



TOBACCO CESSATION GUIDANCE

FOR ORAL HEALTH PROFESSIONALS



FDI is an international, membership-based organization that serves as the main representative body for more than 1 million dentists worldwide, active in some 200 national dental associations (NDAs) and specialist groups in close to 130 countries. Founded in 1900, FDI is a pioneer in the field of modern dentistry.

As a convener of the oral health community, FDI fosters exchange and develops a common vision to advance the science and practice of dentistry. FDI delivers innovative congresses, campaigns, and projects to address the global oral disease burden and improve oral health. As the leading global advocate for oral health, FDI strives to achieve its vision of leading the world to optimal oral health by working at both the national and international level.

FDI is committed to representing the interests of member NDAs globally to help support their national efforts to raise awareness on oral health. FDI transforms this commitment into action through active engagement with the World Health Organization, as well as other United Nations agencies, health organizations, governments, and global partners to ensure that oral health is recognized as an essential component of general health and well-being.

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The World Health Organization (WHO) World No Tobacco Day 2005 campaign emphasized that health professionals, including oral health professionals, have the greatest potential of any group in society to promote the reduction of tobacco use.¹ As oral health professionals, we have several roles to play in comprehensive tobacco control efforts, including that of role model, clinician, educator, scientist, leader, opinion builder, and alliance builder.

As oral health professionals, we should at least:

- serve as tobacco-free role models for our patients;
- address tobacco dependence as part of our standard of dental care practice;
- assess exposure to second-hand smoke and provide information about avoiding all exposure.

01.

Why should we, as oral health professionals, help tobacco users quit?

We, as oral health professionals, can reach large numbers of tobacco users and we have considerable potential in persuading them to quit. In developed countries, more than 60% of tobacco users see their dentist or dental hygienist annually.² We are as effective as other health professionals in helping tobacco users quit.

Available evidence suggests that behavioural counselling (typically brief) conducted by oral health professionals in conjunction with an oral examination in the dental office or community setting can increase tobacco abstinence rates by 70% (odds ratio [OR] 1.71, 95% confidence interval [CI] 1.44 to 2.03) at six months or longer.³ The WHO World Oral Health Report 2003 outlined several other ethical, moral, and practical reasons why we can play an important role in helping tobacco users quit:⁴

- We are particularly concerned about the adverse effects caused by tobacco use in the oropharyngeal area of the body.
- We typically have access to children, young people and their caregivers, thus providing opportunities to influence individuals to quit or never begin using tobacco.
- We often have more time with patients than many other health professionals, providing opportunities to integrate tobacco cessation interventions into daily practice.
- We often treat women of childbearing age and are thus able to explain the potential harm to babies from tobacco use.
- We can build patient interest in discontinuing tobacco use by showing them the actual effects of tobacco in the mouth.

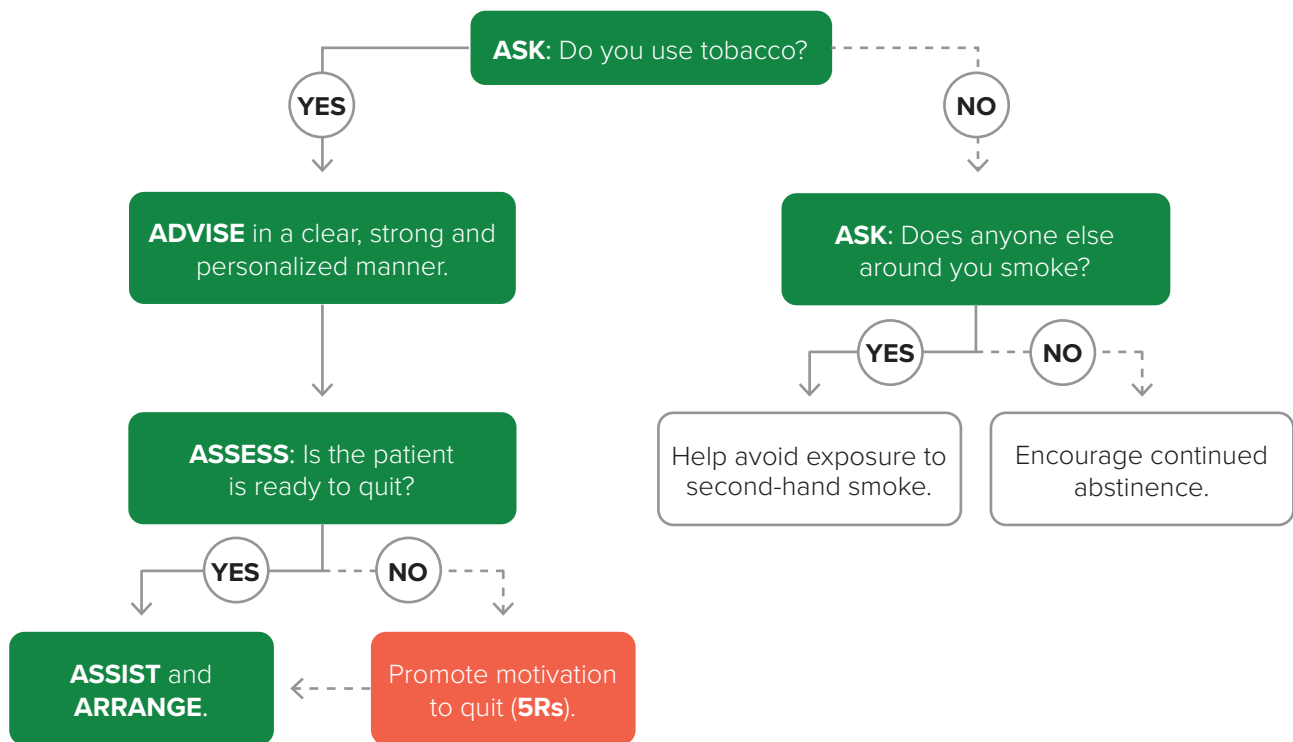
02.

What should we, as oral health professionals, routinely do to help all tobacco users in primary care?

There are a range of effective treatments for tobacco dependence, including advice to stop tobacco use (brief tobacco interventions), more intensive behavioural support to quit (given individually, in a group or by phone), and pharmacological treatments. In line with Article 14 of the WHO Framework Convention on Tobacco Control,⁵ we should, at least, deliver brief tobacco interventions as part of our routine services in primary care.

Helping dental patients quit smoking as part of our routine practice takes only three to five minutes and is feasible, effective and efficient. The algorithm below can guide us to deliver three-to-five-minute, brief tobacco interventions to dental patients in primary care by using the **5As** and **5Rs** models (Figure 1).

Figure 1. Algorithm for delivering brief tobacco interventions



In addition, we should:

- raise awareness about the dangers of second-hand smoke;
- encourage patients to avoid exposure to second-hand smoke;
- encourage patients to create a smoke-free home for their children.

2.1 The 5As model to help patients prepare to quit

There are several structured models available to help deliver brief tobacco interventions. The **5As** and **5Rs** are the most widely used delivery models for brief tobacco interventions in primary care. The 5As (Ask, Advise, Assess, Assist, Arrange) summarize all the activities that an oral health professional can do, within three to five minutes in a primary care setting, to help a tobacco user make a quit attempt.⁶

A similar model was also recommended for oral health professionals in the FDI and WHO joint publication *Tobacco or oral health - an advocacy guide for oral health professionals* in 2005.⁷



Ask

Systematically identify all tobacco users at every visit.

Advise

Advise all tobacco users that they need to quit.

Assess

Determine readiness to make a quit attempt.

Assist

Assist the patient with a quit plan or provide information on specialist support.

Arrange

Schedule follow-up contacts or a referral to specialist support.

The 5As model can guide us on how to talk about tobacco use and deliver advice to patients who are ready to quit. In the next section are recommended actions and strategies for implementing each of the 5As.⁸

Ask

Systematically identify all tobacco users at every visit

Action

- Ask ALL of your patients at every encounter if they use tobacco, and document it.
- Make it part of your routine.

Strategies for Implementation

Tobacco use should be asked about in a friendly way – not in an accusatory way.

Keep it simple. Some examples may include:

“Do you smoke cigarettes?”

“Do you use any tobacco products?”

Tobacco use status should be included in all medical notes. Countries should consider expanding the vital signs to include tobacco use and put tobacco-use status stickers on all patient charts or indicate tobacco-use status via electronic medical records.



Advise

Persuade all tobacco users that they need to quit

Action

Urge every tobacco user to quit in a clear, strong and personalized manner.

Strategies for Implementation

Advice should be:

Clear – “It is important that you quit smoking (or stop using chewing tobacco) now, and I can help you.” “Cutting down while you are ill is not enough.” “Occasional or light smoking is still dangerous.”

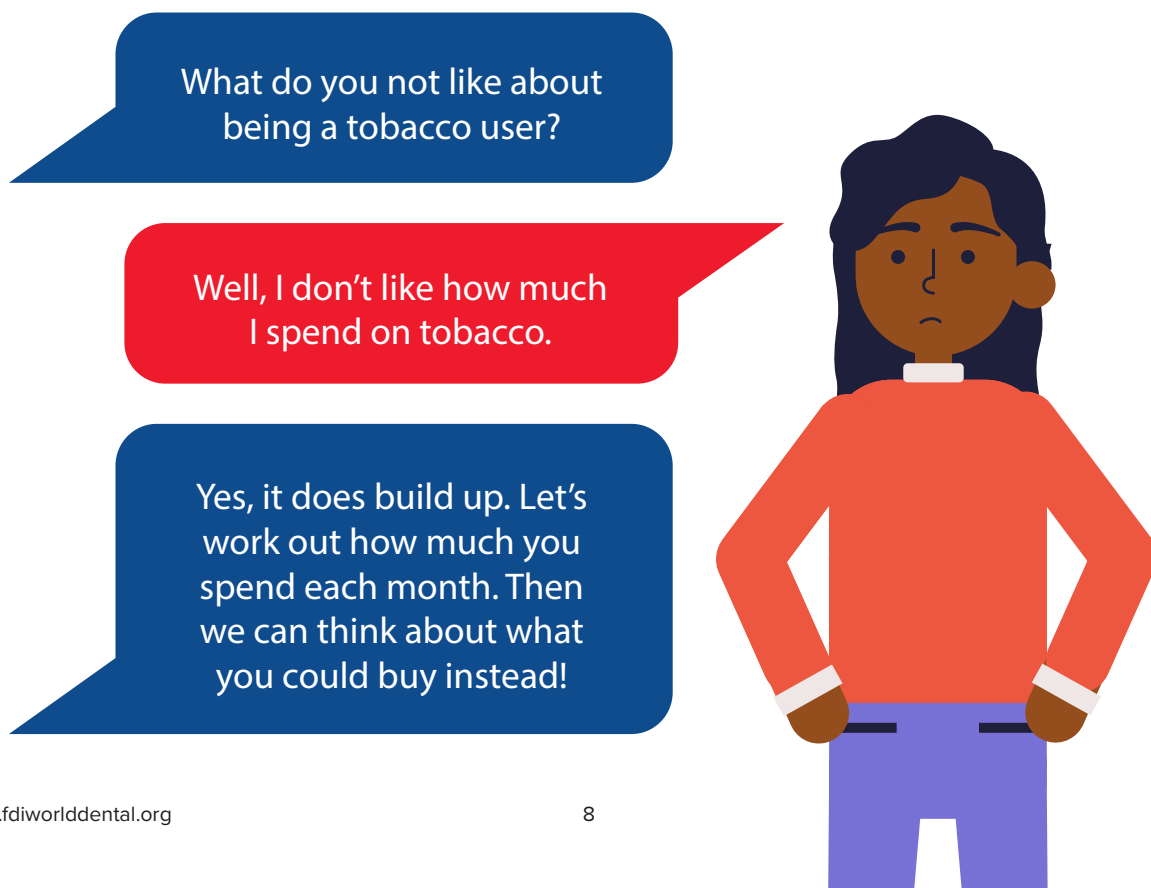
Strong – “As your dentist, I need you to know that quitting tobacco is a very important step you can take to protect your health now and in the future. I am here to help you.”

Personalized – Tie tobacco use to:

- Demographics: For example, women may be more interested in the effects of smoking on fertility, bad breath, stained teeth and dark lips.
- Health concerns: Asthma sufferers may need to hear about the effect of smoking on respiratory function, while those with periodontal disease may be interested in the effects of smoking on oral health. “Continuing to smoke makes your periodontal disease worse, and quitting may dramatically improve your oral health.”
- Social factors: People with young children may be motivated by information on the effects of second-hand smoke, while a person struggling with money may want to consider the financial costs of tobacco use. “Quitting smoking may reduce the number of dental caries your child has.”

In some cases, how to tailor advice for a particular patient may not always be obvious. A useful strategy may be to ask the patient - **“What do you not like about being a tobacco user?”**

You can build upon the patient’s answer to this question with more detailed information on the issue raised.



Assess

Determine readiness to make a quit attempt

Action

Ask two questions in relation to “importance” and “self-efficacy”:

1. “Would you like to be a non-tobacco user?”
2. “Do you think you have a chance of quitting successfully?”

Strategies for Implementation

Any answer in the shaded area indicates that the tobacco user is NOT ready to quit. In these cases, you should deliver the 5Rs intervention (**see section 2.2**).

Would you like to be a non-tobacco user?	Yes	Unsure	No
Do you think you have a chance of quitting successfully?	Yes	Unsure	No

If the patient is ready to go ahead with a quit attempt, you can move on to Assist and Arrange steps.



Assist

Help the patient with a quit plan

Action

- Help the patient develop a quit plan
- Provide practical counselling
- Provide intra-treatment social support
- Provide supplementary materials, including information on quit lines and other referral resources
- Recommend the use of approved medication if needed

Strategies for Implementation

Encourage your patient to use the **STAR** method to develop a quit plan:



S

Set a quit date ideally within two weeks.



T

Tell family, friends, and co-workers about quitting, and ask for support.



A

Anticipate challenges to the upcoming quit attempt.



R

Remove tobacco products from the patient's environment and make the home smoke free.

- Practical counselling should focus on three elements:
 - Help the patient identify challenging situations (events, moods, or activities that increase the risk of smoking or relapse).
 - Help the patient identify and practice cognitive coping skills (such as positive self-talk) and behavioural coping skills (such as deep breathing, drinking water) to address the challenging situations.
 - Provide basic information about tobacco use and quitting.
- Intra-treatment social support includes:
 - encouraging the patient in the quit attempt;
 - communicating caring and concern;
 - encouraging the patient to talk about the quitting process.
- Make sure you have a list of up-to-date and local tobacco cessation services (quit lines, tobacco cessation clinics, mCessation projects and others) on hand whenever a patient inquires.

The support given to the patient needs to be described positively but realistically.

Arrange

Schedule follow-up contacts or a referral to specialist support

Action

- Arrange a follow-up contact with your patient either in person or by phone.
- Refer the patient to specialist support if needed.



Strategies for Implementation

Advice should be:

- **When:** The first follow-up contact should be arranged during the first week after the quit date. A second follow-up contact is recommended one month after.
- **How:** Use practical methods such as a phone call, a personal visit, and/or mail/email to follow up. Following up with patients is recommended through a team approach if possible.

- **What:**

For all patients:

- Identify problems already encountered and anticipate challenges.
- Remind patients of available extra-treatment social support.
- Assess medication use and problems.
- Schedule next follow-up contact.

For patients who are abstinent:

- Congratulate them on their success.

For patients who have used tobacco again:

- Remind them to view relapse as a learning experience.
- Review circumstances and elicit recommitment.
- Link to more intensive treatment if available.



2.2 The 5Rs model to increase motivation to quit

The 5Rs – Relevance, Risks, Rewards, Roadblocks, and Repetition – should be addressed during a motivational counselling intervention to help those who are not ready to quit. Tobacco users may be unwilling to quit because they do not think it is important to them, or they may not feel confident in their ability. Therefore, after asking about tobacco use, advising the tobacco user to quit, and assessing the willingness to make a quit attempt, it is important to provide the 5Rs motivational intervention.⁶



Relevance

How is quitting personally relevant to you?

Risks

What do you know about the risks of tobacco use?

Rewards

What would be the benefits of quitting in that regard?

Roadblocks

What would be difficult about quitting?

Repetition

Repeat assessment of readiness to quit; if the patient is still not ready to quit, repeat the intervention at a later date.

If the patient does not want to be a non-tobacco user (might not think that quitting is important), we should focus more time on “Risks” and “Rewards.”

If the patient wants to discontinue tobacco use but does not think they can quit successfully (might not feel confident in their ability to quit), more time should be spent on the “Roadblocks.”

If the patient is still not ready to quit, we need to end positively with an invitation to return if they change their minds.

The next section summarizes useful strategies to deliver a brief motivational intervention in primary care.⁸

Relevance

How is quitting personally relevant to you?

Strategies for Implementation

Encourage the patient to indicate **how quitting is personally relevant to them as a dental patient.**

Motivational information has the greatest impact if it is relevant to a patient's disease status (in this case, oral diseases) or risk, family or social situation (such as having children in the home), health concerns, age, sex, and other important patient characteristics, e.g., prior quitting experience, personal barriers to cessation.



Risks

What do you know about the risks of tobacco use?

Strategies for Implementation

Encourage the patient to identify **potential negative consequences of tobacco use that are relevant to their oral health.**

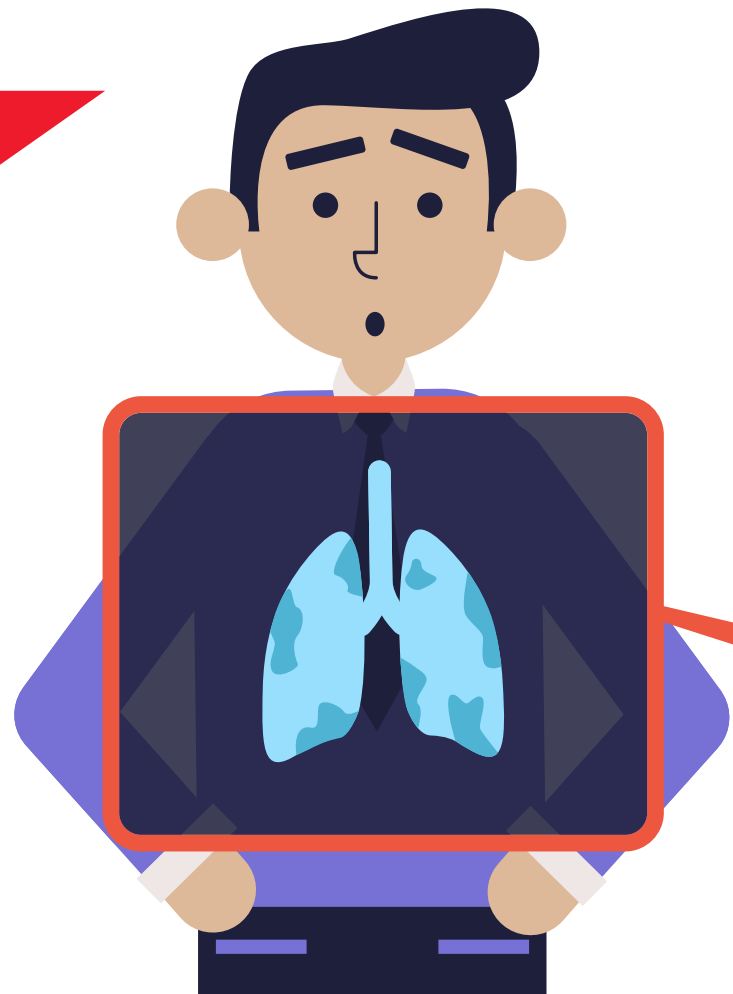
Examples of risks are:

- Short-term risks: oral treatment outcomes.
- Long-term risks: increased risk of periodontal disease recurrence, tooth loss, cancers of the oral cavity and other cancers (larynx, pharynx, esophagus, lung), heart attacks and strokes, chronic obstructive pulmonary diseases, osteoporosis and long-term disability.
- Environmental risks: increased risk of dental caries and melanosis in children.

What do you know about the risks of smoking to your health? What particularly worries you?

I know it could make dental implant treatment less successful. That must be awful.

That's right – the risk of dental implant failure is 2 times higher among smokers.



Rewards

What would be the benefits of quitting in that regard?

Strategies for Implementation

Ask the patient to identify **potentially relevant benefits of stopping tobacco use**.

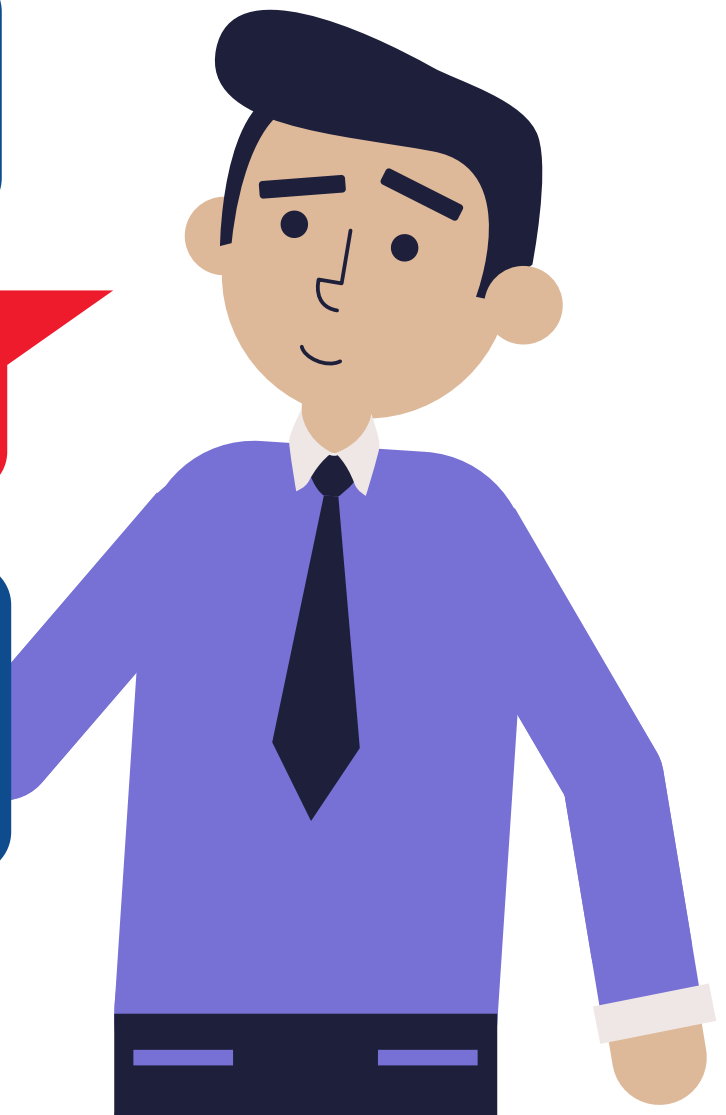
Examples of rewards could include:

- improved oral treatment outcomes;
- food will taste better;
- improved sense of smell;
- saving money;
- feeling better about oneself;
- home, car, clothing and breath will smell better;
- setting a good example for children and decreasing the likelihood that they will smoke;
- having healthier babies and children;
- feeling better physically;
- performing better in physical activities.

Do you know how stopping smoking would affect your periodontal treatment outcomes?

I guess my treatment outcome would be more successful if I quit.

Yes, and it will significantly improve your periodontal treatment outcomes. And it's important to quit as soon as possible



Roadblocks

What would be difficult about quitting?

Strategies for Implementation

Ask the patient to identify **barriers or impediments to quitting** and provide treatment (problem-solving counselling, medication) that could address barriers.

Typical barriers might include:

- withdrawal symptoms;
- fear of failure;
- weight gain;
- lack of support;
- depression;
- enjoyment of tobacco;
- being around other tobacco users;
- limited knowledge of effective treatment options.

So what would be difficult about quitting for you?

Cravings – they would be awful!

We can help with that. We can give you nicotine replacement therapy (NRT) that can reduce the cravings.

Does that really work?

You still need willpower, but studies show that NRT can double your chances of quitting successfully.

Repetition

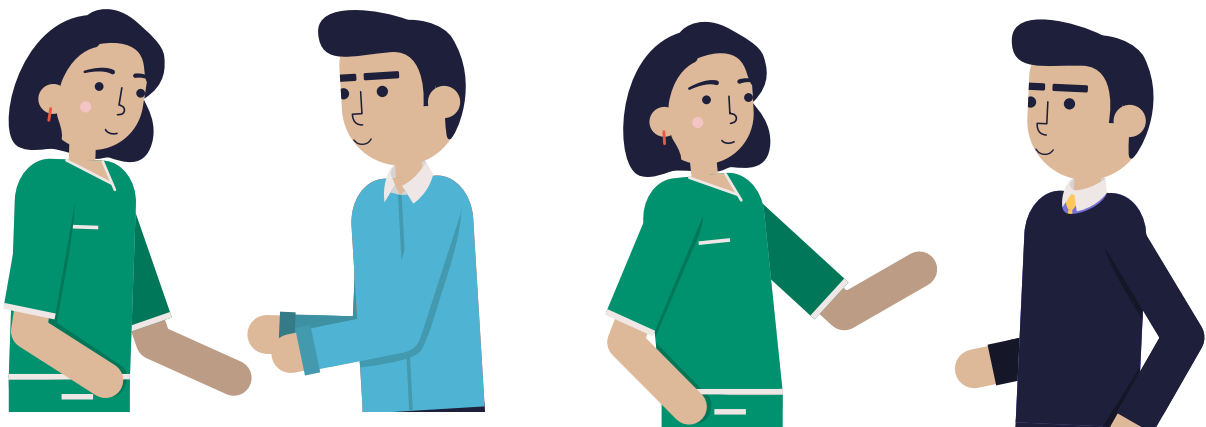
Repeat assessment of readiness to quit; if the patient is still not ready to quit, repeat the intervention at a later date.

Strategies for Implementation

The motivational intervention should be repeated every time an unmotivated dental patient visits the clinic setting.



So, now that we've had a chat, let's see if you feel differently.
Can you answer these questions again...?



(Go back to the Assess stage of the 5As. If the patient is ready to quit, proceed with the 5As. If the patient is not ready to quit, end the intervention positively by saying, **“This is a difficult process, but I know you can get through it and I am here to help you.”**)

03.

What should we, as oral health professionals, not recommend for tobacco users trying to quit?

Many communities offer alternative therapies such as e-cigarettes, acupuncture, laser treatment, and other measures. The high popularity and the high level of interest in these alternative therapies among tobacco users underscores the need for us to have clear guidance on them.^{9,10}

These alternative therapies aim to help tobacco users quit, but there is no (or not enough) evidence to support that they can improve quit rates and increase quit attempt success. A Cochrane review concluded that there is no bias-free, consistent evidence that acupuncture, acupressure, laser therapy, or electrostimulation are effective interventions for smoking cessation.¹¹ According to the *WHO report on the global tobacco epidemic 2019*, the scientific evidence on e-cigarettes as cessation aids is inconclusive and there is a lack of clarity as to whether these products have any role to play in smoking cessation.¹² The *2020 Smoking Cessation: A Report of the Surgeon General* drew a similar conclusion: there is not enough evidence that e-cigarettes help to stop smoking.¹³ Therefore, when advising tobacco users to quit, we should not recommend that they use e-cigarettes and other unproven interventions.



References

1. WHO Tobacco Free Initiative. The role of health professionals in tobacco control. WHO. Available from: <https://www.who.int/tobacco/resources/publications/wntd/2005/bookletfinal.pdf?ua=1> [accessed 26 June 2020].
2. Davis JM, Arnett MR, Loewen J, Romito L, Gordon SC. Tobacco dependence education: A survey of US and Canadian dental schools. *J Am Dent Assoc.* 2016;147(6):405-12. doi: 10.1016/j.adaj.2015.12.012. Epub 2016 Feb 5
3. Carr AB, Ebbert J. Interventions for tobacco cessation in the dental setting. *Cochrane Database Syst. Rev.* 2012;(6):CD005084. doi: 10.1002/14651858.CD005084.pub3.
4. World Health Organization. The World Oral Health Report . WHO. Available from: http://www.who.int/oral_health/media/en/orh_report03_en.pdf [accessed 26 June 2020].
5. World Health Organization. Guidelines for implementation of Article 14 of the WHO FCTC. WHO. Available from: https://www.who.int/fctc/guidelines/adopted/article_14/en/ [accessed 26 June 2020].
6. World Health Organization. WHO monograph on tobacco cessation and oral health integration. WHO. Available from: <https://www.who.int/publications/i/item/who-monograph-on-tobacco-cessation-and-oral-health-integration> [accessed 26 June 2020].
7. FDI World Dental Federation/ World Health Organization. Tobacco or oral health: an advocacy guide for oral health professionals. FDI / WHO. Available from: <https://www.fdiworlddental.org/resource/tobacco-or-oral-health-advocacy-guide-oral-health-professionals> [accessed 26 June 2020].
8. World Health Organization. Toolkit for oral health professionals to deliver brief tobacco interventions in primary care. WHO. Available from: <https://apps.who.int/iris/bitstream/handle/10665/255628/9789241512510-eng.pdf?sequence=1> [accessed 26 June 2020].
9. Sood A, Ebbert JO, Sood R, Stevens SR. Complementary Treatments for Tobacco Cessation: A Survey, *Nicotine Tob Res.* 2006; 8(6):767–771, Available from: doi.org/10.1080/14622200601004109
10. Lazuras L, Muzi M, Grano C, Lucidi F. E-cigarettes as smoking cessation aids: A survey among practitioners in Italy. *J Public Health Int.* 2016;61(2):243–248. doi: 10.1007/s00038-015-0772-x.
11. White AR, Rampes H, Liu JP, Stead LF, Campbell J. Acupuncture and related interventions for smoking cessation. *Cochrane Database Syst. Rev.* 2014;2014(1). doi:10.1002/14651858.CD000009.pub4
12. World Health Organization. WHO Report on the Global Tobacco Epidemic, 2019. WHO. Licence: CC BY-NC-SA 3.0 IGO. Available from <https://www.who.int/teams/health-promotion/tobacco-control/who-report-on-the-global-tobacco-epidemic-2019> [accessed 26 June 2020].
13. U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. U.S. Department of Health and Human Services. Available from <https://pubmed.ncbi.nlm.nih.gov/32255575/> [accessed 26 June 2020].

Recognition

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