



HOLES IN THE SYSTEM

Oral health for
Australians with
intellectual disability

Oral Health Issues

People with intellectual disability

Incidence

Tooth decay is nearly three times more common and 58% of adults with intellectual disability have untreated caries.

Higher rates of extractions and decay leading to higher rates of missing teeth – extraction rather than filling is more likely to occur with resultant impact on image.

Earlier and more extensive periodontal disease

Very few wear dentures

Risk Factors

Inadequate plaque removal

- ▶ Poor manual dexterity and lack of knowledge of good oral habits
- ▶ Higher plaque scores

Poor diet

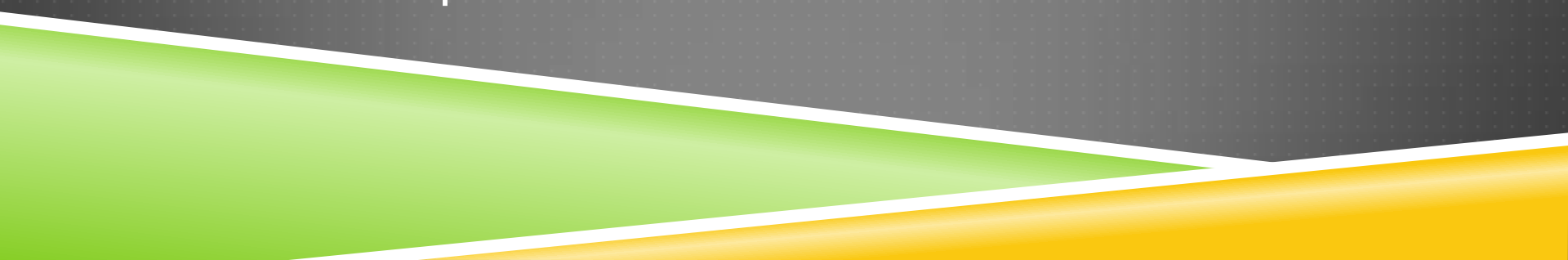
Increased risk of **GORD** (gastro-oesophageal reflux disease) and therefore **dental erosion**

Drug effects (dry mouth, hypersalivation)

Damaging oral habits

- ▶ teeth grinding, mouth pouching, mouth breathing, self-injurious behaviour

More Risk Factors

- ▶ Effects of institutional neglect and/or care provider ignorance
 - ▶ Access barriers (poor attitudes, effect of poverty, uncoordinated care)
 - ▶ Syndrome specific vulnerabilities e.g. Dysphagia Cerebral palsy, gum disease in Down syndrome
 - ▶ Malocclusion and muscular abnormalities
 - ▶ Inability to tolerate daily dental hygiene
 - ▶ Irregular dentition
 - ▶ Teeth trauma
 - ▶ Little focus on prevention
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Associated Issues

Pain associated with unrecognised dental issues is strongly associated with challenging behaviour

Fear and anxiety impact upon patient co-operation and therefore access to dental services

Better oral health outcomes are largely dependent on knowledge, attitudes and support of care providers

The current scene in Australia

2009-2010 review of services

Kelsey Moore on behalf of QCIDD



Good oral health practice – what dentists can teach us

- ▶ Use of non-verbal messages generally
- ▶ Watching for non-verbal indicators of pain
- ▶ Simple teaching of techniques for self-care
- ▶ Awareness that consultations can be paced
- ▶ Simple teaching of basic principles of good health

“You cannot be healthy without oral health. A good diet is a good dental diet.”

Australian Dental Association

Westmead

- ▶ Interdisciplinary approach to treatment
- ▶ Easy access for referral to other medical specialists
- ▶ Access to general anaesthesia and sedative services for high risk patients
- ▶ System of continuous recall and transitional care from child to adult
- ▶ A preventive focus
- ▶ University of Sydney affiliated to allow Bachelor of Dental Science students exposure
- ▶ Outreach services to special schools

Adelaide Dental Hospital

Special Needs patients who are pension or concession cards holders are eligible for treatment at the Special Needs Unit at the Adelaide Dental Hospital.

- ▶ Treatment for a wide range of special needs patients, including adults with intellectual disability.
- ▶ Most cases are treated in the community by Special Needs Dentists.
- ▶ Referral is available for general anaesthetic and IV sedation.
- ▶ This institution is seeking to improve by developing a system of more integrated continuation of care between child and adult services.

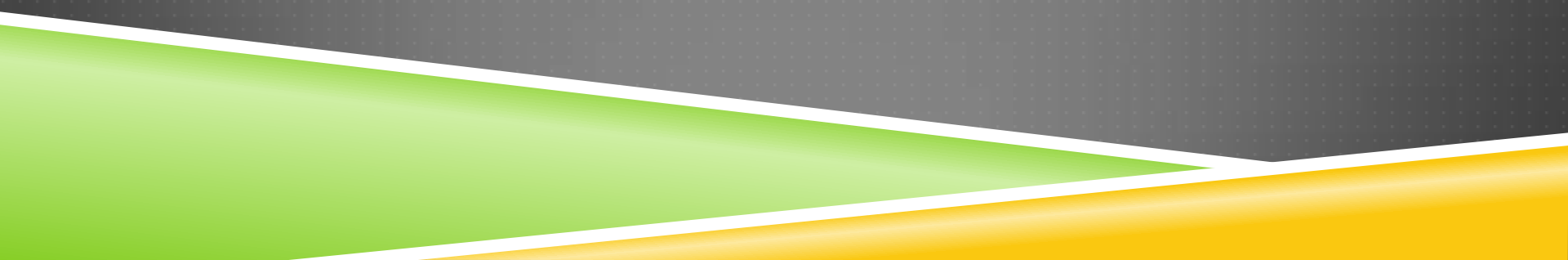
Western Australia

- ▶ The Special Needs Dental Clinic in Western Australia provides general dentistry in the chair or under general anaesthetic and specialist treatment to those patients with intellectual disability and/or autism.
- ▶ The Special Needs Dental Clinic also refers patients for treatment at the Royal Perth Hospital if medically compromised and high risk, and the Oral Health Centre of Western Australia (OHCWA) if eligible.

Other smaller models

- ▶ *University contracted care*
- ▶ *Mobile dental programs*
- ▶ *Community based models*

Recommendations for consideration

- ▶ Greater involvement of dental auxiliaries
 - ▶ Interdisciplinary approach to oral health care
 - ▶ Collaboration between dental, hospitals, tertiary education facilities and disability organisations
 - ▶ Support the Denticare Australia scheme
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Practice Guidelines

Messages to take to the person's oral health practitioner



History taking

Talk with the right person, the person who knows the patient with intellectual disability

Ask person or care provider to bring a health history with them to the consultation

Take a good history

Check all medications

Check consent

Reducing fear

Friendly reception

Caring attitude of dental staff

Schedule early appointments for alertness

Reduce waiting time

- ▶ Call ahead if there is a delay

Practice visits before treatment

Demonstrate procedures beforehand

Communication

Talk to person directly even if care provider is present

Clear, age appropriate language

Listen actively, Check understanding

Be sensitive to the person's communication methods including nonverbal

Extra time to talk

Check for non-verbal indicators of pain

Cognitive challenges

Reduce distractions, unnecessary sights, sounds, stimuli

Allow extra time to explain instructions and demonstrate instruments

Use simple, concrete instructions, repeat

Speak clearly, one direction at a time

Intense fear

Ask the person what would help them feel better

Get ideas from care providers

Keep appointments short

Permit care providers to comfort the person

Allow patient to bring comfort items

Reward cooperation with compliments

Sedation only after legal consent

Practice, practice, practice

Good practice – Desensitisation

Four people with limited communication were supported by dental professionals and support workers to work towards dental treatment through desensitisation processes for each.

Physical challenges

Clear paths for movement

Patient placement

If transfer from wheelchair is needed, ask the patient or care provider about how best to do it

Some cannot be moved. Lock wheels, check neck and head support

Visual impairment

Is common

Ask person what they need for a visit to clinic

Connect with patient through constant verbal feedback

Use descriptive language

- ▶ To explain procedures
- ▶ To demonstrate sound of equipment

Provide written instructions in large print

Hearing Impairment

Is common

Ask person what they need for a visit to clinic

Eliminate background noise

Suggest adjustment of hearing aids to minimise auditory discomfort from sound of instruments

If patient reads lips, speak normally and directly

If patient uses sign language, arrange an interpreter

Maintain eye contact with patient.

Remove facemask first

A stubborn or non-responsive patient may simply have a hearing impairment!

Epilepsy

Epilepsy is common

Dental injury is common (Chip teeth, bite tongue or cheeks)

Consult person's physician

Avoid triggers (flashing lights, sounds)

If seizure occurs, be prepared to manage it and stay with patient

Cerebral Palsy

Occurs in one of four people with intellectual disability

Ask the patient how best to proceed

Sessions may need to be paced

Simple relaxation techniques may be of use

Issues with consent around sedation

Cardiovascular disease

Occur frequently in people with intellectual disability, especially those with Down syndrome or multiple disabilities

Take a good medical history, collaborate with person's cardiologist, physician

Check current medications

Ask the person how to proceed

Damaging oral habits

Bruxism

Mouth breathing

Tongue movements

Self-harm

Pica

Work with allied health providers to reduce these habits

Promote a better lifestyle for the person, habits intensify with boredom and inactivity

Prescribe mouth guard, if it can be tolerated

Trauma

Falls or accidents

Suggest a home tooth-saving kit

Traumas **require immediate professional attention**

Radiographs may be necessary to determine if fragments have been aspirated

Physical abuse

Often presents as trauma

If you suspect abuse,
it must be reported to your local authority

Other issues

Missing permanent teeth

Delayed eruption

Enamel hypoplasia

- ▶ Early examination will identify unusual tooth formation
- ▶ Panoramic radiograph may be more easily tolerated than individual films
- ▶ Reduce sensitivity and risk of caries in patients with enamel hypoplasia

Malocclusion

Support of allied health professionals such as speech pathologists and oral health professionals such as orthodontists is critical

Caries

The prevalence of untreated dental caries is

- ▶ higher among people with intellectual disability
- ▶ particularly those living in non-institutional settings

Emphasise non-cariogenic foods and beverages

No sweets as incentives

If taking medicines that cause dry mouth, drink water often

Change to sugar-free medicine or rinse after taking

Preventive measures such as fluorides and sealants

Periodontal disease

Combined effect of medications, multiple disabilities, and poor oral hygiene

Encourage independence in daily oral hygiene

Check if patient is a smoker

- ▶ **Specific recommendations on brushing methods or toothbrush adaptations**
- ▶ **Involve patients and care providers in hands-on demonstrations of brushing and flossing**

To GA or not to GA

General anaesthesia should be last resort

Prevention issues

Community based oral health promotion

Good physical health means good oral health

**Support of better quality of life for people with
intellectual disability**

“Does s/he have the same life as I do?”

Collaboration

Interdisciplinary approach – oral health with general health and allied health practitioners

Better use of dental auxiliaries

Training of care providers

Political issues

Undergraduate and post-graduate training for oral health professionals

Integrated health care delivery

Re-valuing of people with intellectual disability

endnote

- ▶ The mouth is a pleasure zone
- ▶ Clinical approaches to the mouth deny the sensuality of eating and tasting and drinking
- ▶ Collaboration could in fact extend to those whose profession is pleasurable experiences via the mouth, eg: food tasters, chefs, connoisseurs

Thank you for listening
Any questions?

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