

Alcohol, tobacco, pregnancy and harm reduction – Unlocking resistance and understanding their links



Nancy Poole
British Columbia Centre of Excellence for Women's Health
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AGENDA

- Tobacco, pregnancy and harm reduction
- Alcohol pregnancy and harm reduction
- Forward linkages and movement on harm reducing approaches?

History to current situation

TOBACCO, PREGNANCY AND HARM REDUCTION

Smoking by women in pregnancy

- Approximately 20-30% of pregnant women smoke in Canada and USA
- 50% report a quit attempt
- 23-47% quit spontaneously in early pregnancy
- 25% relapse before delivery
- 70-90% relapse by one year post-partum

Smoking interventions for pregnant women

- There have been numerous interventions aimed at pregnant smokers – resources, streams of quitlines, cessation interventions (group and individual)
- Cessation programs have generally not been effective in preventing relapse
- Existing programs tend to focus only on the period of pregnancy, with little emphasis on pre-pregnancy or maintaining abstinence postpartum

Which pregnant women are more likely to quit?

- More educated
- Older women
- Lighter smokers
- Those with social support
- Those with non-smoking partners and family members
- Immigrant and minority (US) women

Which pregnant women are more likely to continue smoking?

- Women living on low income
- Less social support
- Heavier smokers

Relapse issues for pregnant and post-partum women

- Cessation may be really 'temporary abstinence'
- Stages of change do not necessarily apply to pregnant women in typical ways
- They may be experiencing a suspended identity as a non-smoker
- Because cessation is externally motivated, no actual shift in identity from smoker to non-smoker occurs
- Relapse is viewed as a reward after pregnancy

Historical perspective in Canada

- Smoking cessation campaigns for women in the 70s and 80s focused mainly on pregnancy and smoking
- It wasn't until the late 80s that *women's own health* became a focus in smoking cessation campaigns



Historical perspective in Canada

- There's been a lot of attention to pregnant women smokers, with less for women smokers.
- A *fetus-centred* approach has continued to characterize many cessation campaigns aimed at pregnant women.
- We are now proposing a **woman-centered approach**, with focus on the woman herself, and the mother-child unit.

A typical
1980s health
message -
external
motivation

If you won't
think
of yourself,
think of your
children.

You know how kids love to imitate their parents.
Especially very young kids.
They watch the way you work, the way you eat,
the way you talk, walk, and dress.
And the way you smoke cigarettes.
For the simple reason, they depend on you for
everything.
And you know the dangers of smoking only
too well.
But they don't.
You may not want to give it up.
Well, that's your choice.
But is it fair to show your children how to
seriously damage their health?
If you won't think of yourself,
think of them.
Stop smoking now.



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A guilt
and shame-
based
approach

Is it fair to force your baby to smoke cigarettes?



This is what happens if you smoke when you're pregnant.

Every time you inhale you fill your lungs with nicotine and carbon monoxide.

Your blood carries these impurities through the umbilical cord into your baby's bloodstream.

Smoking can restrict your baby's normal growth inside the womb. It can make him underdeveloped and underweight at birth. Which, in turn, can make him vulnerable to illness in the first delicate weeks of his life. It can even kill him.

Last year, in Britain alone, over 1,000 babies might not have died if their mothers had given up smoking when they were pregnant.

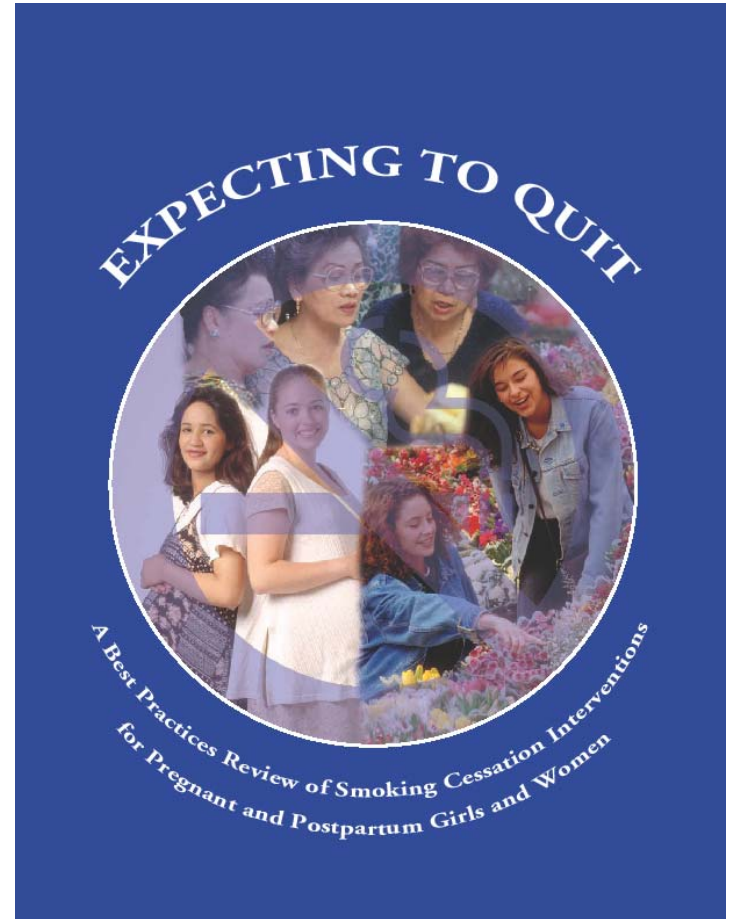
If you give up smoking when you're pregnant your baby will be as healthy as if you'd never smoked.



The Health Education Council
Helping you to better health

Expecting to Quit: Best Practices in Smoking Cessation During Pregnancy

- The Project Team:
Lorraine Greaves, PhD; Renee Cormier, PhD; Karen Devries, BSc; Joan Bottorff, PhD; Joy Johnson, BSc; Susan Kirkland, PhD, and David Aboussafy, PhD.
- This project was conducted at the British Columbia Centre of Excellence for Women's Health, Vancouver, Canada and funded by Health Canada.



Best Practices Methodology

- Examined >65 published reports of interventions geared towards individual pregnant smokers, from Canada, USA, Europe and Australia
- Examined the quality of evidence, then the plausibility of using the intervention in real practice - based on efficacy and effectiveness
- Used BP Methodology developed by the CTCRI

Best Practices Results

- From the literature, we identified 6 interventions and 11 components of programs as effective
- From our analysis, we identified 7 approaches to take in helping pregnant women to quit smoking

6 Interventions to Recommend

- Donatelle et al., 2000
- Ershoff et al., 1989, 1990 & Mullen et al., 1990
- Hjalmarson et al., 1991
- O'Connor et al., 1992
- Walsh et al., 1997
- Windsor et al., 2000

11 Components to Include

- Quit Guides
- Counselling
- Buddy Support
- Partner counselling/ social context
- Information
- Nicotine Replacement Therapies
- Human Follow-up
- Other Follow-up
- Incentives
- Feedback about Biological Changes
- Groups

7 Approaches

- Tailoring
- Woman Centred Care
- Stigma Reduction
- Relapse Prevention
- Harm Reduction
- Partner and Family Support
- Integrate Social Issues

1. Improve Assessment and Tailoring

- *All* pregnant women should be assessed for smoking
- *Spontaneous quitters* should be monitored and supported during pregnancy and post-partum to prevent relapse
- Smokers who cannot quit using behavioural interventions should be encouraged to *try NRTs*

2. Provide Woman-Centred care

- Focus on the *woman's own health* as a motivator for quitting
- This encourages internal motivation and post-pregnancy health and decreases relapse once the baby is born



3. Reduce Stigma

- Acknowledge the negative social responses to pregnant women smoking and assist in dealing with stigma
- Recognize that smoking is an addiction and that relational and social determinants affect ability to quit. Although many pregnant smokers may want to quit, it is difficult for them to do so.

Training Issues

- Be aware of and willing to discuss stigma against pregnant women who smoke
- Be aware of and willing to discuss other stigmatized topics connected to her smoking
- Avoid assumptions, such as
 - ❖ pregnancy is welcome and planned
 - ❖ pregnancy is an opportunity for positive change
 - ❖ expectant mothers know that tobacco is harmful to the fetus
 - ❖ the health of the fetus should be a strong enough motivation
 - ❖ the pregnant woman's partner will want her to quit smoking also
 - ❖ helping pregnant women to quit smoking is essentially the same as helping any smoker quit

4. Do Relapse Prevention

- Despite being smoke-free for a long period, the woman may be at an earlier stage of change
- Do they see themselves as smokers or non-smokers?
- Identify spontaneous quitters and help them to avoid relapse
- Recognize post-partum physical, social & emotional changes that result in increased cravings

5. Practice Harm Reduction

- Encourage women who cannot quit to reduce the number of cigarettes they smoke
- Encourage women to abstain for brief periods of time
- Encourage women to decrease their exposure to environmental tobacco smoke



STARSS (Start Thinking About Reducing Secondhand Smoke)

- developed specifically to meet the needs of CAPC (Community Action Programs for Children) projects, where there are pregnant and parenting women smokers - especially those who don't want, or aren't ready, to quit smoking
- The program's goal is to enable moms to protect their children as much as possible from secondhand smoke in the home without a focus on smoking cessation. During the development of **STARSS**, we learned the importance of the small steps approach to supporting women, especially low-income mothers. More importantly, we rediscovered that the harm reduction approach encourages both cessation and quit attempts by providing a less threatening message regarding smoking.

www.aware.on.ca

Harm Reduction

- Harm reduction strategies aim to lessen and mitigate harm.
- Harm reduction strategies are generally better for the health of the mother and the health of the fetus as compared to continued smoking with no change.
- There is no evidence that NRTs are harmful for pregnant women but should be intermittent Rx
- Better nutrition, folate supplements, reducing stress, and vitamins mitigate harm of smoking

6. Engage Social Support in the Woman's Life

- Examine the patterns of smoking by partner and others in the woman's environment
- Address partner smoking, but in a de-linked fashion (*i.e.*, separately from the woman)
- Recognize differences and power dynamics between partners



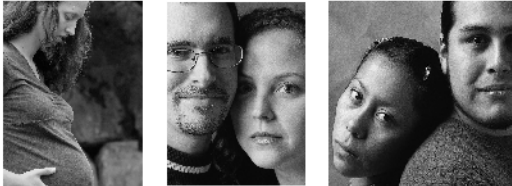
De-Linked Partner Cessation

- Address partner smoking, but in a de-linked fashion (*i.e.*, separately from the woman). Is her partner thinking about quitting or modifying smoking behaviour?
- If there is a conflict in the relationship, quitting smoking may increase the conflict. In other cases, continuing to smoke may increase the conflict.
- Offer skills about conflict resolution, coping, etc.
 - Is her partner angry that the caller is still smoking? It may be useful to help the caller verbalise her fear or knowledge around smoking and pregnancy.



Couples and Smoking

What You Need to Know When You are Pregnant



Couples and Smoking: What You Need to Know When You are Pregnant

7. Integrate Social Issues into the Intervention

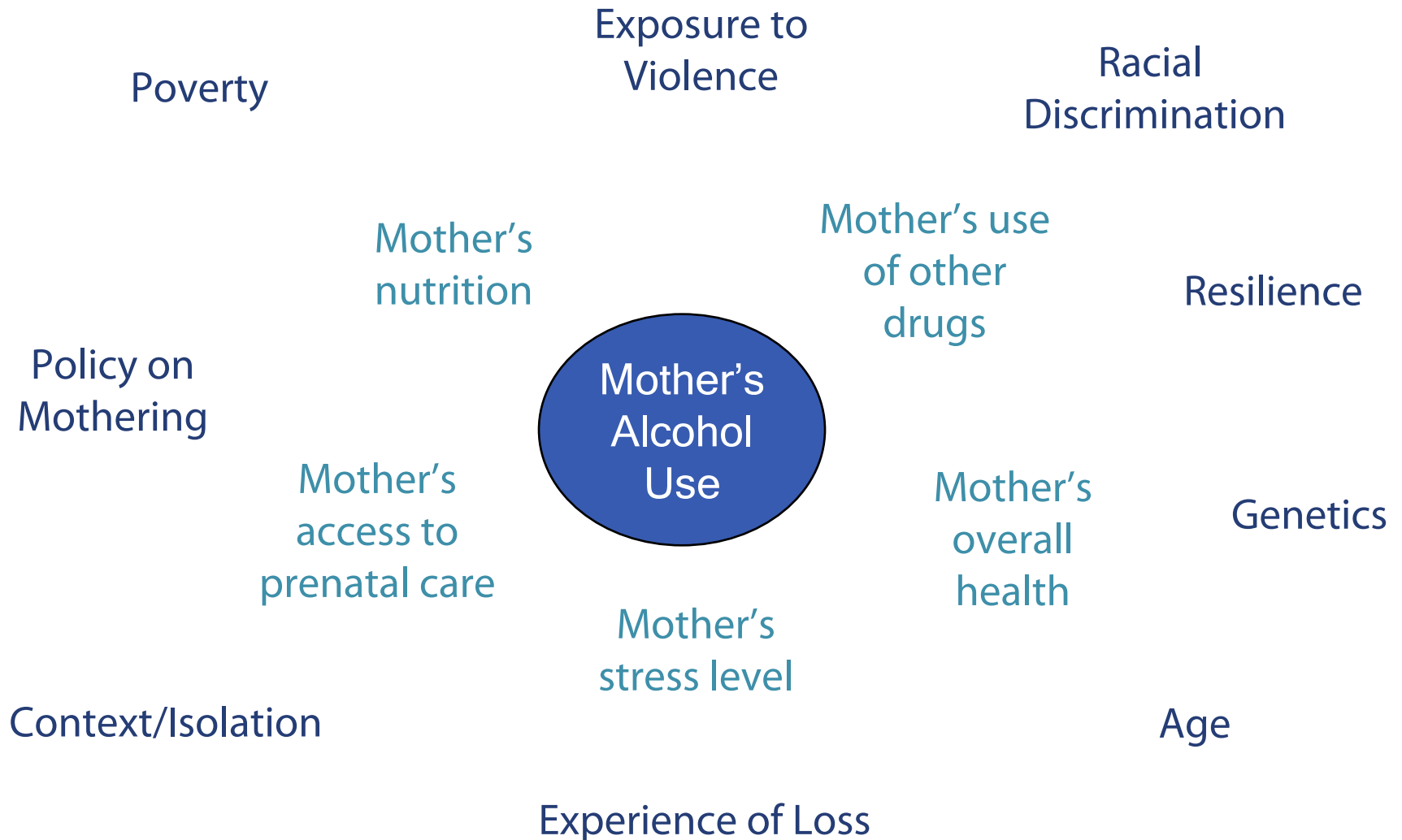
- Recognize that in the context of many women's lives, smoking is a secondary issue - to poverty, violence, lone motherhood and other factors
- Offer free cessation aids and referrals to community support organizations in the area



The evolution of a response to FASD

ALCOHOL, PREGNANCY AND HARM REDUCTION

It's Not Only About Alcohol



Issue: Realities of the lives of birth mothers with children with the full FAS syndrome

Study of birth mothers of 160 children with FAS Of the 80 who were able to be interviewed:

- 100% seriously sexually, physically or emotionally abused
- 80% had a major mental illness
- 80% lived with men who did not want them to quit drinking

4 Levels of FASD Prevention

Level 3 - Specialized, holistic support of pregnant women with alcohol and other health/ social problems

Level 4 - Postpartum support for new mothers assisting them to maintain/initiate changes in their health and social networks and to support the development of their children

Level 2 - Discussion of alcohol use and related risks with all women of childbearing years and their support networks

Level 1 - Broad awareness building and health promotion efforts



Poole, N., *Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives*. 2008, Public Health Agency of Canada: Ottawa, ON.

A Better Practices Review on Alcohol Interventions During Pregnancy

Double Exposure



- The Project Team:
Tessa Parkes, Nancy Poole, Amy Salmon, Lorraine Greaves, and Cristine Urquhart.
- This project was conducted at the British Columbia Centre of Excellence for Women's Health, Vancouver, Canada and funded by the province of British Columbia.



Methodology

- Used NICE (UK) review methods and Canadian Better Practices approach (CTCRI)
- Studies involving women who were pregnant, postpartum or of childbearing age
- Key outcome was change in self-reported alcohol use but many other secondary outcomes also reported
- 38 studies reviewed in total

3 Types of Interventions

Identification and screening

18 studies



Brief Interventions

11 studies

(7 with pregnant women, 4 with women in childbearing years)



Intensive Interventions

9 studies

(all looking at substance use in general but including alcohol)



Screening

- 18 studies on identification and screening instruments
- Majority conclude that screening tools are more effective at identifying potential alcohol use than usual practice
- Assurances of confidentiality increases women's reporting of alcohol use
- No clear evidence on whether certain tools are better with different **sub-populations** of women

“...women in the brief intervention condition were 5-times more likely to be abstinent by the third trimester”

O'Connor and Whaley
(2007)

Brief Interventions

1) with pregnant women

- **5 out of 7 studies** found that the brief interventions reduced women's use of alcohol during pregnancy

2) with women of childbearing years

- **in all four studies** reviewed (3 RCT's) BI's successful in reducing the risk of alcohol-exposed pregnancies amongst women in childbearing years

Level 2 – Discussion by service providers

BC's Healthy Choices in Pregnancy initiative focuses on change on the part of service providers – looking for a 50% increase in number of women counselled about substance use in pregnancy

2 levels of education

- Level 1: Introduction to an evidence-based framework
- Level 2: Skills-based training on using Motivational Interviewing within an integrated framework



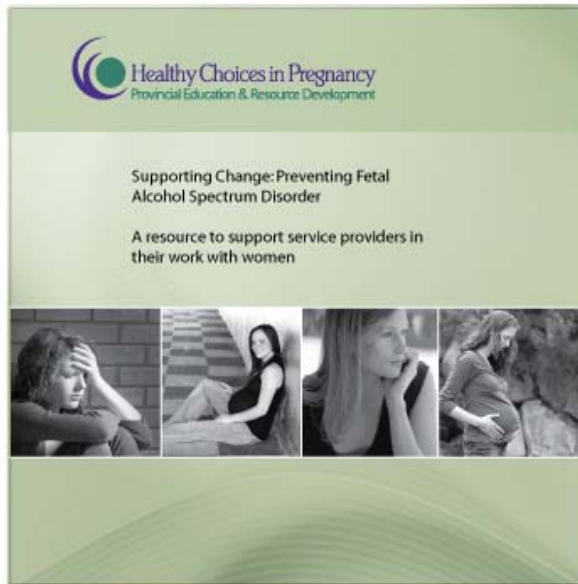
Offering a 3 part framework

- ✓ Mother-centred
- ✓ Harm reduction oriented
- ✓ Use of collaborative approach
Motivational Interviewing

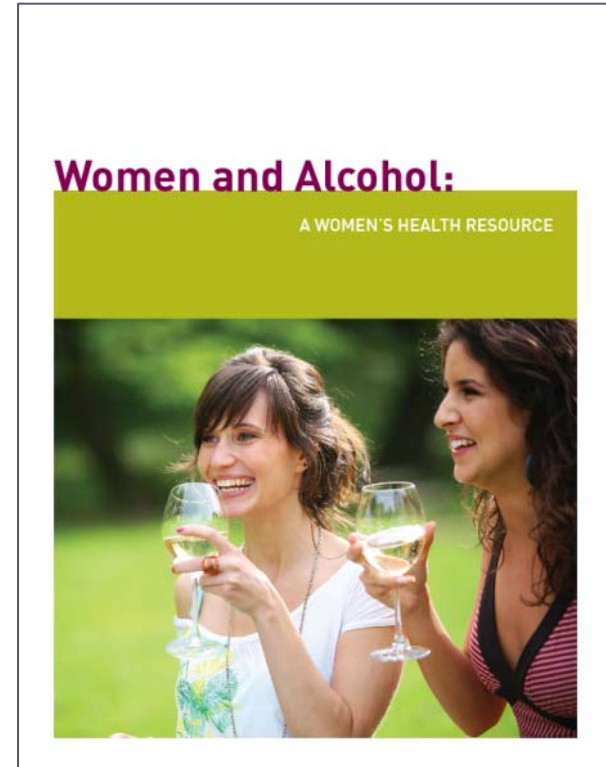




Harm reduction oriented resources



www.hcip-bc.org





Intensive Interventions

- All 9 studies found programming was successful in helping women reduce alcohol use in pregnancy, and improve outcomes for mothers and children
- Many other significant outcomes were achieved
- The program models specifically addressed barriers that usually prevent pregnant women engaging in services
- Values base of staff appeared critical to success

Level 3

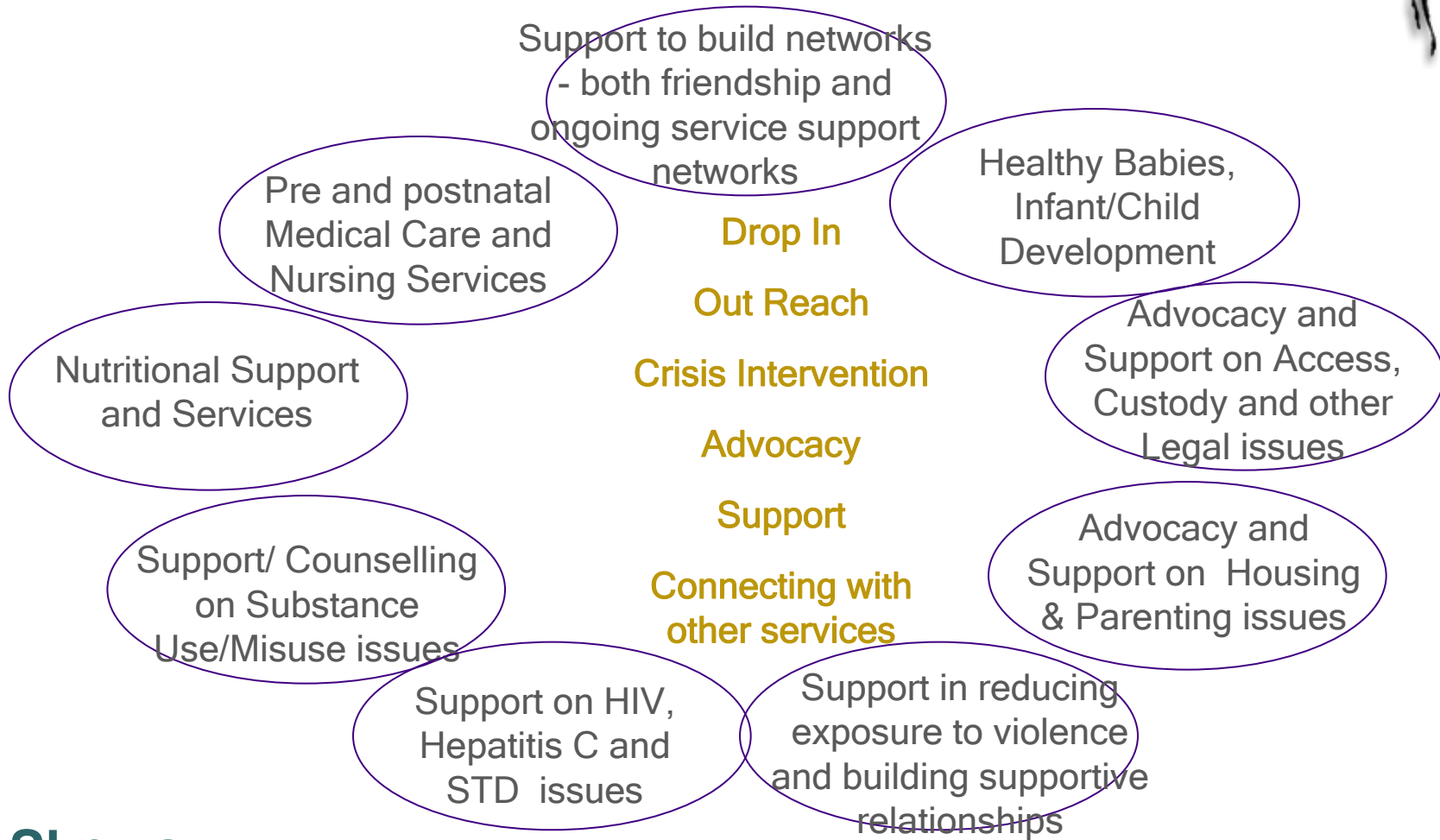
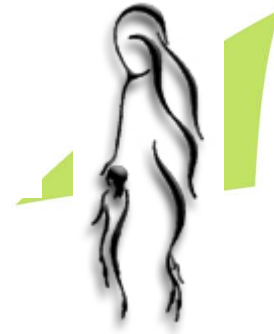


Sheway Project

Based on the recognition that the health of women and their children is linked to the conditions of their lives and their ability to influence these conditions

- Provides services in a flexible, welcoming, non-judgmental, nurturing and accepting way
- Supports women's self determination, choices and empowerment
- Offers respect and understanding of First Nations culture, history and tradition
- Takes a harm reduction approach to substance use
- Links women and their families into a network of health-related, social, emotional, cultural & practical support

Sheway's holistic, harm reduction oriented & transdisciplinary care



Sheway
Project

Reducing barriers to care

Summary

1. Approaches to tobacco and alcohol in pregnancy have evolved in separate streams



Note that in that process we have lost opportunities to apply harm reduction principles and practices between the 2 substances

Summary

2. Tolerance for harm reduction-oriented approaches have been slow to come to acceptance, particularly in the tobacco field, and this is to some degree because:

- interventions (and research on them) have been decontextualized from broader determinants of women's health, and
- focus has been on fetal health not on women's health and potential for change



Summary

3. Frameworks and initiatives that utilize integrated, women-centred, harm reduction-oriented approaches in work with substance-using women of child-bearing years are now being advanced.



We still have a long way to go in evidencing and applying harm reduction principles and practices related to licit substance use by pregnant women and mothers



Nancy Poole
wavelength@telus.net

www.hcip-bc.ca

www.coalescing-vc.org

www.bccewh.bc.ca

www.whrn.ca

www.womenshealthdata.ca

