

Preparedness of oral health practitioners for counselling clients on cannabis use

Kristen M Apothecary,* BDDSc(DH), RRDH

*Faculty of Dentistry, University of British Columbia, Vancouver, BC, CANADA

Corresponding author: Kristen M Apothecary

8 Sydenham Gardens Blvd

Wallaceburg, Ontario N8A 5H3

Canada

Kapothe@student.ubc.ca

ABSTRACT

Objective: This narrative review investigates the current evidence surrounding oral health practitioners' readiness to counsel clients on the oral health implications associated with cannabis use. As cannabis becomes increasingly legalized for medicinal and recreational purposes, concerns have emerged about its association with xerostomia, periodontal disease, caries, and other oral conditions. Oral health practitioners play a vital role in education and prevention, yet many report feeling underprepared due to gaps in education and a lack of clinical guidelines. **Methods:** A comprehensive electronic search was conducted across five databases: CINAHL, PubMed, Scopus, Google Scholar and Education Source. **Results:** A total of 17 articles met the inclusion criteria, as they addressed cannabis-related oral health concerns, the preparedness of oral health care practitioners, or communication strategies within the context of dental care. **Discussion:** Common themes in the literature include inadequate cannabis-specific education in dental curricula and continuing professional development (CPD), stigma-related communication barriers, and the absence of standardized clinical guidelines. Oral health practitioners frequently cite discomfort, uncertainty, and lack of confidence when discussing cannabis use with clients, leading to missed preventive care opportunities. **Conclusion:** Educational deficits and stigma-related barriers significantly hinder oral health practitioners' ability to provide informed, non-judgmental counselling about cannabis use. Implementing standardized clinical guidelines, enhancing curricula, and expanding access to CPD are necessary steps to support

practitioner preparedness. Strengthening communication skills and clinical training will be essential to improve oral health outcomes in the context of increasing cannabis use.

Practice Implications

Oral health practitioners are uniquely positioned to address the oral health impacts of cannabis use. This review highlights key educational and clinical gaps, including stigma-related communication barriers and the absence of standardized practice guidelines. Integrating cannabis-related education into entry-to-practice and continuing professional development (CPD) programs, along with the development of communication tools and clinical protocols, will enhance practitioner preparedness and support more informed, inclusive, and preventive oral health care.

Keywords: cannabis; counselling; health education; oral health; oral health personnel; oral health practitioners; periodontal diseases; professional competence; stigma; substance use screening

CDHA Research Agenda category: capacity building of the profession; risk assessment and management

INTRODUCTION

Cannabis is one of the most widely used psychoactive substances globally, with prevalence increasing in many regions following shifts toward legalization and decriminalization.¹⁻⁶ In Canada, recreational cannabis was legalized in October 2018, allowing individuals to possess up to 30 grams of dried cannabis and cultivate up to four plants per household for personal use.^{4,5} Similar legislative changes have occurred in several jurisdictions, including parts of the United States, Europe, and Australia, reflecting a broader international trend toward regulatory reform.¹ As cannabis consumption becomes more socially accepted and widespread, new public health considerations are emerging, including potential implications for oral health. Current evidence suggests cannabis use may be associated with xerostomia, periodontal disease, dental caries, altered immune response, delayed wound healing, and oral mucosal changes, although long-term causal relationships remain under investigation.^{2,3,6-9}

As cannabis consumption becomes increasingly normalized, oral health practitioners must be prepared to recognize these potential risks and integrate cannabis-related considerations into comprehensive oral health assessment and preventive care. Findings from Wiese et al. suggest that cannabis legalization has led to increased client disclosure related to cannabis use during health history updates, particularly regarding frequency and method of administration.¹⁰ This enhanced transparency presents an opportunity for oral health practitioners

to assess risk factors, tailor preventive interventions, and provide client-specific education on the short- and long-term oral health impacts of cannabis use.

Despite their central role as educators and prevention-focused practitioners, many oral health practitioners, including dental hygienists and dentists, report feeling ill-prepared to engage in cannabis-related discussions with clients.^{11-16,18,19} Barriers include limited formal education, lack of standardized clinical guidelines, professional discomfort, and persistent stigma, both social and self-imposed, that continues to inhibit open dialogue.^{11-16,18,19} This discomfort may result in the avoidance of cannabis-related topics during client care, contributing to missed opportunities for prevention, early intervention, and behavioural change.^{11-14,16,19} Emerging research highlights significant uncertainty among oral health practitioners when counselling clients about cannabis use, with clinicians citing an absence of communication frameworks and evidence-based tools as key challenges.^{10-13,15,16,18} As cannabis consumption becomes increasingly normalized, and as client expectations for informed and non-judgmental care grow, there is an urgent need to support oral health practitioners through targeted educational strategies and practice-ready guidance.^{4,10-13,15,16,18}

This literature review aims to synthesize the evidence regarding the preparedness of oral health practitioners to counsel clients on cannabis use and its associated oral health implications. It explores key knowledge gaps, educational deficits, communication challenges, and the lack of clinical standards

that collectively impact client-practitioner interactions. By addressing these themes, the review seeks to inform evidence-based strategies to enhance professional readiness and improve oral health outcomes in the context of increasing cannabis use. Key terminology used throughout this review is summarized in Table 1.

METHODS

A structured electronic literature search was conducted to identify peer-reviewed studies examining cannabis use, its oral health implications, and the preparedness of oral health practitioners to counsel clients regarding cannabis-related risks. Five databases were searched: PubMed, CINAHL, Scopus, Google Scholar, and Education Source (EBSCO). Searches were conducted between January and March 2025.

Search terms included combinations of keywords such as oral health practitioner, dental hygienist, dentist, cannabis use, oral health, client communication, cannabis and dentistry, and cannabis education. These terms were combined using the Boolean operators AND and OR.

Inclusion criteria were limited to peer-reviewed articles published in English that addressed cannabis-related oral health concerns, professional education, practitioner preparedness, or communication practices within oral health care settings. Studies were excluded if they did not involve oral health professionals or

if they lacked a focus on clinical communication, education, or practitioner preparedness related to cannabis use.

RESULTS

Following the removal of duplicates and screening of titles and abstracts, 43 full-text articles were assessed for eligibility. Of these, 17 studies were included based on their relevance to the research question and their contribution to understanding practitioner preparedness for cannabis-related counselling.

As this study was designed as a narrative literature review, a formal PRISMA flow diagram was not developed. However, the search and selection process followed structured review principles to ensure transparency and consistency in identifying relevant literature.

The synthesis approach allowed for the integration of findings from diverse study designs to identify recurring themes related to educational gaps, practitioner confidence, stigma, and the absence of standardized clinical guidelines.

DISCUSSION

Educational gaps in cannabis counselling

The growing prevalence of cannabis use in Canada and globally, particularly among young adults, has introduced a new dimension to preventive oral health care.^{1,4} Despite evidence linking cannabis use with increased risk for xerostomia, periodontal disease, caries, and oral mucosal conditions, few oral health

programs have integrated structured cannabis-related education into their curricula.^{2,3,6-9} Oral health practitioners, often the first point of contact for risk assessment and client education, are therefore left underprepared to discuss these issues confidently in clinical settings.^{12-14,16,18}

Grover et al. found that dental students exhibited significant uncertainty when asked about cannabis's oral effects, with many expressing concerns over the credibility of their own knowledge.¹² These findings were echoed by Mariño et al., whose research emphasized that even newly graduated dental professionals in Australia lacked familiarity with cannabis-specific oral health concerns and felt unprepared for related clinical discussions.¹⁵ Joffray and Johnson further identified that directors of dental hygiene programs in North America acknowledged gaps in curriculum design regarding emerging topics like cannabis but cited institutional inertia and lack of regulatory guidance as barriers to change.¹⁶

In Canada, the Canadian Dental Hygienists Association (CDHA) Entry-to-Practice Competencies and Standards for Canadian Dental Hygienists emphasize client-centred care, health promotion, and risk-based assessment, including the ability to screen for and address substance use behaviours. Although cannabis is not explicitly named in the document, the competencies clearly support the expectation that oral health practitioners are prepared to engage in preventive counselling related to a wide range of substances.¹⁷ This

underscores a disconnect between professional expectations and actual education received, as highlighted in this review. Incorporating cannabis-specific content into both entry-to-practice curricula and CPD would better align with CDHA's national competency framework and equip practitioners to deliver holistic, non-judgmental, and evidence-based care that addresses emerging public health issues.

Beyond entry-to-practice education, CPD options focusing on cannabis and oral health remain sparse.^{11,13,16,18} This lack of post-graduate education may contribute to the persistence of outdated beliefs or the spread of misinformation in clinical practice. Chaffee et al. found that hygienists who had not received formal education on cannabis counselling were far less likely to ask about substance use histories or offer preventive strategies.¹¹ These findings highlight broader systemic gaps in foundational education and continuing professional development.

The deficiency in education is particularly concerning given the evolving pharmacological landscape of cannabis. With an increasing diversity of product types (e.g., edibles, oils, concentrates) and delivery methods (e.g., vaping, smoking, tinctures), practitioners must now navigate not only health implications but also client misconceptions.^{3,9,12,16} Without adequate training, oral health practitioners may struggle to provide nuanced, evidence-based counselling tailored to diverse client profiles.

Stigma and communication barriers

Even when knowledge is present, cannabis-related counselling is often obstructed by stigma and practitioner discomfort. Social stigma surrounding cannabis use is rooted in its historical criminalization and moral framing, remaining a key barrier to open dialogue in dental settings.^{10,12,14,19} Clients may fear being judged, labeled, or misunderstood, leading to the deliberate withholding of cannabis use information during health history updates.^{22,23} Conversely, oral health practitioners may avoid initiating cannabis-related discussions due to fear of offending the client, concerns about legal ambiguity, or their own lack of confidence.^{9,10,12,14} In a mixed-methods study by Wiese et al., health care providers, including those in oral health, noted reluctance to address cannabis use with youth and young adults, despite recognizing its relevance to care planning.¹⁰ Similarly, Joshi and Ashley found that the absence of structured communication tools left practitioners unsure how to phrase questions about cannabis in a non-confrontational and respectful manner.⁹

This mutual discomfort can lead to a breakdown in therapeutic rapport.^{10,23} When cannabis use is not openly discussed, risk factors such as dry mouth, immunosuppression, or delayed healing may go unaddressed, resulting in suboptimal care.^{3,7,9} Research suggests that stigma-induced silence may be particularly harmful for clients who use cannabis medicinally for anxiety, chronic pain, or other conditions and may feel unfairly judged or dismissed by healthcare providers.^{22,23}

In the absence of targeted education in communication strategies, oral health practitioners are unlikely to feel equipped to engage in motivational interviewing or trauma-informed dialogue around cannabis use.^{13,14,16,18} Emerging frameworks in other health disciplines emphasize the value of cultural humility and shared decision-making; however, such models remain underutilized in dental hygiene education and practice.^{13,16}

Absence of standardized clinical guidelines

One of the most cited limitations in addressing cannabis use in dental settings is the absence of standardized clinical guidelines.⁹⁻¹¹ Unlike tobacco or alcohol, cannabis lacks clear documentation protocols, risk classification systems, or intervention pathways in most dental hygiene clinical assessment forms.^{9,11,16} This ambiguity leaves oral health practitioners without a consistent approach to client education and risk-based care.^{9,11,16}

Versteeg et al. emphasized the physiological effects of cannabis, such as delayed wound healing and altered immune response, that require tailored treatment planning, especially for surgical and periodontal procedures.⁷ However, without structured risk assessment tools, these concerns may go unaddressed in practice. Keboa et al. called for national guidelines that specifically address how cannabis use should be incorporated into oral assessments and what clinical recommendations should follow.³

Cannabis-related counselling remains a grey area in dental hygiene, with many practitioners unsure of their role due to the historical absence of formal guidelines.^{12,14,16} Although national bodies like the CDHA advocate for a broad scope that includes risk assessment and health promotion, ambiguity persists around cannabis-specific communication.¹⁷ Recently, regulators such as the College of Dental Hygienists of Ontario (CDHO) have begun encouraging cannabis use screening as part of medical history reviews.²⁴ The British Columbia College of Oral Health Professionals (BCCOHP) promotes client-centred care for individuals who use substances, including cannabis.²⁵

Despite this progress, barriers remain. These include legal uncertainty, lack of training, and the absence of standardized risk assessment tools and clinical protocols.^{9-11,16} Unlike tobacco and alcohol, cannabis is rarely integrated into routine screening or documentation forms, leaving many oral health practitioners to initiate conversations.^{9,11,16} This hesitancy is compounded by the pharmacological complexity of cannabis, its varied delivery methods, and persistent social stigma.^{3,7,12,22,23} The key barriers identified in the literature and potential strategic interventions are summarized in Table 2.

Practice guidelines could bridge this gap by providing scripting options, red flag symptoms to monitor, decision trees for product type discussions, and referral pathways.^{3,9,11,13,16} The absence of such tools contributes to inconsistent,

reactive care and reinforces a siloed model in which substance use is viewed as the responsibility of medical, rather than oral health practitioners.^{3,10,11,16}

Literature strengths, limitations, and future directions

The studies reviewed offer timely and valuable insights into the preparedness of oral health practitioners in addressing cannabis-related care. Many studies highlight consistent themes, such as educational gaps, clinical uncertainty, and stigma across diverse clinical contexts and geographical regions.^{10,12,14,16,18,22,23} The inclusion of both qualitative and quantitative designs allowed for a more comprehensive synthesis of the practitioner experience. Studies employing focus groups and semi-structured interviews offered rich, nuanced understandings of the challenges faced by oral health practitioners, while surveys provided broader insights into population-level trends.^{10,12,14,16,19,23}

Several qualitative and mixed-methods studies, such as those by Wiese et al., Sumodhee et al., and Brondani et al., provided valuable insights into practitioners' experiences and communication barriers. However, few explicitly reported using strategies to enhance methodological rigour, such as pilot testing interview guides, conducting interviews to the point of data saturation, or incorporating member checking.^{10,20,23} The absence of these details limits the ability to assess the trustworthiness and credibility of their findings and highlights the need for greater transparency in qualitative dental research.

Many studies relied on self-reported data, which can be influenced by recall bias or social desirability bias, particularly when addressing stigmatized topics such as cannabis use.^{12,14,17,19,22,23} The predominance of cross-sectional designs also limits the ability to draw causal inferences or assess changes in practitioner confidence over time.^{12,14,18}

Moreover, most of the research has been conducted in Canada, the United States, or Australia, reducing global generalizability.^{10,12,15,16} There is limited representation from underserved populations or jurisdictions with different legal frameworks, such as countries with more restrictive cannabis laws.^{1,15}

Future research should prioritize the development and evaluation of structured educational interventions that integrate both cannabis-related knowledge and communication instruction. Randomized controlled trials (RCTs) and mixed-method evaluations can assess the long-term impact of curricula and CPD programs on practitioner behaviour and client outcomes.^{13,16,18} Additionally, Delphi studies may help establish consensus on core competencies required for cannabis-related care in oral health.^{13,16}

To ensure relevance and inclusivity, future studies must also incorporate client perspectives. Currently, little is known about how individuals experience cannabis-related discussions in dental settings or which communication approaches are perceived as respectful, supportive, or stigmatizing.^{22,23} Including

diverse client voices will be essential in developing trauma-informed, culturally responsive models of care.^{19,22,23}

Finally, an emphasis on methodological rigour and representation across diverse populations will enhance the validity, ethical integrity, and generalizability of future findings, ultimately strengthening practitioner preparedness and improving client outcomes.^{12,14,15,20,21}

Clinical implications

The findings of this review have significant implications for oral health practitioners, particularly those who serve as frontline providers of preventive education and risk-based care.^{11,16} As cannabis use becomes more normalized among clients of all ages, hygienists must be prepared to assess its relevance to oral health and provide evidence-based counselling without stigma or hesitation.^{3,9,10,12}

Integrating cannabis-related questions into routine health history updates should become standard practice. Doing so enables clinicians to assess potential oral health risks, such as xerostomia, increased plaque retention, and periodontal instability, allowing for the initiation of tailored prevention strategies.^{3,7,9,23} For example, clients who report frequent cannabis use may benefit from increased fluoride exposure, hydration counselling, or earlier periodontal interventions.^{3,7,9} However, in the absence of structured communication frameworks and scripting

guidance, many practitioners remain uncertain about how to broach the topic professionally and compassionately.^{9,11,13,16}

Incorporating cannabis education into entry-to-practice programs and CPD is a critical next step. Curricular content should address not only the biological effects of cannabis but also legal, ethical, and communication considerations.^{13,16,18} Role-playing, standardized client scenarios, and motivational interviewing techniques may support the development of confidence and empathy in practice.^{13,16,18}

Clinical protocols and regulatory support are also essential. Professional associations such as the CDHA or provincial colleges should consider developing practice guidelines and documentation standards to support consistent, high-quality care.^{11,16} These tools can empower hygienists to engage in difficult conversations and ensure that cannabis use is considered alongside tobacco, alcohol, and other client health behaviours during assessments.^{3,9,11,16}

Ultimately, normalizing cannabis-related dialogue within the dental setting will improve both the quality of preventive care and the trust clients place in their oral health practitioner.^{10,22,23}

CONCLUSION

As cannabis use becomes more widespread, oral health practitioners face increasing challenges in delivering informed, evidence-based care, largely due to persistent educational gaps and stigma.^{3,9,11,13,16,22,23} This underscores the urgent need for enhanced clinical tools, improved education, and supportive

communication frameworks.^{3,7,12} This review highlights critical gaps in entry-to practice education, CPD and communication practices that undermine the ability of practitioners to provide consistent, evidence-based care.^{9,11,13,16} In the absence of standardized clinical guidelines, cannabis-related counselling remains inconsistent and underutilized across dental settings.^{3,10,11,16}

To address these challenges, it is essential to integrate structured cannabis education into dental hygiene curricula and to expand CPD opportunities.^{13,16,18} The development of standardized practice guidelines will further support practitioner confidence and foster a more unified, client-centered approach to care.^{11,16}

Future research should evaluate the effectiveness of educational interventions and explore client experiences to better inform inclusive communication strategies.^{16,18,22,23} By prioritizing education, research, and policy development, oral health practitioners can play a key role in reducing the risks associated with cannabis use and advancing preventive care in a rapidly evolving clinical landscape.^{3,9,10,22,23}

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ORIGINALITY STATEMENT

This manuscript was previously submitted to the 2025 CDHA/CJDH Student Writing Competition, where it received Honourable Mention in the literature review category. It has not been previously published, has not undergone peer review, and is not under consideration for publication elsewhere.

CONFLICTS OF INTEREST

The author declares no actual or potential conflicts of interest related to the content, authorship, or publication of this narrative review.

AI DISCLOSURE STATEMENT

No generative AI tools were used in the writing, analysis, or preparation of this manuscript.

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Table 1. Key terms and definitions

Term	Definition
Cannabinoids	The active chemical compounds found in cannabis, such as THC (tetrahydrocannabinol) and CBD (cannabidiol), which interact with the body's endocannabinoid system.
THC (Tetrahydrocannabinol)	The primary psychoactive cannabinoid responsible for the "high" sensation; associated with potential xerostomia, impaired healing, and immune modulation.
CBD (Cannabidiol)	A non-psychoactive cannabinoid noted for its anti-inflammatory properties; less associated with oral side effects compared to THC.
Delivery Methods	The ways cannabis is consumed, including smoking, vaping, edibles, tinctures, and oils, each with distinct oral health risks.
Edibles	Cannabis-infused foods or drinks; associated with caries risk due to high sugar content in many products.
Vaping	Inhalation of aerosolized cannabis products; associated with dry mouth and potential mucosal irritation, though fewer combustion byproducts compared to smoking.

Table 2. Summary of barriers and strategic interventions

Barrier	Strategic Intervention
Insufficient cannabis-specific education in dental hygiene curricula	Integrate structured cannabis-related modules into entry-to-practice programs and continuing professional development (CPD) opportunities.
Practitioner discomfort and stigma when discussing cannabis use	Incorporate motivational interviewing, trauma-informed care, and culturally sensitive communication approaches into professional practice.
Absence of standardized clinical guidelines for cannabis risk assessment	Develop national practice standards, including risk screening tools, documentation templates, and client education protocols.
Lack of structured communication frameworks to support client dialogue	Create clinical scripts, decision trees, and resource toolkits to guide cannabis-related discussions and preventive care planning.