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Section 4

Young Parents, Health & Community Worker Resources

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KEY POINTS

Key points from this resource:

1. Knowledge about the Effects of Smoking During Pregnancy

Young parents identified that they required further information and explanation about the potential effects of smoking during pregnancy and the significance of these effects for the baby. Increasing young parents knowledge of the effects of smoking may change their attitudes and intentions to quit or reduce smoking but not necessarily result in the immediate cessation of smoking. Increased knowledge is however an essential factor in making informed healthy choices.

2 Relationship with Health Services and Health Workers

The relationship between the health worker and the young parent is crucial to the outcome of any intervention. Young parents wanted to be treated with respect and acknowledged for their knowledge, skills and experience. Young parents wanted the opportunity to discuss issues related to their pregnancy and its impact on their lives. They also emphasised the need for antenatal groups to be specific to their age group, as their issues differ from older women.

3. Smoking Cessation and Young Parent Programs

Smoking is just one of the issues that may impact on the health outcomes for young parents and their children. Smoking cessation programs are more likely to increase their effectiveness if integrated with current young parent programs and other social supports (Miller, Wood. 2001).

Effective young parent programs have a focus on developing skills and confidence to access and interpret health information and make informed choices about their own health and that of their child.

4. Smoking Cessation Interventions

There is considerable evidence to support the use of motivational interviewing or brief intervention as an effective smoking cessation intervention. It can be further supported if used in combination with personalised self-help material, and telephone support.

5. Supporting People who are Quitting

Changing smoking behaviour is a process not an event. Any attempts by young parents to reduce their own, or their child's exposure to smoking should be viewed positively, as this shows an increase in self-efficacy.

BUTT OUT FOR BABY

Background

The National Tobacco Strategy identifies a number of strategies to reduce tobacco related morbidity and mortality through prevention and cessation interventions, as well as protecting people from environmental tobacco smoke (ETS). These strategies have been drawn from the vast body of research and evaluation of individual community programs and government policies focussing on reducing the rates of smoking in Australia. Evidence of best practice is drawn from these studies to provide guidelines for prevention and cessation interventions.

One of the themes to emerge from these studies is the diminishing cultural acceptance of smoking across the population. There are however, communities in which smoking rates are higher than that of the general population, in particular Aboriginal and Torres Strait Islanders, women who are pregnant, people with mental illness and culturally and linguistically diverse communities (Anti Tobacco Ministerial Advisory Taskforce 2001).

Resource Development

The 'Butt Out For Baby' project was developed in response to the concerns of community health workers (Young Mothers Program, South) of the high rates of smoking amongst young parents. The Project utilised a peer education approach that enabled young parents to take an active role in the development of health promotion resources. This partnership approach sought to ensure that the information in this resource is relevant and appropriate to the needs of young parents. The young parents (including young pregnant women) that participated in this project were generally aware that smoking represented a health risk during pregnancy. They however identified several barriers to accessing adequate information and support in interpreting this information. Review of the literature and consultation with a wide range of young parents, service providers also informed us that for health education to be effective the content and methods of delivery needs to focus on the development of young peoples skills and confidence, rather than being limited to the transmission of information (Renkert et al 2001).

The 'Butt out for Baby' booklet for Health Workers

This booklet is intended to provide health and community workers with information about the effects of smoking during pregnancy, an overview of young parents, young people, drugs and health promotion, and effective smoking cessation interventions. Comments from young parents have been included, conveying their thoughts, attitudes and ideas.

Section 4 'Young Parents and Health Worker Resources' which includes:

- An illustration of the "Readiness to Change" model (Stages of Change). Assessing a young parents readiness to change is the first step in smoking cessation intervention and support.
- Topics for group discussion that emerged from, young parent focus groups.

Note: Reference to young parents/people refers to those aged under 25 years.

YOUNG PARENTS

1.1 Young Parents and Health Promotion

Effective health promotion programs, that target specific community groups, need to acknowledge the social context and developmental stage of the individuals that make up that community and who participate in the programs.

Pregnancy can significantly impact on young peoples' psychosocial development during the time of transition from adolescence to adulthood (Smith et al 1999, Stevenson et al 1999). It creates additional stress and conflict for particularly the young women, between their own developmental needs and those of their child. The impact of early parenting, although not uniform across all young parents, can result in compromises for the young women in terms of education, employment and lifestyle. In addition to being pregnant, these young women may also experience social isolation, depression, lack of family support and relationship difficulties with their partners, homelessness, domestic violence and low income (Quinlivan et al 1999, Jolley 2001).

Pregnancy is a time when young women view their future with optimism and want to make their pregnancy a positive experience (Quinlivan et al 1999). They are also more likely to have increased contact with health services, providing opportunities for these services to identify psychosocial issues, including smoking and other drug issues. While hospital antenatal clinics recognise the level of antenatal care by the number of antenatal visits, this intervention is not designed to identify the level of physical, social and emotional support required by young parents. Health and community services may need to be proactive in reaching young parents and provide appropriate intervention that is accessible during pregnancy and early childhood. Smoking cessation programs are more likely to increase their effectiveness if integrated with current young parent programs and other social supports (Miller, et al. 2001).

The young parents (including young pregnant women) that participated in this project were generally aware that smoking represented a health risk during pregnancy. The majority of these young parents accessed a health service during their pregnancy, however they reported that they didn't receive adequate information about smoking and pregnancy and support in interpreting this information.

Young Parents

"Older pregnant women might read this information, but younger people don't always, so we need someone to talk with us, this might work better."

"I don't want a lecture about smoking, just someone to talk with about my pregnancy."

"Doctors and Midwives judge us because we are young parents."

"When people criticise me, this stresses me out more."

YOUNG PARENTS

1.11 Barriers to Accessing Information

Young parents participating in the Butt out for Baby project identified a range of barriers to accessing this information and support. These included:

Relationship between Health Worker and Young Parent

Young parents highlighted the importance of their relationship with health/community workers.

They wanted to be treated with respect, supported and acknowledged for their ideas, experience, knowledge and skills. Young parents reported that they wanted an opportunity to discuss with health workers issues related to their pregnancy and its impact on their lives, not just to focus on the health of the unborn baby.

Health Information, Smoking and Pregnancy

Young parents received information about the effects of smoking during pregnancy from: Health workers (Medical Practitioners, Midwives, Community Health Workers), written material and families.

They also identified strategies to improve the content and method of delivery:

- Information to be factual and illustrated with visual images of the harm associated with smoking.
Young parents were able to associate the harm associated with alcohol during pregnancy, because it was more visible (Alcohol Foetal Syndrome).
- Provide information and support to access smoking cessation interventions.
- Information about smoking during pregnancy, to be integrated with other relevant information specific to young parents.

The resources developed by young parents have therefore focussed on providing a visual and written explanation of the effects of smoking during pregnancy as well as resources to quit or reduce their smoking.

(refer to posters, postcards and "Young parents tips to help you quit")

Young Parents

"They keep telling us, but not showing us" (referring to effects of smoking during pregnancy).

"Nothing – I told them I smoked but they didn't respond."

"Midwife at hospital told me to quit. But this is not easy."

"So what if I have a small baby. I need to know why this may be harmful to my baby."

"Midwife explained about what happens – like less oxygen supply to the baby and small babies."

"My Doctor talked to my boyfriend about the effects of passive smoking when I was pregnant, which was good."

"My mum found information on the Internet and told me about it."

Access to Antenatal Groups

Young parents reported that they experienced limited opportunities to attend antenatal groups. This was due to a number of reasons i.e. lack of transport, feeling intimidated in a group with older women and their partners and issues discussed not always relevant to their needs.

Improving access to pregnancy and health related information is not just about access to pamphlets and the Internet; it also involves improving people's ability to interpret and use this information.

Young parent programs need to focus not only on pregnancy information, but also drugs, social networks, self-esteem, relationships, decision making, access to services and information etc.

Young Parents

"Felt intimidated going to antenatal classes with older women and their partners."

"They (antenatal classes) told us lots about what not to do."

"It was so good just having antenatal classes with other young pregnant women."

"Our partners need this information to."

"When you find out you are pregnant, you need time to discuss all the things you need to be aware of during pregnancy."

"Teenage mothers need to talk to other teenagers about pregnancy and smoking."

1.2 Young Parents, Young People and Drugs

Drug use amongst young people may best be viewed as transitional behaviour that occurs within normal development from adolescent to adulthood. It is a means of experiencing new sensations and taking risks, without always considering the longer term effects, feeling of acceptance with peers and developing a sense of identity (Dale et al 2000, Marsh 1996).

Drugs most commonly used amongst young people are tobacco, alcohol and marijuana, which may be used in combination (AIHW 2002). While most drugs are used infrequently and on an experimental basis, tobacco is more likely to be used frequently and on a daily basis. Frequent use of tobacco contributes to a persons' physical and psychological dependence to nicotine (Whelan 1998).

The continued use of tobacco (including other drugs) for some young people may be that they perceive that the advantages of using the drug, outweigh the harm associated with use. The weighing up of the advantages and disadvantages of using tobacco (including other drugs) is an important component of motivational interviewing (*refer to Section 3*).

YOUNG PARENTS

Young parents perception of the benefits of smoking included; reducing stress, depression, 'time out' for themselves, weight control and socialising. The use of drugs to gain some control of moods and behaviour, is not only restricted to tobacco. Alcohol, caffeine and marijuana are common drugs that provide an external control, which helps us to socialise and cope with the stresses of life. The less control people perceive they have over their lives, the more likely they may be to use drugs and increase their risk of dependence to a drug/s (Bell 1997).

Attempts to reduce smoking amongst young parents are therefore less likely to be successful, if other acceptable strategies to buffer; stress, isolation, depression, and concerns about body image are not addressed.

Young Parents

"Love having a smoke when I drink."

"At parties everyone I know smokes cigarettes and dope."

"I did speed."

" We get looked at as young teenagers and get told – don't do this (Smoke, drugs, alcohol)."

"Smoking was like that best friend that's always there. You know in the middle of the night when you can't sleep because there's so much on your mind, like life sucks, but your smokes are there."

"I guess having a cigarette makes you feel better and you end up carrying on with things until you get to a point when you need another one."

"I can't talk about the other drugs I have given up, but this was a huge change for me."

"We need opportunities to talk about smoking and other drug taking."

SMOKING AND PREGNANCY

2.1 Nicotine and Addiction

Nicotine is recognised as an addictive drug and smoking is a simple way of self-administering this drug regularly to maintain a certain level of nicotine in the blood (Royal College of Physicians 1999). The pharmacological and behavioural processes of nicotine addiction are similar to those of heroin and cocaine addiction (US Surgeon-General Report 1988).

Nicotine causes a release of the chemical dopamine, a neuro-transmitter, involved in the experience of pleasure. Over a period of time nicotine depresses the level of dopamine and so a person will respond by increasing the use of nicotine to experience the same level of pleasure (*Leshner 1998*). This change to the dopamine system results in people experiencing withdrawal symptoms that involve cravings, irritability, anger, anxiety, difficulty concentrating, sleeplessness and weight gain (*ASH 1999*). While the majority of these symptoms may be felt more intensely in the first few days they will generally decline over a period of weeks. The desire to smoke may however, remain for years, especially if a person experiences stress or depression (*ASH 1999*).

Variations in drug dependence are due to the properties of the drug, characteristics of the person, their environment (social, physical) and biological factors.

Young Parents

Young women identified that they had abstained from alcohol and other drugs when pregnant, but found it very difficult to give up smoking.

"I just can't quit smoking ... It is the last thing I would like to quit but it is the hardest."

"I have smoked since I was 9 years old, this has contributed to my difficulty giving it up now."

"Smoking is very addictive, I don't think health workers realize or appreciate how difficult it is to give up for some people."

"I know some people can just give up easily, but this is not how it is for me."

2.2 Smoking During Pregnancy

Tobacco smoke is a complex mixture of chemicals; including, nicotine, carbon monoxide heavy metals (cadmium, lead etc) and other toxic chemicals which readily cross the placenta and can adversely affect the outcomes of the pregnancy (*Royal College of Physicians 1999*).

Nicotine alters the foetal heart rate and decreases foetal breathing movements, which may be signs of insufficient foetal oxygenation (*Walsh 1994, Walsh et al 2001*). Carbon monoxide binds with haemoglobin and reduces the availability of oxygen, including foetal oxygen.

SMOKING AND PREGNANCY

These may all have a direct effect on the structure and function of the umbilical cord, decreasing the placental blood flow to the foetus.

2.21 Cannabis

Cannabis is also a psychoactive drug containing the ingredient delta-9-tetrahydrocannabinol (THC), which crosses the placenta in pregnant women (*Astolfi et al 1998*). Cannabis produces more tar than the equivalent amount of tobacco and contains more of the carcinogens than cigarettes. Smoking marijuana also increases the carbon monoxide levels of the blood and has also been linked with an increased risk of low birth weight infants (*DASC 1998*). Marijuana is however, more likely to be used as a recreational drug and on an infrequent basis. Although dependence can develop, it is far less likely than nicotine.

2.3 Adverse Effects of Smoking During Pregnancy

There have been a considerable number of studies into the effects of smoking during pregnancy. These studies conclude that women who smoke have an increased risk of:

- Small for gestational age infants;
- Low birth weight;
- Preterm delivery;
- Sudden Infant Death Syndrome (SIDS); (*McDermott et al 2002, Walsh 1994, US Surgeons report 1988, Royal College of Physicians 1999*).

The effects of smoking on children's physical and cognitive development is less clear due to many other associated environmental factors. Some studies show a small but measurable effect (*Walsh et al 2001, Walsh 1994, Royal College of Physicians 1999*).

Other adverse effects include an increased risk of preterm rupture of membranes, spontaneous abortion, placenta previa, abruptio placentae, stillbirth and neonatal deaths (*McDermott et al 2002*).

2.31 Implications of Low Birth Weight, Preterm Delivery and Small for Gestational Age Baby

Low Birth Weight (< 2500 grams) and Preterm Births (< 37 weeks gestation)

This is either due to preterm delivery or reduced foetal growth during gestation. The relative risk of having a low birth weight baby is nearly doubled for women who smoke during pregnancy, compared to women who don't smoke during pregnancy (*McDermott et al 2002, Walsh 1994, Lowe et al 1998*).

Low birth weight and preterm delivery are important risk factors for neonatal, infancy and childhood health outcomes. These may include respiratory complications, nutritional difficulties, growth and developmental delay, infection and infant deaths.

Small for Gestational Age

Small for gestational age refers to infants born at less than the 10th percentile for gestational age. There is a dose relation between birth weight and smoking (*Walsh 1994, Cnattingius et al 1996*). Infants born to women who smoke weigh on average 250 grams less than infants born to women who don't smoke (*McDermott et al 2002, Walsh et al 2001*).

Cigarette smoking is the largest and most important known preventable risk factor for low birth weight and infant death (Lumley 2001).

2.4 Incidence of Smoking During Pregnancy

While smoking is not the only health risk for many young parents, it may be one of the more complex and difficult for them to change. In Australia approximately 20 per cent of women smoke during pregnancy (*McDermott et al 2002*).

The results of the 2001 National Drug Strategy Household Survey showed that 16% of Australian women 14-19 years old, reported smoking daily (AIHW 2002).

In South Australia the rates of smoking amongst pregnant women under 20 years are:

- Aboriginal women 55%;
 - Non-Aboriginal women 42%;
- (*Chan, Keane, Robinson 2001*).

Chan (*Keane and Robinson 2001*) reported that in South Australia the proportion of adverse pregnancy outcomes attributed to maternal smoking are:

- Aboriginal women.
 - 20% of preterm births.
 - 48% of small for gestational age births,.
 - 35% of low birth weight infants.
- Non-Aboriginal women.
 - 11% of preterm births.
 - 21% of small for gestational age births.
 - 23% of low birth weight infants.

Note: The percentage of confinements in South Australia: (*Chan, Scott et al 2001*).

- To women under 20 years, is 5% of births.
- To women aged 20-24 years is nearly 15% of all births.
- Percentages are higher for Aboriginal women in both age Groups, 19.5% and almost 26%.

SMOKING AND PREGNANCY

2.5 Maternal Risks

While the health effects of smoking during pregnancy may be more immediate for the infants, the health effects for women are more likely to be long term. Smoking is a significant risk factor in diseases including circulatory disease, cancer and respiratory diseases (*McDermott 2002*). In addition, women who smoke also have an increased risk of infertility and spontaneous abortion (*McDermott 2002*).

2.6 Environmental Tobacco Smoke (ETS)

There is consistent evidence of the adverse health effects of ETS for all people (*US Dept of Health and Human Services 2000, McDermott et al 2002*). In particular, infants and children exposed to the toxins from environmental smoke have a greater risk of; Sudden Infant Death Syndrome (*Wisborg et al 2000*), asthma, middle ear infections and respiratory infections (*Jamrozik et al in Scollo, Chapman 1999*).

(refer Section 4 'Making Home and Environment Smoke Free').

Young Parents

"I already knew about smoking, but my partner still smokes around me."

"Some women who don't smoke won't get this information on smoking and passive smoking, but they need this information."

"I remember always having a 'cold/cough' when I was a young child and both my parents smoked."

"Show what they put in cigarettes. This is what kids then inhale if people smoke around them."

EFFECTIVE INDIVIDUAL INTERVENTIONS

3.1 Models of Intervention

This health promotion resource has included a brief introduction to the models of behavioral change and counseling qualities that together are associated with successful intervention in the treatment of drug use, including alcohol and tobacco.

Individual interventions are more effective when implemented alongside of population or environmental intervention, such as policy and regulation of the product, industry, community and work environments (*Green et al 2001*).

3.2 Evidence for Practice Guidelines (Individual Interventions)

People make several attempts to quit smoking before they are successful and the majority achieve this with minimal intervention. Attempts to cease smoking can be more successful if supported by additional smoking cessation intervention (*Miller, Wood. 2001*).

Due to the physical and psychological effects of nicotine, individual treatments for drug addiction have involved behavioural change and often medication.

Reviews and Meta-analysis of smoking cessation treatments show that behavioural change support, together with pharmacological treatment of nicotine addiction is an effective treatment (*US Dept of Health and Human Services 2000, Lumley et al 2001, Thorax 1998, Miller, Wood. 2001*).

In particular, brief intervention or motivational interviewing used in combination with self-help materials and nicotine replacement therapy (NRT is not recommended in pregnancy and lactation) is most effective (*Lumley et al 2001, Thorax 1998*).

Generic self-help materials can be widely distributed, however they do not necessarily reach the intended audience. Generic self-help materials are more effective if they are personalised to the individual needs and stage of cessation (*Lancaster et al 2000 & 2002, Lumley et al 2001, Messecar 2001, Thorax 1998, Miller, Wood. 2001*). Minimal clinical intervention (4 A's) which consists of brief cessation advice from health workers, has a modest effect on smoking cessation (*Miller et al 2001*).

Quit-lines or telephone support calls used in conjunction with advertising campaigns, self-help materials and minimal clinical intervention are also effective methods of providing smoking cessation intervention (*Miller, Wood. 2001, Stead 2001*).

3.3 Effective Interventions

3.3.1 Pharmacological Interventions

Pharmacological treatments are an effective treatment for smoking cessation, however they are more effective if used in conjunction with behavioural change interventions.

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The effects of continuous low doses of nicotine on the developing foetus are unknown, but are the focus of current research studies (*Walsh et al 2001, Hotham 2000, Miller, Wood. 2001*). Some classes of antidepressant medication (i.e. Bupropion) are another effective smoking cessation treatment, although their mechanism of action in smoking cessation is unknown (*McDermott et al 2002, US Dept of Health and Human Services 2000*).

Other pharmacological treatments are on trial, but their effectiveness and safety have not been well documented.

Note: *Australian categorisation of risk of drug use in pregnancy, identifies; nicotine replacement therapy as category D, which is **not recommended** during pregnancy and lactation, and Bupropion as category B2, precautions to be observed, prescription required (Mims 2001).*

3.32 Counselling and Behavioural Interventions

The Stages of Change model demonstrates the process by which individuals change health related behaviours. Assessing an individual's readiness for change is important in developing or adapting effective interventions. While this model highlights the importance of motivation to change behaviour, motivational interviewing emphasises the skills required to enhance motivation.

Brief intervention is based on assessing an individual's readiness for change and a briefer adaptation of motivational counselling.

3.321 Stages of Change (Readiness to Change)

This model is based on the premise that changing behaviour is a process, not an event and that individuals have varying levels of readiness to change (*Helfgott*). It also emphasises the importance of tailoring programs to the needs and the varying circumstances of individuals rather than assuming a particular intervention will suit all people (*Shinitzky et al 2001*).

There are five stages to this change process (*Helfgott*):

- Precontemplation
What problem!
- Contemplation
Hmm perhaps I do need to make a change!
- Preparation
Identify the good things about smoking; these will be the triggers
- Action
Coping with the triggers. Quitting.
- Maintenance
What has changed now I am not smoking?

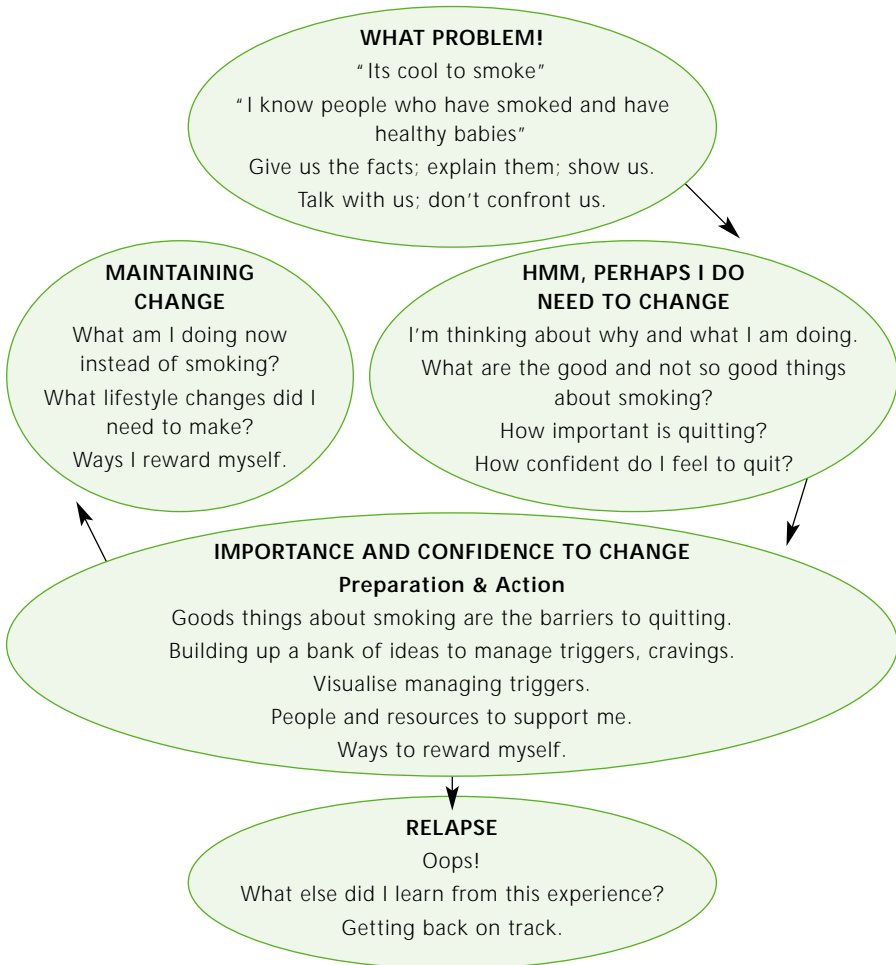
The stages of change approach is a quick guide to assist health workers to assess a client's readiness for change. Evidence for the validity of the Stages of Change model as it applies to tobacco cessation interventions is strong. While assessing an individual's readiness to

EFFECTIVE INDIVIDUAL INTERVENTIONS

change is the first step in planning an intervention, acknowledgement of their social context and developmental stage is important in individualising plans (Miller et al 2001).

To illustrate this model, refer to 'Readiness to Change' see below.

READINESS TO CHANGE (Stages of Change)



EFFECTIVE INDIVIDUAL INTERVENTIONS

3.322 Motivational Interviewing

“ This is a client centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence” (*Emmons et al 2001 p 69*). Confronting people or trying to convince people to change is more likely to result in resistance from the person. It is more effective to elicit arguments for change from the person, so they are in control of interpreting the information for themselves and making a decision about its relevance (*Emmons et al 2001*).

Emmons (et al 2001) describes several key principles in motivational interviewing:

- Expressing empathy. Non-judgemental reflective listening.
- Developing discrepancies between client’s goals and current issues, with reflective listening and objective feedback.
- Avoid argumentation. The client is responsible for the decision to change.
- Roll with resistance. Defensiveness is a likely outcome of confrontation.
- Supporting self-efficacy. A person’s belief in their ability to change is important.

3.323 Brief Intervention

Brief Intervention has been adapted from motivational counseling so that it is more flexible and responsive in various settings and situations where resources and time are limited. It is an opportunistic intervention to communicate the effects of smoking and other drug use (*Emmons et al 2001*).

Brief Intervention is effective when:

- Recognises significance of client interaction (one to one contact);
- Maintains basic principles of motivational counseling (i.e. avoids confrontation);
- Attracts the attention of young parents;
- Communicates accurate information without persuasion, which is relevant to client group (i.e. brief, factual, visual);
- Recognises individual readiness for change (Stages of Change).

Brief approaches may be strengthened by providing ongoing support and building on the relationships that were initiated in person (*Emmons et al 2001*). This may include young parents groups, individual counselling or telephone follow up. (*refer to Resources*).

3.4 Training for Health Workers

While health workers have direct contact with the majority of people who smoke, particularly during pregnancy, they do not provide any form of smoking cessation intervention. Studies carried out of the use of brief intervention or minimal clinical intervention (4 A's) show that it is not widely utilised by hospitals in Australia (Cooke 2000, Lowe et al 1998, Walsh et al 1995).

Barriers identified by health workers included; lack of knowledge and training in smoking cessation methods, lack of referral options and self-help materials, a concern that they would alienate people if they are not interested in quitting, limited time with clients, knowledge of the effects of smoking and personal smoking status (Bishop et al 1998, Cooke 2000, McCarty et al 2001). Health workers also identified concerns about the adverse effects of quitting smoking, or the increased guilt and anxiety of continuing to smoke for women and their psychological well-being (Lumley et al 2001).

Brief intervention and motivational counselling training for health workers, can optimise the limited time that health workers have with pregnant women and their partners. Referral to quit-lines, health lines and personalised self-help materials can support brief intervention approaches.

(Refer to Resources).

Note: Minimal clinical intervention refers to the 4 A's (Miller et al 2001);

- Ask if person smokes.
- Assess readiness for change.
- Advice; provide brief information.
- Arrange referral or follow up.

EFFECTIVE INDIVIDUAL INTERVENTIONS

3.5 Maintaining Cessation

While there is a high rate of women who quit or reduce their smoking during pregnancy, approximately 70% of women resume smoking within 12 months following the birth (McDermott *et al* 2002). This trend is very different to the general population, where there is a high rate of long-term cessation after an initial three-month cessation period (McBride 2000). Women taking up smoking after a cessation period of six to nine months may be due to a number of reasons.

Pregnant women all desire a healthy baby and a pregnancy and birth without complications. Women quit smoking for the health of her unborn child, but the longer-term health issues associated with smoking for themselves may not be a high priority.

The social influence of partners, family and friends are important in determining a woman's success at smoking cessation and maintaining this change (McDermott *et al* 2002, Ying Lu *et al* 2001, McBride 2000). Factors such as stress, isolation and depression before, during and after pregnancy also influence smoking cessation and relapse.

Young Parents

"I think depression and isolation were a big factor in me smoking heaps after the birth of my child."

"I had given up but then my family visited and they went outside for a smoke, so I went outside with them to talk and had a quick puff and pretty much by the weekend I was smoking again."

"I tried to give up, but my boyfriend brought me smokes because I was not good to be around."

"I stopped smoking when I was pregnant."

3.6 Measuring Change

Change is a process and any change, however small, is a successful outcome. Measuring only cessation of smoking may be an unrealistic outcome, as the rate of relapse is high.

While some young parents will spontaneously quit smoking others will not be as confident. Success may be establishing smoke free habits i.e. identifying times, places and activities that are smoke free. Also establishing the home and car as smoke free environments (Ford *et al* 2001). These actions along with any attempts to reduce smoking or quitting should be viewed positively, as they show increases in self-efficacy.

Short-term measurable outcomes may include:

- Young parents identifying their strengths as parents.
- Accessing information about smoking and quitting.
- Increased knowledge and understanding of the effects of smoking (active and passive).
- Creating smoke free environments for their children and themselves.
- Increased understanding of what meaning smoking has in their lives (The benefits of smoking may still be relevant i.e. stress relief and depression).
- Increased awareness of their own resources and support networks to quit or reduce smoking.

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- Increased knowledge of additional resources to support smoking cessation or reduction.
- Reduction in smoking.
- Any attempt to quit or reduce smoking.
- Learning from relapses.

Young Parents

"My partner doesn't smoke around me anymore" (pregnant women).

"I limited myself to 3 packets a week."

"I didn't want my children to smoke, so I quit."

"I need support to quit."

"I don't let anyone smoke around my kids."

Group Discussion

While smoking cessation support groups have been an effective intervention with some community groups, they are less likely to be successful with young parents. Specific health risks may be more effectively addressed if incorporated in to young parent programs. Effective young parent programs have a focus on developing skills and confidence to access and interpret health information and make informed choices about their own health and that of their child.

The following topics resulted in considerable discussion amongst young parents during the community consultation process, which increased young parents understanding of not only the effects of smoking, but the role it has in their lives.

“What are the facts about smoking, alcohol and other drugs during pregnancy?”

Young parents identified that they required further information and explanation about the potential effects of smoking during pregnancy and the significance of these effects for the baby. Increasing young parents knowledge of the effects of smoking may change their attitudes and intentions to quit or reduce smoking but not necessarily result in the immediate cessation of smoking. Increased knowledge is however an important factor in making informed choices.

“My Doctor talked to my boyfriend about the effects of passive smoking which was good.”

“Midwife explained about what happens; about the oxygen supply to the baby and small babies.”

“At antenatal classes they didn’t talk to us about smoking, just gave us pamphlets.”

What young parents experience, hear and observe may not seem to provide evidence to them of the harms of smoking during pregnancy. The harm associated with smoking is less visible than the harm associated with alcohol. Tobacco, marijuana and alcohol may also be used in combination, which can make identifying the harm attributed to a single drug difficult. Therefore, the significance of low birth weight and preterm delivery and small for gestational age requires further discussion.

“So what if I have a small baby. I need to know why this may be harmful to my baby.”

“Need to be shown visually what happens to a baby in pregnancy when the mother smokes.”

“Discuss the ‘how’ and ‘why’ of the effects of smoking.”

“They kept telling us, but not showing us.”

“Don’t lecture us.”

Refer to:

* Resources

* Section 2 for discussion of the effects of smoking.

* Quit SA

Conflicting Information

Young parents emphasized the need for information to be factual and include an explanation, which is conveyed in a non-confrontational style.

"Health Workers told me that it was OK if I cut down to 10 cigarettes a day."

There is no safe level of smoking. However, reducing the amount smoked all helps. There is a relationship between the amounts a pregnant women smokes and the baby's birth weight.

"My Health Worker said it would be too stressful for the baby if I quit."

There is no documented evidence to recommend that women should not quit smoking because it could be too stressful or detrimental to the health of their baby.

People who smoke report that it reduces their stress and improves their mood. These benefits may also be due to the relief of nicotine withdrawal. Withdrawal from smoking can result in people experiencing cravings, irritability, anxiety, difficulty concentrating and sleeplessness, which are felt more intensely in the first few days and generally decline over a period of weeks. Identifying supports and planning strategies to manage these situations can reduce the stress of quitting.

Support to Quit

Young parents reported that when they were advised to quit smoking, they did not receive any additional information about the resources available to support them to quit.

"Health worker told me to quit, but this is not easy."

"I hate it when they tell me to quit, as if I don't know that or haven't heard it before."

Some young parents were able to quit smoking by themselves or with support from family. Others found it extremely difficult to quit. Nicotine is a psychoactive social drug to which people can become physically and psychologically dependent (Whelan 1998). The pharmacological and behavioural processes of nicotine addiction are similar to those of heroin and cocaine addiction (US Surgeon-General Report 1988).

"I have stopped other drugs, but I can't quit smoking. It is the last thing I would like to do, but the hardest."

"All my friends smoke and its hard to give up."

"I have tried to give up, but I get stressed and cry."

"Smoking is very addictive, I don't think health workers realize or appreciate how difficult it is to give up for some people."

"If you have an addiction to drugs or alcohol, you can go and see someone. You don't have to just ring up on the phone. I know I would prefer to go and talk to someone face to face."

There is a strong dose relationship between counselling session length, number of sessions and cessation rates.

Face-to-face counselling can be supported by referral to Quitline, Youth Health Line or Alcohol and Drug Information Service (ADIS)

(refer to Resources)

YOUNG PARENTS & HEALTH WORKER RESOURCES

Discussing the good and not so good things about smoking can help people to identify the reasons or the benefits that they initially got from smoking, some of which may no longer be relevant. Identifying the enjoyable or beneficial aspects of smoking will also highlight the potential barriers to quitting.

This also provides an opportunity for young parents to discuss some potential strategies to overcome these barriers.

Good Things About Smoking

"It helps me to relax when I'm stressed."

"Time out for me."

"It's a quick fix."

"I guess having a cigarette makes you feel better and you end up carrying on with things until you get to a point when you need another one."

"Something in common with my friends, I can't sit with them and not smoke."

"After a meal or with a coffee."

"Mixing cones with cigarettes."

"Its cool to smoke."

"To lose weight."

"Don't eat as much if I smoke."

Not So Good Things About Smoking

"The cravings, I hate it because it's so bloody hard to give up."

"The smell, foul taste, bad breath."

"Stains in fingers and teeth."

"The smell hangs around inside the house."

"Reduces your breast milk."

"Smoking around babies."

"Feeling sick the next morning after a night of smoking too much at parties."

"The cost."

"Smoking the butts left over, raiding the ashtrays."

"Someone asking you for a smoke and you only have one left."

"The social stigma. I now don't smoke in public."

Young parents identified smoking as a way of coping with stress, 'time out' and socialising with peers and family. The use of drugs to gain some control over moods and behaviour, is not only restricted to tobacco. A cup of coffee (caffeine) in the mornings is used to help us 'wake up'. Alcohol and tobacco are common drugs that help us socialise or cope with life. Attempts to reduce smoking amongst young parents are therefore unlikely to be successful, if other acceptable strategies to buffer; stress, isolation, depression and concerns about body image are not addressed. These change processes are likely to occur over varying periods of time. Any change, no matter how small needs to be acknowledged. (refer to 3.5 Maintaining Cessation and Section 4 Relapse)

Making Home Environment Smoke Free

While many young women were aware of the effects of passive smoking on their children, they were not always able to influence their partners, family and friends to smoke outside, keeping their homes smoke free.

"I couldn't quit, but I didn't smoke in the house around my baby. It was difficult to tell my mum to smoke outside, as she was very supportive of me during my pregnancy."

"I knew about smoking, but my partner still smokes around me."

"All my family smoke inside."

"My mum smoked when I was born and we had asthma and she still smokes around babies."

"I remember always having a 'cold, cough' when I was a young child and both my parents smoked."

"My grandmother smokes heaps, I think her dog has emphysema."

"My boyfriend didn't smoke around our baby. He and his mates smoked outside."

Young fathers may also experience limited support from peers, family and health services. They are less likely than their partners to have had access to information about pregnancy and parenting. Young parent programs also need to involve partners where appropriate.

Relapse

Women taking up smoking after a cessation period of 6 to 9 months may be due to a number of reasons. Women quit smoking for the health of their unborn baby. Factors such as; isolation, stress, depression and the influence of family, friends and partners are significant factors.

"I felt I could smoke again after the birth, but I couldn't when I was pregnant."

"I gave up for 18 months, but my family hated it as I was a reformed smoker, so I took it up again."

"I had postnatal depression, was very stressed, so I started smoking again."

"I cut down a lot during my pregnancies, but then after they were born I smoked even more. I was up most of the night with my baby, so took up smoking during the night."

"I think depression and isolation were a big factor in me smoking heaps after the birth of my child."

RESOURCES

Quitskills Training for Health Workers

Quitskills workshops provide training for health workers supporting people to quit smoking.
Quit SA 8291 4282
www.quitsa.org.au

Young Parents

The Second Story (a division of Child and Youth Health)
Youth Healthline 1300 13 17 19
Young parent programs, information and support.
www.cyh.com.au

Pregnancy Information and Support

Hospitals, Doctors, GP, Midwives.
Community Health Centres.
Department of Human Services
www.dhs.sa.gov.au

Smoking Information and Support

Quitline 131 848.
Youth Healthline 1300 13 17 19 (a service of Child and Youth Health)
OxyGen
Created and funded by the SA Smoking and Health Project 'Smarter than Smoking' Project (WA) and Quit Victoria. www.oxygen.org.au
General Practitioner's.

Drugs and Alcohol Information

ADIS (Alcohol and Drug Information Service) 1300 13 1340
Australian Drug Information Network (ADIN) www.adin.com.au
Centre for Information and Education on Drugs and Alcohol CEIDA Australia
www.ceida.net.au

Other Resources

"Give it up Sista" (video) young indigenous women examining the effect smoking has on their lives.
Department of Human Services and Women's Health Statewide
Aboriginal Health Council of SA Inc. 'Puyu Wiya' (no smoking)
Quit SA Health Promotion Resources

RESOURCES BY YOUNG PARENTS FOR YOUNG PARENTS

Posters, Postcards, Tri-fold Card



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