# Summary of: Current practices and intention to provide alcohol-related health advice in primary dental care

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VERIFIABLE CPD PAPER

## FULL PAPER DETAILS

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**Objectives** To determine whether general dental practitioners (GDPs) currently provide alcohol-related advice (ARA) and to inform the development of an intervention, should one be required. **Method** Cross-sectional postal survey of a random sample of 300 GDPs in Scotland. The questionnaire assessed beliefs derived from psychological models that explain behaviour in terms of beliefs that are amenable to change, and so may inform development of an intervention to encourage the provision of ARA. **Results** Sixty percent of GDPs responded. Eighty-three percent of participating GDPs (145/175) had not provided ARA to patients in the previous ten working days. Attitude (perceived consequences), control beliefs (perceived difficulty), subjective norm (perceived social pressure), and self-efficacy (confidence) significantly predicted intention to provide ARA. Alcohol-related knowledge or personal alcohol behaviour did not predict intention to provide ARA. **Conclusions** There is scope to increase the provision of ARA in primary care dentistry and this study identified predictive beliefs, which could be targeted to encourage this behaviour. The next phase is to develop and test an intervention to encourage GDPs to provide ARA.

## EDITOR'S SUMMARY

Western society, at least, has a very strange relationship with alcohol. No other drug has such a protected and accepted place and no other addictive substance is so lightly and uncritically dismissed.

The subject of alcohol-related health advice in clinical dental practice has featured on these research pages previously and I have every expectation that it will continue to do so into the future. To the same end, I am also aware that I have, more than once, drawn parallels between the situation we now find ourselves in, in relation to alcohol, and that in which we were some years ago in relation to tobacco use and cessation advice. I do not propose to run over the same territory again other than to note that I still believe we will in time come to regard this as an important part of our history taking, patient care and overall disease prevention role. However, this is likely to be at a much slower rate than with tobacco, partly because of the status of alcohol and its social acceptability compared with tobacco, which now has a huge majority of public opinion against it thanks in no small measure to its known adverse health consequences.

This research, in Scotland, found that only a very small percentage of GDPs provided alcohol-related advice to their patients although neither the practitioners' own knowledge of the subject nor their personal alcohol behaviour affected this choice. As pointed out in the Commentary, medical practitioners also express two of the major barriers to this approach brought forward by dentists in relation to tobacco advice – lack of time and lack of adequate reimbursement. These are both serious obstacles and emphasise the relatively low priority still accorded to the need for this service.

The authors of this paper intend to take these findings and develop a method of intervention that will overcome these barriers by providing supportive mechanisms for practitioners to engage more easily with their patients on this topic. The need for increasing awareness, regular reinforcement and eventual implementation will continue.

**The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 211 issue 7.**

Stephen Hancocks
Editor-in-Chief

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## IN BRIEF

- The delivery of alcohol-related health advice to patients is advocated as one measure to moderate alcohol consumption.
- Highlights that GDPs are in an ideal position to identify excessive alcohol consumption and offer advice.
- Posits that beliefs derived from psychological models may be helpful in understanding this behaviour and may provide targets for an intervention to encourage behaviour change.



## COMMENTARY

Among those interested in reducing the burden of alcohol-related harm to society, there is much interest in the potential of 'brief interventions' delivered by healthcare professionals not specialising in the treatment of alcohol problems but seeing many excessive drinkers routinely in their daily practice. These interventions range from simple advice to more intensive, but still brief, forms of motivational interviewing. Evidence for effectiveness is strongest for general medical practice but there is a current impetus to extend the range of medical and non-medical settings in which brief interventions are offered. The starting point for the article by Shepherd and colleagues is that this list now includes, importantly, general dental practice. The benefits of such an expansion are of two kinds: first, reducing excessive drinking reduces the patient's risk for oral cancer and periodontal disease; secondly, the opportunity is provided to make improvements to the patient's general health and well-being. Advice on cutting down drinking apparently follows the example of introducing advice to quit smoking as an integral part of dental practice.

Despite these obvious benefits, however, it can be expected that the same obstacles to routine incorporation in practice will be found here as have been encountered over the years in medicine. Indeed, this is confirmed by the article's findings of a low rate of current advice-giving and of intentions by dentists to offer advice in future. The two main barriers to implementation in medical practice – lack of time and of adequate reimbursement – are likely to be repeated here and ways must be found of overcoming these and other barriers identified in the article. Another kind of obstacle is the lack of intervention methods and materials – screening instruments, practitioner guidelines, self-help materials for the patient – specially adapted for dental practice and it is noted that this is the next phase of research for this team of investigators. Lastly, while there is good evidence for effectiveness in other healthcare settings, it remains to be shown that they are also effective in dental practice; hence the need for well-designed randomised controlled trials, hopefully also on the team's research agenda.

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## AUTHOR QUESTIONS AND ANSWERS

**1. Why did you undertake this research?**

Alcohol advice provided by primary healthcare professionals is known to reduce excessive alcohol consumption. Apart from the general health benefits, an obvious link between dentistry and alcohol is provided by the known association of alcohol as a risk factor in the development of oral cancer. There is a relative paucity of information regarding whether general dental practitioners (GDPs) currently provide alcohol-related advice, despite them being in an ideal position to do so. This research was undertaken in order to further understand the current attitudes, beliefs and practices of GDPs in relation to providing alcohol advice and to inform the development of an intervention to encourage this behaviour, should one be required.

**2. What would you like to do next in this area to follow on from this work?**

The results suggest that there is scope to increase the provision of alcohol-related health advice in primary care dentistry and indicate that an intervention designed to encourage alcohol advice delivery by GDPs could be developed using this psychological model of behaviour change. An intervention would aim to target those specific issues as identified by the five key questionnaire items. The results suggest that disseminating information, or an intervention linked to increasing knowledge alone, is unlikely to encourage GDPs to provide alcohol related advice. The next phase of research will be to design, implement and evaluate an intervention to encourage GDPs to provide alcohol-related advice to patients.



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