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# Oral Health in Patients with Mental Illness

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**Abstract**

Mental illness is a continuum ranging from minor distress to severe disorder of mind or behaviour. One of the primary targets of the health of the nation initiative is to improve the health and social functioning of mentally ill people. People with mental illness are often excluded for health promotion activities as they are perceived to be a nuisance. The common risk factor approach with the dental team linking in to preventive programmes for promoting health is likely to be effective. The goals of this article reviews the oral manifestations of mental illness, effect of medication of mental illness on oral health, medical problems, training programmes and health promotion for oral health.

## INTRODUCTION

Oral health contributes to general health, self esteem and quality of life 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. 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.[1] Illness, whether physical or mental may lead to deterioration in self care, and oral care may already have a low priority. 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.

## ORAL MANIFESTATIONS ASSOCIATED WITH MENTALLY ILL PATIENTS

Oral symptoms may be the first or only manifestation of mental health problem eg. facial pain, preoccupation with dentures, excessive palatal erosion or self injury. Oral manifestations of bulimia nervosa can develop within six months of onset[2] and enamel erosion is reported in suffers of both anorexia and bulimia.[3] A patients attending a temperomandibular joint dysfunction clinic had evidence of a mental disorder.[4] High rates of psychiatric disorders are reported in patient attending a specialist pain clinic.[5] Burning mouth syndrome includes anxiety and depression as aetiological factors.[6] 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.[7] Caries is high due to high sugar, poor diet and use of methadone linctus in syrup form.[8,9] There is an increased incidence of periodontal disease, due to neglect and high incidence of smoking.[10] Trauma and dentofacial injury are common and often untreated[11].

## ORAL MANIFESTATIONS OF MENTAL ILLNESS DRUGS

The most common side effects is a reduction in salivary secretions which may or may not be subjectively experienced as a dry mouth. This condition has a significant impact on oral health and increase the risk of dental caries, periodontal disease and oral infections such as candidiasis, glossitis, generalized stomatitis and in extreme cases may cause acute inflammation of the salivary gland. This may present as difficulty with speech, chewing, swallowing, poor denture tolerance, problems with retention and stability of dentures or dental trauma. Dyskinesia and dystonia are distressing side effect of long term anti-psychotic medication, characterized by abnormal jaw movements. Tongue protrusion and retraction and facial grimcing are frequent presentations.[12] Dyskinesia poses difficulties in the construction of retentive dentures and interferes with client's ability to manage and control.

## LIFESTYLE FACTORS, MEDICAL PROBLEM AND ORAL HEALTH

Lack of knowledge about the cause 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. Poor diet and an increased sugar intake in drinks is reported.[13] 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 at high risk for oral cancer.[14] Smoking leads to an increased incidence of periodontal disease, erosion, cervical abrasion, gingival necrosis and other mucosal lesions are reported in oral cocaine users.[15] An alcohol user, there may be anemia with angular cheilitis, recurrent apthae and glossitis.[16] Alcohol is bone marrow suppressant and may cause thrombocytopaenia nad leucopenia with a resultant potential for prolonged bleeding and decreased resistance to infection.[12]

## BARRIERS

Dementia affects an individual's ability to accept dental care.[17] Fear, anxiety and dental phobia are significant factors which influence acceptance of dental care.[18] The knowledge and skills of dental team in managing patients with mental health problems has been cited as a barrier.[20]

## SCREENING AND ACCESS ORAL HEALTH

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 is a need for more extensive collaboration between mental health, social and oral health are sectors.

Screening is a means of making an initial assessment and identifying those that need referral for further assessment of treatment. 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.

## TRAINING PROGRAMMES

Lack of formal training in oral health for professional carers is reported.[20] Training programmes for health professionals both undergraduate and post graduate need to be urgently addressed. For the dentist's, 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.

## ORAL HEALTH PROMOTION

Preventive advice for clients and their cares including family members is paramount. 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. Health promotion programmes developed in partnership with health, social and voluntary agencies should be client centered, tailored to meet their needs and with equal access. The common risk factor approach with the dental team linking in to preventive programmes for promoting health is likely to be more effective. It is recommended that an oral health needs assessment is included in general health assessment by care staff.[21]

## CONCLUSION

People with mental health problems are entitled to the same standards of care as the rest of the population. Health professionals should therefore be aware of the impact of mental illness and its treatment on oral health. Training programmes for health professionals both pre and post qualification need to be urgently addressed. Joint service planning between health authorities, local authorities, social and voluntary services is a positive development and provides forum to raise the issues of oral health and access to oral health care.

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