B S D H

UNLOCKING BARRIERS TO CARE

Oral Health Care for People with Mental Health Problems
Guidelines and Recommendations

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INTRODUCTION

The term, mental illness, is used to describe clinically recognisable patterns of psychological symptoms or behaviour causing acute or chronic ill-health, personal distress or distress to others[1]. Mental illness is not a single 'condition' nor do mentally ill people form a homogeneous group of the sick in society. Mental illness is a continuum ranging from minor distress to severe disorder of mind or behaviour[2]. One of the primary targets of the Health of the Nation initiative is to improve the health and social functioning of mentally ill people[3]. Oral health contributes to general health, self esteem and quality of life[4] and although oral health may have a low priority in the context of mental illness, the impact of mental illness and its treatment on oral health must be addressed.

EPIDEMIOLOGY

It is estimated that in the UK, one in seven adults (aged 16-64) living in private households suffer from a mental disorder at any one time (approximately six million people)[5] of which 55% are women[2]. The commonest disorders are anxiety and depression (80% of recognised types of mental illness). Up to 2.8 million suffer from anxiety and 2.3 million from depression[2]. Depressive disorders are the biggest single category accounting for admission to hospital. Two per cent of men and 4% of women will suffer from a major depressive illness at any one time[6]. One and a half million, which is fourteen per cent of people aged 65 and over are thought to be suffering from depression[2].

The prevalence of bi-polar affective disorders and schizophrenia is estimated to be 4 in every thousand people[5]. Acute stress disorders are thought to account for 1 in 10 cases of mental illness identified by GMPs. Alcohol and drug misuse account for 1 in 20 cases (approximately 300,000). Men are more likely than women to have an alcohol or drug dependence[2].

Between 60,000-200,000 people in the UK suffer from an eating disorder. The prevalence of anorexia nervosa is reported to be 1.3 per 1000 women. Only 10% of all those affected are male. One in 500 women aged 15-25 requires extensive treatment for anorexia[7].

It is estimated that there are 700,000 people aged over 65 years who have dementia, affecting 25% of the over 85 age group and 0.6% of 40-64 year olds. Demographic changes will lead to an increase in older people with dementia. Very few elderly people who are depressed and only a quarter with dementia are known to GMP's, and only 10% are known to psychiatrists[2].

The audit commission maintains that in the course of a year, in a general population of one thousand people, about 300 suffer from mental health problems, of which approximately 230 will go to their GP, 102 will be identified as having mental health problems, 24 will be referred to outpatient clinics and 6 admitted to hospital[8]. (See Appendix 1 for diagnostic definitions).

Behaviour problems are common in childhood. However children who have a psychiatric disorder are often seen as being difficult rather than disturbed. Child psychiatric disorder would have in its definition the following features: anomalies in behaviour, emotion or thoughts
persistent for at least two weeks
severe enough to interfere with the child's everyday life
a handicap to the child, carers or both
and taking account of the child's stage of social development and the socio-cultural context[9]. Child psychiatric disorder, as defined, has a prevalence of roughly 10% in the general population, which is much the same as it is for adults. Using the term mental illness for children is not helpful. Disorder is probably more appropriate as it includes a wide range of social, family and educational factors. For example, hyperactivity is a disorder of development, not a mental illness. However, psychotic disorders are found in children.

IDENTIFICATION OF POPULATIONS

Given the reported high prevalence of mental health problems in adults, individuals can be found throughout society. Residential and day care, social work and domiciliary services provided by health and local authorities with support from private and voluntary organisations together provide care for a small proportion of people with mental health problems.

The vast majority of this diverse and changing population is not institutionalised and therefore presents problems for identification if they are not in contact with primary health care, statutory or voluntary agencies.

There are broadly three groups defined by residence or lack of residence:

- Institutions: Psychiatric hospitals
  District General Hospitals
  Secure units
  Prisons
- Residential care: Hostels
  Residential homes
  Group homes
  Sheltered accommodation
  Drug and alcohol rehabilitation centres
- Community: Private households
  Homeless people

INSTITUTIONAL CARE

These range from psychiatric hospitals, district general hospitals providing acute mental health admissions, psychogeriatric units, secure units housing mentally disordered offenders and prisons.

Psychiatric hospitals

A small proportion, approximately 0.57% of the population suffering from the most serious mental health problems requires admission to hospital for specialised care. They fall into three broad categories:

- those with long term needs for care
- those with severe mental disorders who may have experienced admission at some time
- those with acute episodes of distress such as anxiety and depression[8].

Care in the community has led to a shift in the balance of care away from large psychiatric hospitals, with a reduction in the number of beds, shorter periods of admission and ultimately closure of many psychiatric hospitals. However it is suggested that this has created a 'revolving door' effect where fewer patients are initially admitted, discharged and then readmitted, perhaps because they do not stay long enough to make a full recovery[10].

District General Hospitals

Care in large psychiatric hospitals is likely to be replaced with local hospital beds and a range of accommodation services in the community. DGHs do not traditionally have access to routine dental care and given the reported low level of knowledge of oral health by health professionals, oral health and care is unlikely to appear on the nursing / medical agenda[11-13]. Because of the transient nature of this population, the development of services is administratively complex and requires a proactive approach to ensure access to continuity of oral health care in hospital and community residence.

Secure Units

In May 1992 there were 650 places available in regional special units and approximately 1,100 places in private hospitals. Over the last few years there has been an increase in the number of independent sector mental nursing homes[14].

Medium Secure Provision

By the end of 1996 the number of NHS places will be 1,200 in the medium secure units. There are 450 places in interim secure psychiatric units with a further 2,000 in hospitals[14].

Prisons

5,000 prisoners per year are referred for NHS treatment for a mental illness. In 1991 the Institute of Psychiatry found that 37% of men and 56% of women serving prison sentences of 6 months or more may have a medically identifiable mental health problem[15]. The oral health needs of residents of secure units are addressed within guidelines for residential and continuing care[16].

RESIDENTIAL COMMUNITY CARE

Residential community care is provided in hostels, group homes, and a variety of forms of sheltered accommodation such as family fostering. Retirement and nursing homes provide asylum and sanctuary for elderly people. Care is provided by health, statutory and voluntary agencies and there has been a dramatic growth in private sector provision for this type of care.

Resettlement of 'long-stay residents' has presented fewer problems when part of a planned programme, however residents with challenging behaviour and physical problems have tended to remain in institutional care[8]. It is argued that the concept of discharge has changed and no longer means continuity of contact with psychiatric services[10]. This poses problems for continuity of other services.

A proactive approach in partnership with the agencies organising and providing residential community care is essential to identify populations and individuals in order to establish oral healthcare and access to services as an auditable standard for residential care[16].

ADULTS IN THE COMMUNITY

The vast majority of adults with mental health problems live in the community. A small proportion (2.35%) are users of mental health services and this group can be divided into adults living in private households and the homeless.

Adults in private households

A major survey reported that overall, about 1 in 7 adults (aged 16 - 64) in private households (aged 16 - 64) had a neurotic disorder[17]. Significant associations were found in relation to gender, marital status and employment status with the risk doubling among the unemployed and economically inactive compared to the employed. Alcohol or drug dependence, particularly in males, is more likely to occur in single parent family units. Other groups with high scores were women who had increased risk of a range of generalised anxiety and depressive disorders, people living alone, those living in rented rather than owned accommodation, and urban rather than rural dwellers.

Homeless people

Homeless people are described as street people, squatters, travellers, hostel and bedsitter residents, discharged psychiatric patients and people sleeping on friends' floors. It is estimated that there are between 1 and 2 million homeless in Great Britain[18]. Of the 3,000 homeless in London, more than half are in touch with specialist mental health services, of which less than 2% have been in a psychiatric hospital for more than a year and 68% for 3 months or less[18]. The mean age of this population is falling, and the rate of increase of women with and without children is outstripping that of men. The population of homeless people has a high prevalence of mental health problems including serious mental illness, alcohol and drug related problems, personality disorders and chronic stress.

It is a major problem that many homeless people are extremely difficult to locate because they are 'hidden' or hide themselves from appropriate support. Their suspicion of statutory services may be the reason that the voluntary sector is the major provider of resources and the gateway to exploring the oral health needs of homeless people. Rights under the Patients' Charter include registration with a general medical practitioner. This is a major point of entry to mental health services and provides a means of identifying those with oral health needs and demands.

ACCESS TO INDIVIDUALS AND POPULATIONS

Current Department of Health policy is that specialist psychiatric services should target their efforts on severely mentally ill people to ensure that they receive the treatment, care and follow up that they need and do not drift out of contact with services[8]. New patterns of care are being developed and delivered on a multi-agency and multi-disciplinary basis, with active participation of service users and carers[19].

GPs and Primary Care teams are the main providers of care for people with less severe mental illness and have an important role in caring for the long term severely mentally ill. Community Mental Health Teams (CMHTs) form the cornerstone of the new patterns of care and are at the leading edge of service delivery. CMHTs comprise a wide range of health professionals which include community mental health nurses, psychiatrists, psychologists, occupational therapists, dietitians, social workers, psychotherapists, counsellors, auxiliaries and carers. They provide assessment, treatment and care for individuals and groups outside hospitals and are frequently the focal point of the service covering day and hospital services, housing and support, specialist services and rehabilitation teams. Care provided during an acute phase of illness or a psychiatric crisis does not necessarily entail hospital care[19]. Other health disciplines link in when required eg dentistry, podiatry.

Access to and identification of people with mental health problems relies on an understanding of the organisation of mental health services and the key professionals involved in their care. Community mental health nurses are the most numerous professionals in mental health with a range of skills for long-term support, counselling, administering depot medication and psychological therapies.

The role of statutory and voluntary agencies must also be recognised and understood. The NHS and Community Care Act 1990 defines Social Services as the lead agency responsible for vulnerability due to ill-health or age for those who need care and support to live independently in the community. The role of voluntary agencies and charities (Appendix 3) and their local activity and involvement in care and support must also be considered. As advocates for service users, they provide a means of identifying the demands of potential clients and can assist in developing oral health care services that are client centred. Joint service planning between Health Authorities, Local Authorities, Social and Voluntary Services is a positive development and provides a forum to raise the issues of oral health and access to oral health care.

Children who suffer with mental health problems can be identified through the educational system, in liaison with psychiatric and social services, and specialist assessment units.

ORAL HEALTH

This diverse and changing population experiences similar oral and dental problems, and barriers to oral health as the general population. Whether institutionalised or in the community, they are entitled to the same standards of care as the rest of the community. However evidence suggests they have a greater risk of experiencing oral disease and have greater oral treatment needs[20-26].

There is a complex interrelationship between socio-economic factors, illness, its treatment and oral health. Cost and fear are the most commonly cited barriers to dental care[27]. Illness, whether physical or mental may lead to deterioration in self-care, and oral care may already have a low priority. Risk factors are inter-related and are often barriers to oral health. It is important to ensure that individuals have sufficient information and support in order to live independent lives including oral self care and access to appropriate dental care services.

Factors which influence oral health, mitigate against self care and affect routine access and provision of oral care include:

- Type, severity and stage of mental illness
- Client's mood, motivation and self-esteem
- Lack of personal perception of oral health problems
- Client's habits, life-style and ability to sustain self-care and dental attendance
- Environmental factors which mitigate against preservation of self-care
- Socio-economic factors which limit choices for healthy living
- Language and culture
- Lack of information on how to access information or dental services
- Oral side-effects of medication in particular the impact of xerostomia (dry mouth)
- Attitudes to oral care and knowledge of health professionals and health care workers
- Dental team's attitudes and knowledge of mental health problems
- Local dental personnel unable or unwilling to provide adequate dental care

Oral symptoms associated with psychiatric disorders

Oral symptoms may be the first or only manifestation of a mental health problem eg facial pain, preoccupation with dentures, excessive palatal erosion or self-inflicted injury. Oral manifestations of bulimia nervosa can develop within six months of onset[28] and enamel erosion is reported in sufferers of both anorexia and bulimia[29]. A third of patients attending a temperomandibular joint dysfunction clinic had evidence of a mental disorder[30]. High rates of psychiatric disorders are reported in patients attending a specialist pain clinic[31]. Burning mouth syndrome includes anxiety and depression as aetiological factors[32].

Oral symptoms in injecting drug use

Drug use is associated with significant detrimental psychological, nutritional and social change, any of which can affect the general and oral health of the user[33]. Chronic drug use is generally associated with decreased self-image, depression and lack of motivation, all of which impact oral health and adversely influence dietary habits and oral hygiene procedures[34]. Caries is high due to poor diet, high sugar intake and use of methadone linctus in syrup form[20,35,36]. There is an increased incidence of periodontal disease, due to neglect and a high incidence of smoking[20,36,37]. Trauma and dentofacial injury are common and often untreated[38].

Mood, motivation and behaviour

These are important factors that influence compliance with oral self-care and all aspects of personal hygiene. This is particularly notable in individuals suffering from dementia or memory loss[39]. Lack of interest and low self esteem associated with the disorder are factors that contribute to inadequate self-care and regular dental attendance. Depression is also often associated with a disinterest in oral self-care[40].

Access to oral health care

Lack of knowledge on how to access information or services as well as a fear of dental treatment are barriers to oral health care. The attitudes, knowledge and skills of health professionals and the dental team in providing care for people with mental health problems may affect access to information and oral care services. There may be a lack of or inadequate dental facilities and lack of support for continuity of dental care on discharge from hospital or residential care. There is a need for more extensive collaboration between mental health, social and oral health care sectors.

Irregular dental attendance

Behavioural factors may lead to poor compliance, unreliable attendance and late cancellation of appointments. Such behaviour is often a source of frustration and sometimes bewilderment, resentment and hostility to staff delivering the service[23]. Fear, anxiety and inability to meet the perceived cost of treatment may contribute to irregular attendance. Dental treatment may have a low priority in the context of ill health, poverty or homelessness particularly if there is no perceived need. For some, access to emergency pain relief will be the only requirement whereas others may be unable to cope or cooperate with treatment despite an urgent or perceived need.

Ability to accept dental care

This is related to a number of factors such as mood, motivation, self-esteem, ability to think logically, accept and understand the treatment plan, and ability to cooperate with dental treatment. Dementia affects an individual's ability to accept dental care[39]. Fear, anxiety and dental phobia are significant factors which influence acceptance of dental care[27,41,42]. Symptoms associated with psychotic illness may severely interfere with the acceptance of dental care, delaying treatment until tooth loss is inevitable. Access to prompt treatment under sedation and general anaesthesia is essential for those whose disability or anxiety limits their ability to co-operate for routine care but the question of informed consent to treatment must be addressed.

Side effects of medication

Oral and systemic side effects of medication may prejudice oral health and give rise to patient management problems in planning treatment[43]. The most common side-effect is a reduction in salivary secretions (xerostomia) which may or may not be subjectively experienced as a dry mouth. This condition has a significant impact on oral health and increases the risk of dental caries, periodontal disease and oral infections such as candidiasis, glossitis, generalised stomatitis and in extreme cases may cause acute inflammation of the salivary glands (parotitis). This may present as difficulty with speech, chewing, swallowing, poor denture tolerance, problems with retention and stability of dentures or denture trauma. It is reported that subjects respond to xerostomia by an increased intake of candy and chewing gum to promote salivation and by a greater consumption of cariogenic fluid to slake their thirst[43,44].

Dyskinesia and dystonia are distressing side effect of long term anti-psychotic medication, characterised by abnormal, involuntary movement of the tongue or facial muscles, sometimes associated with abnormal jaw movements. Tongue protrusion and retraction, and facial grimacing are frequent presentations[45]. These symptoms pose problems for patient, carer and the dental team in providing routine dental care. Dyskinesia poses difficulties in the construction of retentive dentures and interferes with the client's ability to manage and control dentures.

Drugs with oral and systemic side effects, possible interactions between drugs prescribed for oral conditions and the most frequently prescribed psychiatric drugs are summarised in Appendix 2.

Lifestyle factors

Lack of knowledge about the causes of oral disease, poor self care and embarrassment regarding neglected oral care, attitudes to and value of oral health, low perception of dental treatment needs, inability or unwillingness to accept treatment and mistrust of dental health professionals contribute to oral neglect.

Diet has a significant impact on both oral and general health. Poor diet and an increased sugar intake in drinks is reported[43]. Housing conditions, homelessness, and access to privacy for personal hygiene are issues which influence personal care. Alcohol and drug use adversely affect oral health and the combination of alcohol consumption and cigarette smoking poses a high risk for oral cancer[46]. In people who misuse alcohol, there may also be folate deficiency or anaemia with glossitis, angular cheilitis or recurrent apthae[47]. Smoking leads to an increased incidence of periodontal disease, particularly necrotising gingivitis, candidasis and xerostomia. Erosion, cervical abrasion, gingival laceration and occasionally gingival necrosis and mucosal lesions are reported in oral cocaine users[48-50].

Medical problems

People with mental health problems by virtue of their illness, disease, lifestyle or cultural practices are at greater risk of poor oral health. Oral health and dental management may also be compromised by medical problems associated with alcohol abuse, drug addiction, smoking, stress, eating disorders as well as prescribed medication.

Long term alcohol abuse compromises bone marrow function. Alcohol is a bone marrow suppressant and may cause thrombocytopaenia and leucopenia with a resultant potential for prolonged bleeding and decreased resistance to infection[45]. Alcoholic liver disease is a reported complication[51]. Cigarette smoking is a major hazard to health, contributes to the development of many diseases and may enhance immune depression.

Children with psychiatric disorders

Some of the more common medications used for behaviour disorder in children include methylphenidate hydrochloride (Ritalin) for Attention-Deficit Hyperactivity Disorder (ADHD), dexamphetamine sulphate for hyperactivity, haloperidol for challenging behaviour and in Tourette syndrome, and tricyclic antidepressants. Fluoxetine may also be prescribed for depression and in the treatment of eating disorders. Their side effects and possible interactions are covered in Appendix 2.

Children may present with management problems such that a general anaesthetic may be necessary to complete dental treatment. Dietary habits may require careful counselling and responsibility for oral hygiene may have to be reassumed by parents or carers. Care must be taken to observe for oral habits or self inflicted trauma. The clinician has a responsibility to work closely with GMP, psychiatrist and other relevant health workers to share concerns.

Professional barriers

Attitudes to and knowledge of causes and effects of oral disease among health professionals and healthcare workers are issues which need to be addressed in reducing barriers to oral health. The knowledge and skill of the dental team in managing patients with mental health problems has been cited as a barrier[52]. Low tolerance on the part of dental staff in dealing with clients' lack of compliance with oral hygiene, care of prostheses and other issues and the unwillingness or inability of local dental personnel to provide adequate dental care is reported[23,53]. An understanding dental team, aware of the problems of mental ill-health, with good patient management skills, and a sympathetic attitude, may help to allay fears.

Overcoming barriers to oral health care

The key to reducing barriers is to establish effective and ongoing communication between the client, dental team, mental health and primary care teams. Liaison with Social Services, General Medical Practitioners, Psychiatrists, Community Mental Health Teams, clients, relatives and carers is essential to enable planned referrals for continuing oral and dental care. Information on accessing dental services including emergency and specialist care should be easily available. Clients and carers, both personal and professional need access to preventive advice, oral hygiene equipment, oral health promotion literature, information on the cost of NHS dental care and eligibility for exemption from payment or reduced charges and support to maintain contact with services.

Consent for treatment should be obtained following professional guidelines[54]. Treatment planning which is client centred, realistic and flexible, and which takes into account the problems associated with mental illness is more likely to be acceptable and successful. A small number of patients will require specialist care and the use of sedation techniques or general anaesthesia. Training for the dental team in the management of clients with mental health problems, with the support of key professionals who have experience of this client group will help to reduce barriers.

HEALTH PROMOTION

Health promotion programmes developed in partnership with health, social and voluntary agencies should be client centred, tailored to meet their needs and with equal access[55]. It is reported that people with mental illness are often excluded from health promotion activities as they are perceived to be a nuisance[56]. The common risk factor approach with the dental team linking in to preventive programmes for promoting health is likely to be more effective, e.g.

To promote good mental health (information on accessing services including dental services)
To promote healthy eating including reduction of dietary sugars (dental decay)
Smoking cessation policies (periodontal disease and oral cancer)
Decrease alcohol intake (oral cancer, dental erosion)
Input to local strategies to meet national targets eg Health Improvement Programmes to reduce inequalities in health[55].

It is recommended that an oral health needs assessment is included in general health assessment by care staff[16,57-59] (See Appendix 4[57]). Each client's care plan should have an oral health input. Skill training programmes, carried out through occupational therapy to promote the activities of daily living, should include oral hygiene in personal care. Such programmes provide the opportunity to include dietary advice which promotes general and oral health in the context of skills for daily living.

ORAL HEALTH SCREENING

Epidemiological studies on the oral health needs of different client groups provides base line data for planning dental services and appropriate health promotion strategies, following which screening programmes can be established. Screening is a means of making an initial assessment and identifying those that need referral for further assessment or treatment. However, screening does not provide an holistic assessment of individual need and there may be problems of access to the population with mental health problems. There may also be problems in obtaining consent for an oral examination and clients may decline to participate in an examination.

ORAL HEALTH PROMOTION

Preventive programmes need to be tailored to meet the individual needs of clients with different diagnoses, prognoses, severity and stages of mental illness, and developed with the support and involvement of the multidisciplinary team. Close attention must be paid to the maintenance of periodontal health by promoting effective oral hygiene techniques.

Preventive advice for clients and their carers including family members is paramount. This should include instruction on the proper care and use of prosthetic devices where appropriate, and information on the oral side effects of medication. Advice on the dietary control of sugars and the importance of sugar free lubrication to relieve the symptoms of a dry mouth are essential to reduce the adverse oral side effects of anti-psychotic medication causing xerostomia. Above all, clients need encouragement and support to make regular use of dental services.

PROFESSIONAL TRAINING

All health personnel should receive training to support the concept of primary oral health care[60]. Lack of knowledge of oral and dental disease, awareness or oral need, oral side-effects of medication and organisation of dental services are highlighted in the literature[61-67]. Lack of formal training in oral health for professional carers is reported[61,66,68-70]. Training programmes for health professionals both pre and post-qualification need to be urgently addressed. However, the training needs of direct care givers employed by a range of service providers pose an even greater challenge.

For the dental team, training must include a wider knowledge and understanding of the major diagnostic conditions and the potential impact of mental illness and its treatment on oral health. With rapid advances in drug treatments, the dental profession needs to be updated on the pharmacological risks to oral health and the complexity of interactions of drugs used in dentistry. Improved communication skills, behavioural management techniques, an understanding of the organisation of mental health services and roles of mental health professionals will facilitate multidisciplinary care, networking and lead to improvements in the quality of dental services for this client group.

Health care workers are usually expected to cope and the need for support in stressful situations has been slow to be recognised by employers. Training and support groups are valuable to discuss difficult issues and help staff to be sensitive to patients' and their own needs. Studies show that nurses who have high levels of social support with which they are satisfied, report less stress and burn-out than others, regardless of the stress inherent in the job[71] and yet only one in ten Health Authorities and Trusts have a written policy on staff support[72].

CONCLUSION

People with mental health problems are entitled to the same standards of care as the rest of the population. Oral health has a significant impact on holistic health. Health professionals should therefore be aware of the impact of mental illness and its treatment on oral health. Guidelines which address the needs of this diverse client group must be non-discriminatory in practice and based on the principles of choice and equity of access to oral health care, information and services regardless of illness, financial or other personal constraints. Above all, they must focus on the demands and needs of clients. Oral health and quality oral health care contribute to holistic health. It should be a right rather than a privilege[73].

RECOMMENDATIONS FOR THE DEVELOPMENT OF ORAL HEALTHCARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

Client Centred Services

- Development of dental services which:
  a) are acceptable and accessible to clients
  b) target clients with limited access to NHS dental services.
- Oral assessment criteria to be included in psychiatric health assessment to identify:
  a) risk factors for oral health
  b) individual oral care needs and to develop a personal oral care plan
  c) appropriate oral hygiene equipment
  d) preventive measures
  e) need for and access to dental services.
- Provide oral health advice and support for clients, families and carer, appropriate to their needs.
- Provide oral health education and promotion for clients, carers and health professionals which address:
  a) the oral health needs of clients
  b) dietary issues in the context of healthy eating for oral and general health
  c) techniques for plaque control and the maintenance of gingival and periodontal health
  d) oral side effects of medication.
- Establish a dental input to multi / inter-disciplinary assessment where appropriate including
  a) procedures for ensuring access to pain relief, appropriate general and specialist dental services, oral hygiene advice and support
  b) support for health professionals and carers in oral care
  c) procedures for ensuring continuity of dental care on discharge from hospital.

Service Planning

- Establish liaison between health, social and voluntary agencies to identify clients and those living in residential accommodation without a dental service or with inadequate access to dental services.
- Epidemiological studies to identify base line data for dental service planning and oral health promotion strategies appropriate to clients' demands and needs.
- Purchasers must ensure that resources are provided to address the oral health needs of clients with mental health problems wherever they reside.

Training Issues

- Provide training for health care professionals in:
  a) the scientific basis of oral health and disease
  b) oral assessment criteria and tools for oral assessment
  c) the identification of oral health risk factors, stressors and oral side-effects of medication
  d) current oral care practices appropriate to individual needs
  e) practical oral care to motivate, encourage, support and assist clients in oral and denture hygiene
  f) eligibility for free or partial exemption for the cost of NHS dental care
  g) accessing local dental services.
- Provide formal training for the dental team in:
  a) mental illness and mental health awareness
  b) social and behavioural aspects of mental illness
  c) oral side-effects of medication and drug interactions
  d) dental management
  e) coping with aggression and handling stress
- Counselling and support for the dental team

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APPENDIX 1

DIAGNOSTIC GROUPS

In accordance with the International Classification of Diseases (WHO, 1993) the following disorders are some of the major diagnostic groups. There are other classification systems but this is the most commonly used in the UK.

Neurotic, Stress-related and Somatoform Disorders:
anxiety states including phobias, panic and generalised anxiety disorders. Also depressive disorders described as depressed mood, loss of interest, reduced energy, suicidal ideas, sleep and appetite disturbance.

Organic Mental Disorders:
dementia, delirium and brain damage which leads to a decline in intellectual functioning and memory caused by organic brain disease.

Schizophrenia, Schizotypal and Delusional Disorders:
may include delusions, hallucinations and interference with thinking plus psychotic disorders.

Mood (affective)Disorders:
profound changes in mood, either depression with reduction in levels of activity or elation with over-activity.

Disorders of Adult Personality and Behaviour:
where behaviour patterns may be dominant and inflexible to certain personal or social situations.

Mental and Behavioural Disorders due to Psychoactive Substance Abuse:
dependence or misuse of alcohol or drugs etc.

Behavioural Syndromes:
this includes anorexia and bulimia nervosa affecting mostly women who have an obsession with weight gain or body image. Abuse of non-dependence-producing substances such as laxatives, vitamins and antacids is also included in this category.

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World Health Organisation International Classification of Mental and Behavioural Disorders. ICD 10th ed, 1993

Appendix 2: Side effects of medication affecting management or oral health

The following tables illustrates the interactions that are described in the referenced literature, which may occur between drugs used to treat mental illness and those used in dentistry. Drug 1 is the mental health drug, and drug 2 is a drug of dental relevance. As new drugs become available, it is advisable to consult the British National Formulary (BNF) for further information.

DRUG 1	DRUG 2	INTERACTION
AMYTRIPTILINE	**ANXIOLYTICS & HYPNOTICS** **SYMPATHOMIMETICS** **LOCAL ANAESTHETIC WITH ADRENALINE**	**Enhanced sedative effects** **Potentiates drug 2** **Increased heart rate and blood pressure**
CANNABIS	**LOCAL ANAESTHETIC WITH ADRENALINE**	**Abnormal response to local anaesthetic**
CHLORPROMAZINE (*Largactil*)	**ANXIOLYTICS and HYPNOTICS** **ANALGESICS and ANAESTHETICS**	**Enhanced sedative effects** **Potentiation of drug 2**
CHLORDIAZEPOXIDE (*Librium*)	**OPIOID ANALGESIC** **ANTIHISTAMINE**	**Enhanced sedative effects**
CLOZAPINE	**CARBAMAZEPINE** **COTRIMOXAZOLE** **ANXIOLYTICS and HYPNOTICS**	**Increased incidence of agranulocytosis** **Increased incidence of agranulocytosis** **Enhanced sedative effects**
DEXAMPHETAMINE SULPHATE	**ADRENALINE**	**Possible hypertension**
DOTHIEPIN (*Prothiaden*)	**ANXIOLYTICS and HYPNOTICS**	**Enhanced sedative effects**
FLUOXETINE (*Prozac*)	**ANTICOAGULANTS (*Warfarin*)**	**Potentiation of drug 2**
FLUPENTHIXOL DECANOATE (*Depixol*)	**ANXIOLYTICS and HYPNOTICS**	**Enhanced sedative effects**
FLUPHENAZINE DECANOATE (*Modecate*)	**ANXIOLYTICS and HYPNOTICS**	**Enhanced sedative effects**
HALOPERIDOL	**CARBAMAZEPINE** **ANXIOLYTICS and HYPNOTICS**	**Accelerates metabolism** **Enhanced sedative effects**
METHYLPHENIDATE HYDROCHLORIDE (*Ritalin*)	**ADRENALINE**	**Possible hypertension**
PROCHLORPERAZINE (*Stemetil)*	**ANXIOLYTICS and HYPNOTICS**	**Enhanced sedative effects**
PROCYCLIDINE	**ANTIFUNGALS** **ANTIHISTAMINE**	**Reduced absorption** **Increased antimuscarinic effects**
PROMAZINE HYDROCHLORIDE	**ANXIOLYTICS and HYPNOTICS**	**Enhanced sedative effects**
RISPERIDONE	**ANXIOLYTICS and HYPNOTICS**	**Enhanced sedative effects**
THIORIDAZINE (*Melleril*)	**ANXIOLYTICS and HYPNOTICS**	**Enhanced sedative effects**

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Appendix 2: The main side effects of drugs used in mental health that are relevant to the provision of oral care are listed below.

	Xerostomia	Drowsiness	Agranulo-cytosis	Tardive Dyskinesia	Tremor	Syncope	Hypo-tension	Thrombo-cytopenia	Immuno-suppression	Apathy
AMITRYPTILINE (TCA'S)	√						√	√	√	
BENZODIAZEPINES	√	√					√			
CANNABIS	√									
CHLORPROMAZINE (Largactil)	√	√					√			√
CHLORDIAZEPOXIDE (Librium)		√								
CLOZAPINE	Hypersalivation		√	√						
DEXAMPHETAMINE SULPHATE	√				√					
DOTHIEPIN (Prothiaden)	√									
FLUPHENAZINE DECANOATE (Modecate)	√	√		√						
FLUOXETINE (Prozac)										Aggression
HALOPERIDOL	√	√								
LITHIUM CARBONATE					√	√				
LOFEPRAMINE	√			√	√					
METHYLPHENIDATE HYDROCHLORIDE (Ritalin)	√				√			√		
MONO-AMINE OXIDASE INHIBITORS	√						√	√	√	
PROCHLORPERAZINE (Stemetil)	√	√		√			√			
PROCYCLIDINE	√	√								
PROMAZINE HYDROCHLORIDE	√	√								√
RISPERIDONE	√	√								√
THIORIDAZINE (Melleril)	√	√								√

Appendix 3: Organisations

The following organisations represent clients with mental health problems both nationally and locally. Addresses were obtained from the Disability Rights Handbook, Contact and other sources. The list is not comprehensive but covers most major organisations involved with mental health. Contact organisations for general information and entitlement to benefits are included.

The **Disability Rights Handbook** is published annually by **Disability Alliance Education and Research Association**, 1st Floor East, University House, 88-94 Wentworth Street, London, E1 7SA. Tel: 0171 247 8776.

Contact is a directory of mental health services published by the BBC and Department of Health. It can be obtained by calling the Health Literature Line on **0800 555 777**.

Accept Services, 724 Fulham Road, London, SW6 5SE. Tel: 0171 371 7477. Help for people with alcohol problems, their families and friends.
African Caribbean Mental Health Association (ACMHA), Suite 37, Eurolink Business Centre, 49 Effra Road, London, SW2 1BZ. Tel: 0171 737 3603. Offers a variety of services to black clients diagnosed as suffering from a mental illness.
Age Concern England, Astral House, 1268 London Road, London, SW16 4ER. Tel: 0181 679 8000.
Age Concern Cymru, 1 Cathedral Rd, Cardiff, CF11 9SD. Tel: 02920 371566.
Age Concern Northern Ireland, 3 Lower Crescent, Belfast, BT7 1NR. Tel: 01232 245729.
Age Concern Scotland, 113 Rose Street, Edinburgh, EH2 3DT. Tel: 0131 220 3345.
Al-Anon Family Groups, 61 Great Dover Street, London, SE1 4YF. Tel: 0171 403 0888. Self-help group for relatives and friends of problem drinkers.
Alateen, 61 Great Dover Street, London, SE1 4YF. Tel: 0171 403 0888. Part of Al-Anon for young people affected by a drink problem.
Alcohol Concern, Waterbridge House, 32-36 Loman Street, London, SE1 0EE. Tel: 0171 928 7377.
Alcoholic's Anonymous, PO Box 1, Stonebow House, Stonebow, York, YO1 7NJ. Tel: 01904 644026. Has local helplines listed in the telephone directory.
Alzheimer's Disease Society, Gordon House, 10 Greencoat Place, London, SW1P 1PH. Tel: 0171 306 0606. Advice and support to those coping with dementia.
Alzheimer's Disease Society (N. Ireland), 403 Lisburn Road, Belfast, BT9 7EW. Tel: 01232 664100.
Alzheimer's Disease Society (Wales), Heol Don Resource Centre, Heol Don, Whitchurch, Cardiff, CF14 2XG. Tel: 01222 521872.
Alzheimer Scotland, 22 Drumsheugh Gardens, Edinburgh, EH3 7RN. Tel: 0131 243 1453.
Asian People with Disabilities Alliance (APDA), The Old Refectory, Central Middlesex Hospital, Acton Lane, London, NW10 7NS. Tel: 0181 961 6773. Respite care, advice and day care for elderly Asians and disabled people.
BBC Family Directory. From Health Education Authority, Hamilton House, Mabledon Place, London, WC1H 9TX
Benefits Agency Publicity Register. Tel: 01645 540000. Up-to-date information on benefits.
Black Mental Health Resource Centre, Bushberry House, 4 Laurel Mount, St Mary's Road, Leeds, LS7 3JX. Tel: 0113 237 4229. Provides counselling, support, self-help groups, information and advice in Leeds.
British Association of Social Workers (BASW), 16 Kent Street, Birmingham, B5 6RD. Tel: 0121 622 3911.
Carer's National Association, 20-25 Glasshouse Yard, London, EC1A 4JT. Tel: 0171 490 8818. Informs and supports carers.
Chinese Health Information Centre, 628 Houldsworth Street, Manchester, M1 1EJ. Tel: 0161 228 0138.
Chinese Mental Health Association, c/o S. Wan, Oxford House, Derbyshire Street, London, E2 6HG. Tel: 0171 613 1008.
Combat Stress (Ex-Services Mental Welfare Society), Broadway House, The Broadway, London, SW19 1RL. Tel: 0181 543 6333.

Contact -a- Family, 170 Tottenham Court Road, London W1 0HA. Advice and help for families caring for disabled children. Produces a directory for self-help and support groups of children who suffer from every imaginable syndrome, however rare.
Crossroads Care, 10 Regent Place, Rugby, Warwickshire, CV21 2PN. Tel: 01788 573653. Practical support to carers and people with care needs throughout UK.
Depression Alliance, 35 Westminster Bridge Road, London, SE1 7JB. Tel: 0171 633 0557. Self-help for depressives and their families.
Eating Disorders Association, National Information Centre, First Floor, Wensum House, 103 Prince of Wales Road, Norwich, NR1 1DW. Tel: 01603 621414.
Fellowship of Depressives Anonymous, PO Box FDA, Ormiston House, 32-36 Pelham Street, Nottingham, NG1 2EG. Tel: 01702 433838. Offers self-help for depressives, friends and families.
Headlines: Mental Health Media, The Resource Centre, 356 Holloway Road, London, N7 6PA. Tel: 0171 700 8129. An advocacy project which aims to broaden the mental health debate by raising the profile of users and user-led groups.
Headway, National Head Injuries Association Ltd, 4 King Edward Court, King Edward Street, Nottingham, NG1 1EW. Tel: 0115 924 0800. Help, information and support to people with problems created by head injuries.
Health Information Service. Tel: 0800 66 55 44. National freephone network designed to help callers make better use of NHS services.
Help the Aged, St James's Walk, London, EC1R 0BE. Tel: 0171 253 0253. Advice and information.
Huntingdon's Disease Association, 108 Battersea High St, London, SW11 3HP. Tel: 0171 223 7000.
Manic Depression Fellowship, 8-10 High Street, Kingston upon Thames, KT1 1EY. Tel: 0181 974 6550. Provides support, advice and information for people with manic depression, their families, friends and carers.
Manic Depression Fellowship (Wales), Palmyra Place, Newport, NP20 4EJ. Tel: 01633 244244.
Mental After Care Association (MACA), 25 Bedford Square, London, WC1B 3HW. Tel: 0171 436 6194. Provides a range of services for people with mental health needs.
Mental Health Foundation, 20 - 21 Cornwall Terrace, London, NW1 4QL.. Tel: 0171 535 7400. Funds and supports research, and funds community and self-help projects. Plays a vital role in prevention, treatment and care.
MIND, (The Mental Health Charity), Granta House, 15-19 Broadway, London, E15 4BQ. Tel: 0181 519 2122.
National Schizophrenia Fellowship, 30 Tabernacle Street, London, EC2A 4DD. Tel: 0171 330 9100. Helps people with severe mental illness, their families and carers.
Northern Ireland Association for Mental Health, 80 University Street, Belfast, BT7 1HE. Tel: 01232 328474.
Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG. Tel: 0171 235 2351.
SAD (Seasonal Affective Disorder), PO Box 989, London, SW7 2PZ. Tel: 01903 814942. Informs public and health professionals about SAD and supports and advises sufferers.
Schizophrenia Association of Great Britain, Bryn Hyfryd, The Crescent, Bangor, Gwynedd, LL57 2AG. Tel: 01248 354048. Provides helpline and information.
Scottish Association for Mental Health (SAMH), Cumbrae House, 15 Carnton Court, Glasgow, G5 9JP. Tel: 0141 568 7000.
Shelter, (National Campaign for Homeless People), 88 Old Street, London, EC1V 9HU. Tel: 0171 505 2000.
Standing Conference on Drug Abuse (SCODA), Waterbridge House, 32-36 Loman Street, London, SE1 0EE. Tel: 0171 928 9500.
Stroke Association, Stroke House, 123-127 Whitecross Street, London, EC1Y 8JJ. Tel: 0171 490 7999. Provides advice, publications and welfare grants.
Wales MIND Cymru (National Association for Mental Health), 3rd Floor, Quebec House, Castlebridge Road East, Cardiff, CF11 9AB. Tel: 02920 395123.

Appendix 4 ORAL HEALTH ASSESSMENT

Oral health assessment by health professionals provides a mechanism for opportunistic identification of clients who have oral and/or dental problems, are not receiving regular dental care and/or are at risk of poor oral health. Subjective indicators include the ability to speak, smile or eat without pain or discomfort. This example of an Oral Health Assessment may be adapted to suit any client groups or used for self-assessment. It should be used in collaboration with local dental services in order to facilitate access to an appropriate dental service. The Community Dental Service is best placed to fulfil the role of facilitator. **A response in a highlighted box may signify a need for action.**

Name: _____ **Date of birth**: _____
Mr / Mrs / Miss / Ms
Address: _____

Telephone:

1. Does the client have natural teeth? No ☐ Yes ☐

2. Does the client have dentures? No ☐ Yes ☐ Specify Upper ☐ Lower ☐
   a) If Yes, are dentures labelled? Yes ☐ No ☐ Don't Know ☐
   b) If Yes, how old are dentures? Less than 5 yrs ☐ More than 5 yrs ☐ Don't Know ☐

3. Does the client have any problems? No ☐ Yes ☐ Don't Know ☐
   e.g pain, difficulty eating, decayed teeth, denture problems, dry mouth, ulcers, halitosis, other etc. If Yes, describe problem
   Teeth ☐ Gums ☐ Denture ☐ Other ☐

4. Has the client ever smoked? No ☐ Yes ☐ Current smoker ☐ Don't know ☐

5. Is the client on medication with oral side effects? No ☐ Yes ☐ Don't Know ☐

6. Does the client need urgent dental treatment? No ☐ Yes ☐ Don't Know ☐

7. When did the client last see a dentist? Less than 1 year ☐ More than 1 year ☐ Don't know ☐

8. Is the client registered with a dentist? Yes ☐ No ☐ Don't Know ☐
   If Yes, record name and address of dentist: _____

Signature:..... **(Job title)**.....

Date.....

Adapted from Griffiths[57]