



Information
Kit for Dental
Professionals



Oral Health for People with a Mental Illness

Information Kit

for

Dental Professionals

***Part of the Yarra Oral Health Promotion Project
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by the Department of Human Services***

This information kit has been produced by the North Richmond Community Health Centre in collaboration with Dental Health Services Victoria, St. Vincents Mental Health Service, North Yarra Community Health and the City of Yarra.

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Yarra Oral Health

Foreword

Good oral health is integral to overall health and wellbeing. Pain and discomfort associated with oral disease can result in eating difficulties, poor diet and consequently affect appearance, self-esteem and quality of life.

People with a mental illness/disability are a group vulnerable to oral disease. It is recognised that this group is likely to have poorer oral health than average, is less likely to access available dental care, unless for an emergency and is more difficult to provide appropriate and acceptable care (DHS, 1999).

The Yarra Oral Health Promotion Project aims to improve the oral health status of people with a mental illness/disability. It is one of a number of pilot oral health projects, funded by the Department of Human Services (DHS) and the North Richmond Community Health Centre.

The project model focuses upon workforce development of primary mental health and dental workers. Raising awareness and improving knowledge about oral health issues will assist workers in providing the necessary information and support to clients for improving their oral health and overcoming barriers to accessing care.

The project also fosters the development of partnerships between mental health and dental health service providers in the City of Yarra. These links provide for greater understanding between services of the issues affecting the oral health of the target group.

Special thanks to the project co-ordinator and steering committee for their contribution towards project development and implementation. The organisations represented include, the City of Yarra, Dental Health Services Victoria, North Yarra Community Health, North Richmond Community Health Centre and St. Vincent's Mental Health Service. The committee also wishes to acknowledge Colgate Oral Care for their sponsorship of the project.

The Importance of Oral Health

For Quality of Life

- To eat and talk comfortably. Pain or difficulty with eating can lead to poor levels of nutrition.
- To feel happy with appearance, maintain social interaction and self-esteem. Poor oral appearance, bad breath and dental incapacity can reinforce feelings of inadequacy, social isolation and rejection (Lemon & Reveal 1991).
- To stay pain free.

Medical reasons

- To manage medication side-effects e.g. dry mouth, gingival overgrowth, tardive dyskinesia (oral muscle spasms) and problems with speech, swallowing and taste.
- To manage effects of the illness and provide support for increasing individual's responsiveness to therapy (Lemon & Reveal 1991).
- To minimise behavioural problems due to dental pain.
- To assist with nutritional intake.
- To prevent dental emergencies through early preventive intervention.

Oral Health Profile of People with a Mental Illness/disability

Oral Health Status

- Chronic and significant oral disease is noted in this group. A number of factors contribute to this increased risk (Stiefel et al. 1990, Tesini & Fenton 1994).
- Extensive unmet oral health needs, including high need for gum treatment, restorations and extractions (Friedlander & Liberman 1991, Barnes et al 1988).
- A legacy of institutionalisation may be that some inpatients were required to have full clearance. Extractions were often a protective strategy against patients biting carers (Chalmers 2001).
- Older people in this group tend to experience more anticholinergic and tardive dyskinesia side effects. This is most likely a result of the more traditional drugs, such as Melleril, taken over long periods, compared to newer antipsychotics with less of these side effects (Chalmers 2001a).

Oral Health Behaviours

- Lower use of dental services and longer periods between visits (Barnes et al 1998).
- Irregular visits leading to increased disease, less favourable and more invasive treatment eg. extractions (AIHW 2001).
- Emergency care motivates clients to attend the dental clinic more than general care (Chalmers et al 1998).
- Poor knowledge of oral side effects of psychiatric medications despite high usage (Chalmers et al 1998).

Oral Health Needs

- Prevention and treatment services required, however need for emphasis on prevention and daily maintenance of oral hygiene before disease development (Chalmers et al 1998).
- Patient, parent, staff, and caregiver education and training required (Tesini & Fenton 1994).
- Advocacy for daily oral care to motivate and promote patient involvement to encourage independence (Tesini & Fenton 1994).

Factors Predisposing People with a Mental illness to Oral Disease

- Depressive illness is associated with disinterest in performing oral hygiene (Friedlander et al 1993, Stiefel et al 1990).
- Lacking dexterity, physical ability or capacity to perform personal oral hygiene (Barnes et al 1988).
- Neglect of a properly balanced diet, with a high sugar content e.g. soft drinks and sugary coffee (Friedlander et al 1993, Friedlander et al 1993a, Lemon & Reveal 1991).
- Sugar addictions or cravings, ‘sweet snack dilemma’, a major side effect of antipsychotic medications, lead to uncontrolled consumption of a highly cariogenic diet and subsequent weight gain.
- Xerostomia: reduction in saliva flow due to both anxiety related depression of the parasympathetic nervous system and as a side effect of long term use of psychiatric medications. This reduces natural cleansing and protection of the mouth by saliva, leading to greater predisposition to oral diseases (Friedlander et al 1993).
- Higher rates of smoking leading to increased rates of oral cancer, increasing dry mouth and reducing periodontal healing (Friedlander et al 1993).
- Prevalence of undiagnosed mental illness in the community.

Barriers to Oral Health & Accessing Care

Patient Factors

Lack of ‘perceived’ need

By patient for treatment, despite high levels of clinical need.
Often when need is perceived, the complaint is due to poor appearance (Tesini & Fenton 1994, Walpington et al 2000, AIHW 2001).

Dental fear

Anxiety due to past experiences, emergency pain and a high need for extractions and treatments which are more stressful.
Lack of ongoing links with familiar dental staff (Chalmers 2001).

Lack of knowledge

About oral hygiene & available dental services (Walpington et al 2000).

Financial difficulties

Paying for care/transport/dental aids with limited finances. Often clients are on disability pensions.

Illness characteristics

Such as withdrawal, anxiety and confusion (Lemon & Reveal 1991).

Inability to keep appointments and follow homecare instructions

Service Factors

Waiting times

Complex medical histories

Long and complex treatment plans (Freeman 1999)

Suggested Solutions

- *Support clients to identify and understand their oral health needs, the causes of oral disease and its effect on overall health and wellbeing*
- *A reassuring and caring approach is important and appointments with the same operator may be helpful*
- *Constant reinforcement of oral hygiene education*
- *Exemption from payment*
- *Provision of transport for small groups accompanied by support workers to appointments*
- *Awareness of illness symptoms. It is recommended that treatment not be attempted during a psychotic period, unless for an emergency*
- *Liaise with carers and case workers for advice on client’s current and past psychiatric state*
- *Involve caregiver/caseworker in treatment plan where possible for them to follow up, motivate and support clients*
- *Provide priority appointments suited to the client*
- *Liaison with client’s GP/case worker to obtain medical history prior to visit*
- *Often efforts seen as a waste of time. Sensitivity to patients attitudes and need for reassurance is required*

What is Mental Illness?

Mental illness is an illness with psychological or behavioural manifestations and/or impairment in functioning due to a social, psychological, genetic, physical/chemical or biological disturbance (Lemon & Reveal 1991). The illness or disorder may occur as an episodic or prolonged disturbance of mood or behaviour that significantly lessens an individual's ability to interact, work, or communicate with others effectively (Tesini & Fenton 1994).

A psychotic illness or, psychosis, refers to conditions such as schizophrenia and some types of depression.

Non-psychotic illnesses refer to illnesses such as phobias, anxiety disorders, eating disorders and some types of depression.

How to Identify Signs of Mental Illness

Signs and behaviours which may be considered abnormal:

- Deterioration in personal grooming and self-care skills.
- Disinterest in oral hygiene and general grooming.
- Withdrawal from family, friends and workmates.
- Sleeping or eating poorly.
- Extreme preoccupation with a particular theme e.g. death, politics or religion.
- Uncharacteristic neglect of household, personal or parental responsibilities.
- Deterioration in performance at school or work to the point of leaving.
- Difficulty concentrating, following conversation or remembering things.
- Talk about or write things which do not make sense.
- Panic, extreme anxiety or marked depression or suicidal thoughts.
- Loss of variation in mood e.g. flatness and lack of emotional expression.
- Marked changes in mood, e.g. from quiet to excited or agitated.
- Hearing voices that no one else can hear.

(Sane Australia 2000)

What is Schizophrenia?


Schizophrenia is a chronic psychiatric disorder characterised by thought disturbances and severely disordered behaviour (Friedlander et al 1993).

Symptoms of schizophrenia include:

- Positive: delusions, hallucinations, disordered thinking.
- Negative: flat affect, lack of motivation, lack of socialisation.
- Cognitive dysfunction: problems with concentration, memory, planning.
- Motor symptoms
- Depression and mood elevation.
- Hostility and self-harm.

Neuroleptic (anti-psychotic) medications are often used in the treatment of schizophrenia.

Clozapine (Clozaril) is commonly used as it treats both the ‘positive’ and ‘negative’ symptoms of schizophrenia (DHS 1999).

Table 1. Neuroleptics (Antipsychotics)		
	Generic Name	Brand Name
Strong anticholinergic effects  Least anticholinergic effects	Chlorpromazine	Largactil
	Pericyazine	Neulactil
	Thioridazine	Melleril
	Droperidol	Droleptan injection
	Flupenthixol decanoate	Fluanxol
	Fluphenazine decanoate	Modecate
	Pimozide	Orap
	Haloperidol	Serenace
	Haloperidol decanoate	Haldol
	Clozapine	Clozaril
Olanzapine	Zyprexa	

(Adapted from DHS Antidepressant Information pamphlet for patients, 1999)

Dental Considerations for treating someone diagnosed with Schizophrenia

- Greater oral disease and deterioration in personal grooming and self care skills.
- Hypochondriachal delusions and hallucinations centering on the mouth are common (Friedlander & Liberman 1991).

Treatment issues:

- Impaired ability to think logically.
- Propensity for substance abuse.
- Awareness of and treatment for medication side effects and possible adverse interactions with medications used in dentistry e.g. adrenaline (Sreebny & Valdini 1987).

Referral to a GP or mental health worker is suggested where bizarre behaviour may indicate an undiagnosed disorder.

What is Bipolar Mood Disorder (BMD)?

This disorder is when a person's moods, thoughts and behaviours vary between depression and extreme elation. The disorder was previously referred to as manic depressive illness. The term 'mania' describes the most severe state of extreme elation and overactivity (Dept Health & Aged Care 2000).

Manic symptoms:

- rapid thinking and speech
- grandiose plans and beliefs
- lack of inhibitions
- hyperactivity
- irritability
- reduced need for sleep

Depressive symptoms:

- loss of interest or pleasure
- loss of appetite and weight
- lack of concentration
- sadness
- apathy
- insomnia

Lithium Carbonate (Lithicarb) is commonly used in the treatment of the disorder as it effectively controls abnormal mood changes.

Dental Considerations for treating someone diagnosed with BMD

- Lithium treatment increases caries, stomatitis, xerostomia and oral cancers.
- Unique factors of the disorder cause advanced oral disease(Friedlander & Birch 1990).

Depressed state:

- Disinterest in preventive oral hygiene
- reduced saliva flow
- motivation and drive absent

Manic state:

- task oriented attention lacking e.g. toothbrushing

What is Depression?


Feeling depressed describes normal reactions of sadness or unhappiness as a result of stress, relationship problems, disappointments or frustration. When depressed feelings become chronic or long term, affecting daily life, this is referred to as ‘clinical depression’ (Dept Health & Aged Care 2000).

Symptoms of depression include:

- Anxiety, poor sleep and loss of appetite.
- Lack of concentration and energy.
- Feelings of guilt and hopelessness.
- Thoughts of suicide.

Antidepressant medications are used in the treatment of depression.

There are different types of antidepressants classed according to their mode of action. The following table includes drug classes, generic and brand names.

Table 2. Antidepressants			
Class	Generic Name	Brand Name	Anticholinergic Activity
MAOIs	Phenelzine	Nardil	
	Tranylcypromine	Parnate	
SSRIs	Fluoxetine	Erocap/Lovan/Prozac/Zactin	
	Sertraline	Zoloft	
Tricyclics	Amitriptyline	Amitrol/Endep/Tryptanol/Tryptine	Strong
	Imipramine	Melipramine/Tofranil	
	Doxepin	Deptran/Sinequan	
	Trimipramine	Surmontil	
	Clomipramine	Anafranil/Placil	
	Nortriptyline	Allegron	
	Desipramine	Pertofran	
			Weak
			Weak

(Adapted from DHS information pamphlet for patients 1999)

Dental considerations for treating someone diagnosed with clinical depression

- Depression is associated with a disinterest in performing oral hygiene.
- Impaired taste perception, for sweet foods in particular, leads to consumption of a high sugar diet.
- Decreased salivary flow is proportionate to the severity of depression.
- High prevalence of cigarette smoking in this group (Friedlander et al 1993).

Treatment issues:

- Details of current psychological status and medications required.
- Medical history, including in particular, client and familial history of cardiac disease.
- History of alcohol and illicit drug use.
- Adverse drug interactions noted between antidepressant medications and drugs used in dentistry.

What are Anxiety Disorders?

Anxiety disorders are characterised by persistent feelings of high anxiety, continual or extreme discomfort and tension and a fear of panic attacks (Dept Health & Aged Care 2000).

Common anxiety disorders include:

- Obsessive Compulsive Disorder (OCD): obsessive thoughts and/or compulsive actions causing the person distress.
- Post-traumatic stress disorder: nightmares and flash backs of major traumas experienced in the past.

Dental Considerations for treating someone diagnosed with OCD

- May show disinterest in oral hygiene self care.
- May have obsession with oral cleanliness. Practicing excessive and often ritualised brushing, causing abrasion of the teeth and gums.
- Obsessions with imagined disease or defect in physical appearance.
- Fear of body secretions e.g. saliva and HIV/AIDS.
- Reassurance in regard to denture work required – e.g. that no contamination is present.
- May have unrealistic treatment demands.
- Chronic motor tics, commonly with the orofacial region e.g. spasmodic grimaces of facial muscles and involuntary eye blinking.
- Clomipramine, a commonly used drug treatment, causes hyposalivation (dry mouth) (Friedlander & Serafetinides 1991).

General Side Effects of Psychiatric Medications

Adverse effects from antipsychotic and antidepressant medications include:

- Sedation impaired thought.
- Anti-cholinergic side effects.
- Xerostomia (dry mouth).
- Increased appetite leading to weight gain.
- Dystonic reactions (muscle spasms).
- Motor restlessness e.g. pacing, fidgeting and shifting position whilst sitting or standing.
- Drug induced parkinsonism e.g. fine tremors, rigidity and bradykinesia.
- Tardive dyskinesia: rhythmic involuntary movements of the orofacial muscles e.g. chewing, teeth grinding, grimacing, tongue protrusion, lip smacking and sucking, rapid eye blinking, staring and rotation of the eyes (Chalmers 2001).

Anti-parkinsonian drugs are often prescribed to reduce some of these side effects.

Examples of these include Benhexol (Artane) and Benztropine (Cogentin).

Newer antipsychotics such as clozapine (Clozaril), olanzapine (Zyprexa) and risperidone (Risperdal) have fewer of the side effects associated with the more traditional medications which include: haloperidol (Haldol, Serenace), thioridazine (Melleril), fluphenazine (Modecate), pericyazine (Neulactil), pimozide (Orap), trifluoperazine (Stelazine), chlorpromazine and lithium carbonate (Chalmers 2001).

Drug Interactions

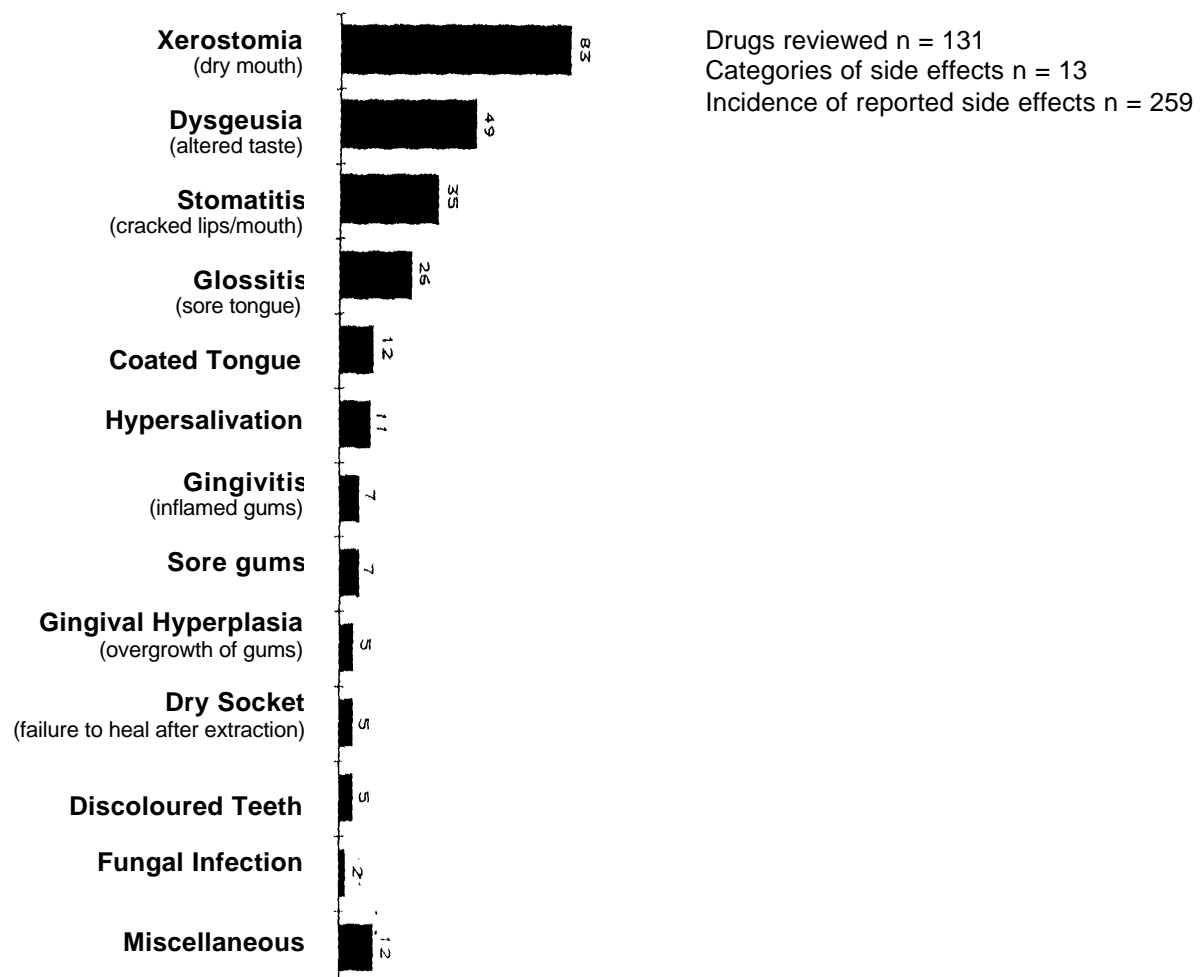
- Drug combinations can increase the side effects of medications, particularly xerostomia.
- Antipsychotic and antidepressant medications may interact with one another and other medications.
- All psychiatric medications should be checked for possible contraindications with drugs used in dentistry, as indicated in the MIMS guide.

Common Oral Side Effects of Psychiatric Medications

- Xerostomia (dry mouth)
- Muscle spasms
- Exaggerated facial expressions
- Problems eating, chewing, swallowing and with speech due to dry mouth
- Sialorrhea (hypersalivation)
- Pain response – sensitivity varies

(Friedlander et al 1993, Lemon & Reveal 1991)

Diagram 1 *Incidence of Oral Side Effects of frequently prescribed drugs*
(Smith & Burtner 1994)



Saliva and Xerostomia

Saliva secretions:

- Lubricate and cleanse the oral tissues providing protection.
- Act as a buffer to neutralise plaque acids.
- Aid speech, swallowing, chewing, and digestion.
- Have anti-bacterial properties.

(Remick et al 1983, FDI 1999)

Reduced saliva means reduced self-cleansing with food particles adhering to tooth surfaces more easily. Without saliva, acids produced by the action of plaque bacteria on dietary carbohydrates are not diluted or neutralised (Remick et al 1983).

Xerostomia

- Persistent dry mouth can be caused by systemic conditions and/or drug induced.
- Prevalence of oral dryness increases with age and use of medications.
- A wide variety of medications and illicit drugs referred to as 'xerogenic' drugs may induce dry mouth.
- The severity of dryness increases with multiple drug use.
- Anti-psychotic and anti-depressant medications can cause chronic xerostomia.

(FDI 1999, Remick et al 1983)

Oral problems associated with Xerostomia

- Rampant caries
- Plaque formation is increased
- Decreased buffering capacity
- Gingivitis
- Glossitis
- Stomatitis
- Candidiasis
- Ulcers and lesions

(Stiefel et al 1990, Sreebny 2000)

Other related problems include:

- Difficulties eating and swallowing.
- Burning sensation in tongue and lips.
- Difficulty speaking.
- Changes in taste sensation (dysgeusia).
- General discomfort and pain.
- Difficulty retaining dentures.
- Increased consumption of cariogenic fluids e.g. soft drinks to slake thirst (Friedlander & Birch 1990).

Counselling & Treatment Plan for Xerostomia

Questions to ask clients if Xerostomia suspected

- Is your mouth usually dry?
- Do you keep water at your bedside at night or do you get up at night to drink?
- Do you have any difficulties eating dry foods?
- Do you get cracked lips and soreness at the corners of the mouth?

Advocate if appropriate for:

- Use of the least anticholinergic medication.
- Reduction in the dosage of medication if possible, as xerogenic effects are dose-related.

- Provide dietary advice regarding the avoidance of highly refined carbohydrates, processed foods and carbonated drinks.
- Ensure client maintains non-sugary fluid intake e.g. water.
- Promote use of sugarless sweets and chewing gum to enhance natural saliva flow.
- Avoid alcohol and tobacco.
- Advise on possible use of artificial saliva preparations (e.g. Biotene's Oral Balance, Oralube).
- There is increasing interest in systemic pharmacological agents and stimulants of salivary function. Two available in Australia are bromhexine and pilocarpine hydrochloride. Oral pilocarpine 5mg tablets are commercially available as Salagen. Pilocarpine is a potent stimulant of exocrine secretions and should be prescribed only where appropriate due to the possibility of adverse effects of the drug (Rogers 1996, Winer & Bahn 1967).

Most importantly:

- Instruct clients in good oral hygiene maintenance – brushing teeth daily with a fluoride toothpaste (preferably twice a day or after meals).
- Recommend regular dental checkups for the long-term management of clients.
- Recommend use of a fluoride product e.g. toothpaste, rinses, gels (Remick et al 1983).

Special Needs Care for People with a Mental Illness

Dental workers require a positive and optimistic approach to client management and dental care delivery.

Guidelines include – consistency, reliability, regularity and familiarity with the same dentist. Building a trusting relationship is very important to positive outcomes (Freeman 1999).

Treatment factors:

- **Pain control:** consider and provide options for care that may be least stressful and painful to the client.
- **Preventive care:** is crucial for this client group.
- **Active follow up:** provide regular recall appointments.
- **Dietary compliance:** must be monitored during delivery of treatment.
- **Drug side effects & interactions:** awareness of current medication client taking and the possible interactions with other medications and drugs used in dentistry.
- **Informed consent:** careful explanation of treatment plan.
- **Management of emergencies:** ensure that all staff is aware of occupational health and safety procedures, in particular, for the management of psychotic episodes.

Treatment Planning:

Important Information to obtain with client permission (& involve case workers and GPs where possible)

- Medical histories (recent hospitalisations and dental history details including previous dental treatment at other clinics).
- Current medications client taking, dosages and any adverse side effects.
- Assessment of current psychological status.
- Assessment of client's ability to participate in treatment, especially to perform oral hygiene.
- Contact details of current doctors including GPs and psychiatrists.
(Walpington et al 2000)

Preventive Strategies (involving caseworkers and carers):

- Oral hygiene instruction with clients - get clients to watch, do and feel correct toothbrushing actions. (traditional educational methods using posters and model demonstrations have been less successful with this and other special needs groups) (Chalmers 2001).
- Promotion of home fluoride treatments
- Promotion of saliva-enhancing products e.g. sugar free chewing gum
- Discourage drinking of soft drinks e.g. 'coca -cola'
- Provide easy referral for a dental 'checkup' before further onset of disease which necessitates emergency and often more invasive treatment

Communication Strategies

Approaches which may be useful for different client behaviours:

Client Behaviour	Approach
Withdrawn, apathetic	Active friendliness
Suspicious	Passive friendliness
Depressed	Kind firmness
Seductive, manipulative	Matter-of-fact
Out of control	No demands

(Freeman 1999)

The C-L-A-S-S communication strategy described below may be a useful tool when dealing with clients (Freeman 1999).

Acronym	Meaning	Skills Needed
C	<i>Context of the interview</i>	<ul style="list-style-type: none"> - provide an empathetic setting e.g. quiet area - maintain eye contact - be aware of body language
L	<i>Listening Skills</i>	<ul style="list-style-type: none"> - use open ended questions - active listening
A	<i>Acknowledging</i>	<ul style="list-style-type: none"> - empathise, clarify, reflect - paraphrase using client's own words
S	<i>Strategy</i>	<ul style="list-style-type: none"> - assess client's treatment expectations - develop, propose and negotiate treatment and preventive plans
S	<i>Summary</i>	<ul style="list-style-type: none"> - provide a summary of treatment and preventive options - obtain feedback

Client Motivation

Clients fear criticism and blame

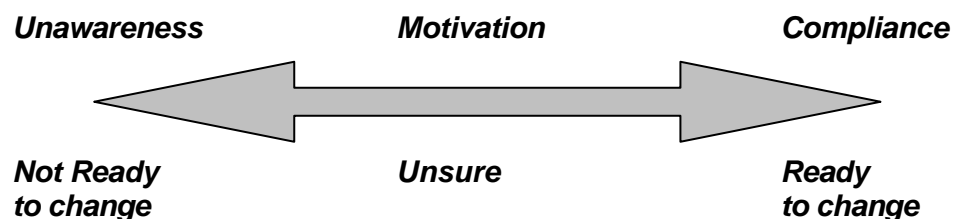
- Using an advice approach may not be successful.
- A client's resistance to change may increase, reinforcing unhealthy behaviours.
- Dental health professionals may feel their words are being ignored and become frustrated.

Health related approach

- Information should be presented in a way clients feel it is important to them, and therefore encourage ownership and acknowledge readiness to change.
- Encourage clients to participate in identifying and expressing their own dental health needs.

The Change Continuum

- Change is a slow and gradual process along a continuum from unawareness, to motivation to compliance.
- The health professional, through motivational interviewing, can identify which clients are ready to change and provide them with appropriate help and support.



Motivational interviewing

- Encourage clients to identify their oral health needs and develop their own health goals.
- Allow client to recognise lifestyle barriers.
- Readiness to change runs along a scale of 'not ready' to 'unsure' to 'ready'.
- Negotiate, implement and renegotiate goals with an understanding of the difficulties of compliance with preventative regimes for this client group.
- ***a compromised health goal may not be ideal but may be appropriate and achievable for the client at that point in time (Freeman 1999).***

Behaviour Management

Guidelines for dealing with a person with a mental illness

- Be respectful to clients as adults.
- Be calm, clear, and direct in communication.
- Be as consistent and predictable as possible.
- Set clear limits, rules and expectations.
- Accept the illness of the client.
- Attribute symptoms to the illness.
- Maintain a positive attitude, even during failures or setbacks.
- Allow the ill person to retain dignity when unable to do things.
- Notice and praise any positive steps or behaviour.
- Offer frequent praise and, separately, specific criticism.
- Focus on current functioning and achievement of the best outcomes possible in the present.
- Translate long-term goals into a series of short-term goals.
- Help the ill person attain realistic short-term goals.

(Sane Australia 2000)

Guidelines when Someone is Severely Distressed

Communicate ~ directly in an honest, understanding manner. Do not crowd or rush the person.

Calm ~ provide a calm, safe environment. Move to quieter, more open surroundings. Remove any items, which might be a danger. Seek help.

Control ~ take control of the situation. Be firm and quietly assertive in manner.

Reassure the person that help is on the way.

(Schizophrenia Fellowship of Victoria 1993)

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