

Screening for alcohol misuse and alcohol brief interventions in primary dental care settings: A literature review

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Learning outcomes:

- Identify the three alcohol drinking categories defined by Public Health England
- Implement the use of an appropriate alcohol screening tool at patients' dental visits
- Justify the need for undertaking a training programme to carry out alcohol screening and brief interventions with confidence.

eCPD aligned with GDC development outcomes: A,B,C,D

Key words: Alcohol misuse, alcohol screening, alcohol brief intervention, dental patient, dental setting

ABSTRACT

Aim: To determine why screening for alcohol misuse and the delivery of brief alcohol interventions are not consistently carried out for patients in a primary dental care setting.

Method: A literature review was undertaken. Key words were used to establish search terms. A hierarchy of evidence and inclusion and exclusion criteria provided structure for the search of six electronic databases. Following initial exclusions, eleven papers were critically appraised and seven excluded. Four studies were deemed relevant to answer the review question.

Results: The studies found a culture of negativity among dentists in contrast to patients' perceptions, which were positive. They reflected a lack of confidence, knowledge and motivation, no perceived need or relevance, combined with embarrassment and discomfort when discussing alcohol related matters with patients.

Perceived barriers by dentists were cited as: time constraints, disruption to the patient-clinician relationship, provision of screening tools, effectiveness of the intervention and the need for referrals.

Conclusion: Two recent studies have indicated successful outcomes, firstly for training dentists and, secondly, for dentists providing screening for alcohol misuse and delivering Alcohol Brief Interventions (ABI). The authors of these studies both recognise the need for further research to assess the effectiveness and cost effectiveness of dentists delivering the intervention. Completing evidence-based training specific to the dental team, importantly, to include dental hygienists and dental therapists, fulfils the General Dental Council's (GDC) expectations of a commitment to continually develop knowledge and skills throughout our working life, whilst delivering a holistic approach to patient care.

Introduction

Alcohol is widely consumed and socially acceptable in the UK,¹ with 85% of men and 80% of women reported to drink alcohol.² Described by The World Health Organisation (WHO) as ‘a psychoactive substance with dependence-producing properties,’³ harmful use can significantly impact on a person’s physical and mental health. The Chief Medical Officer’s alcohol guidelines review, published in January 2016,

highlights that the risk of developing mouth, throat and breast cancers increases with any amount drunk on a regular basis.⁴

Public Health England defines three alcohol drinking categories:⁵

Hazardous drinking: the level or pattern of drinking that, if continued, increases the risk of harm;

Harmful drinking: a pattern of drinking that causes mental and/or physical damage;

Alcohol dependence: behavioural, cognitive and physiological factors that lead to a person’s desire to continue to drink, despite the negative impacts on their physical and/or mental health.

Alcohol can potentially cause damage to every system in the body.⁶ Dental professionals should employ a holistic approach to patient care and consider the patient’s oral and systemic health, psychological and social needs.⁷ Alcohol misuse in a patient can be easily missed, due to the time constraints of short appointments, where a patient’s oral health concerns are generally the main focus.

Alcohol dependent patients often present with a variety of symptoms including: periodontal disease, dental caries, dental erosion, a burning or inflamed tongue and recurrent aphthous ulceration. The risk of oral and pharyngeal cancer is significantly increased, reinforcing the need for a thorough soft tissue evaluation at every appointment.¹

Roked *et al.* (2014)⁸ carried out a clinical audit to determine how effective the question, ‘How many units of alcohol do you drink each week?’ (on a medical history form, or asked by a clinician), is in helping identify patients’ drinking patterns. The audit demonstrated limited compliance as a quarter of the patients’ alcohol consumption levels could not be identified from the answers they gave. Screening tools, however, identify levels of alcohol misuse effectively and efficiently. In a second clinical audit by Roked and his co-workers⁸ the team assessed the efficiency of the Modified-Single Alcohol Screening Question (M-SASQ) (Fig.1). The group found that 98% of patients interviewed were able to complete the screening questions, of which 25% were identified as hazardous drinkers.

Research carried out in Scotland using the Alcohol Use Disorders Identification Test (AUDIT) (Fig.2) recorded 31% of dental patients drinking at hazardous and harmful levels. The AUDIT, ten-item questionnaire and scoring system provides guidance for the appropriate level of advice or referral.⁹

Alcohol Brief Interventions (ABI) provide an evidence-based approach. Non-confrontational, short, structured conversations provide motivation and support behaviour change, to reduce the risk of harm.¹⁰ A recent Cochrane review reported significant reductions in drinking at a one-year follow-up.¹¹

Whilst smoking cessation programmes in primary dental care settings are widely accepted and routinely implemented by dental professionals, there appears to be limited screening for alcohol misuse and delivery of ABI. The aim of this literature review is to assess why screening for alcohol misuse and the delivery of alcohol brief interventions is not consistently carried out for patients in a primary dental care setting.

Methodology






A literature review was undertaken. PICO (Population, Intervention, Context, Outcomes)

TO BE COMPLETED BY CLINICAL STAFF








Screening procedure

For the following question - 1 standard drink = 1 unit of alcohol, an indication of standard drinks is provided in the diagram below.

One Standard Drink is

 Half pint of regular beer, lager or cider	 1 small glass of wine	 1 single measure of spirits	 1 small glass of sherry	 1 single measure of aperitifs
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The following quantities of alcohol contain more than 1 standard drink

 2	 3	 1.5	 2 440ml	 4 440ml	 2	 9
Pint of Regular Beer/Lager/Cider	Pint of Premium Beer/Lager/Cider	Alcopop or can/bottle of Regular Lager	Can of Premium Lager or Strong Beer	Can of Super Strength Lager	Glass of Wine (175ml)	Bottle of Wine

Please place a cross in the relevant box.

MEN: How often do you have EIGHT or more standard drinks on one occasion?
WOMEN: How often do you have SIX or more standard drinks on one occasion?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring the M-SASQ

If the patient's response is 'Monthly', 'Weekly' or 'Daily or almost daily' the score is M-SASQ positive.

If their response is 'Never' or 'Less than monthly' the score is M-SASQ negative.

Please indicate the result of the screening procedure by placing a cross in the appropriate box below.

Positive Negative

If the result is **negative** thank the patient, terminate the interview and store the survey securely, to be collected by research staff.

If the result is **positive** explain the study to the patient, provide an information sheet and request written consent.

Is the patient willing to provide written informed consent? Yes No

If **yes** continue with the consent details overleaf.

If **no** terminate the interview and store the survey securely, to be collected by research staff. Remember to provide the patient with a Patient Information Leaflet.

Participant ID:






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Fig. 1








TO BE COMPLETED BY THE PATIENT

These questions ask about the alcohol you have drunk in the **last 6 months**. The questions ask about how many standard drinks you have consumed. Please note that 1 standard drink = 1 unit of alcohol. So, for example, a pint of regular beer or lager is equal to 2 standard drinks or 2 units. A description of a standard drink is given in the box below.

One Standard Drink is

 Half pint of regular beer, lager or cider	 1 small glass of wine	 1 single measure of spirits	 1 small glass of sherry	 1 single measure of aperitifs
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The following quantities of alcohol contain more than 1 standard drink

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1. How often do you have a drink containing alcohol?

Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 to 5 times a week	6 or more times a week
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How many standard drinks containing alcohol do you drink on a typical day you are drinking?

None	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How often have you had 6 or more standard drinks if female, or 8 or more if male, on a single occasion in the **last 6 months**?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often during the **last 6 months** have you found that you were not able to stop drinking once you had started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Fig. 2

enabled key words and phrases to be identified for use in the systematic search of published literature. These included: alcohol misuse, alcohol abuse, heavy drinking, alcohol screening, alcohol screening tool, alcohol brief intervention, alcohol brief advice, dental patient, dental setting and dental practice.

The primary focus of the literature review was to identify attitudes, opinions and perceptions of dental professionals and patients. Qualitative primary research was deemed the most applicable, in the form of cross-sectional studies. Questionnaires and surveys demonstrate the views at a point in time of a specific population.

Six databases retrieved a wide range of studies. Dental and Oral Sciences, Embase (Ovid), Medline (full text) and ProQuest, all provide access to evidence-based resources from a range of healthcare journals and databases, with selective coverage of dentistry. CINAHL Complete is a dependable resource for healthcare professionals, with limited dental research experience. The Cochrane Library is considered the 'gold standard' of evidence based systematic reviews, providing high quality evidence for all areas of medicine

and dentistry. Consistent use of the search terms, limitations and Boolean operators throughout each database search ensured a systematic approach. However, truncation was used for ProQuest searches as the search terms used produced high volumes of studies.

The CASP tool and a list of ten questions presented by Greenhalgh (2014)¹² were the most appropriate way to assess the quality of cross-sectional studies, in the form of questionnaires and surveys. A data extraction table presented the developing themes from four papers critically appraised: Shepherd *et al.* (2010)¹³, Shepherd *et al.* (2011)¹⁴, Neff *et al.* (2013)¹⁵, Miller *et al.* (2006)¹⁶.

Ethical approval was obtained by the University of Central Lancashire on behalf of the study. As it was a review of published literature that was being undertaken, patients or the public were not directly involved.

Results

The initial search across the six databases produced one hundred and ninety-nine papers.

Please answer each question by placing a cross in the box. Please only cross one box for each question.

5. How often during the **last 6 months** have you failed to do what was normally expected from you because of your drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often during the **last 6 months** have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often during the **last 6 months** have you had a feeling of guilt or remorse after drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often during the **last 6 months** have you been unable to remember what happened the night before because you had been drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you or somebody else been injured as a result of your drinking?

No <input type="checkbox"/>	Yes, but not in the last 6 months <input type="checkbox"/>	Yes, during the last 6 months <input type="checkbox"/>
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10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

No <input type="checkbox"/>	Yes, but not in the last 6 months <input type="checkbox"/>	Yes, during the last 6 months <input type="checkbox"/>
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Fig. 3

Duplicate papers were eliminated, followed by papers that did not fit the hierarchy of evidence, while further papers were excluded according to the identified inclusion and exclusion criteria.

Eleven papers were read in full and the final four selected (Table 5). Exclusions were made if the papers were: not primary research; had no clear aim, objectives or methodology; presented a clinical audit which focused on the efficacy of screening tools; an abstract of a soon to be published randomised control trial; or a paper detailing the methodology for a large-scale randomised control trial, which although was relevant to the review question, presented no findings.

The final four papers selected include: two cross-sectional studies in the form of questionnaires, presenting the results as quantitative research; one study using a mixed methodology, undertaking both quantitative and qualitative research methods; and one qualitative study of a phenomenological nature. The papers are different in terms of study design, the context in which they are set and their perspectives. However, they are all relevant to answering the review question.

Discussion

The four papers primarily identify the attitudes and perceived barriers of dentists, however one paper includes dental hygienists, whilst another reflects the patients' views: Shepherd *et al.* (2010)¹³, Shepherd *et al.* (2011)¹⁴, Neff *et al.* (2013)¹⁵, Miller *et al.* (2006)¹⁶. Strategies for implementation are also discussed throughout. The context of all four papers related to the negative impact on systemic health and the increased risk of oral and pharyngeal cancers, with alcohol as the risk factor, thus emphasising the need for dentists to routinely screen patients.

Attitudes

In both studies by Shepherd *et al.* (2010, 2011)^{13,14} the research teams identified a culture of negativity among dentists. The teams found respondents to be lacking in knowledge, confidence, motivation and the conviction for successful outcomes.¹³ Dentists felt no pressure for implementation, considered ABI ineffective, difficult to integrate and of little relevance to clinical practice.¹⁴ However, in contrast, Neff *et al.* (2013)¹⁵ reflected a positive attitude from dental hygienists. Similarly, Miller *et al.* (2006)¹⁶ determined a positive attitude from patients towards receiving ABI.

Lack of knowledge and confidence

A recent BBC documentary 'The truth about... alcohol,' informing the general public of the potentially negative impacts of alcohol, is an example of media involvement for increasing awareness. The dentists who confessed to 'a lack knowledge' is a worrying concept, when information and guidance is freely available. Publications, such as 'Delivering Better Oral Health,' provide clear guidance for dental teams about their role in supporting patients who drink alcohol.⁵ Interestingly, significant parallels can be drawn from the successful integration of smoking cessation programmes into primary dental care settings. Rosseel, *et al.* (2010)²⁰ also identified a lack of knowledge, confidence and difficulties initiating conversations with patients about smoking.

Conviction

There is limited evidence specifically related to dentistry for the successful outcomes of screening and delivery of ABI,¹⁰ justifying the dentists' lack of conviction. However, two randomised controlled trials have determined the feasibility of screening for alcohol misuse and providing ABI in primary dental care settings.^{11,19} Ntouva *et al.* (2015)¹¹ explore both dental professionals' and patients' views on the relevance and importance of screening, developing and evaluating an ABI specific to NHS general dental practice. In comparison, Roked *et al.* (2015)¹⁹ carried out their study with a dentist and dental hygienist providing ABI in response to positive scores on M-SASQ screening tool. Their results revealed

that 43% scored positively, with 7 patients' scores changing from positive to negative following the ABI, clearly demonstrating the need for a new approach towards the screening and intervention.

Relevance

Links between alcohol and oral cancer were first identified in papers published more than 50 years ago. Stronger evidence has emerged over time

associating harmful and hazardous drinking with an increasing risk of oral cancer; approximately 75% of oral cancers arise in association with alcohol (and tobacco) use.^{17,18}

Perceived barriers

Time constraints are key barriers, described by both Neff's group¹⁵ and Shepherd's teams.^{13,14} Unease in the patient-clinician relationship and

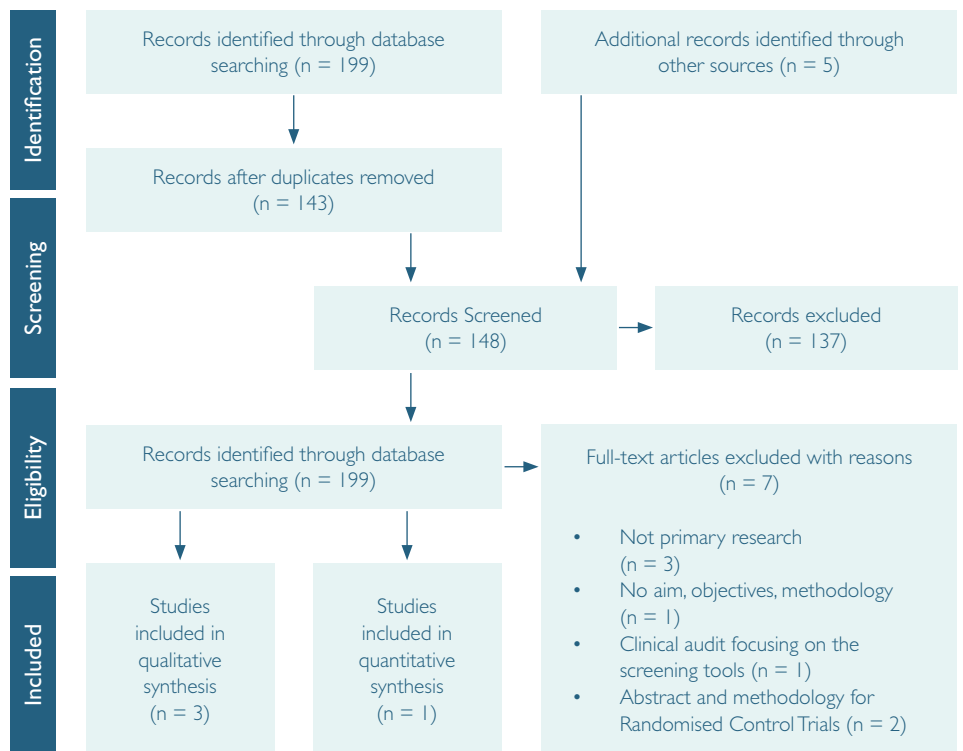


Table 1. PRISMA flow chart

Inclusion	Exclusion	Rationale
Primary research relating to alcohol screening and/or alcohol brief interventions in a dental setting	Primary research not relating to alcohol screening and/or alcohol brief interventions in a dental setting	Addresses the research question with clarity and focus.
English Language	Other Languages	Understand the paper to the full extent
2006 onwards	Pre- 2006	Most relevant and most recent research and evidence, little dental evidence before 2006
Published literature only	Unpublished	'Grey' literature is difficult to find and identify
Qualitative and Quantitative studies	Case controlled	Addresses the research question providing the opinions, perceptions and attitudes and effectiveness.
Cross-sectional studies (surveys and questionnaires)	Cohort studies	
Randomised controlled trials		
Systematic Reviews		

Table 2. Inclusion and exclusion criteria

Reference and Location	Design and Sample	Data Collected	Quality rating
Csikar <i>et al.</i> (2015) ³¹ Bradford	Practice literature Patients and Dental Care Professionals in a dental practice in Bradford, West Yorkshire	Training module for the dental team AUDIT C questionnaire for new patients to complete	Weak
Dyer <i>et al.</i> (2011) ³²	Summary of a rationale and overview of the evidence	Summary of the full paper	Weak
McAuley <i>et al.</i> (2011) ¹⁰	Rationale and overview if the evidence	No recognised screening tool designed dental practices Effectiveness of ABI's in dental practices is limited Barriers to providing alcohol screening and ABI's	Moderate
Miller <i>et al.</i> (2006) Charleston, South Carolina, USA ¹⁶	Cross-sectional study 408 patients attending an emergency walk in dental clinic at the University of South Carolina	AUDIT - C and DPOS questionnaire 25% of respondents had positive AUDIT-C scores DPOS described patients value questioning and ABI's provided by dentists	High
Neff <i>et al.</i> (2013) Virginia, USA ¹⁵	Mixed Methodology 164 dentists and 93 dental hygienists practising in Virginia, USA. 2-3 dentists and 8-10 dental hygienists practising in Hampton Roads area	Web based survey and informal interviews Attitudes and barriers towards implementing ABI's Strategies and facilitators to enable use of ABI's in dental practice	High
Ntouva <i>et al.</i> (2015) London ¹¹	Randomised control trial methodology 12 NHS Dental Practices in North London	EQ-5D-5 L (quality of life) questionnaire face to face interviews No outcomes as this is a detailed methodology	Moderate
Roked <i>et al.</i> (2015) Cardiff, Wales ¹⁹	Randomised control trial abstract Patients aged 18-25years attending a local general dental practice	Modified single alcohol screening question (M-SASQ) questionnaire Short survey to collect patient details 106 patients were recruited, 43% scored positively to the M-SASQ. 2 patients went from a positive to a negative score in the intervention group, 5 in the control group.	Moderate
Roked <i>et al.</i> (2014) Cardiff, Wales ⁹	Clinical audits Each day for four weeks 10-15 male and female patients aged 18-75 years old attending the emergency clinic at the University of Cardiff Dental Hospital where randomly selected	Three versions of a Medical History forms - one with alcohol units question only, one with M-SASQ only one with both alcohol units and M-SASQ Limited compliance to the alcohol units question M-SASQ Greater compliance than alcohol units only and combined alcohol units and M-SASQ	Moderate
Shah <i>et al.</i> (2015) ¹	Practice literature	Outlines recognition of 'at risk' patients by dentists and practical advice	Moderate
Shepherd <i>et al.</i> (2011) Scotland ¹⁴	Cross-sectional study 300 GDPs practising in Scotland	Postal Survey Intention to provide ABI Beliefs that could predict intention to provide ABI	High
Shepherd <i>et al.</i> (2010) Scotland ¹³	Qualitative study 12 GDPs practising in the Scottish Highlands	Semi – structured interviews Attitudes, perceived barriers and facilitators to provide alcohol screening and ABI's	High

Table 3. Study identification table

embarrassment when asking questions with potential financial implications are also considered barriers.¹³ Dentists appear to be unaware of valid screening tools to enable the dissemination of credible information, with the opportunity to offer appropriate referrals.¹⁴

Time

Lack of time is a major barrier described by dentists,¹³⁻¹⁵ and by dental hygienists.¹⁵ Rosseel *et al.* (2010)²⁰ explain that experience gained, and following advice protocols, diminished this key barrier.

Similarly, this same barrier featured heavily during the integration of smoking cessation programmes in primary dental care settings. The teams led by Neff¹⁵ and Stacey²² invited dental hygienists to participate and utilise their skills as oral health educators. A team approach for a time efficient smoking cessation programme

was then established, led by dentists with dental hygienists and dental nurses providing the intervention, creating a complete and structured intervention. The team approach ethos is in line with recommendations by the National Institute for Clinical Excellence (NICE), the General Dental Council (GDC) and the British Dental Association's (BDA) Inequalities of Oral Health Policy.^{7,21,23}

Patient - clinician relationship

Miller *et al.* (2006)¹⁶ identified a positive attitude from patients towards screening and the delivery of ABI by dentists, especially if the patient's drinking patterns were having a negative impact on their oral health. In contrast, Shepherd *et al.* (2010)¹³ found that the dentists expressed embarrassment and unease in their relationship with the patients, which is often built on trust. In a study by Beich *et al.* (2002)²⁴ a group of general practitioners (GP), experienced negative reactions from a minority of patients to alcohol screening and ABI. However the majority of their patients displayed positive reactions as they felt reassured that the GP was concerned about their holistic health and well-being. Dentists should be perceptive to the positive attitudes of patients as increased acceptance and success builds trust in the patient – clinician relationship.

Screening tools

There is a wealth of evidence indicating that the use of appropriate screening tools, which necessitate treatment recommendations, are effective. However, a formally recognised tool specifically for use in primary dental care settings is not yet available.¹⁰ The AUDIT tool, developed by WHO is highly reliable, valid and accurate, often described as the 'gold standard.' The M-SASQ, which was used in a randomised controlled trial to determine the feasibility of a suitable screening tool for alcohol misuse in a dental setting, also had some success.¹⁹ To encourage behaviour change, techniques such as motivational interviewing provide workable strategies for delivering ABI.²⁰

Strategies for implementation

Training and education should help to offset feelings of embarrassment, lack of knowledge and confidence. By encouraging the adoption of best strategies, this will ensure the effectiveness of the intervention, as identified by the dentists and dental hygienists.¹³⁻¹⁵

In one study, although smoking cessation is considered to be part of their role by 89% of dentists interviewed, only 69.5% felt the same about delivering ABI.²⁶ Dentists' knowledge, attitudes, practice environment, patient influences and demands are likely to prevent changes to their clinical practice.²⁵ Funding, is also a contributory factor. Motivation, such as peer pressure, the ease with which the intervention can be carried out and reflection on past positive experiences, can influence behavioural change. Training and education, focusing on evidence-based

Dental Professionals Attitude	Patient Attitudes	Perceived Barriers	Strategies for implementation
Lack of knowledge	Expect dentists to ask questions	Time constraints	Short ABI (3-5mins)
Lack of motivation	Not embarrassed by questions	Need for training	Respective roles of dentists and dental hygienist
Lack of confidence	Accepting of advice	Unaware of the best strategy	Continuing education accreditation.
Lack of conviction		Ineffective	Media and awareness campaigns
Low intention for implementation		Disrupt patient-clinician relationship	Training for GDPs
Difficult to carry out		Financial implications	Published guidelines
Ineffective		No perceived need	Support for behaviour change
No peer pressures		Irrelevant	
Aware of negative impacts		Embarrassing	
Appropriate for team members to implement		Lack of knowledge	

Table 4. Developing themes

research, motivational theory and improving communication skills to increase confidence, has been found to change attitudes and reduce the perceived barriers.²⁷

Limitations

The search strategy carried out in this work, using a wide range of key words, retrieved two good quality studies.^{13,14} The first study was carried out with a small group of dentists in the Scottish Highlands, the results of which may not be reflective of other communities in or outside of Scotland.¹³ Furthermore, the same authors used the findings of their initial study to inform the design of a larger second study, limiting the empirical evidence available.¹⁴

Conclusion

Recommendations that both men and women, should not regularly exceed 14 units of alcohol per week,⁴ (Fig.3) are potentially linked to the general trend that in 2016 adults and young people in Great Britain were drinking less.²⁸ Additionally, a systematic analysis of 694 data sources and 592 prospective and retrospective studies from 195 countries and territories between 1990-2016 confirmed that alcohol is a leading risk factor for global disease specifically cancer. The collaboration goes on to clearly state that the level of alcohol consumption to minimise health loss is zero.²⁹

Implications for clinical practice

Ntouva, *et al.* (2015)¹¹ and Roked, *et al.* (2015)¹⁹ address the themes identified and provide the fundamental evidence required for change. Whilst Roked *et al.*¹⁹ reported findings related to the successful implementation of screening for alcohol

misuse and delivery of ABI in a primary dental care setting, Ntouva *et al.* (2018)³⁰ evaluated a 'novel brief alcohol advice training programme' specifically designed for NHS dentists: two, four-hour, highly interactive training sessions were undertaken by fifteen NHS dentists in North London. Their knowledge, attitudes and confidence scores were assessed before and after the training sessions. The results showed positive changes. Overall knowledge improved by 23%, positive attitudes towards carrying out the screening and intervention increased by 40%, furthermore, confidence levels increased by 80%. The authors concluded that NHS dentists can be successfully trained to carry out screening and deliver ABI. Both authors discuss the need for continued research, increasing the sample size, widening the location and extending the duration of the studies, since they both used small groups of participants in a single location for a limited period of time.^{19,30}

Shepherd S, Young L, Clarkson JE *et al.* General dental practitioner views on providing alcohol related health advice; an exploratory study. *Brit Dent J.* 2010; **208** (7):E13-5.

Shepherd S, Bonetti D, Clarkson JE *et al.* Current practices and intention to provide alcohol-related health advice in primary dental care. *Brit Dent J.* 2011; **211** (7): E14..

Neff JA, Walters ST, Braitman AL *et al.* A brief motivational intervention for heavy alcohol use in dental practice settings: rationale and development. *J Health Psychol.* 2013; **18**(4):542-53.

Miller PM, Ravenel MC, Shealy AE *et al.* Alcohol screening in dental patients: the prevalence of hazardous drinking and patients' attitudes about screening and advice. *J Am Dent Assoc.* 2006; **137**(12):1692-8.

Table 5: Papers selected for review

The study by Neff *et al.* (2013)¹⁵ was the only one in this review that interviewed dental hygienists, valuing their role as oral health educators. The inclusion of dental hygienists and dental therapists should be considered in future studies, similar to the role they play in delivering smoking cessation programmes. NICE guidance states that all appropriate members of the dental team should be trained to deliver alcohol related advice.²³ Evidence-base, the standard by which the approach to treatment and clinical care is measured, ensures good quality patient care.²⁵ Ntouva's team concluded that further research will need to assess the effectiveness and cost effectiveness of dentists delivering the intervention.³⁰

Professional responsibilities

Health Education England provides an on-line platform consisting of four sessions of evidence-based tailored education specific to dental teams, an example of training that is becoming more available. The BDA identified a need to advise patients on sensible drinking, in their 'Inequalities of Oral Health Policy'.²¹

By undertaking appropriate training we fulfil the GDC's expectations of dental teams having a positive attitude, respect, integrity, good communication skills and a commitment to continually develop knowledge and skills throughout our working life, whilst delivering a holistic approach to our patients' care.⁷

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The author is a dental hygienist working in private practice. This review was undertaken as part of her dissertation module of the dental studies for dental care professionals BSc at UCLAN in 2016.

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