



Health Development Agency

Helping smokers stop
A guide for the dental team



Acknowledgements



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Preface

Smoking is the most important public health challenge facing the NHS. Although rates of smoking have steadily declined in recent years, tobacco use continues to inflict a significant burden of disease and premature death, especially among the most deprived sections of society. The detrimental effects of tobacco use on oral health are also well recognised.

In recent years a range of complementary strategies have been implemented with the aim of reducing tobacco use across the population. Publication of evidence-based smoking cessation guidelines has encouraged health professionals to provide effective support for their patients. The establishment of NHS Stop Smoking Services across the NHS now also enables health professionals to refer smokers to specialist smoking cessation services.

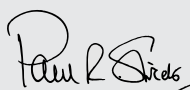
Dentists and their teams have an important role to play in this area of prevention. Asking patients routinely about their tobacco use and assessing their motivation to quit are simple but important pieces of information that can be collected during a clinical history. Patients who are motivated can be referred to the local NHS Stop Smoking Service or given practical advice in the dental setting.

Helping smokers stop: a guide for the dental team aims to outline practical ways in which dental practitioners and their teams can effectively support people to quit smoking. The Continuing Professional Development (CPD) component of this document is an incentive for future action. Involvement in smoking cessation provides an ideal opportunity for the dental team to become actively engaged in an interesting, relevant and important area of prevention. We support the authors in calling for greater dental commitment in smoking cessation initiatives and hope that this *Guide* will provide the platform for doing so.



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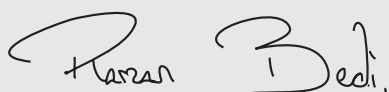
Foreword

Smoking is the largest single preventable cause of death and disability in the UK. Each year smoking kills more than 120,000 people, 20% of all deaths. The smoking epidemic costs the NHS a great deal of money: £1.7 billion a year in England is spent on treating smoking-related diseases, money that could be used elsewhere in the NHS.

Tobacco use has many harmful effects on oral health. More than 2,000 cases of oral cancer are reported each year in the UK, with smoking being one of the key aetiological factors. Smoking is also linked to many other oral health problems, including periodontal disease. These effects provide a very visual and stark illustration of what smoking is doing to people's bodies. The oral health effects of smoking can be a useful indicator and motivator for smokers to quit.

The dental team has a major role to play in smoking prevention. Evidence indicates that smoking cessation interventions are both effective and cost effective. For a modest cost, a brief intervention will result in significant health gain and, in the long term, reduce smoking-related healthcare costs to the NHS. However, advising on giving up smoking is still not a routine part of clinical practice for many health professionals.

This *Guide* aims to provide information to encourage members of the dental team to offer advice to their patients who smoke. With a greater emphasis now being placed on health promotion and prevention, the time is right for the dental team to get involved in this rewarding and effective area of clinical practice.



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The smoking epidemic Smoking is one of the greatest public health challenges the world faces today. Every year over 4.9 million deaths are caused by tobacco (WHO, 2002). The latest figures in the UK indicate that smoking causes more than 120,000 deaths and costs the NHS at least £1.7 billion a year (Callum, 1998). Although the prevalence of cigarette smoking in adults in the UK has dropped significantly, to 27% in recent decades (Royal College of Physicians Tobacco Advisory Group, 2000), it is still higher than in some other western nations (Mackay and Eriksen, 2002).

Aims

Outline the general pattern of smoking in the UK.

Highlight current UK policy initiatives focusing on tobacco control.

Starting to smoke

By the age of 15 years, more than one in four boys (28%) and one in three girls (33%) in England smoke. Most smokers start during their adolescence. Half of these will eventually be killed by tobacco (Peto *et al.*, 2003). Many of these deaths could be averted if people alive today stop smoking. Starting smoking is caused by a combination of environmental, behavioural and personal factors (Box 1).

Box 1.

Reasons for starting to smoke

Environmental:

- parental smoking (twice as likely to smoke)
- smoking by siblings and friends
- advertising and promotions targeting young people
- deprived background

Behavioural:

- linked to poor school performance, truancy and early drop-out
- associated with other problem behaviours – alcohol and other drug misuse

Personal:

- low self-esteem
- limited knowledge of adverse effects
- anxiety and depression.

Smokers want to stop

Surveys show that over two thirds of smokers want to stop and approximately one third try to stop in any year. Unfortunately, due to the highly addictive nature of nicotine their chances of success are low unless they are offered support and treatment. The unaided cessation rate in middle-aged smokers is approximately 2% a year, making nicotine one of the most addictive drugs (Royal College of Physicians Tobacco Advisory Group, 2000).

A high proportion of smokers have attempted to quit. For example, 88% of 45–54 year olds have made at least one attempt to quit. Smoking cessation is influenced by a number of factors, many of which are illustrated in Box 2.

Box 2.

Factors influencing smoking cessation (Jarvis, 1997)

Immediate family circumstances – someone living with a smoker is less likely to quit successfully.

Broader socio-economic setting – poverty is associated with low rates of cessation, those who can least afford to smoke being the least likely to quit.

Psychological wellbeing – depressive illness and stressful life circumstances are associated with low rates of cessation.

Pharmacological dependence – daily cigarette consumption and how soon an individual smokes after waking up are strong indicators of dependence: 17% of smokers light up within five minutes of waking, and over 50% within half an hour.



Social class differences

In the UK, data indicate that there are large socio-economic differentials in smoking. In 2001, 34% of individuals working in routine occupations smoked, compared with only 15% of those in higher professional and managerial jobs (ONS, 2001). Adults in 75% of UK families receiving income support smoked, with one seventh of their disposable income being spent on tobacco (Marsh and McKay, 1994).

Between 1973 and 1994 rates of smoking among affluent people halved in the UK, while among the poorest groups the levels remained relatively unchanged. Among certain minority ethnic groups, chewing tobacco is popular (Gupta and Warnakulasuriya, 2002).

Policy context

In 1998 the Department of Health published *Smoking kills, a white paper on tobacco*, which provides a comprehensive agenda for action on smoking (Department of Health, 1998a). It outlines the need for smoking cessation services and sets targets for a reduction in smoking prevalence. It recommends the establishment of a comprehensive NHS Stop Smoking Service, formerly Smoking Cessation Service. It also encourages all health professionals, including dentists, to assess smoking habits and provide smoking cessation advice whenever possible.

Modernising NHS dentistry (Department of Health, 2000) and *NHS dentistry: options for change* (Department of Health, 2002) both also highlight the need for dentists and dental teams to be involved in smoking cessation.

Specialist Stop Smoking Services are now available throughout the NHS, providing counselling and support to smokers wanting to quit, and increasing the availability of the smoking cessation aids, nicotine replacement therapy (NRT) and bupropion (Zyban). It is now possible for dentists to refer their patients to these clinics. Services are provided in group sessions or on a one-to-one basis, depending on the local circumstances and client's preferences.

The Health Development Agency (HDA) is the national authority and information resource on what works to improve people's health and reduce inequalities in England. It gathers evidence and produces advice for policy makers, professionals and practitioners, working alongside them to get evidence into practice. The HDA has published a number of documents relating to smoking cessation issues. For example, the *Standard for training in smoking cessation treatments* (HDA, 2003) provides a quality framework against which to measure current and future training opportunities. Other HDA publications can be found at www.hda.nhs.uk

The impact of smoking

Aims

Outline the adverse effects of tobacco use on general health.

Highlight the impact of tobacco use on oral health and dental treatment outcomes.



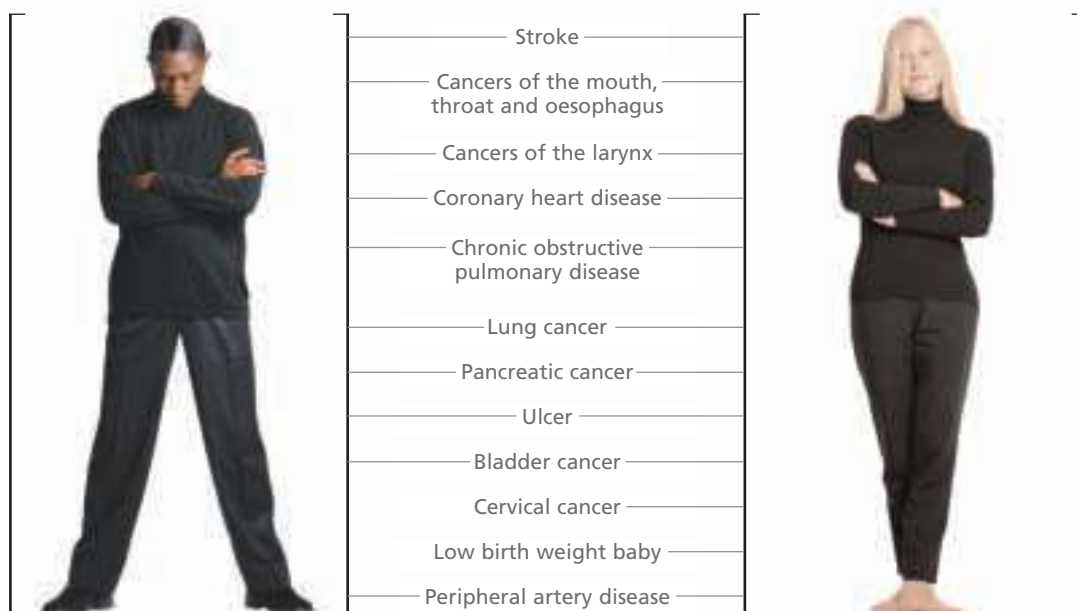
Shortening of life

A smoker's life span is shortened by about five minutes for each cigarette smoked – this is about the amount of time that is spent smoking a cigarette. On average, those killed by smoking have lost 10–15 years of life (Royal College of Physicians Tobacco Advisory Group, 2000).

There is evidence that smoking can cause at least 50 different diseases (Doll *et al.*, 1994), including 30% of all cancers, 90% of all lung cancers, 30% of all ischaemic heart disease and strokes, and 70% of chronic lung diseases (Peto *et al.*, 1996). In the UK 120,000 people die prematurely due to tobacco use, that is 330 deaths every single day. This is equivalent to a plane crashing every day and all the passengers being killed. Figure 2 presents the major health problems associated with cigarette smoking.

Figure 1.

Health risks of cigarette smoking





How smoking affects oral health

The effects of tobacco use on the population's oral health are also alarming. The most significant effects of smoking on the oral cavity are: oral cancers and pre-cancers, increased severity and extent of periodontal diseases, and poor wound healing (Allard *et al.*, 1999). Chewing tobacco is associated with a range of oral pathologies (Gupta and Warnakulasuriya, 2002). Some of the most common diseases and problems are outlined in Box 3. The clear link between oral diseases and tobacco use provides an ideal opportunity for oral health professionals to become actively involved in cessation activity and tobacco control initiatives.

The Report of the Scientific Committee on Tobacco and Health in 1998 stipulated that 'dentists and dental hygienists can play an important role in providing information to the general public on known health risks of smoking, including those associated with dental disease.' The report recommends that all dentists and dental hygienists be given smoking cessation training and be encouraged actively to promote smoking cessation in the dental practice (Department of Health, 1998b).

At the professional level, the dental associations have a role to play in lobbying the government to implement the World Health Organization's Framework Convention on Tobacco Control (Beaglehole, 2003; WHO, 2003).

Box 3.

Tobacco-induced and associated conditions (Johnson, 1997)

Oral cancer

Leukoplakia – lesions which are potentially malignant:

- nodular leukoplakia
- verrucous leukoplakia
- erythroleukoplakia

Oral mucosal conditions:

- smoker's palate
- smoker's melanosis

Tobacco-associated effects on the teeth and supporting tissues:

- periodontal diseases
- premature tooth loss
- acute necrotising ulcerative gingivitis
- staining

Other tobacco-associated oral conditions:

- halitosis
- candidal leukoplakia
- leukoedema.

Oral cancer

Smoking is associated with several changes in the oral mucous membrane and has a direct carcinogenic effect on the epithelial cells of the oral mucous membranes. Indeed, smoking is the major risk factor of developing oral cancer (Steward and Kleihues, 2003). Oral cancer accounts for about 3–4% of all cancers in the UK (Cancer Research Campaign, 2000). The most common type of oral cancer is squamous-cell carcinoma, which includes about 90% of oral malignancies (Mirbid and Ahing, 2000).

Periodontal diseases

An abundance of research exists to suggest a clear association between tobacco use and the prevalence and severity of periodontal diseases (Bergstrom *et al.*, 2000). It is associated with an increased disease rate in terms of periodontal bone loss, periodontal attachment loss and periodontal pocket formation. Numerous studies indicate that smoking adversely affects the outcome of periodontal therapy. Smokers have been reported to show poorer success rates in surgical as well as non-surgical therapy, compared with non-smokers (Preber and Bergstrom, 1990; Kaldahl *et al.*, 1996).

Wound healing

Tobacco is a peripheral vasoconstrictor that influences the rate at which wounds heal within the mouth. Thus healing among smokers is slower, and less successful, following oral surgery. The resulting absence of blood clotting that follows the removal of teeth occurs four times more frequently in smokers than in non-smokers. In addition, smoking has an adverse effect on the healing of extraction wounds (Meechan *et al.*, 1988).



Dental implants

There is a wealth of evidence to suggest that smoking is detrimental to both the initial and long-term success of dental implants, and that smoking cessation can be beneficial in improving implant success rates (Allard *et al.*, 1999). In one study, the most significant factor predisposing to implant failure was smoking. Smokers had more than twice the failure rate (11%) compared with non-smokers (5%) (Bain and Moy, 1993).

Smell and taste

Smoking has been shown to affect both taste and smell acuity. Tobacco, whether chewed or smoked, can cause halitosis (Allard *et al.*, 1999).

Aesthetics and social impacts

Tobacco stains can penetrate into enamel, dental restorations and dentures, creating unsightly brown to yellow darkening of teeth (Mecklenburg *et al.*, 1996). Halitosis and tooth staining, which are both visible and reversible, have been shown to be common concerns of smokers and can be used as motivations for quitting (Watt *et al.*, 2003).



Box 4

The World Oral Health Report

The World Health Organization has suggested several moral, ethical and practical reasons why oral health professionals should strengthen their contribution to tobacco cessation programmes (Petersen, 2003):

- They are concerned about adverse effects in the oro-pharyngeal region
- They often have access to children, youths and their carers, providing opportunities to educate these individuals on the dangers of tobacco
- They often have more time with patients than many other clinicians, providing opportunities to integrate education and intervention methods into practice
- They often treat women of childbearing age, and are thus able to inform them about the potential harm to their babies from tobacco use
- They are as effective as other clinicians in helping tobacco users quit, and it is known that a multi-disciplinary approach increases cessation rates
- They can stimulate their smoking patients to quit by showing the actual effects of tobacco on the mouth
- They are the only healthcare professionals who frequently see 'healthy' individuals
- They are trusted, and patients believe the advice given.

Healthcare professionals are in a unique position to contribute to tobacco control in a number of complementary ways: as role models by not smoking; in counselling patients not to smoke; in referring patients to smoking cessation services; in speaking out publicly; and in lobbying for comprehensive public policies to control tobacco use (American Cancer Society, 2003).

Smoking behaviour One of the reasons why people continue to smoke, despite the known health risks, is the complex nature of tobacco use. It is important to understand the complex and compulsive nature of the smoking habit. Cigarettes are associated with emotional as well as physical dependence.

Aims

Outline the psychological nature of smoking and the effects of nicotine dependence.

Describe different motivations – why do smokers want to quit?

The physical/chemical addiction

Smokers smoke to maintain a certain level of nicotine in their blood. When the nicotine falls below that level they feel the desire to smoke. This results in smokers responding to cravings at regular intervals.

The automatic habit of smoking cigarettes

Smoking often becomes an unconscious habit, so that smokers can find themselves smoking without even remembering lighting up.

The psychological aspect

This is associated with emotional dependence. Cigarettes are used to cope with stress. Most smokers use cigarettes to provide breaks as part of the structure of their daily routine. This aspect can be triggered by boredom, anger and excitement.

It is important to recognise the love/hate relationship that smokers have with their smoking habit, and the 'double bind' of using cigarettes for both stimulation and relaxation at different times of day.

Motivations for quitting

There is no single reason why people try to stop smoking. Every smoker is different, and success in quitting depends partly on the personal circumstances and support available to the smoker. Success in helping smokers will depend on recognising when the time is right to offer support. There are a number of motivations to quit smoking (Box 5).

Box 5.

Potential reasons for stopping smoking (Watt *et al.*, 2003)

- Save money
- Feel better and more energetic
- Break dependence on tobacco
- Reduced risk of cancers and heart disease
- Improve appearance – less staining on teeth, better skin texture
- Reduce risk of halitosis
- Better periodontal health – greater chance of retaining teeth for life
- Reduced risk of oral cancers.

It is important for members of the dental team to assess the patient's readiness to quit, and to realise that many patients often make repeated attempts to stop before succeeding in breaking their habit. All patients will have different motivations for making a quit attempt.

Whether or not a smoker is successful in their quit attempt depends on the balance between that individual's motivation to stop smoking, and his or her degree of dependence on cigarettes. In the clinical setting it is important to be able to assess both these characteristics.

A smoker's tale

Rob, a 44 year old, started smoking when he was 16. For over 28 years he smoked, on average, 20 cigarettes a day. After many previous attempts he quit smoking 18 months ago.

He started smoking largely because everyone else in his social group already smoked. As a teenager it was just the thing to do. Smoking for Rob was an enjoyable experience for many years. As a regular drinker he smoked a lot, especially when socialising with his friends.

According to Rob, 'smoking and alcohol are perfect together.' He also liked the taste of tobacco. For him, smoking was particularly useful in stressful social situations: 'If you are not sure of yourself and what to do, smoking really helps.'

On several occasions he tried to stop smoking. At times he would manage to stop for a few weeks, but always ended up smoking again. For Rob, the biggest problem was the link between smoking, drinking alcohol and socialising. He also found it very difficult to break the daily routines that smoking was associated with, such as drinking coffee at break times at work. However, 18 months ago he went to his GP for help. She was helpful but

didn't seem to have a great deal to offer. Rob asked for a prescription for Zyban as he had heard about the value of this drug for smokers wanting to quit. He also decided to attend the local NHS Stop Smoking clinic.

Rob found the Zyban really did help him get through the difficult periods: 'For me it helped with the cravings for nicotine. I had tried patches before but the Zyban was better. It also helped me deal with my mood. Stopping smoking can make you very edgy.' While taking Zyban he went to five sessions at the local NHS Stop Smoking clinic. These were group sessions which he found supportive and stimulating, but he would have preferred to continue going to the clinic for a longer period. Having a supportive partner also made a huge difference for him, as giving up smoking was a huge challenge.

Rob goes to his dentist on fairly regular basis but has never been asked about smoking there. For him the link between smoking and his mouth wasn't very obvious: 'If my dentist had said to me look at your tongue or gums, this is what smoking is doing to you, I might have taken notice and really thought about it.'



Smoking cessation works Brief advice from health professionals and more intensive behavioural support have been shown to increase a smoker's chance of quitting (Fiore *et al.*, 2000). The evidence base indicating that smoking cessation in the clinical setting is strong and very convincing is based on the findings of many randomised controlled trials, the so-called 'gold standard' in research design (West *et al.*, 2000; Rice and Stead, 2004; Silagy and Stead, 2004).

Aims

Review the evidence base for smoking cessation advice and support.

Table 1 summarises the central findings from recent effectiveness reviews on smoking cessation interventions. Very brief advice given by a health professional, lasting less than three minutes, will help about 2% of smokers to stop smoking successfully, over and above the percentage who quit without professional assistance. With more intensive support, lasting up to 10 minutes, plus the use of NRT, 6% of smokers will quit. Evidence from studies undertaken in the dental setting reveals similar rates of success (Warnakulasuriya, 2002).

A quit rate of 2% or even 6% may seem somewhat insignificant. But when translated into a population estimate, between 63,000 and 190,000 people may quit smoking each year in the UK if all general dental practitioners were to offer smoking cessation advice routinely. Less than ten minutes spent with a smoker can really help that person to stop smoking.

Table 1

Smoking cessation evidence (West *et al.*, 2000)

Intervention element	Target population	Increase in percentage of smokers abstaining for six months or longer
Very brief advice to stop (three minutes) by clinician, versus no advice	Smokers attending GP or outpatients	2
Brief advice to stop (up to ten minutes) by clinician, versus no advice	Smokers attending GP or outpatients	3
Adding NRT to brief advice, versus brief advice alone or brief advice plus placebo	Smokers attending GP or outpatients	5–8
Intensive support (Smoking Cessation Service), versus no intervention	Smokers attending GP or outpatients	7
Intensive behavioural support (Smoking Cessation Service) plus NRT or Zyban, versus no intervention	Smokers attending specialist service	13–19

It is recognised that face-to-face behavioural support can lead to 7% of smokers stopping for at least six months (Lancaster and Stead, 2000). Adding NRT or Zyban to the behavioural support increases six month success rates on average by 8% (Silagy *et al.*, 2001). Thus the combined effect of behavioural support and NRT or Zyban on six month abstinence rates is between 13 and 19% (Table 1).



Best practice

With the widespread establishment of NHS Stop Smoking Services, the opportunity now exists for smokers to be given expert guidance and help to quit. These services can have a significant impact on smoking rates. Dentists and other primary healthcare professionals have an important role to play in referring smokers to these services. The following section (The four As) considers the best ways of offering support to smokers, and the appropriate referral procedure to adopt.

Smoking cessation is cost effective

It is well known that helping smokers stop is extremely cost effective (Raw *et al.*, 2001). The cost per life year saved by a comprehensive cessation service is approximately £900. Numerous health economists consider a treatment that costs from £5,000 to £10,000 per life year saved as excellent value for money (Parrott *et al.*, 1998). For a modest cost, smoking cessation will result in a significant public health gain and, in the long term, reduce smoking-related healthcare costs to the NHS.

Stopping smoking is a process

Quitting smoking is mostly a slow process, not a single event. Your objective should be to help each smoker take the next step along the path towards his or her last cigarette. Each smoker is different, and you will be most effective if you tackle his or her individual problems one step at a time.

Advice and support provided in a clinical setting will be most effective with patients who are interested and keen to make a quit attempt. Pressurising 'contented' smokers will usually achieve very little. It is crucial to tailor advice and support to smokers who are ready and willing to change their behaviour. The use of appropriate questioning techniques is therefore essential (Box 7).

Box 7.

Questioning techniques and styles (Watt *et al.*, 2003)

Use both closed and open questions, as appropriate, depending on what information you require.

Give patients time to answer your questions – don't rush them.

Encourage patients to speak openly and honestly.

Take care not to be seen as nagging or judgemental – this achieves nothing.

Sum up any information given to you, to check that you understand what has been said.

All health professionals can play a role in encouraging smokers to stop and promoting the use of NHS Stop Smoking Services.

The four As Brief advice from health professionals and more intensive behavioural support have been shown to increase a smoker's chance of quitting (Fiore *et al.*, 2000). The evidence base indicating that smoking cessation in the clinical setting is strong and very convincing is based on the findings of many randomised controlled trials, the so-called 'gold standard' in research design (West *et al.*, 2000; Rice and Stead, 2004; Silagy and Stead, 2004).

Aims

Outline the different steps involved in providing smoking cessation support.

Highlight the importance of referring motivated patients to smoking cessation services.

Identify the ways of assisting a smoker to successfully quit.

The four As model is a straightforward and quick means of identifying smokers who want to quit, and how best to help them be successful (Silagy and Stead, 2004). The modified four As approach is an appropriate model for dentists to incorporate into their daily clinical practice. The modified approach, which places greater emphasis on the 'Arrange' component, highlights the importance of appropriate referral of smokers to specialist smoking cessation services.

Box 8.

The modified four As approach to smoking cessation

ASK

All patients should have their smoking status checked at regular intervals.

ADVISE

All smokers should be advised on the value of quitting.

ARRANGE

Refer motivated smokers to the local smoking cessation service.

ASSIST

For those smokers who want to stop, but are not prepared to attend a smoking cessation service, appropriate support should be offered.

ASK

All patients should have their smoking status (current, ex-, never smoked) established and checked at regular intervals. A simple and quick system is provided in Appendix 2, which enables smoking details to be recorded in the patient's clinical notes (West *et al.*, 2000).

Box 9 suggests questions that can be asked in order to determine the patient's motivation to stop smoking. Box 10 highlights simple questions to ask in order to test the patient's dependence on cigarettes.

Box 9.

A simple test of motivation to stop smoking

Q1

Do you want to stop smoking for good? No/Yes

Q2

Are you interested in making a serious attempt to stop in the near future? No/Yes

Q3

Are you interested in receiving help with your quit attempt? No/Yes

If the patient answers 'Yes' to all the above questions, this would provide the basis for offering support and assistance.



Box 10.

Simple test of cigarette dependence

Q1 How many cigarettes do you usually smoke per day?

- 10 or fewer
- 11–20
- 21–30
- 31 or more

Q2 How soon after you wake up do you smoke your first cigarette?

- Within 5 minutes
- Within 6–30 minutes
- Within 31 or more minutes

Smoking at least 15–20 cigarettes a day and/or smoking within 30 minutes of waking indicate high levels of nicotine dependence.

Whether or not a smoker succeeds in stopping smoking depends on the balance between that individual's motivation to stop smoking, and his or her degree of dependence on cigarettes (West, 2004).

ADVISE

All smokers and those using other forms of tobacco should be advised of the value of stopping and the risks to health of continuing. The advice should be clear, firm and personalised (Box 11). It is important to encourage the whole dental team to reinforce the cessation message and to support the patient's attempt to stop smoking.

Although most people are aware of the harmful effects of smoking in relation to lung cancer and heart disease, fewer people know about the detrimental effects of smoking on their oral health. This provides a unique opportunity for the dental team to highlight the dangers of smoking. A range of reasons for stopping smoking can be highlighted, some directly related to oral health, others more general.

It is necessary to consider what is likely to be most significant and relevant to the patient. For example, stained teeth, halitosis and soft tissue changes in the mouth may be especially pertinent to young people. The early effects of tobacco use on the mouth are visible and reversible, and may be a useful means of motivating smokers on the benefits of stopping.



Box 11.

Factors that may reinforce advice to stop smoking

Emphasise the fact that stopping smoking is the most effective step they could take in improving their present state of health and the health of those around them. It is also the most important decision they could take to ensure future good health.

Past failures may actually improve their chances of success this time. Those smokers who keep trying to stop are more likely to succeed in the end.

Estimating the cost of smoking to the individual smoker is a useful exercise. Writing down the actual costs can reinforce the smoker's decision to give up. ASH has estimated that, based on 2003 prices, smoking 20 cigarettes a day for the next 10 years would cost over £16,000.

Smokers know that their smoking is dangerous, but very few realise the full extent of the risks to their health.

In particular, all pregnant smokers should be advised of the dangers of smoking to the foetus and themselves, and be advised to stop smoking. Details of the NHS Pregnancy Smoking Helpline (0800 169 9169) which is open from 12 noon to 9 pm daily, should be given to any smokers who are pregnant.

ARRANGE

The 'Arrange' component of the modified four As approach places an emphasis on referring smoking patients to specialist NHS Stop Smoking Services.

Across the country, specialist NHS Stop Smoking Services have been established to provide assistance to smokers willing to quit. These services offer one-to-one or group counselling sessions. Dentists can arrange an appointment by referring patients to these services, details of which should be available with your local PCT or health promotion service. Smokers can also refer themselves to their local NHS Stop Smoking Service.

The NHS Smoking Helpline (0800 169 0169), open daily from 7am to 11pm, will provide details of the local NHS Stop Smoking Services. Help is also available in Asian languages via the NHS Asian Tobacco Helpline, open on Tuesdays from 1pm to 9 pm. The following languages are available: Bengali, 0800 169 0885; Gujarati, 0800 169 0884; Hindi, 0800 169 0883; Punjabi, 0800 169 0882; and Urdu, 0800 169 0881.

If your patients have access to the Internet, you might want to suggest that they look at the NHS 'Don't give up giving up' website (www.givingupsmoking.co.uk). Alternatively, try some of the other websites listed in Appendix 3.

When referring smokers to NHS Stop Smoking Services, it is important to consider the following:

- Is the individual really motivated to quit?
- Do they need any particular assistance to access the NHS Stop Smoking Services?
- Have they got the contact details and opening times of the NHS Stop Smoking Services?
- Do they have particular questions about the NHS Stop Smoking Services that you may be able to answer?
- How can you encourage them to attend the NHS Stop Smoking Services?
- Ensure you monitor at a later stage how they got on at the NHS Stop Smoking Services.

ASSIST

For those patients who want to stop smoking but do not wish to be referred to the NHS Stop Smoking Services, help should still be offered. A few central points can be covered with the smoker in 5–10 minutes:

- Set a date to stop, and stop completely on that day
- Review past experience: what helped, what hindered?
- Plan ahead: identify future problems and make a plan to deal with them
- Tell family and friends and enlist their support
- Plan what you are going to do about alcohol
- Try NRT: use whichever product is best suited to the patient
- Call the NHS Smoking Helpline (0800 169 0169) for free support and advice about stopping smoking
- Discuss the health benefits of quitting.

Give practical advice and tips on how to stop. Discuss with the smoker his or her decision to stop, and start to plan how this goal will be achieved. Appendix 1 provides examples of responses to common questions that smokers may ask.

Recommend NRT to smokers who want to stop and provide accurate information and advice. More information on NRT is given on page 26.

Monitoring progress is an essential part of successful cessation. Therefore it is essential to make a follow-up appointment within one or two weeks after their quit date. This may fit in with a subsequent dental appointment for ongoing treatment or a visit to the hygienist. At this early stage people need support and encouragement. Congratulate patients who have managed not to smoke over this period. Praise and encouragement can help motivate and maintain patients' determination to succeed.

Those patients who have smoked since their quit date need your support and encouragement too. It is important to remember that most smokers make several attempts to stop before finally succeeding.

Figure 2

The modified four As approach
(see pages 20-21)

Staying stopped

It is essential for the patient to decide on a quit day. Few smokers can quit without feeling cravings – they are hard to avoid altogether. Patients need to be informed that cravings may occur. In addition they may feel some other withdrawal symptoms which can also be unpleasant in the early stages. Coughing may increase as the lungs clear out accumulated mucus, bowel upsets may occur, some dizziness may be felt, and sleep may be disturbed. It is important to reassure the patient that all these symptoms should disappear over the first two to three weeks.

Team approach

The entire team at the dental practice should be committed to smoking cessation in order to achieve the greatest success in helping smoking patients quit (Smith *et al.*, 1998). The importance of good communication between team members, the need for regular meetings, and access to training in smoking cessation advice should be stressed.

It is necessary to delegate roles and responsibilities for each team member in the practice (Table 2). For example, the receptionist may be able to ask new patients about their smoking status and provide information on their local NHS Stop Smoking Service; dentists and hygienists can discuss the four As approach; and the practice manager

can encourage effective communication among the dental team and ensure a non-smoking practice policy.

Opportunities where dental nurses could highlight smoking advice include when they give out post-operative advice, and when they escort patients from the surgery to the reception area. Often patients feel more at ease with the dental nurse than the dentist, and may be more open to discussing difficult issues such as smoking. The link between aesthetics (eg discoloured teeth) and smoking place hygienists in an ideal position to become involved in smoking cessation initiatives through their clinical work in promoting periodontal health.

Table 2.

Roles and responsibilities of dental team members

Team member	Roles and responsibilities in smoking cessation
Dentist	Lead team Identify training needs Ensure smoking history routinely taken and updated Advise smokers on harmful effects of tobacco use Assess smokers' motivation to quit Refer motivated smokers to smoking cessation services Monitor and review progress
Dental hygienist	Raise smokers' motivation to quit – link with aesthetics Provide detailed advice and support Review and monitor progress
Dental nurse	Provide opportunistic advice, eg post-operative information Reinforce advice from dentist and/or hygienist
Receptionist	Display information on local smoking cessation services Encourage and reinforce information given by other team members
Practice manager	Supervise other team members Ensure supply of appropriate information materials for patients
Oral health promoter	Provide detailed support to motivated patients Provide training and assistance to other team members Link with other local smoking cessation initiatives

A dental practitioner's perspective

Khalid Anees is a dental practitioner who has been working in a Personal Dental Services (PDS) Dental Access Centre in Rochdale for the past three years. During this time Khalid and his colleagues have made real progress with smoking cessation in the dental setting.

His initial interest in tobacco control started when he was an undergraduate and spent an elective in Pakistan, where he saw cases of oral submucous fibrosis and oral cancers linked to tobacco use. Since then he has spent several years developing his clinical knowledge and skills in tobacco control, particularly in relation to ethnic minority groups: 'This is an under-developed but very important area of clinical practice which needs further consideration.'

In Rochdale he has established an innovative, integrated smoking cessation service within the PDS Dental Access Centre. Very good links have been made with the local NHS Stop Smoking Services, which have provided training and support for the dental staff. In addition the PCT provides trained smoking cessation counsellors on site, who give guidance to dental patients keen to quit smoking. Khalid and his colleagues also undertake targeted oral cancer screening for high-risk patients.

For Khalid, being involved in this area of clinical practice is important: 'Tobacco use is associated with a range of preventable diseases and is a particular problem for deprived communities.' It links oral health to general health and wellbeing and provides the opportunity to work with other professional groups, which helps improve job satisfaction. 'We have close working links with the local smoking cessation service and communication is very good.'

As a salaried practitioner, financial concerns are not a barrier to involvement in this area of practice. Khalid acknowledges that, at present, the remuneration system does not encourage dentists to become actively engaged in smoking cessation. However, the new contract provides a real opportunity for progress to be made.

Patients have responded in a variety of ways to having tobacco advice delivered in the dental setting. Some have been negative but overall a positive response has been forthcoming and, as a result, success has been achieved with many smokers. A team approach has been developed, with clearly defined roles and responsibilities for each team member.

Figure 2

> The four As

Ask

Ask all patients about their smoking status and record information in clinical notes

Do you smoke?
(If no, record in notes)

Are you interested in stopping?

Interested ?

If no interest shown

Record smoking status in notes

Make note to ask at next visit



Advise

- Advise all smokers to stop.
- Give clear, strong, personalised advice.
- Highlight oral health effects of tobacco use.
- Emphasise reversible nature of oral health effects.
- Assess interest in attending NHS Stop Smoking Service.





Arrange



- If interested refer to local NHS Stop Smoking Service*
- Provide encouragement and information on services
- Stress oral health benefits of quitting.

Assist

- If interested in quitting but not keen to attend NHS Stop Smoking Service, provide support and encouragement to quit
- Review past experiences of quitting
- Set quit date
- Identify preparation required
- Encourage use of NRT and Zyban as necessary
- Assess progress at next appointment.



Review

Re-assess smoking status at next recall

*Refer need only mean handing a card with the helpline number and/or contact details of the local services to the patient

Barriers Many dentists in the UK have a positive attitude to smoking cessation activities. However, some lack confidence in their effectiveness in this area of clinical care. Other barriers to the incorporation of tobacco cessation activities in the dental practice are summarised in Box 13.

Aims

Identify the range of barriers that may prevent dental team members from becoming involved in smoking cessation activity.

Outline ways of addressing identified barriers to facilitate greater involvement in smoking cessation activity.



Box 13.

Possible barriers to smoking cessation activities in the dental setting (West *et al.*, 2000)

- Lack of time
- Lack of reimbursement mechanisms
- Lack of confidence and skills
- Concerns over effectiveness of support
- Lack of readily accessible patient education materials
- Expected patient resistance.



Overcoming the barriers

The barriers that have been proposed are not insurmountable. The following points review how they could be addressed.

Lack of time

It has been also recommended that brief smoking cessation clinical interventions require three minutes or less of direct clinical time (Fiore *et al.*, 2000). It has been estimated that dentists spend less than two minutes per patient in cessation on this activity (Cohen *et al.*, 1989). This indicates that dentists actually do spend an appropriate amount of time on this activity. Following the recommended protocol need not take dentists a great deal of clinical time, especially if they work with other members of the team.

Lack of reimbursement mechanisms

At present no fee is available to reimburse dentists for giving smoking cessation advice. This is a problem that needs to be tackled. Recognition of the very limited clinical time involved may provide some reassurance. However, progress is being made in some areas where the local PCTs are providing dentists with a fee when they refer motivated smokers to NHS Stop Smoking Services. The forthcoming introduction of new contractual arrangements in primary dental care services may also address this issue.

Lack of confidence and skills

Confidence and skills can be built and developed with appropriate training. Many PCTs now offer smoking cessation training courses for primary healthcare professionals. These courses are tailored to different levels of activity. In addition, courses designed specifically for dentists and their staff are increasingly available. These courses provide a useful way of acquiring verifiable continual professional development (CPD) points. This *Guide* also includes a CPD component that can be completed in order to qualify for 3.5 hours of CPD. In addition, the dental team needs to be aware of the local NHS smoking cessation services where they can refer smokers for expert help.



Concerns over effectiveness of support

Reviews of the evidence reveal that smoking cessation advice is one of the most effective forms of health promotion support. By following the recommended protocol, advice given by the dental team can have a significant effect.

Lack of readily accessible patient education materials

This *Guide* has been designed to inform and encourage the dental team to become involved with smoking cessation initiatives for their patients. Other patient education information is provided by the Department of Health through local health promotion departments (see Appendix 4 for contact details). As outlined below, in some areas PCTs have developed smoking cessation resources specifically for use in dental practices.

Expected patient resistance

Surveys of dental patients have revealed that many patients believe dentists should actively encourage smoking cessation (Campbell *et al.*, 1999). This is encouraging as it means patients actually expect their dentist to be concerned about their overall health, including their smoking status.

Tackling the barriers

In 2002 the NHS Stop Smoking Services in Sheffield South East PCT started working directly with local general dental practitioners. John Green, the local Consultant in Dental Public Health, outlines how this partnership was established and the challenges they still face.

Initially an approach was made by the local NHS Stop Smoking Service to establish if general dental practitioners would be willing to refer patients to the service. Challenging performance-related smoking cessation targets have been set for PCTs, which were therefore keen to enlist the help of a range of health professionals. Following a meeting with the local dental committee, a referral system was agreed in which general dental practitioners would receive a payment equivalent to a check-up fee for successful referrals to the smoking cessation services. As John outlines, 'a successful referral was defined as a patient turning up to the smoking clinic and setting a quit date.' Once the system had been agreed, the PCT then wrote to all general dental practitioners explaining the details of the scheme.

Initial evaluation suggested that, compared to other health professionals such as nurses and pharmacists,

dentists were not as successful at identifying patients who could benefit from expert support. However, some dental practitioners did refer a number of their patients, who then subsequently set a quit date. A more detailed evaluation is planned to assess the uptake and outcome of the referrals. According to John, 'When the referral system was first set up no training or practical support was provided to dental practitioners. If this had been provided a greater success rate may well have been achieved.'

John is hopeful, however, that more progress will be made in this area: 'Once the new contract settles down a real opportunity will arise to move this forward.' He hopes to establish smoking cessation training for dentists and their team members to equip them with the skills needed to deliver short interventions. Of particular importance is the ability to take a good smoking history, and to identify smokers who will be receptive to help. According to John, 'It is essential that smokers who are motivated and keen to quit are referred for specialist support.' Establishing a good working relationship with the smoking cessation service is of central importance.

Aids to cessation Two kinds of pharmacological product are available as aids to smoking cessation: NRT and bupropion (Zyban).

Aims

Review the different types of NRT products and their value in smoking cessation.



Nicotine replacement therapy

At present, dentists cannot prescribe NRT on the NHS. However, it was recently announced that from 1 April 2005 dentists in the UK will be able to prescribe from the British National Formulary.

Nicotine replacement therapy provides smokers with an alternative source of nicotine at lower doses than tobacco. It also reduces the severity of symptoms associated with nicotine withdrawal, and doubles cessation rates compared with controls irrespective of the intensity of adjunctive support (Fiore *et al.*, 2000).

Nicotine replacement therapy has been proven to be safe, and few ex-smokers become long-term users (Benowitz, 1998). It can routinely be recommended to smokers who require extra help with withdrawal symptoms. Nicotine replacement therapy is provided free at NHS Stop Smoking Services, and can also be obtained from GPs on prescription or bought over the counter at pharmacies.

Box 15.

Nicotine replacement therapy is most effective when:

- The patient is motivated to quit
- The patient agrees to stop tobacco use completely with the start of NRT
- Previous quit attempts have failed because of withdrawal symptoms.

Which product?

Nicotine replacement therapy comes as six products: gum, patch, nasal spray, inhalator, lozenge and sublingual tablet, all of which have similar success rates (Table 3; Molyneux, 2004). The choice of product will depend on personal and practical factors. The gum, nasal spray, lozenge, sublingual tablet and inhalator permit more control over the dose.



Table 3.

Prescribing details for NRT formulations (Molyneux, 2004)

Formulation (dose)	Use
Patch (16 hour patch, 15, 10 or 5 mg; 24 hour patch, 21, 14 or 7 mg)	One daily on clean, unbroken skin; remove before bed (16 hour patch) or next morning (24 hour patch); new patch, fresh site
Gum (2 or 4 mg per piece)	Chew gum until taste is strong, then rest gum in buccal sulcus; chew again when taste has faded
Inhalator (10 mg per cartridge)	Inhale as required
Sublingual tablet (2 or 4 mg per piece)	Rest under tongue until dissolved
Lozenge (1, 2 or 4 mg per piece)	Place in buccal sulcus and allow to dissolve
Nasal spray (10 mg/ml, 0.5 mg spray)	One spray each nostril as required

The nicotine skin patch is the easiest product to use. It is put on each morning for 16 or 24 hours, and comes in different doses. Unless people smoke fewer than ten cigarettes a day they should normally use the highest dose patch. Some patients find the adhesive in the patches a skin irritant and should choose another form of NRT.

Nicotine gum comes in 2 or 4 mg doses, and in several flavours. The taste may be unpleasant at first but most people get used to it within a few weeks. Because the nicotine is absorbed through the mouth, it is important to advise patients to chew each piece of gum slowly for 30 minutes. Heavy smokers should consider using the 4 mg gum.

Nicotine from nicotine nasal spray is absorbed more quickly than from the patch, gum or

inhalator, and thus can be better for more addicted smokers. However, it can be difficult to get used to because the spray may irritate the nose. The recommended usage is one spray in each nostril hourly up to 16 times a day. Smokers who still experience severe craving and withdrawal symptoms with the other NRT products should try the nasal spray.

The nicotine inhalator consists of a plastic mouthpiece and a supply of nicotine cartridges that fit on the end of it. Smokers draw on it like a cigarette. Despite its name, the nicotine does not reach the lungs but stops in the mouth and throat. The inhalator delivers nicotine in a similar way to the gum. Users are advised to use six to 12 cartridges per day.

The lozenge should be placed in the mouth and allowed to dissolve over 20–30 minutes.

Initially one lozenge should be used every one to two hours, with a maximum of 15 per day. Over a set period of time the frequency of use is reduced.

The sublingual tablet is designed to be held under the tongue until it dissolves, usually within 20–30 minutes. The nicotine absorption and dose delivered are similar to the gum, lozenge and inhalator.

Who should use nicotine replacement therapy?

Except for certain medical reasons, NRT can be used by all smokers. Although most NRT research has been done with people who smoke at least 15 cigarettes a day, the patch and 2 mg gum are as effective with lighter smokers in research trials (Fiore *et al.*, 2000).

Advice on NRT and pregnant smokers has recently been changed in the British National Formulary (British Medical Association and Royal Pharmaceutical Society of Great Britain, 2003). Pregnancy is no longer listed as a contraindication for NRT.

Box 16.

- NRT increases the chance of success of smokers wishing to stop.
- NRT is not a magic cure. It does not provide a complete replacement for cigarettes, nor replace the need for willpower. But when the smoker is abstinent, it will help with the craving and withdrawal.
- NRT usually provides nicotine in a way that is slower and less satisfying, but safer and less addictive than cigarettes.
- Although NRT provides nicotine, it does not contain tar and carbon monoxide as tobacco smoke does.
- NRT reduces withdrawal symptoms such as irritability, depression and craving, although it does not eliminate them entirely.
- Very few people become addicted to NRT. Some ex-smokers continue to use it for a year or more, but this is mainly because of concern about returning to smoking.
- For the best results NRT should be used in sufficient quantities and for long enough. Smokers should follow the instructions in the package, and seek advice from the pharmacist if more information is needed.



Bupropion

Bupropion (Zyban) is an atypical antidepressant that has been shown to be effective in treating smokers by assisting with nicotine withdrawal. A meta-analysis of published trials demonstrates that the drug improves 12 month abstinence rates and reduces the severity of withdrawal symptoms (Jorenby *et al.*, 1999). At present dentists cannot prescribe bupropion on the NHS. However, it is available on prescription through GPs and NHS Stop Smoking Services.

Summary and recommendations *Helping smokers stop: a guide for the dental team* outlines how dentists and their teams can support smokers to quit effectively. It follows the four As approach to smoking cessation, and emphasises the importance of referring motivated smokers to smoking cessation services.



In summary

- Smoking is a significant public health problem in the UK, and a major cause of inequality.
- Smoking, along with other forms of tobacco use, adversely affects oral health and dental treatment outcomes.
- Quitting tobacco use is a difficult challenge, although many smokers wish to give up.
- Smoking cessation advice and support is effective when delivered in a systematic fashion.
- Dentists and their team members have an opportunity to engage in this important activity.

Recommendations

- Dentists should assess and record the smoking status of their patients at every opportunity.
- All smokers should be advised of the value of quitting, and the effects of tobacco on the mouth should be highlighted.
- Motivated smokers who want help to quit should be referred to their local NHS Stop Smoking Services.
- For smokers who want to stop, but who are not prepared to attend an NHS Stop Smoking Service, appropriate advice and support should be offered in the dental setting.
- Members of the dental profession have a role to play as advocates for wider tobacco-control policies.

Appendix 1

Questions commonly asked by smokers

Will I gain weight if I stop smoking?

Many people do gain weight when they quit smoking. The average weight gain in the first year is 6 kg. The main reason people put on weight is that they eat more food. Avoid high calorie snacks such as cakes, biscuits and sweets. Eat raw vegetables (such as carrot sticks) and fruit instead, or chew sugar-free gum. Exercise is effective in helping to cope with withdrawal and avoid weight gain. Drink lots of water.

I smoke low-tar cigarettes, so why should I stop?

There is no such thing as a safe cigarette. Most smokers inhale more often, or more deeply, to compensate for low nicotine levels in their cigarettes.

When will the patches in the mouth go away?

Many white patches (leukoplakia), which can be pre-cancerous, disappear after stopping. Most patches should disappear within a few weeks.

Is it better to stop 'cold turkey' or over a period of time?

There is no best way to stop. Many successful ex-smokers have given up 'cold turkey'.

What about insomnia?

Many smokers report having problems sleeping after they stop. If these symptoms are related to nicotine, they should stop within two to three weeks.

Will I cough more if I give up smoking?

In the first few weeks many smokers suffer from upper respiratory infections. This is thought to be due to a change in the body's immune system, but is only a short-term effect of stopping.

What other withdrawal symptoms will I have?

A small percentage of people have no withdrawal symptoms. Common symptoms include irritability, mild headaches and gastrointestinal problems such as constipation.

Do smokers really lose their teeth sooner?

As smokers tend to have more periodontal disease, some will lose their teeth sooner than non-smokers.

When will my body recover from the effects of smoking?

Some of the damage may be permanent, such as loss of lung tissue in emphysema. Other functions recover, such as the lung's ability to remove mucous. The increased rate of heart disease is halved in the first year and approaches that of a non-smoker in about five years. The increased risk of lung cancer diminishes and approaches that of a non-smoker in 15 to 20 years.

Should I tell people I am trying to stop?

Yes. You should enlist the support of family, friends and coworkers.

Can a smoker advise on quitting?

If you smoke it does not mean you cannot help others to quit, but you may find that you come under pressure. You can use the following suggestions to move the discussion forward. Explain you are there to help them quit, and ask how knowing whether or not you smoke would help. Explain that to be successful, one must be ready to quit; you are not ready yet but you are glad that they are further down the path than you are. Turn the discussion to their progress, not yours.

Appendix 2

Tobacco-use assessment form

Many computerised patient record systems now include smoking information. However, the way it is recorded is quite variable and not always very useful. A simple and effective system is shown below.

A system for recording smoking information	
Smoking status	<input type="checkbox"/> Smoker <input type="checkbox"/> Recent ex-smoker (less than one year) <input type="checkbox"/> Long-term ex-smoker <input type="checkbox"/> Never smoked
Date advice last given	
Response to advice	<input type="checkbox"/> Not interested <input type="checkbox"/> Wants to stop, but not at the moment <input type="checkbox"/> Intends to stop now, but help not wanted <input type="checkbox"/> Intends to stop now and wants medication <input type="checkbox"/> Intends to stop now, will attend smoking cessation service <input type="checkbox"/> Not applicable

Smokers and recent ex-smokers should have a trigger on the practice database which indicates if more than a year has elapsed since status was last checked.

Appendix 3

Is it worth the effort? Yes it is!

Helping smokers quit takes time and effort, but it is definitely worth it. Here are a few facts to remember:

- Every year at least 120,000 people in the UK die prematurely from smoking-related diseases
- Stopping smoking prolongs life regardless of the age at which a person quits
- Smoking causes seven out of ten cases of chronic obstructive lung disease
- Smokers under 65 are twice as likely as non-smokers to die from cardiovascular disease; heavy smokers run more than three times the risk
- This extra risk diminishes rapidly after they quit and will have disappeared completely ten years after their last cigarette
- There are over 2,000 cases of oral cancer, of which about 900 people die, each year
- Pregnant women who quit in their first trimester can substantially reduce their chance of miscarriage, stillbirth, premature labour or producing a low birth weight baby
- The dental team can play a vital role in the prevention and early detection of oral cancer.

Appendix 4

Additional resources

www.givingupsmoking.co.uk

The Department of Health tobacco control website provides details of NHS Stop Smoking Services and other useful information

www.quit.org.uk

Home page of the organisation QUIT, with a wealth of practical guidance and materials relating to tobacco cessation

www.quitnow.info.au

Helpful advice on quitting is provided by this excellent site of the Australian National Tobacco Campaign

www.cdc.gov/tobacco

Provides practical information for those who want to stop smoking, as well as an overview of tobacco information

www.hda.nhs.uk

Home page of the HDA, with links to authoritative reviews and educational materials on smoking cessation topics

www.ash.org.uk

An excellent source of up-to-date information on all aspects of smoking, with numerous links to relevant resources and documents

www.who.int/tobacco/en

The website of the World Health Organization

www.bda.org

The website of the British Dental Association

www.dentalhealth.org.uk

The website of the British Dental Health Foundation

www.fdiworldental.org

The website of the FDI World Dental Federation

www.nosmokingday.org.uk

The official website for No Smoking Day

www.tobacco-control.org

The Tobacco Control Resource Centre works in partnership with national medical associations across Europe, supporting them in their efforts to educate their members, help patients and inform public policy with respect to tobacco. It also acts as a resource for individual doctors who are interested or involved in tobacco control.

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> Helping smokers to stop: a guide for the dental team

Aim

This booklet aims to:

- Develop the dental team's ability to provide effective smoking cessation advice within the dental setting



Learning outcomes

On reading this booklet, the reader should be able to:

- Describe the current pattern of smoking in the UK
- Outline the impact of tobacco use on oral health and dental treatment outcomes
- Describe the psychological nature of smoking behaviour
- Summarise the evidence base for smoking cessation advice within the dental setting
- Identify ways of providing practical support to smokers who want to quit
- Identify the barriers that may prevent dental team members from becoming involved in smoking cessation and outline ways of overcoming these.

Verifiable CPD Certificate

On reading this *Guide* and answering the questions, you will be eligible for up to 3.5 hours of verifiable CPD. You can claim your CPD certificate by logging onto the BDA website (www.bda.org) and following the link on the front page. You can also type in the address: www.bda.org/education/smokingcpd.cfm. Once you have answered the questions online, you will be emailed a copy of your certificate which you can print straight away.

If you do not have access to the internet or email, please fill out the claim form and send it to the following address:

Education and Professional Development
British Dental Association
64 Wimpole Street
LONDON
W1G 8YS

Feedback

If you wish to contribute any feedback about this *Guide*, please email your comments to education@bda.org or call 0207 563 4131. Alternatively, you can write to the address above.

Questions

- 1. In the UK, what percentage of adults are smokers?**
 - A 23%
 - B 37%
 - C 27%
 - D 17%
- 2. Which of the following statements best describes the social class pattern of smoking in the UK?**
 - A Smoking rates are broadly similar across the social classes
 - B The most affluent and the poorest in society smoke the most
 - C Senior managers smoke more than people working in manual occupations
 - D Smoking is significantly more common among people in manual and routine occupations than managerial positions
- 3. How many people in the UK die prematurely each day due to a smoking-related disease?**
 - A 130
 - B 330
 - C 630
 - D 230
- 4. Which of the following oral health conditions is not associated with tobacco use?**
 - A Periodontal diseases
 - B Acute necrotising ulcerative gingivitis
 - C Squamous cell carcinoma
 - D Dental caries
- 5. Most smokers successfully quit:**
 - A Only after several repeated attempts at stopping
 - B During their teenage years
 - C When they are highly stressed
 - D At the first attempt
- 6. Which of the following statements does not describe accurately smokers' motivations for stopping?**
 - A Many smokers may be worried about the harmful health effects of tobacco use
 - B Often smokers report a desire to break their dependence on tobacco as a motivation to quit
 - C The majority of smokers do not want to quit smoking
 - D Many smokers are motivated to quit for social reasons
- 7. Nationally, how many smokers would quit each year if dentists routinely provided brief advice (lasting less than 3 minutes) to their patients who smoked?**
 - A 83,000
 - B 73,000
 - C 63,000
 - D 53,000
- 8. Smoking cessation advice is most effective:**
 - A When nicotine replacement therapy is not used
 - B With patients who are heavy smokers
 - C With patients who are interested and keen to make a quit attempt
 - D When patients are pressurised into quitting

Questions (continued)

9. What two pieces of information give a strong indication of a smoker's level of nicotine dependence?

- A Number of years smoking and sex
- B Patient's age and sex
- C Number of years smoking and weight
- D Number of cigarettes smoked each day and timing of first cigarette in the morning

10. The NHS Stop Smoking Service

- A Only accepts referrals from health professionals
- B Is based at the Health Development Agency in London and provides specialist advice to primary care trusts
- C Is a website designed to provide information to teachers on smoking prevention activities for schools
- D Offers one-to-one or group counselling through local primary care trust services across the country

11. Which of the following are not recognised barriers hindering dentists' involvement in smoking cessation?

- A Lack of time
- B Limited knowledge of the effects of tobacco use on oral pathology
- C Lack of confidence and skills in smoking cessation
- D Fears over the effectiveness of smoking advice delivered in the dental practice

12. Smoking cessation patient education materials are available through:

- A Dental Protection Society
- B Local health promotion departments
- C Department for Education and Skills
- D General Dental Council

13. Nicotine replacement therapy:

- A Is only available on prescription
- B Is available in six different products all of which have a similar level of effectiveness
- C Is effective at reducing weight gain for female smokers attempting to quit
- D Is not recommended for light smokers

14. Zyban (Bupropion):

- A Can be prescribed on the NHS by dentists
- B Is an antidepressant which aids nicotine withdrawal
- C Is an analgesic which helps smokers deal with any respiratory discomfort associated with quitting
- D Is an antibiotic which treats upper respiratory tract infections associated with the initial stages of quitting

> CPD Claim Form

Name _____

GDC Membership Number _____

Address _____

_____ Postcode _____

Please tick the box which corresponds to your answer

	A	B	C	D
Q1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Feedback

Did you find this guide to be useful?

(not at all) (extremely useful)

Comments

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