Information Kit for Mental Health Workers

Oral Health for People with a Mental Illness

Information Kit

for

Mental Health Workers

Part of the Yarra Oral Health Promotion Project
An Oral Health Grants project funded 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.

YARRA ORAL HEALTH

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YARRA ORAL HEALTH

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.

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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, overgrowth of the gums, 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 et al 1998).
- 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 (caries causing) 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 gum healing (Friedlander et al 1993).
- Prevalence of undiagnosed mental illness in the community.

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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

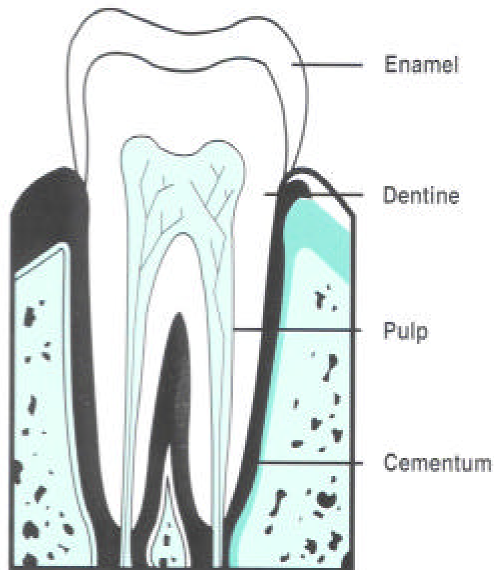
Long and complex treatment plans
(Freeman 1999)

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*

Oral Health

Tooth Structure



The **crown** is the visible part of the tooth and is covered with **enamel** This is a hard, white, shiny substance, which is the protective layer of the tooth.

The layer found under the enamel is **dentine**. This is yellowish in colour, is softer than enamel and carries sensations such as temperature and pain to the pulp.

Pulp is the innermost part of the tooth and is soft tissue made up of blood vessels, cells and nerves, which transmit pain and temperature sensations.

Cementum forms a thin layer over the root of the tooth and is similar to bone. It is yellowish in colour and also carries sensations to the pulp. If exposed by receding gums, sharp sensations when brushing teeth or eating may be experienced.
(DHS 1998)

What causes Tooth Decay (dental caries)?

Dental caries is a disease caused by the interaction of a number of factors:

- tooth structure can predispose to decay
- plaque
- carbohydrates
- acidic foods and drinks
- time
- saliva

Plaque, which contains cariogenic bacteria, is the primary cause of tooth decay (Kempe et al, 1982).

Bacterial plaque acting upon dietary carbohydrates and sugars produce acids, which decalcify the tooth structure.

Effective removal of plaque by brushing with fluoride toothpaste and flossing is essential for good teeth and gums (Sreebny 2000).

The Relationship between Teeth, Diet and Decay

The following factors need to be considered:

- **Discourage continuous eating, drinking and snacking between meals.** This increases and maintains acid production in the mouth leading to tooth decay.
- **Consistency of foods eaten** – foods that stay around the mouth longer e.g. sweet and sticky foods have more decay causing potential.
- **Acidic foods and drinks -** e.g. soft drinks, sports drinks, lemons, oranges, pickles, salad dressing, cordials, syrups and some fruit juices, consumed frequently will dissolve tooth structure.
- **Time** – these factors interplay over time to cause decay.
- **Saliva** – neutralises acid and provides calcium and phosphates for the remineralisation of enamel, saliva is very important in the protection against tooth decay. Diseases and drugs that reduce the flow of saliva increase the risk of tooth decay.
  (DHS 1998)

The Role of Saliva for Oral Health

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).

Saliva, Dry Mouth and Medications

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

(FDI 1999, Remick et al 1983)

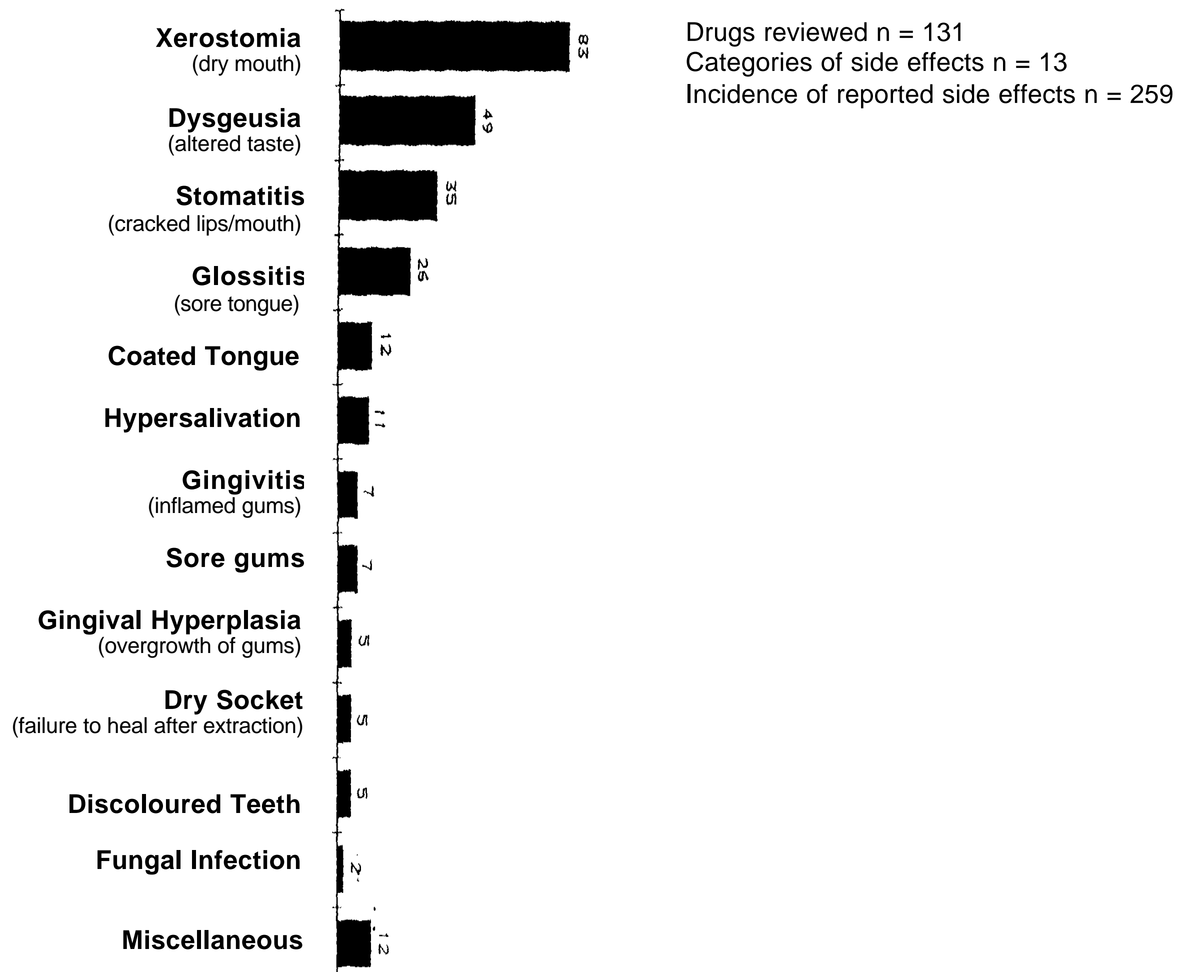
Common Oral Side Effects of Psychiatric Medications

- Xerostomia (dry mouth)
- Mouth, face and neck muscle spasms.
- Exaggerated facial expressions.
- Problems eating, chewing, swallowing and with speech due to dry mouth.
- Sialorrhea (excessive salivation).
- 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)



Oral Problems associated with Dry Mouth

- rampant tooth decay
- plaque formation is increased
- decreased saliva buffering capacity
- gingivitis (inflamed gums)
- glossitis (sore tongue)
- stomatitis (cracked lips and mouth)
- candidiasis (fungal infection)
- 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
- change in taste sensation (dysgeusia)
- general discomfort and pain
- difficulty retaining dentures
- increased consumption of cariogenic fluids e.g. soft drinks

(Friedlander & Birch 1990)

Other Common Side Effects of Psychiatric Medications

- Restlessness – pacing, fidgeting, shifting positions
- Increased appetite
- Weight gain
- Vomiting

Some of these also have a detrimental effect upon oral health.

Counselling & Treatment Plan for Dry Mouth

Questions to ask clients if dry mouth 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.
- Avoidance of alcohol and tobacco.
- Advise on possible use of artificial saliva preparations (e.g. Biotene's Oral Balance, Oralube).
- There is increasing interest in stimulants of salivary function. Two available in Australia are bromhexine and pilocarpine hydorchloride. Oral pilocarpine 5mg tablets are commercially available as Salagen. Pilocarpine is a potent stimulant of exocrine secretions and should be prescribed where appropriate due to the possibility of adverse effects of the drug drug (Rogers 1996, Winer & Bahn 1967).

Most importantly:

- Instruct patients 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 patients.
- Recommend use of a fluoride product e.g. toothpaste, rinses, gels (Remick et al 1983).

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The Role of Fluoride in Preventing Oral Disease

Fluoride

- Acts topically on teeth, promoting remineralisation of the teeth enamel and protects teeth against plaque acids (FDI 1999, Loe 2000).
- Has proven anti plaque and anti decay properties
- Has played an important role in the reduction of dental decay due to:
  - fluoridated water
  - fluoride toothpastes
  - fluoride mouthrinses and gels
- Standard, frequently used toothpaste contains 1000 parts per million (ppm) of fluoride (Loe 2000).
- 5000ppm fluoride toothpaste is a suitable regime for high caries risk groups and is available as Colgate Neutrafluor 5000, only form pharmacies and dental clinics.
- Very high consumption of fluoride may cause dental fluorosis. This is a mottling of the teeth occurring usually when the teeth are at their development stage, as in children (DHS 1998).
- A person would need to drink over 1900 litres of water containing one milligram of fluoride per litre, before toxic effects would occur (DHS 2000).
- Similarly, the average adult would need to swallow an excessive amount of high concentration fluoride toothpaste to cause any harmful effects, like vomiting.
- As with any medication, it is important to follow the prescribed directions for high fluoride toothpastes and keep them out of reach of children.

Special Needs Care for People with a Mental illness/disability

Treatment Planning:
(Important information to provide dental workers where possible)

- Medical histories (eg recent hospitalisations and dental history details for accessing earlier dental treatment information if necessary).
- Current medications client taking, dosages and adverse effects.
- Assessment of current psychological status.
- Assessment of client's ability to participate in treatment plan e.g. perform oral hygiene.
- Contact details of current doctors including GPs and psychiatrists.

(Walpington et al 2000)

Prevention Strategies:
(Involving case workers and carers)

- Oral hygiene instruction with clients by getting 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 referral for a dental 'checkup' before further onset of disease which necessitates emergency and often more invasive treatment.

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Client Motivation

Clients fear criticism and blame

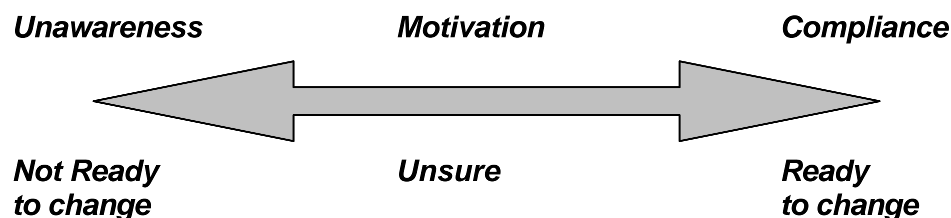
- Using an advice approach may not be very successful.
- A client's resistance to change may increase, reinforcing unhealthy behaviours
- Health professionals may feel their words are being ignored and they are wasting their time.

Health related approach

- Information should be presented in a way client's feel it is important to them, so they can take ownership and acknowledge their readiness to change.
- Encourage client's 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 patients are ready to change and provide them with appropriate help and support.



Motivational interviewing

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

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Checklist for Observation of Teeth & Mouth

1. Are teeth visibly clean?
   - free of food particles
   - excessive plaque

2. Colour & condition of teeth – note any:
   - discolouration or stains
   - plaque
   - decay
   - broken teeth

3. Any unusual swelling, lumps, sores, abscesses, bleeding – does the mouth cavity look healthy?

4. Is the client suffering from any dental pain?

5. Problems eating or refusing to eat?

6. Is the client avoiding smiling or opening the mouth to talk e.g. mumbling?

7. Bad breath or bad taste in the mouth?

8. Grinding teeth, pulling at face or chewing lip?

9. Loose or lost dentures, or doesn't want to wear dentures?

If your client is suffering any pain or has any of the above problems, refer them to a dental professional.

What does a healthy mouth look like?

- *Gums* – pink and firm
- *Teeth* – no broken teeth, no decay/cavities/soft, light brown decayed areas (changing colour to become yellowed/browned with age is normal)
- *Tongue* – free from ulcers, lumps, should be moist
- *Lips* – not cracked or dry
- *Inside cheeks* – pink, free from ulcers, lumps, white or red patches and, moist with saliva.

(Alzheimer's Association South Australia 1997)

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