in consultation with medical staff
- Help develop a quit plan: inform the woman to tell family, friends, co-workers of her intention to quit and asked for support; advise the woman to remove all tobacco products from her environment.

- Set a quit date (ideally should be within 2 weeks)
- Offer practical counselling: review smoking history and motivation to quit, help in identification of roadblocks, smoking cues and generate strategies to deal with the identified roadblocks.
- Advise that the health care team is available to help when the woman is ready

Stage 4: For women 'recently quit'

- Identify high-risk situations and important smoking triggers i.e. alcohol consumption, stress
- Review and reinforce benefits of quitting
- Congratulate and encourage quitters
- Offer the woman referral to Quitline: use fax form (07) 3238 4075 and provide phone number 131 848
- Plan ahead – discuss coping strategies, anticipated problems
- Discuss with patient how to deal with a slip-up to prevent it becoming a full relapse
- Discuss that relapse is a normal part of the process (may take up to 4 Quit attempts before finally succeeding) which reinforcing the importance for herself and the baby of not smoking during pregnancy⁽¹⁴⁾

2.6.4.2.5 ARRANGE support:

B

For all women who are ready to quit or who have recently quit offer referral to Quitline: use fax form (07) 3238 4075 and provide phone number 131 848.

✓

To enable continuing support for women choosing Shared antenatal care with a General Practitioner (GP), information on the woman's current smoking status, readiness to quit, and the support provided at the hospital antenatal clinic should be included in the routine hospital correspondence to the GP.

Refer Appendix 3: Quitline Fax Referral Form

2.6.5 Motivation interventions - the 5Rs (relevance, risk, rewards, roadblocks & repetition)

C

Motivation interventions using the 5R's (relevance, risk, rewards, roadblocks and repetition) framework may be utilised to promote the motivation to quit for women not ready to make a quit attempt. Clinicians should use motivational interventions with empathy and understanding, promoting the woman's choice and supporting self efficacy.

Motivational consulting has shown to increase activity aimed at quitting⁽²⁹⁾. Patients who may be reluctant to make a quit attempt may lack information regarding risks of smoking and benefits of quitting, have fears or concerns regarding barriers or impediments and of failure in not managing to quit⁽⁴⁾.

The 5Rs framework can be used to provide motivational interventions. Motivational interventions are more likely to be successful when delivered empathetically and supportively. In using motivational interventions, the clinician should promote the woman's choice, avoid arguments and support patient self efficacy⁽²⁾.

(1) Relevance:

- Ask the woman why is quitting personally relevant?
- Discuss smoking relevance to pregnancy and baby, family or social situation

(2) Risks:

Ask the woman to identify negatives of smoking and discuss the risks in terms of acute, long term and passive (environmental)

- Acute Risks: harm to baby (preterm birth, growth restriction, stillbirth, respiratory and behavioural problems) shortness of breath, harm to pregnancy (antepartum haemorrhage, miscarriage)
- Long Term Risks: heart attacks and strokes, lung and other cancers

- Passive (environmental) Risks: to children (SIDS, asthma, middle ear disease, respiratory infections) and to spouse (increased risk of lung cancer; heart disease)

Emphasise that smoking low-tar/low-nicotine cigarettes will not eliminate these risks

(3) Rewards:

Ask the woman to identify the benefits of not smoking and discuss the rewards in terms of improved health for her and her baby; food will taste better; improved sense of smell; money saved.

(4) Roadblocks:

Ask the woman to identify barriers to quitting and discuss ways to address these barriers. Potential barriers: desire for a small baby, concern about increased weight gain, added stress and depression, withdrawal symptoms.

- **Small Baby:** women are less concerned than health care providers of giving birth to a small baby ⁽³⁰⁾. Having a small (low birth weight) baby may be perceived that the labour and delivery will be easier. If women know other women who smoke and have had healthy babies they are more likely to discount the purported risks of poor growth, premature birth and fetal death ⁽³⁰⁾. Women need to be advised that a small baby can be a sick baby and may require more intensive nursing care in either an intensive care or special care nursery.
- **Weight Gain:** some women may be concerned about weight gain if they stop smoking during pregnancy ⁽³⁰⁾. Women need to be advised on the greater risks of smoking to their health and their baby's health than gaining weight.
- **Stressors:** women perceive that smoking helps them deal with common life stressors ⁽³⁰⁾. Women need to receive practical counselling and problem solving strategies to cope with the stressors.

(5) Repetition:

Repeat this process, at each visit, with all women requiring motivation to attempt to quit.

2.6.6 Written materials

A

Offer pregnancy specific, culturally appropriate written material on smoking cessation. Offer: Smoking & Pregnancy and Healthy 2 (Baby and You) and/or Smoke Check (for Indigenous women) to all women who are identified as smokers and recent quitters.

Whilst more intensive interventions achieve greater success, brief intervention including offering self help material achieves estimated abstinence rates of 6.6% for pregnant women ⁽⁴⁾. Pregnancy specific, self-help smoking cessation materials are recommended as part of interventions provided. The written materials recommended in this guideline are: *Smoking & Pregnancy and Healthy 2 (Baby and You) and/or Smoke Check (for Indigenous women)*. *Smoking & Pregnancy and Healthy 2 (Baby and You)* were chosen as they are pregnancy specific and were recommended by the Queensland Cancer Fund and the *Healthy 2* brochure has been evaluated for use in the Australian antenatal clinic setting ⁽³¹⁾. The *Smoke Check* brochure is again pregnancy specific and has been developed in consultation with Indigenous Health Workers ⁽¹²⁾.

2.6.7 Information for partners smoking cessation support should be provided to the woman's partner if a smoker.

B

Smoking cessation support should be provided to the woman's partner if a smoker.

✓

Offer written materials "Important News for Fathers Who Smoke" and "QUIT Because You Can" brochures and offer referral to Quitline: using a fax form (07) 3238 4075 and providing phone number 131 848

The number one predictor for women returning to smoking is if they have a partner who smokes^(32, 33). There is an increased success rate for women quitting if their partner is a non-smoker, is supportive in their quit attempt or quits with them. *Important News for Fathers Who Smoke* and *QUIT Because You Can* brochures were recommended by Quit Victoria and *the Important News for Fathers Who Smoke* was chosen because it addresses issues of pregnancy, passive smoking, and smoking around babies.

B

2.6.8 Relapse prevention

Postpartum relapse prevention should commence after birth of the baby and continue in the community at routine postnatal health checks and non routine consultations to health care professionals.

✓

Postpartum relapse interventions should follow the 5As approach and include provision of written materials and advice which reinforces the importance of staying a non smoker including the risks to the baby of passive smoking.

✓

Offer the brochure "Staying Stopped - remaining a non-smoker after your pregnancy" at the 36 week antenatal visit or at delivery prior to discharge home.

Whilst pregnancy is a strong motivator to quit smoking, many women will relapse post delivery. Approximately half the pregnant women who quit smoking during pregnancy will have started smoking again within 6 months and up to 70% will have recommenced smoking within 12 months⁽²⁾. Therefore women who quit during pregnancy should not be regarded as if they have quit permanently.

To reduce postpartum relapse, postpartum interventions should begin as part of routine antenatal care and continue after delivery⁽²⁾. As part of a motivation approach to staying quit, emphasis should be placed on health risks to the baby and other children. Although limited, there is some evidence to suggest that more intensive postpartum relapse prevention strategies, may be effective^(7,16). These interventions included: a 10 minute counselling session using smoking relapse prevention materials highlighting the benefits of maintaining cessation, possible problems encountered, smoking triggers, signing a contract, additional clinic reinforcement through reminder forms in the notes and staff training to provide and encourage continued cessation⁽³⁴⁾.

Whilst intensive interventions may be beneficial, due to limited evidence and the resources required to undertake such interventions, the working party has not recommended this approach. However, the Working Party felt it inappropriate not to provide women with some relapse prevention support. Therefore, the Working Party recommends that women should be provided with advice and written materials on relapse and in addition a fax referral to Quitline. The Working Party acknowledges that the area of relapse prevention research requires urgent attention.

Staying Stopped - remaining a non-smoker after your pregnancy brochure was recommended by Quit Victoria, and chosen because it is pregnancy specific and addresses postpartum relapse.

Relapse prevention strategies aim to assist people to avoid or cope with high-risk smoking situations. Advice should include:

- Identify high risk situations and important smoking triggers i.e. alcohol consumption, stress
- Plan ahead – discuss coping strategies, anticipated problems
- Reinforce benefits of quitting
- Discuss with patient how to deal with a slip-up to prevent it becoming a full relapse
- Discuss that relapse is a normal part of the process (may take up to 4 Quit attempts before finally succeeding)⁽¹⁴⁾.

C

2.6.9 Pharmacological interventions

Pharmacological Interventions, such as Nicotine Replacement Therapy, should be considered when a pregnant woman is otherwise unable to quit and where the likelihood and benefits of quitting outweigh the risks of pharmacotherapy and continuation of smoking.

The safety of Nicotine Replacement Therapy in pregnancy is still debated, therefore pharmacotherapy should only be considered after psychosocial interventions have failed⁽¹⁴⁾.

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4.0 METHODS FOR GUIDELINE DEVELOPMENT

The Centre for Clinical Studies (CCS) at Mater Health Services, South Brisbane coordinated the development of the Smoking Cessation in Pregnancy Guideline. The CCS conducted the literature search and collation of the findings. Information was then presented to the Working Part (WP) for interpretation and discussion. The CCS then compiled a draft guideline for comment by the WP. Following comment and necessary amendments, a final consultation draft of the guideline was submitted to the Queensland Health Southern Zone Maternal Neonatal Gynaecological Network and the Mater Mothers' Hospital Policy and Procedure Committee for comment and endorsement.

4.1 Working Party

4.1.1 Objectives of the Working Party

- (1) To develop and maintain the evidence-based clinical practice guideline on smoking cessation programs for women during pregnancy and in the postpartum period. In fulfilling this task, the Working Party have undertaken to follow the procedures recommended in the NHMRC handbook series on preparing clinical practice guidelines endorsed November 1999, with attention to the following steps:
 - (i) Review the scope of the guidelines in order to: ensure clinical relevance; identify further questions, target groups and relevant health outcomes to be addressed by the guideline;
 - (ii) Assess any existing guidelines;
 - (iii) Undertake a systematic review of the literature and evaluate the extent and strength of the scientific evidence relating to the effectiveness and appropriateness of the relevant interventions;
 - (iv) Refine the evidence-based guidelines and other materials to explain guidelines to consumers and other defined target groups;
 - (v) Undertake wider consultation;
 - (vi) Disseminate and implement the guideline; and
 - (vii) Evaluate and maintain the guideline.
- (2) To identify gaps in current information and data for the ongoing refinement and evaluation of the guideline.
- (3) To collaborate with local and national bodies in the development, implementation and evaluation of guideline for the smoking cessation in pregnancy, including the impact on health outcomes.

4.1.2 Working Party membership

Dr David Cartwright	Neonatologist, Director of Neonatology, Royal Brisbane & Women's Hospital, Brisbane
Prof Allan Chang	Obstetrician, Director, Centre for Clinical Studies, Mater Health Services, South Brisbane
Ms Liz Davis	Consumer Representative: Stillbirth and Neonatal Death Support Group, Brisbane
Ms Vicki Flenady (Coordinator)	Perinatal Researcher, Deputy Director, Mater Research Support Centre and Centre for Clinical Studies, Mater Health Services, South Brisbane
Ms Katherine Gillett	Tobacco Issues Coordinator, Queensland Cancer Fund
Ms Gail Hamilton	Manager, Alcohol & Drug Service, Queensland Health
Ms Lynn Heilbronn	Nurse Practice Coordinator, The Townsville Hospital, Townsville
A/Prof Claire Jackson	Associate Professor, University of Queensland General Practice, Mater Integrated Health Care and General Practice
Prof Ian Jones	Obstetrician, University of Queensland Obstetrics & Gynaecology Department

Dr Helen Liley	Neonatologist, Mater Mothers' Hospital, South Brisbane
Ms Karen New (Project Officer 2004)	Neonatal Nurse, Clinical Research Coordinator, Centre for Clinical Studies, Mater Health Services, South Brisbane
Dr Lucinda Pallis	Obstetrician, Gold Coast Hospital, Southport
Ms Barbara Soong	Midwife, Clinical Nurse Consultant, Antenatal Clinic, Mater Mothers' Hospital, South Brisbane
Ms Jocelyn Toohill	Midwife, Midwifery Educator, Mater Mothers' Hospital, South Brisbane
Ms Robin Turnbull	Nurse Practice Coordinator, Royal Brisbane & Women's Hospital, Brisbane
Dr David Watson	Obstetrician, Maternal Fetal Medicine, Mater Mothers' Hospital, South Brisbane
Ms Julie MacPhail (Project Officer 2005)	Midwife, Research Assistant, Centre for Clinical Studies, Mater Health Services, South Brisbane.

4.2 Literature search and synthesis of the evidence

4.2.1 Questions raised by the Working Party

The following questions were raised by the Working Party and formed the basis of the search strategy.

- (i) What is the optimum method of identifying pregnant women who smoke or who have recently quit in order to assist them to quit smoking and to stay quit?
- (ii) Are there effective smoking cessation interventions for pregnant women?
- (iii) What are the characteristics of smoking cessation interventions that are most effective in reducing smoking among pregnant women?
- (iv) Are smoking cessation interventions cost-effective?
- (v) Do smoking cessation interventions for pregnant women reduce smoking rates?
- (vi) Do smoking cessation interventions decrease perinatal morbidity and mortality?
- (vii) Does the provision of information and support to the pregnant woman's partner assist her to quit smoking and prevent relapse?
- (viii) What is the potential risk to the pregnant woman and her baby of nicotine replacement therapy and are these outweighed by the potential benefits?
- (ix) What is the evidence for smoking interventions in high-risk groups such as Indigenous women and teenagers?
- (x) What effective strategies can be implemented to promote smoking cessation in pregnancy within a shared care model?

4.2.2 Search strategy

The Working Party made a decision at the outset of development of this guideline to search for and utilise existing high quality guidelines where possible. A literature search was undertaken of major guideline websites (see below) and electronic databases: PubMed (1980-2003), CINAHL (1982 – 2003) and Cochrane Library databases (Issue 2, 2003). The search was updated in August 2005.

The search of electronic databases was limited to the English language, and searches were undertaken using MeSH terms: 'Smoke', 'Smoking-Cessation', 'Smoking', 'Tobacco-Smokeless', 'Smoking-Cessation-Programs', 'Intervention-Trials', 'National-Health-Programs', 'Hospital-Programs', 'Health-Promotion', 'Intervention-Studies', 'Postnatal-Care', 'Education', 'Expectant-Mothers', 'Pregnancy-in-Adolescence', 'Pregnancy', 'Pregnant-Women', 'Costs-and-Cost-Analysis', 'Cost-Benefit-Analysis', 'Health-Care-Costs', 'Thiocynates', 'Cotinine', 'Urine', 'Clinical-Trials', 'Clinical-Trials-Phase-I', 'Clinical-Trials-Phase-II', 'Clinical-Trials-Phase-III', 'Clinical-Trials-Phase-IV', 'Controlled-Clinical-Trials', 'Randomized-Controlled-Trials'; and text terms: *pregnan**, *tobacco*, *smok**, *nicotine*, *cessation*, *quit*, *intervention*, *relapse*, *birth weight*, *morbidity*, *mortality*, *validation tools*, *self reporting*, *nicotine replacement therapy*, *pharmacotherapy*, *bupropion*, *indigenous*, *teenage pregnancy*, *guidelines*, *policies* and *protocols*.

Article citations were searched to identify additional references. In addition members of the Working Party contacted experts in the field for additional information.

A search of the following Internet sites was undertaken in an effort to identify existing guidelines for smoking cessation during pregnancy and the postpartum period:

Site	Web Address
National Guideline Clearinghouse	http://www.guideline.gov/
Centre for Disease Control (CDC)	http://www.cdc.gov/
New Zealand Guideline Group	http://www.nzgg.org.nz/
Royal College of Obstetricians and Gynaecologists (UK)	http://www.rcog.org.uk/
British Columbia Guidelines	http://www.rcp.gov.bc.ca/
Canadian Task Force on Preventive Health Care	http://www.ctfphc.org/
Department of Health and Ageing – Tobacco, Alcohol & Other Drugs	http://www.health.gov.au/
Agency for Healthcare Research & Quality	http://hstat.nlm.nih.gov/hq/
Canadian Medical Association: InfoBase: Clinical Practice Guidelines	http://www.cma.ca/
Scottish Intercollegiate Guidelines Network	http://www.show.scot.nhs.uk/
National Institute for Clinical Excellence	http://www.nice.org.uk/
Medline Plus Health Information	http://www.nlm.nih.gov/medlineplus/smokingcessation.html
Health Education Board for Scotland	http://www.hebs.scot.nhs.uk/
Three Centres Consensus Guidelines	http://www.3centres.com.au

4.2.3 Search findings and synthesis of the literature

The search identified a number of existing guidelines. All, apart from one (Three Centres Consensus Guidelines on Antenatal Care), addressed smoking in pregnancy as a part of a larger document on smoking cessation in general.

Three reviewers at the Centre for Clinical Studies evaluated five existing guidelines/practice recommendations/statements on smoking cessation in pregnancy (see below) using the AGREE appraisal instrument⁽³⁵⁾. Following evaluation, a decision was made to base the development of the guideline on the document: National Tobacco Strategy 1999 to 2002-03 occasional paper: Smoking cessation interventions: review of evidence and implications for best practice in health care settings. Canberra: Commonwealth Department of Health and Ageing; 2001. Four other guidelines were also consulted by the WP as follows: Treating Tobacco Use and Dependence. A Clinical Practice Guideline. Rockville (MD); Smoking cessation guidelines for health professionals: an update. Health Education Authority; Guidelines for Smoking Cessation Wellington, New Zealand and; Three Centres Consensus Guidelines on Antenatal Care. Victoria, Australia.

The search of electronic databases failed to reveal any significant studies or reports which were not included in these existing guidelines. Individual studies or systematic review/meta analyses referenced in the sourced guidelines were not retrieved unless additional information was thought to be needed.

Existing guidelines which were evaluated:

Miller M, Wood L. National Tobacco Strategy 1999 to 2002-03 occasional paper: Smoking cessation interventions: review of evidence and implications for best practice in health care settings. Canberra: Commonwealth Department of Health and Ageing; 2001.

Fiore EB, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz ER, et al. Treating Tobacco Use and Dependence. A Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2000.

West R, McNeill A, Raw M. Smoking cessation guidelines for health professionals: an update. Health Education Authority. Thorax 2000;55 (12):987-99.

National Advisory Committee on Health and Disability. Guidelines for Smoking Cessation. Wellington, New Zealand: National Health Committee; 2002.

Three Centres Consensus Guidelines on Antenatal Care Project. Three Centres Consensus Guidelines on Antenatal Care. Victoria, Australia: Three Centres Consensus Guidelines on Antenatal Care Project, Mercy Hospital for Women, Southern Health and Women's & Children's Health; 2001.

Royal Australian College of Obstetricians and Gynaecologists. Women and Smoking. Statement no. C-Gen5. November 2003.

4.2.4 Strength of the recommendation grading

The key recommendations are evidence based and where possible were taken directly from the National Tobacco Strategy 1999 to 2002-03 occasional paper. A simplified grading system for levels of evidence was used in this statement and for consistency; additional recommendations made by the WP in this guideline used the same grading system. In addition, recommendations which were made on the basis of consensus of the WP were also acknowledged as such. This grading system is as follows:

- A Multiple well-designed, randomised, controlled trials directly relevant to the recommendation, yielding a consistent pattern of findings.
- B Some evidence from randomised controlled trials, but not optimal. More interpretation of the evidence was needed. For example, there were not many randomised-controlled trials. For trials that did exist results were not consistent or the trials were not directly relevant to the recommendation. They may not have been directly relevant because, for example, the study population was different.
- C NO randomised controlled trials but the issue was important enough to merit a recommendation based on published evidence and expert opinion of review panel (of the National Tobacco Strategy 1999 to 2002-03).
- ✓ Consensus of the Queensland Smoking Cessation Working Party. Insufficient evidence for the interventions in pregnancy and no clear consensus by the expert review panel (of the National Tobacco Strategy 1999 to 2002-03) in relation to pregnancy, however the Working Party thought the issue important enough to merit a recommendation.

APPENDIX 1 Smoking Assessment and Intervention Form

ASK

Have you ever smoked? No Yes

Which of these statements best describes your cigarette smoking?

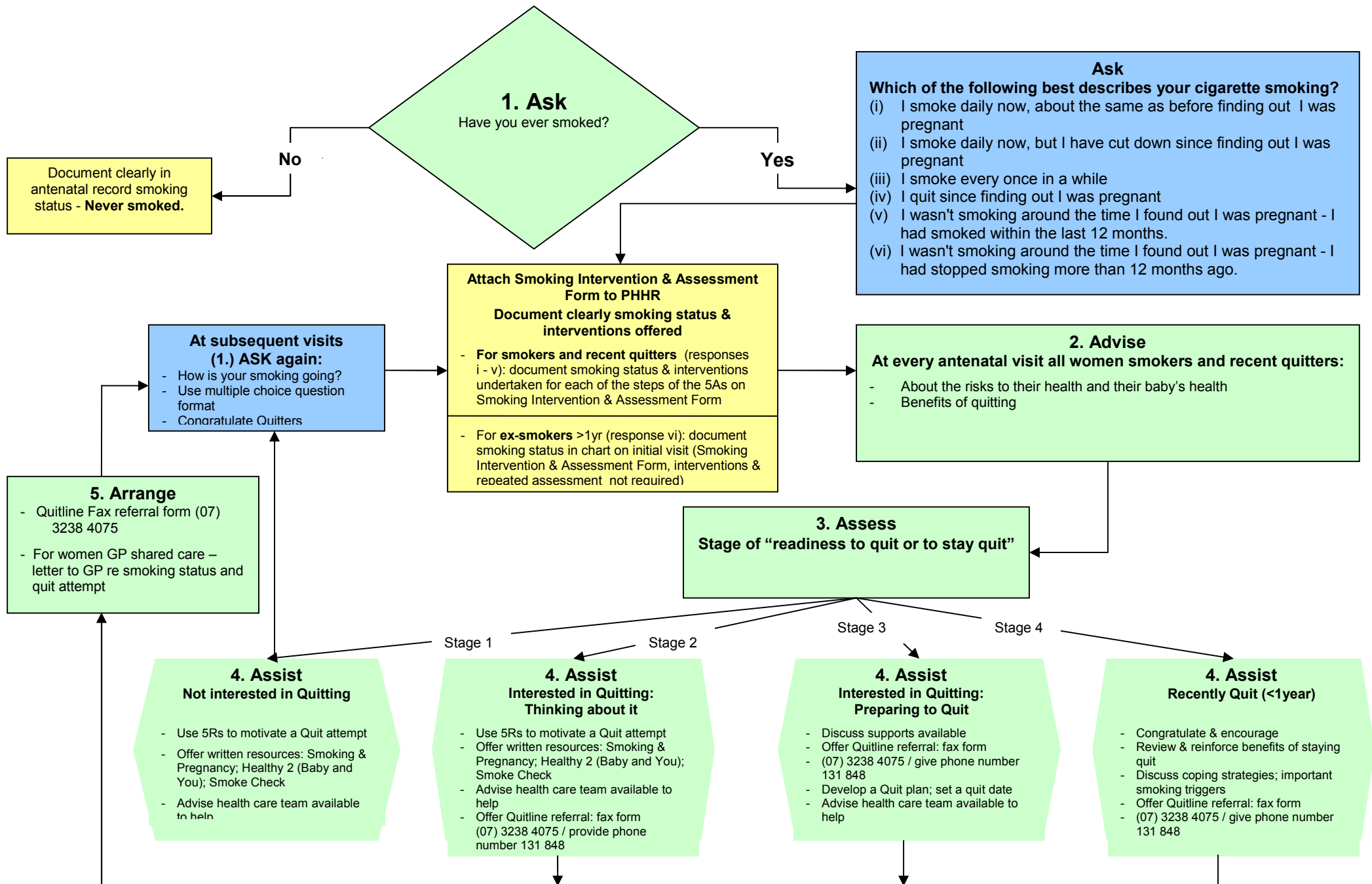
I smoke daily now, about the same as before finding out I was pregnant.
 I smoke daily now, but I have cut down since finding out I was pregnant.
 I smoke every once in awhile.
 I quit smoking since finding out I was pregnant.
 I wasn't smoking around the time I found out I was pregnant – I had smoked within the last 12 months.
 I wasn't smoking around the time I found out I was pregnant – I stopped smoking more than 12 months ago.

If currently smoking, number of cigarettes per day?

Does your partner smoke? No Yes N/A

ADVISE	ASSESS	ASSIST/ARRANGE
<p>Benefits of quitting</p> <p><input type="checkbox"/> <u>Woman / partner</u></p> <p>↑ Self esteem ↓ Cancers ↓ Cardiac / respiratory disease ↑ Energy, breath easier Save money</p> <p><input type="checkbox"/> <u>Pregnancy</u></p> <p>↑ Oxygen and nutrients to baby Normal birth weight ↓ Risk of complicated delivery ↓ Risk of pre-term birth ↓ Risk of APH & PPH</p> <p><input type="checkbox"/> <u>Baby</u></p> <p>More settled ↓ Risk of SIDS, asthma Baby more likely to be discharged with mother Fewer colds, ear, respiratory infection</p> <p><input type="checkbox"/> <u>Breastfeeding</u></p> <p>↑ Milk supply / improved feeding No chemicals in milk to baby</p> <p><input type="checkbox"/> <u>Families</u></p> <p>↓ Risks of passive smoking Healthy environment</p>	<p>Quitting Stage</p> <p><input type="checkbox"/> 1. Recently Quit <input type="checkbox"/> 2. Preparing to quit <input type="checkbox"/> 3. Thinking about quitting <input type="checkbox"/> 4. Not interested in quitting <input type="checkbox"/> 5. Relapse/Slip-up</p> <p>Barriers to quitting (tick responses)</p> <p><input type="checkbox"/> Withdrawal/cravings <input type="checkbox"/> Partner smoking <input type="checkbox"/> Weight gain <input type="checkbox"/> Stress <input type="checkbox"/> Other</p> <p>NOTES:</p> <p>..... </p> <p><i>This form was developed in collaboration with Quit South Australia</i></p>	<p>Education/Quit plan</p> <p><input type="checkbox"/> Congratulate decision makers <input type="checkbox"/> Encouragement given <input type="checkbox"/> Discuss supports GP, Quitline</p> <p>Written resources given (for woman)</p> <p><input type="checkbox"/> Smoking and pregnancy <input type="checkbox"/> Baby and you – Healthy Two <input type="checkbox"/> Smoking and Pregnant <input type="checkbox"/> Staying stopped – remaining a non-smoker after your pregnancy</p> <p>Written resources given (for partner)</p> <p><input type="checkbox"/> Quit because you can <input type="checkbox"/> Important news for fathers who smoke</p> <p><input type="checkbox"/> Quitline referral faxed (for woman and / or partner)</p> <p><input type="checkbox"/> Quitline number 131 848</p> <p><input type="checkbox"/> Quitline declined</p>

ASK AGAIN (Please complete the following at EVERY opportune visit for smokers and recent quitters)					
Visit date	Weeks gestation	Cigarettes per day	Advice offered Benefits of quitting √	Quitting stage (As above, in ASSESS)	Support / Assistance given √
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	



Smoking Cessation Referral Form

Referral to Quitline

Fax Numbers:

ACT (02) 6262 2223 • NSW (02) 9361 8011 • NT (08) 8922 8403 • Qld (07) 3238 4075 • SA (08) 8291 4280
 Tas (03) 6228 4149 • Vic (03) 9635 5520 • WA (08) 9222 2088

From: Dr _____

Address: _____

Phone: _____

Fax: _____

Confidential

Patient's Name _____

D.O.B _____

Patient's preferred phone no. (h) _____

(w) _____

(m) _____

What is the best time & day for Quitline to call?

Monday – Friday 9am – 1pm 1pm – 5pm 5pm – 8pm

Is it okay for Quit to leave a message?

Yes No

Smoking status

Daily

Weekly

Less than weekly

Number per day _____

What stage is your patient at with quitting?

Not ready (not currently thinking of quitting)

Unsure (thinking about quitting within 6 months)

Ready (planning to quit within 1 month)

Recent quitter (within the last year)

Use of medication?

Currently using/ planning to use Bupropion Hydrochloride (Zyban)

Currently using/ planning to use nicotine patches/gum/inhaler/lozenge

What are the patient's health issues relevant to Quitline counsellors?

Heart/lung disease Respiratory disease Diabetes Depression Anxiety

Pregnancy Other – please specify _____

Please note

The interaction of chemicals in cigarettes and some medications eg. Insulin, some antidepressants / antipsychotics, and the interplay between the chemicals and some symptoms can mean some smokers need monitoring of drug levels and symptoms by their GP through the quitting process.

GP is monitoring the above

I consent to this information being sent to Quitline and for Quitline to call me at a time that I have suggested on this form. I also consent for Quitline to provide feedback to my doctor about the calls to me to help me achieve my goal.

signature

Patient's signature

____/____/____
Date

For use by Quitline staff

Quitline Confirmation of Action on Referral

Date: ____/____/____

Your referral for _____

has been received by Quitline on ____/____/____

A call back time has been organised for ____/____/____

Quitline
131 848

The Quitline is answered 24 hours a day. Counseling is available with hours varying dependent on State or Territory. Specialist staff will call your referred patient back at an agreed time within the next week to provide information, support and advice on smoking cessation.