CHAPTER 3 – Offering Tobacco Interventions

Chapter Three references are located in a separate section of the Baby Steps Help Guide e-resource.
Participant handout references are not included but are available upon request by contacting the tru@ahs.ca.

Contents

This chapter provides

Key information on intervening with and supporting women who are planning a pregnancy, pregnant women and new mothers, as well as their partners and support networks, including

- algorithms and tools
- information on tailoring all elements of evidence-based tobacco interventions to address specific risks, influences and barriers

Using a Principle-Based Approach

In all tobacco interventions with women, it is important to apply the four principles discussed in the previous chapter.

Principles
1. *Woman-centred*
2. *Harm-reducing*
3. *Trauma-informed*
4. *Equity-informed*

For example, the following elements of empowerment identified by Health Canada exemplify a woman-centred approach when guiding women and girls to quit tobacco:[2]

- Provide the opportunity for women and girls to define their own needs, readiness and ideas for change
- Respect girls' and women's choices, and trust in their ability to make positive life decisions
- Help women and girls identify and engage with accessible treatment and supportoptions
- Help women and girls reframe their experiences in a positive way (e.g., seeing a failed quit attempt as a learning experience that can be built upon)
- Help pregnant women and girls identify how stigma directed at pregnant women who smoke also affects them

It is important to create a safe and respectful context for discussing tobacco use. Practitioners are often too focused on providing information, rather than listening for a woman's strengths, readiness and ideas for change.

- Your client likely is already aware of the harm of using tobacco during pregnancy and postpartum. Ask her what she knows and whether you can share information with her about any effects that she doesn't already know. It is particularly important to create a safe context for discussing harms, and to allow her to set the pace of this discussion.

Please choose the statement that best describes your current tobacco use (including all forms of tobacco):

- ☐ I have never used any kind of tobacco product.
- ☐ I stopped using tobacco before I found out I was pregnant, and I am not using it now.
- ☐ I stopped using tobacco after I found out I was pregnant, and I am not using it now.
- ☐ I use tobacco sometimes now, but I have cut down since I found out I was pregnant.
- ☐ I use tobacco regularly now, about the same amount as before I found out I was pregnant.

- A multiple-choice question is recommended to improve disclosure from pregnant and postpartum women when asking about their tobacco use. This approach has been shown to improve disclosure by 40%, though may not be well suited to all situations or practice settings.[1,3] (See box above for suggested multiple choice question.) Open-ended questions are also recommended in all interactions when ideas for change are being discussed.
- Focus on topics that she identifies as relevant to her. These might include the fact that the pregnancy may not be wanted, that she is worried about the withdrawal from tobacco or that she has heard that quitting tobacco during pregnancy will harm the baby (which is false).
- Consider your clients' tobacco use as something they do, not who they are. Avoid using terms like "smoker" or "tobacco user," which reinforce her seeing her tobacco use as a central part of her identity. Try to help her understand how her use of tobacco fits into her life. Accept and validate her experiences and feelings about her tobacco addiction, rather than focusing on labelling it and shaming her for it.[2]

Every woman and girl has a different story and different needs pertaining to tobacco. There is no one single profile for a pregnant or postpartum tobacco using woman. As you work with your client, consider various ways of tailoring your approach to address her needs, interests and strengths. Identify her tobacco-use history and any success she has already experienced with quitting or cutting down (particularly successes made during past pregnancies or postpartum periods). Looking for ways to tailor her care to meet her unique needs will improve the effectiveness of the intervention.

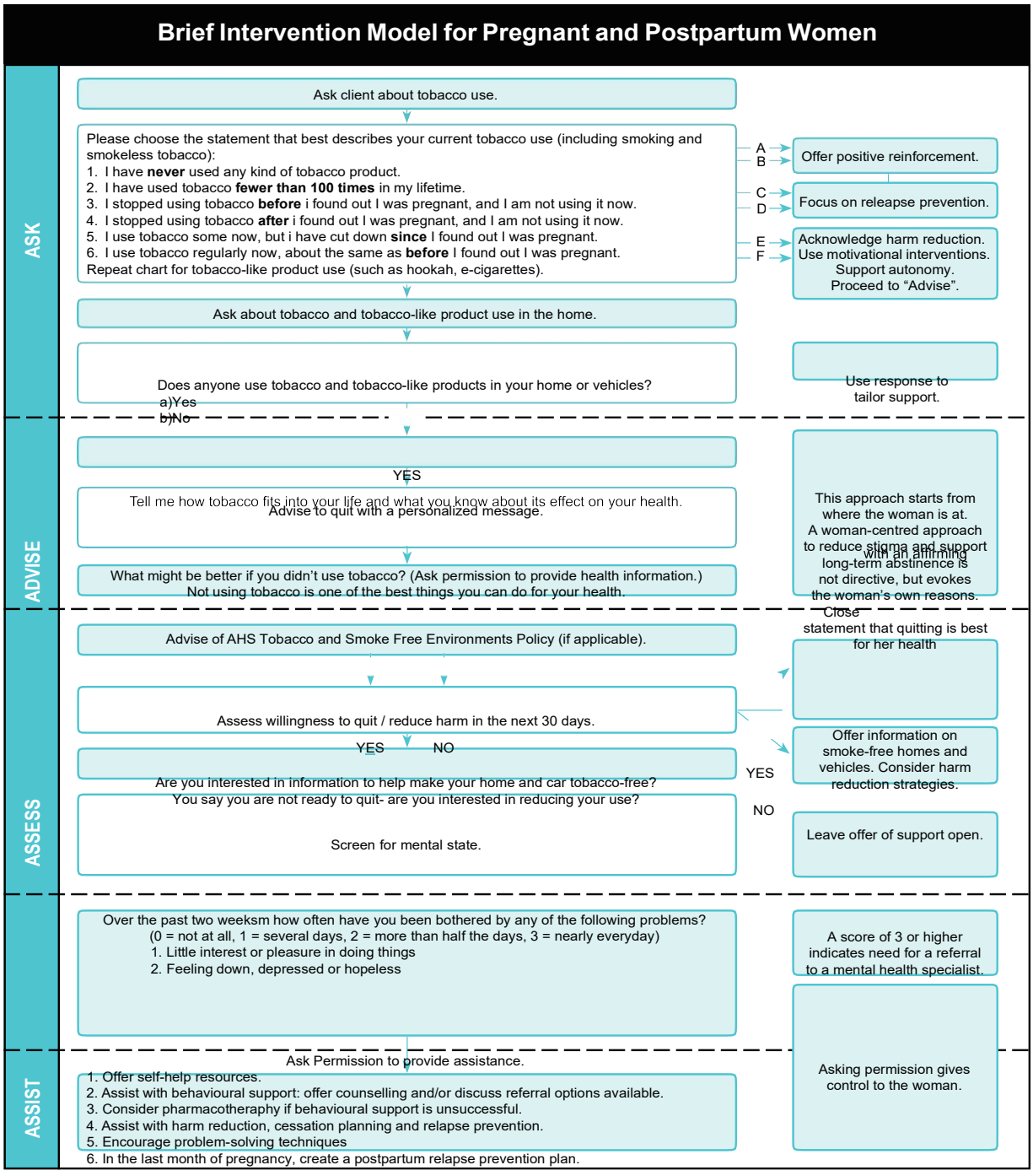
Guidance for Intervening

The 5 A's Approach (Ask, Advise, Assess, Assist and Arrange) for brief tobacco intervention can be applied to care for girls or women. This model follows a specific algorithm, with some supporting module material. The suggested language can be adapted to the health provider's personal style and the client's individual needs. When the 5 A's Approach is integrated into existing routines and the time commitment is manageable within a clinical setting, the potential for reducing the risk that tobacco use poses to mothers and their babies can far outweigh the dedicated effort to offer the care. [3]

Considerations for Pregnant and Postpartum Women and Girls

Tailoring the 5 A's Approach	
ASK…	• all clients if they have used tobacco or tobacco-like products before or during pregnancy • about patterns of use • about exposure to second- and third-hand smoke or nicotine • in an open and non-judgemental manner • all pregnant and postpartum women at every visit if they use tobacco, are exposed to tobacco smoke or have already quit Asking is best done by focusing on the woman's health, both immediate and in the long term. Multiple choice questions are recommended for best client disclosure but may not be well suited to all practice settings or circumstances. Answers may be captured more conversationally as long as questions are not close-ended (not yes/no answered).
ADVISE…	• cautiously, and avoid being directive with advice on quitting • about the benefits of a tobacco-free home and vehicle • of AHS's Tobacco and Smoke Free Environments Policy (as appropriate)
ASSESS…	• each client's readiness to quit or reduce tobacco use • interest in cessation support • interest in making her home and vehicles tobacco-free • her mental health, at a minimum
ASSIST…	• clients who are ready to quit, reduce or prevent relapse with self-support materials and brief information, and links to motivational or behavioural counselling • with pharmacotherapy to improve client success in quitting (as appropriate) • clients who are not ready to quit or reduce by supporting their autonomy
ARRANGE…	• connections to ongoing behavioural and social support • continued pharmacotherapy (as appropriate)

Brief Tobacco Intervention Model for Pregnant and Postpartum Women [1,3,4]



The mental-health questionnaire in the ASSESS column above is from the Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener (Kroenke K, Spitzer RL and Williams JB, 2003) [4]

Assessing Readiness

Not all women and girls want to stop or reduce tobacco when they find out they are pregnant. Recognizing what can be done to guide clients toward change, in a way that takes their readiness into account, is a valuable skill that can be learned and reined.

MI includes four elements:

1. Partnership describes the relationship between you and the client. The provider is not there to solve the client's problem, but rather to facilitate the client's journey toward change.
2. Acceptance and respect for the client, their individuality, and their right toself-determination.
3. Compassion for the client and their situation, using a non-judgmental approach.
4. Empathy acknowledging the client's feelings and supporting their journey.

Readiness to change is based on the importance of change and the confidence in making change. The role of the health-care provider is to help clients discover their own motivation and reasons to quit tobacco as well as the rewards they perceive for staying tobacco-free.

You may find it helpful to review The Stages of Change - 5 Stages of Quitting when working with pregnant women. This model is also reviewed in the Baby Steps Guide, Knowledge Topic #5. At the same time, change during pregnancy may be accelerated in ways that are not reflective of the time required for the five steps of the model. A health provider may want to push ahead, instead of working with the woman where she is at.

Working with readiness helps reframe your role, in that you can influence your client'sreadiness and motivation, yet recognize you are not the person responsible for making that change. The goal is to work collaboratively with the client, drawing upon your expertise about tobacco use and behaviour change, and her wisdom about her goals, strengths and interests in change.

Attending to readiness helps you understand that any resistance to making changes is a function of readiness and motivation. If you experience resistance, you are likely moving or encouraging your client to move forward too quickly.

Tools to Support Change

The tools discussed below can be found in the Tobacco Cessation Toolkit:

1. The Readiness Ruler

One of the most common and quickest ways of assessing motivation is to use the Readiness Ruler, an effective, non-threatening tool that determines a client's readiness, importance and confidence while building rapport and eliciting change talk.[5]

The Readiness Ruler uses three questions to assess motivation: [6]

- "On a scale of 1 to 10, where 10 is the most important thing you have to do, how important is it for you to quit using tobacco?"

Importance

On a scale of 1 to 10 (1= not important, 10= very important) how important is it for you to change right now?

- "On a scale of 1 to 10, where 10 is the most confident you can be, howconfident are you that you can quit using tobacco?"

Confidence

On a scale of 1 to 10 how confident are you that you could make this change?

- "On a scale of 1 to 10, where 10 is the most ready you can be, how ready are you to quit using tobacco?" (Please note that readiness is influenced by the degree of importance and confidence the client feels about making change.)

Readiness

On a scale of 1 to 10 how ready are you to make this change?

The Readiness Ruler legend: What do the scores mean?

- High importance + High confidence = Ready to change/quit

Ask the client if she is ready to quit. If yes, help her set goals and develop a treatment plan.

- High importance + Low confidence = Ambivalent

If this is your client's score, help her increase her confidence to change. Focus on what has worked for her in the past. What strengths does she have and what support will she need to succeed?

If a client reports a 9 on importance, but a 5 on confidence, you mightsay, "Tell me why you rated your confidence at 5 and not 1." This will prompt the client to list the reasons why they think they might be ableto quit. This will elicit change talk. Avoid asking for why she didn't score higher. This elicits sustain talk as the client will focus on all thereasons why she didn't think she could quit.

- Low importance + High confidence = Ambivalent

If this is your client's score, then affirm her confidence level and explore what is needed to increase the importance of changing her tobacco use. Some clients feel they have other priorities. Provide an affirmation on her confidence to change her tobacco use. You can ask her to tell you about why her confidence is so high—this can elicit change talk, as she may tellyou about successful attempts in the past. You have the option of pointing out that at one point, this was an important change for her to make and explore what needs to happen to raise the level of importance.[5]

- Low importance + Low confidence = Not ready to change at all

If this is your client's score, you may want to spend some time focusing on increasing the importance and confidence. You may have to ask her for permission to raise the topic again in the future. For example: "I understandyou are not ready to change your tobacco use at this time. I would like to ask you about your tobacco use again at your next visit (or in the future). Would that be OK?"[6]

2. Change Plan Tool

Depending on your time availability, you may find the My Tobacco Change Plan tool to be useful.

After discussing topic areas with your client, you may find it helpful to assist them in filling out the change plan. Often when someone writes down their plan, they becomemore committed to it. It also is helpful to revisit whether you have the opportunity to see your client again. Following up on how well the plan worked, and what needs to be tweaked to be more successful, is part of the changing journey.

3. Tobacco Tracker Tool

The Tobacco Tracker tool can help your client identify how to cut down her use towards becoming tobacco-free. The client writes down how she feels and what she was doing at the time of each tobacco use. (Use 1 to indicate the least urge and 5 to indicate the strongest.) Analyzing the results can help identify which uses are least needed andwhich ones to eliminate first.

DATE	TIME	RATING (1–5)	SITUATION

4. Decision to Change Tool

The Decision to Change Tobacco Use tool can help you and your client identify her relationship with tobacco use.

When each quadrant of this tool is filled out, it will reveal information that can guideyou and your client on identifying how she can make a strong quit attempt.

For example:

- The “good things about tobacco use” quadrant will reveal her motivation to use and her triggers to lapse back into using tobacco again after she successfully quits.
- The “good things about stopping” and the “not-so-good things about tobacco use” will reveal her motivations to make the quit attempt and stay abstinent.
- The “not-so-good things about stopping” will reveal her barriers to quitting, and things she needs to identify to overcome or replace with healthy choices.

The good things about tobacco use	The not so good things about tobacco use
Helps me feel relaxed	I have to go outside in the cold to smoke

The not so good things about stopping or changing	The good things about stopping or changing tobacco use
I will have to avoid my friends who smoke	I will save lots of money

Supporting Harm-Reduction Efforts

Although becoming pregnant or a new mother often motivates a woman to quit tobacco, stopping may be a low priority for a variety of reasons (e.g., heavy tobacco use, other substance abuse or mental health issues, low level of confidence in her ability to quit, vulnerability in an abusive relationship). It is important to respect a woman's right to decide what she can and cannot take on, and when she is ready to quit tobacco.[2,7]

When it is clear that your client is not ready to consider stopping tobacco now, harm reduction is the second-best option. A key principle of harm reduction, which is compatible with a woman-centred approach, is the respect for individual decision-making and responsibility.[8,9] Harm-reduction approaches are designed to help people reduce harms to their health and make positive choices towards health at an achievable pace. They are concerned with supporting people both to reduce harmful substance use and improve their health in related areas where they can (e.g., housing, nutrition, social support).

When a client is not ready to quit tobacco entirely, you can shift your emphasis from cessation to helping her identify the steps she may be willing to take to reduce the negative impacts of tobacco use on herself and others around her. These steps can include

- setting a plan to reduce her tobacco use (this is the goal for now, but quitting may be re-explored at a later date)
- reducing tobacco exposure for everyone in her home and vehicles
- reducing and changing the form of nicotine she uses to eliminate exposure to the thousands of chemicals in cigarette smoke when quitting without nicotine is not an option

For more information, see Creating Tobacco—*Free Environments for You and Your Family* (addressed in Module 3 of this guide) and *Second- and Third-Hand Smoke and Aids to Quit During Pregnancy and Breastfeeding* (addressed in Topic 7 of this guide).

Tailoring Approaches to Engage Girls and Young Women

A harm-reduction approach is particularly important when working with young people who are at a time in their lives when experimenting and risk taking are normal, and when they may ignore approaches that focus on cessation only. Start where these clients are at, building on what is important to them, listening for their interests and readiness (which may fluctuate widely), and assist in non-judgmental ways that connect their tobacco use to coping with issues that are relevant to a harm-reduction stance (e.g., dating violence).[7] Integrating social issues needs to be the central focus of any approach with adolescent girls and young women.

In the adolescent context, a partner's substance use plays a significant role in clients'own tobacco use, and their orientation to their peers and partners is high. Supports that address the specific influence of tobacco on young women and men's health, and that increase understanding of healthy relationships, are important.[7] Issues that need exploring in this context include violence, child abuse, co-existing heavy substance use, positive body image, self-harm, depression, positive gender identity development, self-worth, sexuality, support for making informed choices, finding purpose and cultural identity, school connectedness, and accessing resources.[7] In some cases, a referral to a mental-health professional may be helpful, so that issuesthat intersect with tobacco use can be well addressed.

Discussing Mental Health Concerns

Psychiatric disorders are more common among people who use tobacco than among the general population.[1] Depression is also more common in women than in men,[1] and women report using tobacco to alleviate depressive symptoms. Research suggests that women may experience greater rewarding effects from tobacco use (nicotine) compared to men, and later, during withdrawal, experience greater suppression of dopamine release.[10] Dopamine is a "feel-good" hormone released in the brain and triggered by nicotine.

Tailoring care for women, including pregnant and postpartum women, needs to include screening for concurrent mental-health issues. Postpartum depression may start during pregnancy and or any time up to one year after giving birth.[11] Alberta Health Services standard practice is to screen all postpartum women for depression.

A two-part mental-health screening tool is included in the Pregnant and Postpartum Women Algorithm (see the ASSESS step) to help you identify whether your client shows any reason to be referred to a mental-health specialist.

The mental-health screening tool is formally called the Patient Health Questionnaire-2 (PHQ-2) and is found in the Tobacco Cessation Tookit along with instructions on how to use it.[4]

Pharmacotherapy

The AHS Tobacco Dependence and Cessation Pharmacotherapy Initiation Orders include five types of NRT products, as well as bupropion SR and varenicline. NRT is available as a transdermal patch, gum, lozenge, inhaler and mouth spray; the patch, gum and lozenges are available in multiple strengths.

These NRT products are available in pharmacies over the counter. The strengths available in retail stores may differ from those available through AHS formulary. Buproprion SR and varenicline are available by prescription only.

Please note that NRT may not be as effective for women as it is for men.

Adapting Medication and NRT Dosages

Women and girls are more likely to take medication for mental-health concerns, such as depression. Reducing or stopping smoking can affect the metabolism of many psychiatric medications and other commonly used drugs like caffeine. Several drugs commonly prescribed for certain mental-health conditions need to be monitored closely when clients quit tobacco.[12-14]

Pregnant women appear to metabolize and clear nicotine from their bodies faster than non-pregnant women do, which makes cessation more difficult.[15-17] The physiological adaptations in pregnancy that accelerate nicotine metabolism mayalso cause more negative feelings of so-called “nicotine hunger” and unpleasant symptoms associated with nicotine withdrawal.[17,18] As a result, some pregnant women who use NRT may find it less effective at managing withdrawal symptoms.

Clients with heavier tobacco dependency may also be at higher risk with experiencing withdrawal symptoms. Once a client has begun taking cessation medication, their dosage may need to be titrated to optimize treatment and prevent relapse. What cautions can you take with your clients to ensure any adjustments to their medications are done timely and safely? Are there any other health providers who should be notified of your client’s desire to try quitting tobacco?

Considerations

Nicotine found in tobacco, tobacco-like products and NRTs is not a harmless drug. It has effects on the developing brains of fetuses, young children and teens.[1] Although NRTs are an over-the-counter medication, pregnant and postpartum women should be advised to use it with caution under the supervision of a qualified professional. NRT should only be offered during pregnancy when counselling has failed and after an informed discussion with the patient regarding the risks and benefits of using tobacco and NRT.[19]

Stopping tobacco use, beginning a tobacco cessation medication or relapsing back to tobacco use can result in the dosage of a client's medications needing adjusting by their primary care practitioners or prescribers. Clients who change their use of smoked tobacco products can unknowingly affect the metabolism of their medications, as well as their safety and effectiveness.[20]

Think about how you will follow your scope of practice in these situations. If you are a non-prescriber, refer your clients back to their prescriber(s) for more information on the suitability, dosage and any adjustments to their medication.

The Drug Interactions with Tobacco Smoke e-resource in the Tobacco Cessation Toolkit can help prescribing health professionals understand whichmedications are known to change their response and effects in the absence of tobacco smoke.

For more information about tailoring NRT for pregnant, breastfeeding and postpartum women, refer to the "Aids to Quitting" section in Module 7 of this guide.

Accessibility to medications

If cessation medication is approved by a physician, access may be an issue for clients who have little income and who face other barriers (e.g., transportation), even though the cessation aids may cost roughly as much as their current tobacco use.[1] To alleviate this cost barrier, consider whether there are resources the client can access to increase her access to the medication.

For more information on programs providing cost-free quitting medications, see the Alberta Drug Benefit or register with the AlbertaQuits HelpLine.

Documenting Tobacco Interventions

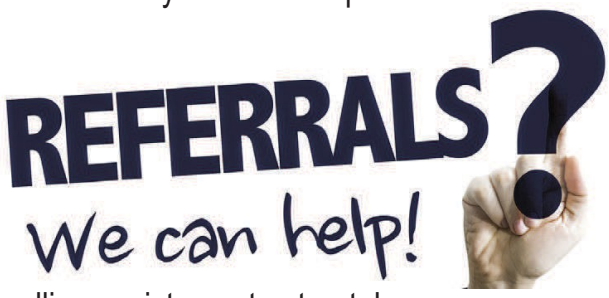
Documentation can serve as an important component of client care because it

- identifies individual needs for intervention
- records those interventions
- enhances coordination between providers and support staff
- facilitates follow-up (wherever possible) and referral arrangements
- provides data for quality indicators

As with all client care, it is important to document the brief tobacco intervention. Each health-care setting may do this in different ways. Although the forms may differ, the important standard information that must be gathered and documented during a brief intervention does not.

As part of enacting the principles of woman-centred, trauma-informed, harm-reducing and culturally safe approaches, it is important to involve women in this documentation process, and to be transparent as to its purpose and who the information will be shared with. Women who chose harm-reduction measures may be particularly concerned about how this information will be seen by other health providers.

Referrals



Alberta Health Services offers a fax referral program designed to make it easy for health providers to refer their clients to the following services:

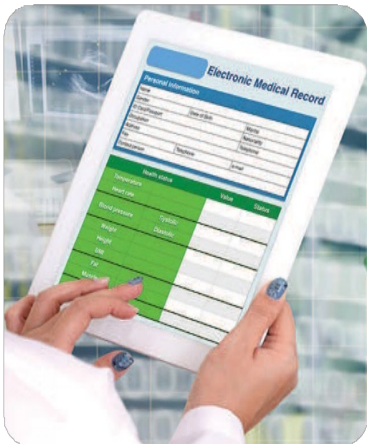
- the AlbertaQuits helpline for counselling assistance to stop tobacco use
- the QuitCore group cessation program for counsellor-facilitated peer group support

An AlbertaQuits referral form can be filled out quickly and sent directly from any health-care site inAlberta:

- Download the AlbertaQuits referral form here and have it signed by yourclient, indicating the best time to reach them at home.
- Fax the form to 1-866-979-3553 for direct follow-up with your client.
- Printed copies can also be ordered (code number Tobacco012) through above link (Print Resources)

Documentation

Documenting a client's tobacco intervention is important for AHS audit purposes and for follow-up care, especially in settings where a client may have multiple staff attending to their care. Many AHS settings use electronic charting systems that capture client or patient-reported tobacco use and exposure, interventions offered and referrals made.



AHS tobacco intervention is currently being integrated into existing provincial electronic medical records (EMR) systems to create a foundation for a future provincial clinical information system (CIS). Depending on what stage of integration your site is at, you may find tobacco records are kept in an olderformat or have been integrated into the EMR system.If you are not aware of how your site is tracking client tobacco interventions, consult your manger.

Two intervention forms are available in the Tobacco Cessation Toolkit for recording client care and referring clients to further supports:

- *Brief Tobacco Intervention*
- *Intensive Tobacco Intervention* (this is for health professionals who offer intense counselling using an outlined exploratory assessment questionnaire)

AHS health providers can also refer to the staff list of forms on Insite.

For Sites Administering Pharmacotherapy

For guidelines on pharmacotherapy for pregnant and postpartum women, see the Please note that NRT may not be as effective for women and is not a first-line intervention for pregnant or postpartum women. [7]

For guidelines on pharmacotherapy for pregnant and postpartum women, see the "Reproductive Years" chapter of refer to the Tobacco Free Futures guidelines.

The following pharmacotherapy forms can be found in the Tobacco Reduction Patient Care Pathway:

- *Pharmacotherapy Initiation Orders*
- *Pharmacotherapy Follow Up/Discharge Orders*

Relapse Prevention

Cessation medication and behavioural cessation support have shown limited effectiveness at preventing tobacco relapse among postpartum women and girls.[21] While many women stop using tobacco while they are pregnant, a high percentage will resume use after giving birth. According to the 2009 Canadian Maternity Experiences Survey, 47% of women who quit smoking by the third trimester had resumed smoking daily or occasionally in the postpartum period.[22] However, reported rates of relapse vary, and may be as high as 70–90% by one year postpartum.[7] This has health implications for both women and their children.[22]

In one study, pregnant women were found to be more likely to use coping strategies to avoid relapse than women who were not pregnant; however, less than a third of these women remained abstinent one year post-delivery.[23] This supports qualitative evidence that many women see pregnancy as a temporary period of abstinence for the sake of their unborn child.[23] This means they are less motivated to stop for good and do not develop long-term strategies to remain tobacco-free.

Around the time of delivery, there is a window of opportunity to intervene to help girls and women re-establish their commitment to stay tobacco-free and reduce the rate of postpartum relapse. Women-centred care provides an effective relapse prevention strategy, as the focus is on the mother's health as the motivation for continued abstinence. Late pregnancy is a good time to initiate discussions about the mother's intention to return to tobacco or remain tobacco-free. Reaffirm her desire to stay healthy for herself and secondly for her family. If your client acknowledges a desire to return to tobacco once her baby is born, ask her if she would be willing to discuss that decision. Has she experienced any benefits to her own health whileabstinent? What are her concerns about providing a safe home environment, breastfeeding or managing stress? Start from where she is now and repeat her reasons, if any, for staying tobacco-free.

For more information about relapse prevention, see Topics 8, 9 and 10 of this guide.

Establishing a Maintenance Plan

For women who have committed to staying tobacco-free, especially after pregnancy, it is important to provide support for establishing a strong maintenance plan. This will involve assisting a woman to identify what triggers she can think of that may cause her to slip or relapse. As you arrange for referrals and assist her with plans to face and avoid her triggers, consider the following list of common ways women fall back into using tobacco. What risks can she foresee? How can you assist her in planning to avoid risks for relapse? For example, environmental exposure is a major trigger, which in one study showed 64% of first cigarettes smoked post-delivery occurred when the woman was in the presence of someone else who was smoking.[19] What places or situations may your client find herself in now that she is no longer pregnant,which may put her at risk of relapsing?

Predictors of relapse:[7,24]

- slips (e.g., taking puffs of a friend's cigarette)
- weak or failing coping strategies
- low self-confidence
- not breastfeeding or weaning early
- high nicotine dependence
- postpartum depression
- weight gain
- stress
- relationship problems
- friends or family who use tobacco
- low education
- low income
- age (youth)
- lack of social support
- alcohol use
- lack of prenatal care

Synchronizing Partner and Social Support

Partners can use support to reduce or stop their tobacco use. A synchronized approach whereby women and their partners receive separate but coordinated tobacco-cessation support is recommended.

Risk of domestic violence is elevated during pregnancy. In fact, forty percent of first incidents of domestic violence occur while a woman is pregnant.[7] While it is necessary to pursue information about a partner's tobacco use and try to intervene effectively, you must do so in a cautious way that respects the complex social dynamics within couples and between friends. When talking to the client, it is important to acknowledge any power, control and abuse issues between her and her partner in a way that ensures the woman's safety.[7] Whenever your client does not feel safe trying to quit tobacco, or appears to be in an abusive situation, offer support, including referral to the 24-hour Family Violence Information Line, at 310-1818 (only a seven digit number), or Health Link Alberta, at 1-866-408-LINK (5465), for confidential, professional advice.

For more information, see the *Couples and Tobacco Use* resource in Topic 6 of this guide.

Addressing Other Social Determinants of Health

In Chapter 2, we offered suggestions for addressing various inequities. The following questions may assist you as care providers in identifying possible barriers to support:

- Can the client attend treatment appointments during the day, or is she limited to evening hours only?
- Is limited transportation or child care a barrier to attending appointments or a cessation group? Can your client get to a cessation program or professional who can help them make changes in their tobacco use? Is there anyone who provides this service in their community? If not, what other ways could they access service?

- Can the client read and understand the materials and instructions provided?
- Is there a cost for the program? Consider your client's income level and ask them whether they can afford it.
- What amount of education has your client completed? Is she literate? Consider materials that are appropriate for her to read. Offer to go through print resources, which may be difficult to read, and discuss them in person.
- Is English her second language? Keep information you share simple, and pause to ask whether the client has any questions or if she needs any clarity. If she would like support in her own language, ask her if she would be willing to call the AlbertaQuits helpline, where tobacco-cessation support is offered in 180 languages through an interpreter.

- Is your client Indigenous? What can she tell you about how tobacco is used in her culture? Is she aware of the differences between traditional and commercial tobacco? Is she connected to her culture? Would involving an elder be helpful?

Advising Breastfeeding Mothers

Breast milk is the healthiest first food for babies. Although being tobacco-free is best, mothers who use tobacco are still advised to breastfeed.

Breastfeeding benefits a baby's short-andlong-term health. Breast milk contains antibodies to fight infections. It also helps protect against sudden infant death syndrome (SIDS). [25]

New mothers who use tobacco are advised to continue breastfeeding while they attempt to quit. However, nicotine ingested through breast milk may cause the baby to refuse feedings, be cranky, sleep poorly and spit up. [26,27] Mothers who use tobacco may also have reduced milk supplies.[28, 29]

Women are advised to time their tobacco use to right after the baby nurses. This will help the nicotine clear from their milk before the next feeding.[30]

If a woman is having difficulty breastfeeding,refer her to a lactation consultant or other health-care provider knowledgeable about breastfeeding.

For more information, refer to Topic 7 of this guide.

Summary

Summary of key best practices pregnant and postpartum women

- Use the tailored 5 A's approach.
- Motivational interviewing techniques are recommended to build on the strengths of the woman to reduce or quit tobacco and to build a plan.
- Behavioural cessation support (e.g., multiple counselling sessions, motivational interviewing, cognitive behavioural therapy) is recommended as first-line treatment before pharmacotherapy at all points during pregnancy.
- NRT should only be offered during pregnancy when counselling has failed and after an informed discussion with the patient regarding the risks and benefits of using tobacco and NRT. Low-dose, intermittent-delivery NRTs (e.g., lozenges, gum, buccal inhalers or mouth spray) are preferred over continuous dosing of the patch.
- New mothers should be encouraged to breastfeed, even if they are using tobacco or NRT.
- Bupropion and varenicline should only be considered with pregnant and breastfeeding women after behavioural interventions and NRT have failed. Prior to initiating either treatment, advise women that current research does not conclusively demonstrate the efficacy and safety of either of these medications in pregnancy and lactation, and discuss the risks and benefits of using them versus using tobacco.
- Pregnant and postpartum adolescents should receive behavioural counselling as first-line treatment. The risks and benefits of pharmacotherapy options for adolescents can be discussed with the patient and their physician prior to initiation.