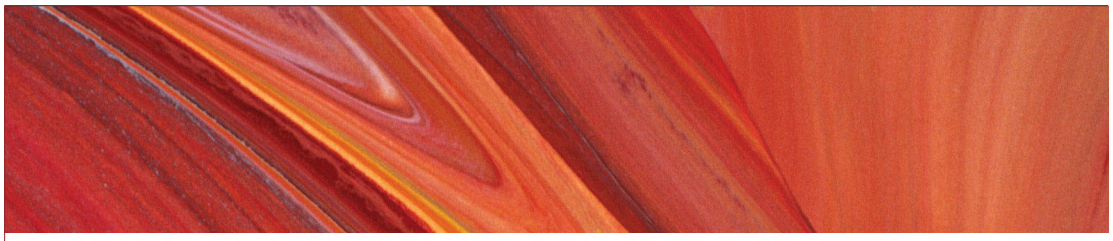

Training for dentists in smoking cessation intervention

Lisa Trotter

Prue Worcester

Abstract

Objective

To identify the factors that facilitate and inhibit dentists' capacities to deliver smoking cessation advice and to inform the development of training for dentists.

Design

Key informant interviews by a) focus group and b) telephone interview (random selection of subjects).

Setting

Metropolitan Melbourne and country Victoria.

Participants

A focus group discussion with 10 dentists was conducted in Melbourne and six Victorian country dentists were interviewed in-depth by telephone. Following this initial qualitative data collection, a random sample of 250 dentists (response rate of 54%) was interviewed by telephone.

Main outcome measures

Dentists were asked about their perceived role, current practices, knowledge of resources and services, and opinions on training in relation to smoking cessation.

Results

The results indicate that dentists are willing to ask and advise patients with regard to smoking, but are less inclined to assist patients to quit or arrange follow-up. A disparity was found between the interventions dentists said were appropriate for dentists to implement and the interventions that they reported implementing in practice. The research showed that dentists were more likely to implement one-off, opportunistic interventions rather than take a systematic preventive approach. The research revealed that dentists were interested in undertaking further education related to smoking cessation and reported that they required training to be realistic and relevant to the context of the day-to-day running of the dental practice.

Conclusions

Training should aim to legitimise the dentist's role in smoking cessation and provide strategies and resources so that dentists can practise interventions as part of their day-to-day work.

Introduction

General practice dentists are ideally placed to deliver smoking cessation advice and assistance to their patients. Fifty per cent of smokers say they would try to quit if their dentist advised them to quit (National Institutes of Health 1994). It is common for people see their dentist at least once or twice a year and there are frequent one- or two-minute opportunities to provide snippets of smoking-related preventive and cessation advice (Mecklenburg et al. 1990). Very brief advice lasting less than three minutes given by a health professional will help about 2% of smokers to successfully stop smoking. Estimated for the UK, this translates to seven smokers quitting per general dental practice. The impact is increased by an additional 6% with more intensive support lasting up to 10 minutes (Watt & Robinson 1999). If the efforts of each dental practice were combined, this would have a significant impact on reducing smoking rates and therefore the effects of smoking on the health of the community.

The evidence indicates that while many dentists do assist patients with smoking cessation, few dentists practise smoking cessation intervention as a routine part of their dental care. Dentists surveyed in New South Wales in 1998 reported high levels of activity regarding smoking cessation intervention with patients (Clover et al. 1999). Activities reported were related to advising patients of the effect of tobacco on oral health, asking patients if they were interested in quitting and advising them to quit. However, international studies by Dolan et al. (1997) found that tobacco control activities, such as asking about tobacco use and documenting tobacco use status in patients' records, were not a routine part of dental practice. Similarly, the literature reviewed by Wood et al. (1997) suggested that even though dentists were willing to participate in smoking cessation, their activities were neither comprehensive nor systematic and there was a need for greater education and training for dentists in this area.

Block et al. (1999) found that dentists were more likely than physicians and other health professionals to accurately estimate their patients' tobacco use, but less likely than other health care professionals to engage in tobacco interventions. They also found that dentists were less likely to report having strong tobacco cessation skill/knowledge levels and more likely to perceive barriers to tobacco use intervention. Barriers that have been identified include lack of resources and patient materials, doubts about their effectiveness to give quit advice and lack of confidence to tackle the problem, anticipated negative patient reaction, uncertainty about the dentist's role, the costs involved, lack of time, and doubts about the dentist's skills in assisting patients

to quit smoking (Clover et al. 1999). Despite a good level of knowledge regarding the negative oral health effects of smoking, it seems that dentists do not feel confident in providing smoking cessation advice. Over half of dentists surveyed in the UK said they had a role in smoking cessation, but lack of training was seen as a major barrier to smoking cessation counselling (Chestnutt & Binnie 1995). Clover and her colleagues (1999) concluded that there was a need to provide dentists with information on the resources available to them and clear guidelines on the effectiveness of providing patients with brief advice to quit. This may address the perceived barriers of lack of time and lack of skills.

A change of dentists' attitudes may also be essential for smoking education to be considered a part of good dental practice. In a study of dentists in Victoria in 1993, dentists were found to be uncertain of their role in smoking cessation and therefore needed encouragement to accept it was an appropriate role for them (Mullins 1994). Skegg and colleagues (1995) found that a large proportion of dentists in New Zealand (62%) were seldom or never involved in smoking cessation activities in their practices and 68% considered that it was not a part of dentistry.

The literature indicates that dentists are interested in further education on smoking cessation. Training programs on smoking cessation in the US, UK and New Zealand in the 1990s have successfully recruited dentists and their staff to participate in training (Skegg, McGee & Stewart 1995; Smith et al. 1998; Wood et al. 1997). They have shown that motivated dentists, with staff support and access to information on smoking counselling, are able to contribute to tobacco control measures in the community (Smith et al. 1998). Seventy-seven per cent of dentists surveyed in the UK in 1995 said they would participate in new smoking cessation programs if they were developed and two-thirds of the sample thought other members of the dental team (hygienists and dental assistants) had a role to play in helping patients give up smoking (Chestnutt & Binnie 1995).

The literature points to a need for clear guidelines regarding provision of brief advice on quitting and associated resources. Some programs have been developed to equip dental health care professionals to be more effective in helping smokers to quit (Watt & Robinson 1999). Strategies include involving the whole dental team, using the practice environment, being smokefree and displaying material and counselling patients using the 5As: Ask, Advise, Assess, Assist and Arrange (US Public Health Service Report 2000).

The current study was conducted to identify dentists' training needs with respect to delivering smoking cessation advice, to identify the major factors

that facilitate and inhibit dentists' capacities to deliver smoking cessation advice, and to inform the development of a training package for dentists.

Materials and methods

To identify the issues for dentists in delivering smoking cessation interventions, data were first collected from a focus group of dentists working in city locations and in-depth telephone interviews of country dentists. Next, structured telephone interviews were held with Victorian dentists.

Areas covered in the focus group and country dentist telephone interviews were: experiences of discussing smoking with patients, the role dentists can play in smoking cessation, opinions on smoking cessation interventions that dentists can deliver and views on training for dentists in smoking cessation.

It was apparent from the first data collection that dentists were aware that they lacked skills and knowledge in smoking cessation and needed training, but they could not specify their training needs. They did identify issues to do with clarification of the role of a dentist in relation to smoking cessation intervention. They also indicated that their willingness, ability and confidence in delivering interventions were limited. On the basis of these findings, the telephone questionnaire was designed to investigate their perceived role, current practices, knowledge of resources and services and opinions on training in relation to smoking cessation. The questions about current practices were based on the Ask, Advise, Assess, Assist, Arrange framework for intervention.

A random sample of 910 dentists was drawn from the membership list of the Victorian Branch of the Australian Dental Association (ADA). The sampling frame included all members except those who worked for the government, were graduates or had no telephone number listed. No contact could be made (i.e. no answer, answering machine, engaged, disconnected, fax, language difficulties) with 48 of these dentists. In attempting to reach a quota of 30% country dentists, a further 361 were not included because the quota for city dentists (70%) had been reached. This left an eligible sample of 501 dentists. A receptionist refused the survey on behalf of the dentist in 88 cases and 128 dentists directly refused to participate in the survey. Of the remaining 285 dentists who agreed to participate in the study, 250 were interviewed using computer assisted telephone interviewing (CATI). Excluding the 35 dentists who agreed to participate but were not interviewed, the response rate was 54%. The telephone survey was conducted over a period of four weeks, from February 8 to March 6, 2001.

Ten dentists participated in a focus group held in Melbourne. They were recruited by advertising the focus group in the ADA's Victorian Branch newsletter and seminar and follow-up phone calls to members of the ADA by staff at the ADA and Quit. A one-hour discussion was facilitated with this group in November 2000. In addition to the focus group, qualitative data were collected from another six country dentists by telephone interview in December 2000. The interview was open-ended and followed similar themes to the city focus group discussion. Results from the statewide telephone survey were analysed using SPSS. Frequency counts and cross-tabulations were used to describe the categorical data. Qualitative data from the focus group and country dentist interviews were analysed for themes.

Results

Telephone survey findings

Most of the respondents (83%) were male. Four per cent of respondents reported that they were smokers and 18% reported smoking regularly in the past. Almost all the dentists surveyed (94%) had a no-smoking policy in their practice and only 2% permitted smoking inside their practice. Ninety-one per cent described themselves as general dentists and 9% described themselves as specialist dentists. More than half (53%) graduated after 1979 and 86% reported working full time. Thirteen per cent said that they had dental hygienists working in their practice.

Dentists were asked their opinion on whether dentists should deliver various smoking cessation interventions. As can be seen in Table 1, most dentists said it was appropriate for them to ask their patients about their smoking, give advice and information and refer their patients for help to quit smoking. Not as many dentists saw discussion of nicotine replacement therapy or follow-up with patients about their smoking as appropriate.

Dentists were also asked about which interventions they currently practise. Table 2 indicates that most of the dentists interviewed inform their patients about the effects of smoking on dental health and the benefits of quitting and advise them to give up smoking. Between 40% and 60% of dentists reported doing at least one of the following in their practice: providing smoking cessation pamphlets, informing their patients about the effects of smoking on their general health, keeping records of patients' smoking status, systematically asking patients about their smoking and putting up anti-smoking posters. Fewer dentists reported practising referral of patients for assistance with smoking cessation, follow-up of patients in relation to their smoking, assisting

patients to quit smoking, involving the dental team and discussing nicotine replacement therapy with patients. It is noteworthy that a high proportion of dentists said that it was not appropriate for dentists to systematically ask all new patients about their smoking, advise about the impact of smoking on their general health, assist patients to quit, involve the dental team, discuss nicotine replacement therapy, keep records or follow up.

Table 1 Opinion on appropriateness of smoking cessation interventions for dentists

Intervention	Response (*n*=250) %		
	Yes	No	Can't say
Systematically ask all new patients about their smoking	76	22	2
Explain to patients who smoke the impact of smoking on their dental health	97	2	1
Advise patients who smoke to give up	86	14	0
Inform patients who smoke of the benefits of quitting smoking	88	10	2
Explain to patients who smoke the impact of smoking on their general health	70	27	3
Provide smoking cessation pamphlets in the waiting room so patients can help themselves	91	8	1
Put up posters on smoking and health in the waiting room	89	10	1
Assist patients who smoke to give up	76	22	2
Refer patients to appropriate services to help them stop smoking	85	15	0
Involve the dental team in helping patients with smoking issues	64	33	3
Discuss the use of nicotine replacement therapy with patients who smoke	40	58	2
Keep records of patients' smoking status	72	26	2
Follow up with patients on their progress in giving up smoking	56	41	3

Table 2 Current practices in relation to smoking cessation interventions

Intervention	Response (*n*=250) %		
	Yes	No	Sometimes
Systematically ask all new patients about their smoking	47	40	13
Explain to patients who smoke the impact of smoking on their dental health	87	5	8
Advise patients who smoke to give up	77	15	8
Inform patients who smoke of the benefits of quitting smoking	73	17	10
Explain to patients who smoke the impact of smoking on their general health	49	38	13
Provide smoking cessation pamphlets in the waiting room so patients can help themselves	56	33	11
Put up posters about smoking and health in the waiting room	40	54	6
Assist patients who smoke to give up	33	59	8
Refer patients to appropriate services to help them stop smoking	37	58	5
Involve the dental team in helping patients with smoking issues	24	67	9
Discuss the use of nicotine replacement therapy with patients who smoke	11	81	8
Keep records of patients' smoking status	48	41	11
Follow up with patients on their progress in giving up smoking	36	49	15

A comparison of the findings in Tables 1 and 2 shows that, for all interventions surveyed, the proportion of dentists who reported actually practising them was substantially lower than the proportion who said it was appropriate for dentists to do so (see Table 3). This was particularly the case for providing pamphlets, putting up posters, referring patients, assisting patients to quit and involving the dental team.

The dentists who said that they did not practise the various interventions were asked why. Their answers to these questions might help explain the disparity between the respondents' perceptions of dentists' role in smoking cessation generally and their own practice. Most gave 'low priority', 'not appropriate' or 'lack of time' as a reason for not practising various interventions. Additional reasons provided that are worth noting are given in Table 4.

The dentists were asked if they had had any training in smoking cessation interventions. Only 4% said that they had. This lack of training could be due

to lack of opportunity rather than lack of interest. Sixty-three per cent of respondents said that they would be likely to attend training on smoking cessation if it were offered. This percentage was even higher among country dentists (72%). A little over half of these country dentists (57%) said that they would be prepared to travel to the city to attend training. The offer of Continuing Dental Education points for attending smoking cessation training would be an incentive for some dentists – 33% of respondents said that they would be more likely to attend training if the points were offered. The dentists were also asked which topics they would like covered in training. A large range of topics was suggested, as can be seen in Table 5.

Table 3 Comparison of views on appropriateness and current practices in relation to smoking cessation interventions

Intervention	Difference* (*n*=250) %
Systematically ask all new patients about their smoking	29
Explain to patients who smoke the impact of smoking on their dental health	10
Advise patients who smoke to give up	s9
Inform patients who smoke of the benefits of quitting smoking	15
Explain to patients who smoke the impact of smoking on their general health	21
Provide smoking cessation pamphlets in the waiting room so patients can help themselves	35
Put up posters about smoking and health in the waiting room	49
Assist patients who smoke to give up	43
Refer patients to appropriate services to help them stop smoking	48
Involve the dental team in helping patients with smoking issues	40
Discuss the use of nicotine replacement therapy with patients who smoke	29
Keep records of patients' smoking status	24
Follow up with patients on their progress in giving up smoking	20

**Appropriateness minus current practice.*

The dentists were asked about their level of confidence in their knowledge of the impact of smoking on dental health and on general health and their ability to assist patients to give up smoking. These questions were only asked of dentists who said that they did these things in their practice. As can be seen in Table 6, most dentists were confident about their knowledge of the impact of smoking on dental and general health. However, their level of confidence in being able to assist their patients to give up smoking was notably lower.

Table 4 Additional reasons for not practising intervention

Intervention	Reasons
Systematically ask all new patients about their smoking	Unnecessary because you can tell (15%) Not on assessment sheet (10%) Not dentists' role (8%)
Explain to patients who smoke the impact of smoking on their dental health	Not dentists' role (8%)
Advise patients who smoke to give up	Patients already know (14%)
Inform patients who smoke of the benefit of quitting smoking	Patients already know (10%)
Explain to patients who smoke the impact of smoking on their general health	Don't have the knowledge (15%) Not dentists' role (13%)
Provide smoking cessation pamphlets in the waiting room so patients can help themselves	Don't know of resources/services (17%) Don't have any (28%) Not dentists' role (11%)
Put up posters on smoking and health in the waiting room	Don't know of resources/services (20%) Unattractive (28%)
Assist patients who smoke to give up	Don't know about resources/services (11%) Don't have the knowledge (10%)
Refer patients to appropriate services to help them stop smoking	Don't know about resources/services (43%)
Involve the dental team in helping patients with smoking issues	Don't have the knowledge (8%)
Discuss the use of nicotine replacement therapy with patients who smoke	Don't have the knowledge (49%)
Keep records of patients' smoking status	Unnecessary (6%)
Follow up with patients on their progress in giving up smoking	Patients' responsibility (6%)

Most of the dentists surveyed were interested in receiving information about Quit resources and training (87%). Respondents were asked what sort of format they would prefer for the training. A package of materials to read (27%) and face-to-face training sessions (22%) were the most popular choices. CD-ROM (17%), audiotape (14%) and web-based training (10%) were also suggested. The remainder (10%) made other suggestions. The dentists were asked which type of face-to-face training sessions would suit most. Evening sessions (37%) and a conference session (35%) were most often mentioned. A half-day training session was less popular (12%) and a full-day training session was even less popular (6%). The remainder (10%) made other suggestions.

Table 5 Suggestions for topics to be covered in training

Topic	Per cent of responses* (*n*=204)
Health effects of smoking	22
Strategies that help patients quit	15
Quit services and resources	13
Smoker behaviour and experience	9
Nicotine replacement therapy	8
Integration into practice	5
Quitting as a process – stages of change	3
Patient motivation	3
Psychology of smoking and quitting	3
Communication with the patient	3
What works	2
Effects of smoking on dental health	2
Benefits of quitting	2
Referral	2
Other	8

* *Multiple responses.*

Table 6 Level of confidence in relation to smoking cessation intervention

Intervention	Very confident %	Confident %	Unconfident %	Very unconfident %	Can't say %
Dental health (*n*=238)	65	32	3	0	0
General health (*n*=156)	51	41	6	2	0
Assist patients (*n*=103)	12	34	47	6	1

Dentists were asked about their knowledge of Quit's resources and services without prompting. Brochures, posters and the Quitline were the most well-known resources and services (see Table 7).

Table 7 Knowledge of Quit resources and services (unprompted)

Item	Per cent of responses (*n*=250)
Brochures and posters	36
Information and support on the telephone	24
Telephone counselling	12
Booklet on quitting	8
Non-Quit services	5
Group smoking course	2
Don't know any	10
Other	3

Focus group findings

It became clear that dentists are inclined to deliver smoking cessation interventions in response to existing pathology rather than as a preventive measure. A reactive rather than proactive approach was also evident when some dentists expressed reluctance to ask patients about smoking, and follow up with respect to their smoking. The main reasons given for this reluctance were concern over their patients' reaction to being asked about their smoking, their patients' apparent lack of motivation to quit and the dentists' lack of confidence in their own ability to help their patients quit. However, the dentists agreed that they could provide an initial motivation but had mixed opinions on whether they could provide further support. They also felt that they could reinforce the advice and support given to their patients by general practitioners. The idea of involving the dental team in helping patients to quit was welcomed even though they were unfamiliar with this practice. Some country dentists interviewed at length by phone indicated that financial and professional incentives would encourage them to be more motivated and systematic in their approach to smoking cessation interventions.

When asked about which smoking cessation interventions they thought worked, there were differences in opinion. Some of the dentists reported having more training than others. They agreed that discussion with patients about smoking needs to be done in small amounts over a number of visits. The dentists overwhelmingly declared that they knew little about which interventions worked and would like to know more. When asked about the key issues for dentists in addressing smoking with their patients, the biggest

concern was their lack of training. They contrasted training that is available to general practitioners with the absence of training for dentists.

When asked which areas should be covered by training, they said that they already knew about the health effects of smoking – it was the psychological aspects of smoking cessation that they most wanted to learn more about. When prompted to explain what it was that they needed in this area, some said that they wanted more training in how to address the issue of smoking in a non-threatening way and to help their patient gain insight. Others said that they particularly needed an ongoing strategy that was simple and brief and provided an appropriate timeslot for discussion with patients. The dentists also indicated that they needed resources that were relevant to their setting, as well as referral options. Information about nicotine replacement therapy was also needed.

The dentists did not like the idea of a full day for training. They said that half a day or evenings would be a possibility. One dentist commented that it would fit well into the ADA's Continuing Education Scheme. It was also suggested that training could also be offered:

- in a one-hour slot such as a lecture through the ADA's groups, offered once a week for three weeks or once a month, perhaps with repeat sessions
- at the ADA midwinter convention
- at specialist society meetings such as the Periodontists Society or Oral Medicine Society
- as part of the University of Melbourne's Continuing Education Program.

City dentists preferred a central location, while country dentists expressed a preference for regional evening sessions – possibly a component of the regional dental dinner meetings which are held four times a year. Some country dentists said that they would be willing to travel to Melbourne if the training were linked in with other activities.

When the dentists were asked what they would like to take away from the training, they said that they did not want to take away a lot of information to read. They were keen to gain some skills that they could put into practice straight away. They thought that a single information sheet and some brochures would be useful. The phrase 'dot points' was mentioned frequently. Most dentists wanted to be able to take away a flow chart, summary of a model for intervention and examples of resources. They agreed with journal articles, presentation notes and case studies, but were less enthusiastic about taking

away such material. Other suggestions included tear-off referral slips, telephone numbers, website and take-away card. The dentists had their own preferences for recording information.

Discussion

A key finding from the research is that many dentists are ambivalent about adopting smoking cessation practices as part of their role. It was surprising to find that nearly one-quarter of dentists said that it was not appropriate to ask systematically about smoking. A similar proportion said that it was not appropriate for them to assist patients to quit. Dentists who held this view were unlikely to practise smoking cessation interventions or to want to invest in training to increase their skills and knowledge in smoking cessation. Thus, making smoking cessation intervention legitimate in dental practice is a prerequisite to facilitating professional development. Although ambivalence was expressed by some dentists, most indicated that they thought it was appropriate for dentists to intervene.

Many dentists said it was appropriate to ask patients about their smoking status. In practice, however, it was found that dentists do not systematically ask all patients about their smoking. Seventy-six per cent of dentists surveyed said that they thought it was appropriate to systematically ask all new patients about their smoking, yet only 47% said that they actually practised this. This finding is consistent with the literature, which indicates that asking about tobacco use is not a routine part of dental practice (Clover et al. 1999). According to survey respondents in this study, the main reasons why they did not systematically ask patients about their smoking were because they did not see it as a high priority; they believed it was unnecessary, because they believed they could see evidence of smoking; or the question was not on the ADA-recommended assessment sheet. Another explanation is that dentists are concerned about a negative reaction from their patients if dentists ask them about their smoking. This is one of the barriers that has been identified in the literature (Watt & Robinson 1999) and was revealed in the focus group.

The findings indicate that advising patients about smoking is regarded by most dentists as appropriate to their role. In particular, providing information about the impact of smoking on dental health and the benefits of quitting, as well as providing advice to give up smoking, were approved of and practised by a large proportion of dentists. Given the findings of the focus group, it is likely that this intervention activity would be in response to finding smoking-related pathology rather than a systematic preventive approach of giving advice to all patients who smoke. The idea of explaining to patients who

smoke the impact of smoking on their general health was less popular among dentists and also less well practised than the provision of other types of advice. The main reasons were that dentists felt they did not have the knowledge or that the provision of this information was not a high priority.

There was a high level of approval for providing smoking cessation pamphlets and putting up posters in the waiting room, but these activities were not well practised. The findings suggest that many dentists prefer not to put up posters because they find them unattractive. Some said that they did not know about these resources. Similar reasons were given for not providing pamphlets.

A large disparity was found between dentists' opinion on the appropriateness of providing assistance to patients to give up smoking and their current practices. The survey indicated that this was because the dentists did not consider provision of assistance to be a priority or because they felt they did not have the appropriate knowledge. Lack of knowledge about resources or services was also an explanation for this. The focus group findings also indicated that dentists' lack of confidence in their ability to assist patients with quitting discouraged them from discussing smoking with their patients. This is consistent with studies that have identified lack of time, resources and confidence in being able to assist patients to quit smoking as major barriers for dentists in participating in smoking cessation activity (Clover et al. 1999).

In the focus group, some dentists said referral for smoking cessation support would often be the most appropriate option for them to assist their patient with smoking cessation. While a large proportion of dentists who were surveyed said that this was an appropriate activity for dentists, only a small proportion of dentists said that they actually did refer patients. The main reasons why dentists did not refer their patients for smoking cessation support were because they did not know about services or they felt they did not have the relevant knowledge.

A large proportion of dentists surveyed said that they thought involving the dental team was appropriate, but only half of these reported actually doing this. Dentists in the focus group suggested that this was a good idea but it was a concept that they had not as yet explored. Survey respondents said that they did not involve the dental team because it was not a high priority or they did not have time. Discussion of the use of nicotine replacement therapy with patients was unpopular among dentists surveyed. The main reason that they gave for this was that it was not a high priority or they did not have time. Not having the relevant knowledge was also given as a reason.

Some dentists in the focus group said that their patients' apparent lack of motivation to quit discouraged them from assisting with quitting and following up. This might explain why follow-up was not reported as a very popular activity. The main reasons mentioned for not doing this were that it is not a high priority or they did not have time. The feeling among dentists for keeping records of their patients' smoking status was similar: low priority and lack of time were the main reasons given.

The focus group discussion revealed that lack of training was the dentists' biggest concern when asked what they thought were the key issues for addressing smoking with their patients. The telephone survey results confirmed that dentists had little training and that there was a strong interest in attending training. Dentists in the focus group found it difficult to articulate exactly what training they wanted; the main interest mentioned was the psychological aspects of smoking cessation. The telephone survey respondents referred to more general topics as being of interest, such as the health effects of smoking, strategies that help patients quit and quit services and resources.

Levels of confidence in regard to knowledge of the impact of smoking on dental health and general health were found to be high, while the finding was the converse for their level of confidence in relation to assisting patients with smoking cessation. This suggests that training content should put greater emphasis on strategies to help patients quit rather than on knowledge of the impact of smoking on dental and general health. Lack of knowledge about smoking cessation services and resources was often mentioned in the telephone survey as a reason for not practising interventions. When dentists were asked, unprompted, about which services and resources they knew of, only a small proportion of respondents was found to be aware of brochures/posters, telephone support, the Quit book, smoking cessation course, and other services. Ten per cent said that they did not know of any services or resources.

A package of materials to read and face-to-face training were the favoured formats for training. However, half-day or full-day training sessions were unpopular; this was also reported in the focus group. Dentists in the focus group and responding to the telephone survey suggested training be in the form of small sessions combined with another activity such as conferences or regular professional meetings. Country dentists said that they would be prepared to come to Melbourne if training were linked to other activities.

The focus group discussion generated many useful suggestions for training outcomes. When asked what they would like to take away from the training, they responded with very practical suggestions, such as skills that can

immediately be put into practice and a flow chart or summary model for intervention.

Recommendations

Content

Initiatives for professional development in smoking cessation should focus on dentists' limited confidence and ability to implement smoking cessation interventions systematically and their underlying ambivalence about including smoking cessation in their role as a dentist, which largely explains the disparity. Content for a dentist training course could include the following:

- Strong evidence that shows the effectiveness of smoking cessation interventions carried out by health professionals, and patients' views about the role of health professionals (and dentists) in helping them to quit smoking.
- Information on the dentist's role, the impact of smoking on dental and general health, the psychology of smoking and quitting, and the impact of pharmacotherapies on quitting.
- Strategies to help dentists consistently raise the smoking issue with patients and, where appropriate, strategies for helping their patients to quit. Offer a more in-depth training package for dental professionals who wish to explore stages of change with smoking cessation, strategies to pass on to patients about quitting and coping with withdrawal and relapse prevention, and patient counselling and motivation.
- Demonstrate to dentists how smoking cessation can be built into their current approach to dental care and how members of the dental team can become involved. Demonstrate simple methods of collecting and recording data on patients' smoking status and the dental team's interventions.
- Information on Quit services available to dentists and their patients and develop literature, display material and services to make accessing Quit services easy. Provide dentists with a mechanism to receive feedback from any referral to Quit services.

Resources

- Develop a model that illustrates the integration of smoking cessation in dental care and test the model with dentists.

- Develop resources for dental professionals that make record keeping of smoking status and referral to Quit services easier and systematic.
- Develop a simple method of recording data on patients' tobacco use and follow-up consistent with the 5As (Ask, Advise, Assess, Assist, Arrange) that can be adapted to a range of dental record formats, both manual and computerised.
- Amend the ADA's medical history questionnaire to include questions about smoking status.
- Develop a card or referral slip with the Quitline phone number and reference to further quitting information for dentists to give patients where appropriate.
- Design display material and patient literature that is specific to the dental practice setting.

Format

Present a range of training package options.

A) Develop a short (one- to two-hour) face-to-face information session that could be incorporated into other professional development meetings. Include in the content broad issues of tobacco control, the dentist's role, the process of quitting and Quit services. Supplement the information delivered with a kit of further information and resources on how to implement smoking cessation strategies in the dental setting.

B) Develop a 'stand-alone' training session for dentists (Module 1) and offer an 'advanced training package' (Module 2) for those interested in further material or encourage the involvement of other members of the dental team (dental hygienist, dental therapist, dental assistant and/or receptionist) and provide them with access to training.

Module 1: Half day. Provide brief information about smoking and health, the psychology of smoking and quitting and pharmacotherapies. Also a demonstration of the development and implementation of strategies to integrate smoking cessation interventions in the dental practice and how to access Quit services.

Module 2: Half day. Provide more in-depth material and interactive skills training on stages of change with smoking cessation, strategies to pass on to patients about quitting and coping with withdrawal and relapse prevention, and patient counselling and motivation.

C) Develop, promote and distribute a smoking cessation training kit for dentists containing information, strategies for integrating interventions into everyday practice and resources to use in the practice. This could be on ADA Victorian Branch and Quit websites, on a CD-ROM or in paper-based form. The package could be promoted to dentists via existing continuing dental education programs in country and metropolitan regions.

Ideas for future development include:

- Build smoking cessation training into undergraduate courses for dentists, dental therapists, dental hygienists and dental assistants.
- Have smoking cessation training accredited for continuing dental education points.
- Produce a regular editorial in the ADA's newsletters on smoking cessation in dental care.
- Work with the federal committee of the ADA to promote the inclusion of smoking cessation activities in the Glossary and Schedule (perhaps as an example of oral hygiene instruction).
- Lobby dental education committees to include smoking cessation within their themes and activities.
- Conduct further research, including a survey to evaluate patients' opinions on dentists providing smoking cessation advice.
- Develop community education initiatives to encourage dental patients to access smoking cessation services through dental professionals.
- Create a scheme that provides incentive for dental professionals to invest time and effort in smoking cessation interventions. For example, a plaque/caption/logo (valued by dentists and patients) that endorses smoking cessation activities as part of dental care.

Acknowledgments

Quit Victoria and the Australian Dental Association Victorian Branch Inc. are grateful to the Department of Human Services (Victoria) for funding this project. Special thanks are extended to members of the Reference Group, who generously provided their time and expertise to the project: Associate Professor Michael Morgan, Professor Clive Wright, Ms Susanne Sofronoff, Dr Praveen Nathaniel, Mr Garry Pearson, Ms Ros Phelan, Ms Suzie Stillman and Ms Pat Kee.

References

Block D, Block L, Hutton S & Johnson K 1999. Tobacco counselling practices of dentists compared to other health care providers in a midwestern region. *Journal of Dental Education* 63: 821–7.

Chestnutt I & Binnie V 1995. Smoking cessation counselling – a role for the dental profession? *British Dental Journal* 179: 411–5.

Clover K, Hazell T, Stanbridge V & Sanson-Fisher R 1999. Dentists' attitudes and practice regarding smoking. *Australian Dental Journal* 44: 46–50.

Dolan T, McGorray S, Grinstead-Skigen C & Mecklenburg R 1997. Tobacco control activities in US dental practices. *Journal of the American Dental Association* 128: 1669–79.

Mecklenburg R, Christen A, Gerbert B, Gift H, Glynn T, Jones R, Lindsay E, Manley M & Severson H 1990. *How to Help Your Patients Stop Using Tobacco – A National Cancer Institute Manual for the Oral Health Team*. NIH Publication No. 91–3191. Public Health Service, National Institutes of Health, US Department of Health and Human Services, Washington DC.

Mullins R 1994. Attitudes and smoking habits of dentists in Victoria: sixteen years on. *Australian Dental Journal* 39: 324–6.

National Institutes of Health 1994. *Tobacco and the Clinician – Interventions for Medical and Dental Practice*. Smoking and Tobacco Control Monograph No. 5. National Cancer Institute, National Institutes of Health, US Department of Health and Human Services, Washington DC.

Skegg J, McGee R & Stewart A 1995. Smoking prevention: attitudes and activities of New Zealand dentists. *New Zealand Dental Journal* 91: 4–7.

Smith S, Warnakulasuriya K, Feyerabend C, Belcher M, Cooper D & Johnson N 1998. A smoking cessation program conducted through dental practices in the UK. *British Dental Journal* 185: 299–303.

US Public Health Service Report 2000. A clinical practice guideline for treating tobacco use and dependence. *Journal of the American Medical Association* 283(24): 3244–54.

Watt R & Robinson M 1999. *Helping Smokers to STOP – A Guide for the Dental Team*. Health Education Authority, London.

Wood G, Cecchini J, Nathason M & Hiroshige K 1997. Office based training in tobacco cessation for dental professionals. *Journal of the American Dental Association* 128: 217–24.