

National Institute for Health and Clinical Excellence

**PUBLIC HEALTH INTERVENTION GUIDANCE:
Quitting smoking in pregnancy and following childbirth**

Consultation on the Draft Guidance from 2nd December 2009 – 8th January 2010

**Comments on the Draft Guidance to be submitted no later than
5pm on Friday 8th January 2010**

Stakeholder Comments

Please use this form for submitting your comments to the Institute.

1. Please put each new comment in a new row.
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Name:	ASH Scotland
Organisation:	Action on Smoking and Health Scotland, 8 Frederick Street, Edinburgh, EH2 2HB, 0131 225 4725, ashscotland@ashscotland.org.uk
Section number Indicate section title or number or ' general ' if your comment relates to the whole document	Comments Please insert each new comment in a new row.
General	<p>ASH Scotland believes the draft guidance as consulted upon is broadly in line with the recent evidence-base, as summarised in Bauld & Coleman's (2009) briefing paper for the PHIAC, and is in agreement with the majority of the recommendations it sets out. The recommendations also appear to be consistent and complementary with the general population guidance on brief interventions for smoking cessation (NICE PH1) and the guidance on provision of smoking cessation services (NICE PH10).</p> <p>The following comments relate to particular aspects of the draft guidance ASH Scotland believes would benefit from further clarification, or that may have particular service implications ASH Scotland is aware of through its work with cessation services in Scotland.</p>
<p>Page 5 Recommendation 1 <i>What action should they take?</i> <i>Refer all those who smoke, even those unwilling to consider quitting ...</i></p>	<p>This recommendation is one which will have significant service implications (as PHIAC is aware, described in Consideration 3.18). At present, as MacAskill et al (2008) describe, some region-specific tobacco cessation programmes for pregnant women adopt an 'opt-out' approach in that any women who is identified as a smoker by CO validation is referred to a specialist cessation service (and then provided with the opportunity to opt-out of the intervention following a telephone call from a specialist adviser).</p> <p>However, services which have not adopted this approach (instead referring to specialist services only those who have shown an affirmative intention to stop smoking during pregnancy – an 'opt-in' approach) argue that opt-out results in a large proportion of service resource expended on contacting clients who are referred but have no desire to stop. In the</p>

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	<p>context of demanding national smoking cessation performance targets in Scotland, feedback from services around this issue suggests that in some areas, specialist services offer an opt-in approach because they feel their resources are better spent on provision of support to those who have made an affirmation to give up. This practice is reinforced by the evidence supporting most existing guidance and training on the provision of smoking cessation interventions in Scotland, which stresses that interventions in which the client does not wish to stop smoking are unlikely to be successful (e.g. West, 2004).</p> <p>ASH Scotland is supportive, in principle, of a recommendation to move towards opt-out referral to specialist services for pregnant women as the default, as the consequences of continued smoking throughout pregnancy are sufficient to warrant a strong intervention in response. However, we recognise that this will have significant implications for service resources, which must be recognised by funding bodies and reflected by allocation of sufficient funds to meet service needs.</p> <p>The evidence supporting this recommendation, as Bauld and Coleman's briefing describes, is also at a very preliminary stage. Although it points towards a greater number of referrals being predictive of a greater number of individuals who genuinely engage with the specialist services (McGowan et al, 2008), further research should be recommended by PHIAC. In particular, research is required examining potential unexpected outcomes from the recommendation in terms of resources expended by services in following up smokers who may not be ready to quit.</p> <p>West, R. (2004) Assessment of dependence and motivation to stop smoking, <i>BMJ</i> 2004;328:338-339</p> <p>Macaskill, S, Bauld, L, Eadie, D and Tappin, D. (2008) <i>Smoking Cessation Support in Pregnancy in Scotland</i>, Health Scotland, Glasgow. http://www.healthscotland.com/documents/2665.aspx</p> <p>McGowan, A, Hamilton, S, Barnett, D, Nsofor, M, Proudfoot, J and Tappin, D (2008) Breathe: the stop smoking service for pregnant women in Glasgow, <i>Midwifery</i>, doi: 10.1016/j.midw.2008.05.005</p>
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Page 5
Recommendation 1
What action should they take?

Refer all those who smoke...with a CO reading of more than 7 parts per million ...

ASH Scotland acknowledges the importance of correctly identifying smokers by biochemical validation. Experience shows it is important that validation and testing of CO or cotinine is presented to professionals and pregnant women as part of a suite of routine tests used during maternal healthcare, not as a 'cheat test' of self-reported smoking status to catch out individuals who misreport. Service experience indicates that using validation in the latter manner can generate resentment towards the intervention, and reduce the prospects of genuine engagement with the service. Hence, the presentation of the validation is an issue which should be handled with some care.

The threshold value for CO readings to positively identify a smoker at booking is variable across Scotland, with some services following manufacturer's guidance of their particular instrument, and some adopting a set value (e.g. 8 or 10 ppm) based on various sources of guidance such as NICE PH10.

Setting the threshold value for a binary test is a balance between the sensitivity and specificity of the measurement. While test sensitivity is of clear importance in this case in order to correctly identify smokers (as incorrectly identifying a smoker as a non-smoker results in a missed opportunity for an intervention), specificity becomes particularly important if an opt-out model is recommended as resources would be expended following-up non-smokers who have been incorrectly identified.

It is not clear how the 7 parts per million recommendation in the draft guidance was derived, hence it would benefit from clarification in the final guidance. Usmani et al (2008), discussed in the evidence briefing, demonstrate in a study of 2,548 women that while a threshold value of 8 ppm has a sensitivity of only 59.4% with a specificity of 98.7%, moving to a cut-off of 2 ppm improved the sensitivity of the test to 86% while keeping the specificity of the test at around 90%.

The authors argue the case for a lowered CO threshold of 2 to 3 ppm (many maternity services in Glasgow use the value of 3 ppm as a result of the above study). A slightly lower threshold than the 7 ppm recommended in the draft guidance could be argued to be a better trade off between sensitivity/specificity.

Usmani et al report that, although increasing sensitivity did increase the number of true non-smokers who would be referred to specialist services this was not seen as overly burdensome or impractical by midwives (though there are obvious resource implications for the specialist services which have to follow up extra individuals). Anecdotal reports from Glasgow also show there can be unexpected benefits in increasing sensitivity of the test; on several occasions true non-smokers who were identified as having a CO measure greater than 3 ppm discovered they were being exposed to other high levels of CO from sources other than tobacco smoke (such as emissions from heating systems) which they were then able to rectify.

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ASH Scotland would suggest PHIAAC consider the benefits of a lower value for the CO threshold. If the threshold is to be set at 7 ppm, more detailed discussion in the guidance on how this conclusion was reached would be beneficial in ensuring uniform practice across services which, at present, use a variety of different values.

Usmani, Z, Craig, P, Shipton, D and Tappin, D (2007) Comparison of CO breath testing and women's self-reporting of smoking behaviour for identifying smoking during pregnancy. *Substance Abuse Treatment Prevention and Policy*, 3, 4, doi. 10.1186/1747-597X-3-4.

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<p>Recommendation 1 Who should take action? <i>midwives (at first booking), GPs and health visitors...</i></p>	<p>ASH Scotland welcomes this aspect of the recommendation, and suggests that consideration be given to whether it is appropriate for wider members of the maternity team (e.g. sonographers) to be included explicitly in this recommendation (or possibly also under <i>Recommendation 2</i> if this is more appropriate).</p>
<p>Page 6 Recommendation 1 What action should they take? <i>Provide information (for example leaflets) about risks of smoking for the unborn child ...</i></p>	<p>Note: These comments apply to any section of the document, including diagrams, where mention is made to '<i>discussing the risks of continued smoking with the woman</i>' or similar, which appear throughout the draft guidance (e.g. page 8, page 9).</p> <p>The presentation of the recommendations in this section would be enhanced by framing the potential behaviour change in a more positive light, in addition to the emphasis placed on describing the risks of negative health effects. For example, by '<i>providing information about the risks of smoking for the unborn child and also the benefits of giving up smoking</i>'.</p> <p>The observation that women who smoke during pregnancy can feel guilty about their behaviour is well-documented and interventions that make the women feel worse about their behaviour through 'nagging' of health professionals have been identified as a barrier to smoking cessation (Lowry et al., 2004). While the risks of continued smoking should of course form part of the intervention, an empathetic, client-centred approach should also present the positive benefits of stopping, which the guidance should reflect.</p> <p>The guidance should also ensure that the woman's own role is not lost, Lowry et al. discuss how interventions that focus on the risk to the unborn child alone can be a turn-off for some women. It treats them as a 'pregnancy with a woman attached'. Smoking cessation interventions should discuss the risks of continued smoking and the benefits of cessation for the woman in addition to the unborn baby.</p> <p>Lowry R.J, Hardy S, Jordan C, Wayman G, (2004) Using social marketing to increase recruitment of pregnant smokers to smoking cessation service: a success story. <i>Public Health</i>. 118, 239-243.</p>
<p>Page 6 Recommendation 1 What action should they take? <i>...and the hazards of exposure to secondhand smoke for the mother and baby.</i></p>	<p>ASH Scotland believes this recommendation is particularly important given the adverse and disproportionate effects of second-hand smoke to infants and the young through known mechanisms such as greater inhalation of particulate matter (Thomson et al, 2005) and greater hand/object/mouth contact than adults (Matt, 2004).</p> <p>It is also important to ensure that a consistent message is presented regarding the hazards associated with secondhand smoke exposure. As sources of smoke exposure to infants and young people in the household often include wider family and household members (whose</p>

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	<p>support may be necessary for behaviour change), it is important that relevant information is provided to these groups, in addition to the mother. Hence these directions should have parity with recommendations for young children older than 12-months (e.g. recommendation 9 in NICE PH10) by emphasising that GPs, Health Visitors, and those working in fertility clinics should provide information to family and household members about secondhand smoke as well as the woman.</p> <p>Thomson, G., et al. Smoky homes: a review of the exposure and effects of secondhand smoke in New Zealand homes. <i>New Zealand Medical Journal</i> 118(1213): U1404, 2005</p> <p>Matt, G., et al. Households contaminated by environmental tobacco smoke: sources of infant exposures. <i>Tobacco Control</i> 13(1): pp.29-37, 2004.</p>
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<p>Page 7 Referral pathway diagram</p>	<p>It may be helpful to clarify the referral pathway (and how the interaction with the specialist stop smoking service the client is being referred to proceeds) if the telephone component where the client is given the opportunity to 'opt-out' is incorporated in some way into the larger referral diagram, or is included in a separate figure in the guidance.</p>
<p>Page 10 Recommendation 3 <i>What action should they take?</i> <i>Biochemically validate self-reported quitting at quit date and 4 weeks after.</i></p>	<p>The recommendation to biologically validate quit attempts by salivary or urinary cotinine in preference to exhaled CO will allow more accurate assessment of smoking status, but seems unlikely to be put into immediate practice without support and resources. To ASH Scotland's knowledge, very few specialist stop-smoking services in Scotland have training or equipment to use cotinine assays so there will be significant resource implications in implementing this aspect of the recommendation.</p>
<p>Page 12 Recommendation 5 <i>Training</i> <i>General comments on section</i></p>	<p>Through our development of an evidence-based brief advice training package - <i>raising the issue of smoking during pregnancy</i> - in partnership with Scottish maternity services, ASH Scotland has seen the importance of securing maternity service management buy-in to ensure staff are able to access training.</p> <p>If the management of maternity services are not aware of/do not prioritise smoking cessation training, staff attendance is extremely difficult to secure due the pressures of case load and the requirement to attend existing mandatory training.</p> <p>An explicit recommendation in the guidance that maternity service management should be responsible for ensuring their staff are trained to at least brief intervention level will help in ensuring that appropriate priority is placed on training in smoking cessation. A recommendation to make such training mandatory is also desired by some maternity services ASH Scotland has contact with.</p> <p>In this section of the guidance it would also be beneficial to clarify the intended levels of training required for different roles in the maternity services. E.g. that non-specialist midwife staff, health professionals, and primary or secondary care staff that support the woman post-birth should receive training to at least 'brief intervention' level so they can raise the issue and effectively refer on, while NHS stop smoking service staff or specialist smoking cessation midwives are trained to deliver at the intensive/specialist level.</p>
<p>Page 13 Recommendation 5</p>	<p>This point could clarify that stop smoking specialist midwives (whose role is to deliver an intensive intervention equivalent to that provided by the</p>

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<p>Training <i>Ensure NHS Stop Smoking Services staff are trained to the minimum national standard...</i></p>	<p>NHS Stop Smoking Services) should also be trained to the same standards as non-midwife specialist advisers.</p>
<p>Page 21 Considerations 3.9 <i>PHIAC could not recommend giving brief advice to pregnant women who smoke due to a lack of evidence of its effectiveness ...</i></p>	<p>Through our work in Scotland, we have seen that there can be a varied understanding of the difference between brief advice/brief intervention. Sometimes the two terms are used interchangeably, which would make this consideration seem to contradict with the primary recommendations in this guidance (as raising the issue, and referring on to a specialist service, is seen by many to fall under the heading of 'brief advice').</p> <p>Using the terminology of PH1 (<i>Brief interventions and referral for smoking cessation in primary care and other settings</i>) 3.9 becomes clear as 'brief advice'; it refers to the less intensive advice to stop provided when a client has declined a referral to specialist services as part of a larger brief intervention process.</p> <p>To clarify this, if confusion as to the relationship between brief advice/brief intervention is a recognised problem in the UK as a whole, it may be useful to reiterate definitions and NICE's understanding of what constitutes both brief 'intervention' and 'advice' at some point in the guidance.</p>
<p>Page 22 Considerations 3.18 <i>PHIAC acknowledged that encouraging practitioners to refer all pregnant women who smoke – even those who are currently unwilling to consider quitting ...</i></p>	<p>Further to the point raised in comment on page 5, recommendation 1, services in Scotland that have adopted an opt-out system for maternity service referrals to stop-smoking services, report that this approach is more resource intensive than an opt-in approach due to additional contact time with extra clients.</p> <p>Because of this extra demand, it is important to accompany this recommendation with a complementary one for those who commission and fund specialist services that deal with a significant volume of referrals of pregnant women from maternity services (which ideally should be all NHS stop-smoking services) who must take account of this extra demand when planning and funding services.</p>
<p>Page 24 Recommendations for research</p>	<p>There is need for research into the effectiveness of opt-in versus opt-out systems of referral for pregnant smokers, focusing on whether referring smokers who may not be ready to quit has benefits for service throughput, the extent it contributes to increased service load, and any detrimental side-effects (e.g. by potentially frustrating smokers who have no desire to give up at present and possibly deterring them from contacting services in the future).</p> <p>Research should be continued into the threshold value of CO used to</p>

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	determine abstinence in smoking cessation for both pregnant women, other target or priority groups, and the general population, seeking the best balance between test sensitivity and specificity.
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