"Dental as Anything" Inner South Community Health Service Dental Outreach to People with a Mental Illness

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This article provides an overview of a unique way to respond to the complex oral health needs of people with a mental illness. People with a psychiatric disability, especially those of low income and insecure housing, are at high risk of developing oral disease, due to issues associated with mental illness, poverty and the side-effects of psychotropic medication. The 'Dental as Anything' program is a collaborative partnership between the mental health, dental and administration teams of the Inner South Community Health Service (ISCHS) in Melbourne. It provides a flexible program incorporating engagement, clinical care, education and support in response to client needs. Utilising a health promotion framework and an assertive outreach model, it accesses people who traditionally do not approach mainstream services. The program manages to "reach the unreachable".

Key words: *Mental illness, Oral health, Assertive outreach, Dental, Health promotion, Partnerships*

Poor oral health impacts negatively on nutrition, speech, appearance, self-esteem, social interactions and life opportunities. Social interactions, including talking, smiling and laughing, may become difficult for people who are self-conscious of the poor condition of their mouths, and can adversely affect a person's sense of self (Spencer, 2004). For some of the most socially and economically disadvantaged people in our community, looking after one's oral health is something that is often a long way down the list of immediate problems, such as getting enough to eat or having a safe place to sleep. People with chronic mental illness who live in rooming houses, Supported Residential Services (SRSs) and parks in the inner south area of Melbourne can receive oral health care through an innovative program.

A dentist, dental assistant and a mental health outreach worker take dentistry and mental health support to a variety of settings to provide increased services to marginalised clients. This program, now in its sixth year of operation, is part of a wider dental program of ISCHS, which delivers general oral health services and targeted oral care for homeless youth, people with HIV/Aids, people with chronic drug and alcohol issues and people with psychiatric disabilities. This article takes a closer look at the Dental as Anything program, which provides outreach dental care to people with a psychiatric disability.

ISCHS is a multi-sited agency, employing some 200 staff in multi-disciplinary teams who provide a comprehensive range of health and welfare services to the communities of Prahran, St. Kilda, South Melbourne and Port Melbourne in Melbourne's inner south. ISCHS is committed to making an impact on the health of marginalised people by delivering innovative, responsive and targeted health services and taking a leadership role in advocacy, evaluation and policy development.

The catchment area of ISCHS has one of the highest densities of people with a psychiatric disability in Victoria. The population in this area demonstrates a below-average general health status and below-average help-seeking activity for mental health problems (Department of Human Services, 2004). Mental health support services in this area include Alfred Hospital acute and community-based psychiatric services, residential psycho-social rehabilitation programs, Sacred Heart Mission, Salvation Army Crisis Services, a number of drop-in services, a comparatively high number of SRSs, Hanover Housing, Support and Research Services, and services provided by ISCHS, such as the Psychiatric Disability Support Outreach Service and Assertive Mental Health Outreach Program.

Client profile snapshot

Clients of Dental as Anything live in the catchment area detailed above and in areas of Malvern

and Elsternwick, have a chronic mental illness and associated psychiatric disability. They are likely to have been previously institutionalised and then moved into the community due to de-institutionalisation occurring in Victoria during the 1980-90s, when the large psychiatric hospitals were closed (Singh & Meadows, 2001). Clients may have a drug and/or alcohol dependency, are likely to be on psychiatric medication, have a low socioeconomic status and be living in insecure accommodation or be homeless. Generally these clients do not have a great deal of support where they live; this is especially notable for clients in private rooming houses, private hotels and the homeless. They are unlikely to access mainstream health, support or oral health services and generally suffer from poor general health.

Specific issues for the client group

Co-morbidity, the occurrence of more than one mental disorder or a mental disorder with other health problems, is common among this client group (Andrews, Hall, Teesson, & Henderson, 1999). Substance use issues are particularly high among people with mental illness, with up to half of those diagnosed also suffering from a substance use problem (Commonwealth Department of Health and Aged Care, 2000). Contributing factors to poor oral health for this client group include issues associated with illicit drug use and adverse effects of psychiatric medications (Bahn, 1972; Friedlander & Brill, 1986; Friedlander & Liberman, 1986).

Poor gingival (gum) health and multiple carious (decayed) teeth are common among this client group (Valenza, Franklin, Simmons, & Godwin, 2005) and both of these diseases can lead to tooth loss and reduced oral function. Multiple missing teeth are common in this client group and higher-than-average levels of edentulism (no natural teeth remaining) occur. Gum disease is pronounced and exacerbated by high levels of tobacco use, with approximately 70% of clients smoking (refer to Figure 1) compared to less than 20% of the general Australian public (Department of Health and Ageing, 2004). Additionally, the following factors can contribute to poor oral health in this client group:

- A dry mouth, which can be a side-effect of (psychiatric) medication, increasing the effects of plaque acids
- Frequent consumption of sugary drinks and food, increasing caries and gum disease
- Neglect of personal oral care
- Presence of other medical conditions
- Poor nutrition (low income, lack of nutritional knowledge, poor or no cooking skills and facilities)
- Low income which limits access to mainstream services.

The client group often experiences high level of transience. Transience dislocates people from support systems. Irregular health care and irregular contact with health care providers leads to inadequate (often no) treatment, incomplete treatments, exacerbated conditions, and reduced (or no) client–practitioner relationships. The compounded result is a client group with chronic and complex health needs and poor help-seeking behaviours being poorly linked to practitioners who have the capacity to provide support and administer treatments.

Furthermore, many clients display extreme dental phobia, high anxiety and/or paranoia. This may be due to a range of factors including traumatic past dental experience, unfamiliarity with medical and dental environments and procedures, and fear health care professionals will judge their personal neglect. This client group has a relatively high rate of broken appointments and for those who do attend, treatment refusal rates are higher than for other client groups. Treating this client group is more time intensive due to:

- Complex treatment needs
- The need for a break during treatment
- Unpredictable behaviour
- Difficulty in obtaining medical history requiring consultation with other health professionals.

Taking dental care to the people

Dental as Anything Outreach Dental Program July 2004- June 2005

Dental as Anything developed from concerns of mental health workers about the high dental needs of many of their clients combined with reluctance to attend a dental clinic. Many clients have not seen a dentist for years, some as long as 25 or 50 years. Staff were successful in obtaining funding from the Victorian Department of Human Services to commence this outreach dental program with the aims of making personal contact, overcoming patients' fears and providing a free dental service.

Multiple barriers have been addressed to increase this population group's uptake of oral health care. Dental as Anything was developed utilising a number of specific strategies and frameworks including:

- Assertive outreach
- Health promotion
- Cross-team collaboration
- Efficient, flexible and sensitive clinical care
- Block funding model, which guarantees a fee-free service
- Peer modelling.

Assertive outreach is described as:

> *A "client-seeking" approach, where the worker actively locates the client (or client target group) in their environment and then take responsibility through an engagement process, to ensure that the client's needs are identified and addressed. It is a relationship-based style of interaction where workers need to be seen, become known and be available, so as to become accepted by the client.* (Victorian Department of Human Services, 2001)

The Dental as Anything team provide weekly two-hour sessions and rotate through venues including SRSs, community-managed rooming houses, private rooming houses, private hotels, local support services, health and housing services and parks frequented by homeless, marginalised and/or Koori people.

ISCHS delivers all services within a health promotion framework, based on the Ottawa Charter for Health Promotion (Watt, 2005; World Health Organization [WHO], 1986). To ensure ongoing good oral health and prevent future problems, staff provide oral hygiene instruction (OHI) where a client's functionality is high enough to comprehend. Furthermore, dentists provide education sessions to staff at SRSs and Mental Health Clinics, which are complemented by written materials. Staff advocate for program and policy development to address the dental health of mental health clients and their access to appropriate health services. The combination of health promotion and assertive outreach appears to be critical in delivering effective programs to this client group (Vigild, Brinck, & Christensen, 1993; Watt, 2005).

Dental as Anything is based on cross-team collaboration. The commitment and collaboration from the dental, mental health and administration/ reception teams is a primary success of the program. It is unlikely that any of these teams on their own would be successful in engaging and facilitating oral health treatments for this client group. The three teams collectively deliver efficiently administrated, flexible and sensitive clinical care.

One administration staff member is responsible for the Dental as Anything operations. They ensure the outreach team are supplied with available appointment lists, medical history forms, registration forms, appointment slips and data collection sheets; they also manage vehicle bookings. Following each outreach session, the administration worker transfers appointments and notes to the clinic's computerised appointment and client records system. One week prior to each appointment they send reminder letters to clients. On a monthly basis they collate program data.

Reception staff at the clinic site are the first site-based staff new Dental as Anything clients have contact with. They are trained by ISCHS to understand clients' complex needs, practice

effective communication and provide efficient, supportive and friendly contact. They answer preliminary questions, often provide reassurance and manage future appointments.

The mental health assertive outreach worker engages with clients in a respectful and sensitive manner in environments that are familiar to clients. The outreach worker obtains a medical history and at the same time can make a preliminary assessment of complementary supports that may support a client's holistic health. They are the linkage between the client, mental health support workers (that provide long-term case management), accommodation support staff, dental staff and administration. They manage the venue rosters and coordinate staff attendance. They support SRS, rooming house and hotel staff to book resident appointments and display oral care information. Outreach workers liaise with case managers and accommodation staff to ensure support is provided for clients to attend dental treatments. The mental health outreach worker and mental health case manager are vital to the ongoing engagement of clients, enhancing the likelihood of successful clinical outcomes.

Once a medical history is obtained, the dentist and dental assistant conduct an oral examination using individual sterile examination packs assembled by the dental assistant that include mirror, probe, periodontal probe, gloves and mask. Examinations take place in an area of maximised light and privacy. This may be a lounge room, office, kitchen or a quieter area in a park. The findings and OHI are discussed with the client using visual instruction tools including posters, handouts, large plastic mouth models and toothbrushes. An appointment is made for follow-up treatment at the clinic and clients are provided with written information of their anticipated treatment plan, referral details, dentists' names and clinic details, including maps and public transport information. Outreach workers, mental health case managers and accommodation staff are also provided with appointment details.

Clinical care is also delivered in a sensitive and empathetic manner, taking people's experience, functionality and anxiety into account. The delivery of a fee-free service is paramount for access to treatment for this client group who would otherwise be unable to attend due to low income and competing financial priorities (while noting there are co-payments for denture care). The block funding models allows dentists adequate time per client to address the issues noted earlier—of complex treatment needs, dental phobia, regular breaks during a treatment sessions and unpredictable behaviour.

The periodic return to venues not only familiarises current or future clients with the service, it also provides the opportunity for peer modelling. Some of the most anxious and reluctant potential clients see their peers undergo examinations and attend the dental clinic for follow-up treatment. Concurrently they become familiar with dental staff and outreach staff in an environment less intimidating than a dental clinic. The "peer modelling" works particularly well in outreach sessions in park settings where higher ratios of people are homeless.

Figure 1: Dental As Anything Outreach Dental Program – July 2003 to June 2004

	Clients seen	Male	Female	Smokers	Edentulous	Dentate	Carious teeth	Missing teeth	Teeth indicated for extraction	Attended first appointment	Course of care completed	Victorian Denture Scheme/other referral	Preio probing 4-7mm
TOTAL	273	195	78	187	N/A	N/A	807	1730	301	171	85	N/A	160
Percentage of total clients	-	71%	29%	68%	-	-	-	-	-	63%	31%	-	59%
Average per client	-	-	-	-	-	-	3.0	6.3	1.1	-	-	-	-

Figure 2: Dental As Anything Outreach Dental Program – July 2004 to June 2005

	Clients seen	Male	Female	Smokers	Edentulous	Dentate	Carious teeth	Missing teeth	Teeth indicated for extraction	Attended first appointment	Course of care completed	Victorian Denture Scheme/other referral	Preio probing 4-7mm
TOTAL	220	155	65	148	16	204	582	1678	306	112	75	24	138
Percentage of total clients	-	70%	30%	67%	7%	93%	-	-	-	51%	34%	11%	63%
Average per client	-	-	-	-	-	-	2.6	7.6	1.4	-	-	-	-

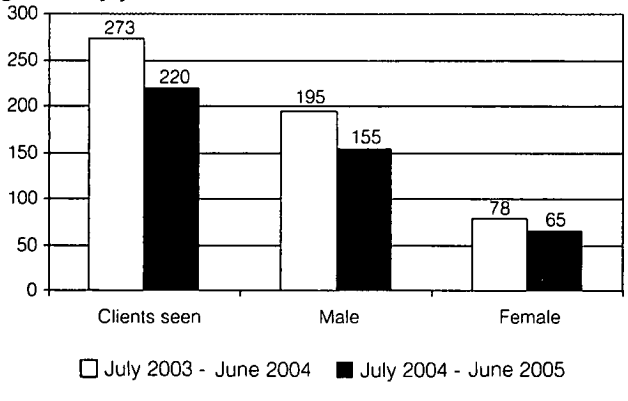
What have we delivered?

During the period July 2003-June 2004 Dental as Anything saw 273 people in their outreach visits, 71% of whom were male and 29% female. The 273 clients were missing 1730 teeth (6.3 per person), had 807 carious teeth (3.0 per person) and 301 teeth required extraction (1.1 per person). Of those clients with whom contact was made, 171 (63%) attended their first appointment and 85 (31%) completed their course of care.

Data for July 2004-June 2005 provides a similar picture. Two hundred and twenty-two people were visited, with a similar gender split as the previous year. The 220 clients were missing 1678 teeth (7.6 per person), had 582 carious teeth (2.6) and 306 teeth (1.4 per person) were indicated for extraction. After initial contact was made, 112 (51%) clients attended their first appointment and 75 (34%) completed their course of care.

The average number of missing teeth per Australian public dental patient (who as public patients are generally from lower socioeconomic backgrounds) was 5.7 in 2001 (Australian Institute of Health and Welfare, 2002). It is difficult to compare oral health data for Australians without a mental illness, not living in poverty and/or with secure adequate housing, as available national data is dated. Anecdotal evidence suggests that oral disease rates in the Dental as Anything client group are much higher than those for Australians without a mental illness.

Figure 3: Dental as Anything program: Clients by gender by year.

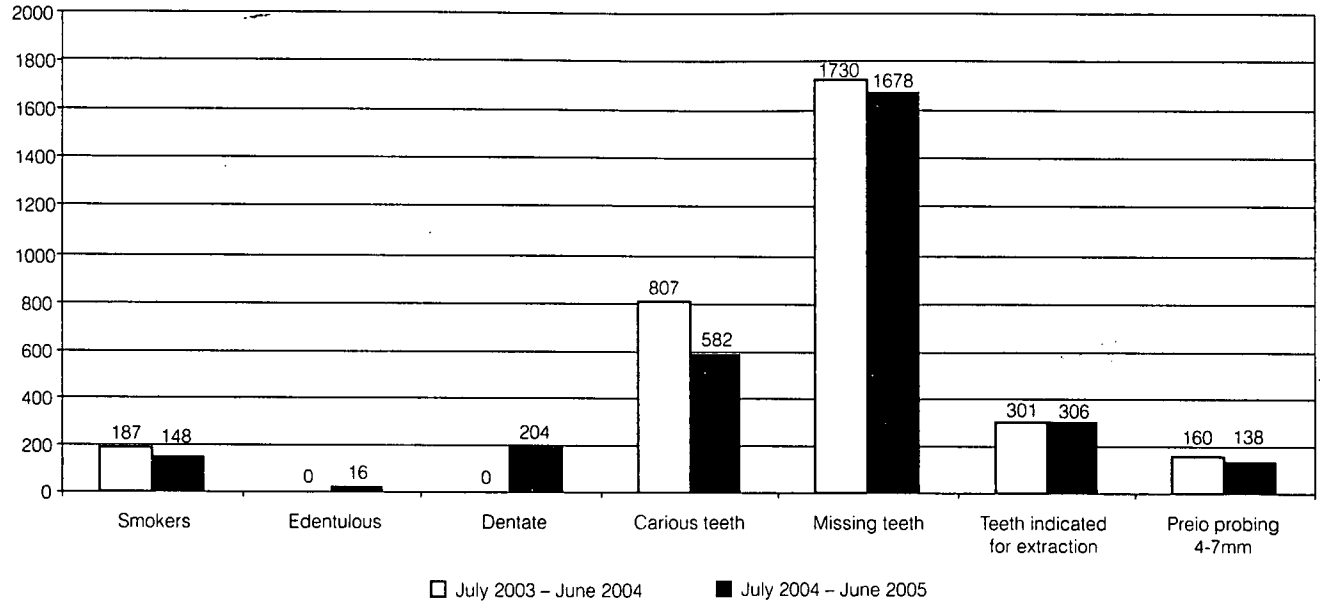


During 2004 the Dental as Anything program was struggling to meet demand. Without additional resources to extend outreach and clinical hours the program revised several program parameters. Firstly the eligibility criteria were tightened to clients in receipt of government pensions only, predominantly Disability Support Pensions, where previously clients on unemployment benefits had been eligible. This in turn targeted outreach visits to SRSs over rooming houses. As a result the average client's level of disability and complexity of issues increased. The number of clients seen per visit was capped to ensure adequate time was available for each client. These factors are supported in the comparison of the 2003-2004 and 2004-2005 statistics.

The total number of clients decreased slightly due to the increased targeting and the capping of clients per sessions. The percentage of female clients rose marginally, reflecting the shift in focus to SRSs where women residents are more common than in private rooming houses.

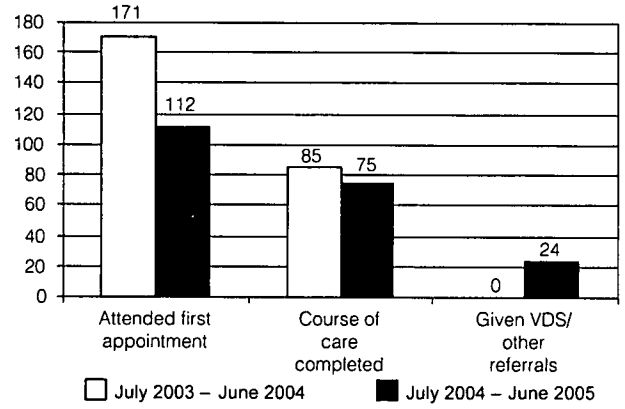
The authors acknowledge that oral health trends are difficult to identify is small quantities of data. What can be drawn from the 2003–2005 oral health issues data is that as the program tightened eligibility, the incidence of serious ailments rose; the numbers of missing teeth and teeth indicated

Figure 4: Dental as Anything program: Occurrence of oral health issue by year.



for extraction increased as did the percentage of clients whose perio probing results were 4-7mm (indicating medium to serious gum disease).

Figure 5: Dental as Anything program: Clients attending first appointment and completing course of care.



It is a pronounced success of the program that, over two years, 160 clients with psychiatric illnesses, complex health issues—many of whom were homeless at first contact—completed courses of dental care. As stated earlier in this paper it is believed to be extremely unlikely such clinical outcomes would have been achieved without the mental health, dental health and aministration teams' partnership approach.

Workforce issues

Part of the learnings from delivering this program relate to workforce development issues and opportunities. Recruiting and retaining dentists, dental assistants, social workers and psychiatric nurses to the community health sector is problematic, primarily as funding does not allow for remuneration that is competitive with other sectors (including private practice and the acute health sector). ISCHS aims to meet this challenge by providing staff with stimulating work environments, skills expansion and professional development opportunities. Mental health outreach team members and the dental program staff are exposed to new opportunities and issues through this project. They have been active in the conceptualisation, development, implementation and running of the program. They have presented at the 2004 National Mental Health Services Conference and designed and delivered extensive peer education sessions.

Dentists are exposed to mental health clients to a far greater degree, developing an understanding of the complex needs and the coordinated care required to deliver effective services to this client group:

> *It's a whole different world from what I do with the rest of my time; it adds interest to my work. It's the sort of stuff not many dentists, not many at all, get to do! Working closely with the other teams, it broadens my focus. They've got great experience and knowledge I learn from, intellectually and professionally.*
> (Dr Andrew Neil, ISCHS Senior Dentist)

All dentists at ISCHS work with patients from diverse backgrounds and experience-challenging clinical situations. For Dental as Anything dentists and dental assistants these experiences are magnified, at times distressing and often extremely rewarding. It takes committed, experienced, brave,

innovative and energetic staff, who are willing to continually expand their skills, to undertake this work.

Mental health staff members have increased their knowledge about dentistry and oral health care. Their appreciation of the impacts of poor oral health is heightened, and their commitment to advocate for this area of their clients wellbeing is strengthened. All workers report a sense of challenge and satisfaction in taking the "service to the people":

> *....the greatest thing is meeting a new client and finding out they haven't seen a dentist for 30 years and knowing we've made that effort, and are the first to make contact...that feels great... It feels fantastic.* (Robert Lewis, ISCHS Mental Health Outreach Worker)

Sustainability

Funding is required to continue Dental as Anything on an ongoing basis. Funders must accept outreach services, long consultations and health promotion as essential program components and fund accordingly.

Skilled dental, mental health, administration and reception staff are essential, therefore funding needs to ensure adequate remuneration to attract, continually up-skill and retain appropriate staff.

Planning, monitoring and evaluation are important to this unique program to ensure it meets the needs of clients and continues to complement the existing oral health service system. There is no pretence that the current model is best practice, rather it is good practice; an informed professional response to a service gap that requires continual learning and development. While not yet formally evaluated, an evaluation is planned for this program. Particular attention will be paid to evaluation methods taking into account the complex issues of the client group including transience, low literacy, psychiatric disabilities, and resistance to forms and questioning.

Dental as Anything's integration into the existing health and support service system assists sustainability. The program does not operate in isolation, does not duplicate nor conflict with other programs, and encourages coordination across multiple support providers. Extensive consultation during the conceptualisation, implementation and delivery of the program encourages cooperation and ownership. The same level of consultation, including client consultation, will inform the evaluation.

Conclusion

Marginalised people with mental illness have poor access to oral health services. Innovative program responses are required to "reach the unreachable". The demand for the Dental as Anything program demonstrates the need for this service, as do the client outcomes. Oral care has been increased to the client group; health promotion is delivered to clients, support staff and the broader sector; clients are engaged with mental health programs, residential services and social networks; and program staff are reporting substantial professional and personal rewards.

Acknowledgments

The authors would like to acknowledge and thank Karen Barnett, David Sharp, Colleen Slater, and Maureen Williams, all of ISCHS. ISCHS grateful acknowledges the Victorian Department of Human Services for Dental as Anything funding.

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