How can we engage people with substance dependency in oral health?

©ah_designs/iStock/Getty Images Plus

Charlotte Bowes[1] writes a self-reflective log on a patient and public engagement project.

Background

There is limited research in the UK related to people with substance dependency and oral health care, despite awareness of the frequent, and often complex, oral problems faced by this community.[1] Further to this, having current experience of working in an NHS dental practice, there are seemingly profound barriers to accessing and seeking primary oral health care for people with substance dependency. There are also challenges involved for dental professionals in so far as being able and willing to deliver oral care. These challenges could include such issues as feeling improperly remunerated for the commonly significant amount of treatment required by this cohort.[2] There may also be fear of cross-infection with blood-borne diseases such as Hepatitis and HIV, specifically from injecting drug-users.[3]

In light of the above issues, frequently the burden of oral health related problems for people with substance dependency falls to secondary care, which has an increased detrimental impact on public funding.[4,5] There is scope for assessing whether oral health care provision can be made more likely to be sought and more accessible. At the moment there are multi-disciplinary teams that provide care and treatment for people with substance dependency,[6] however oral health is not an element of this despite evidence highlighting the importance of oral health in creating a non-addict identity moving forward.[7]

Author information

[1]Charlotte Bowes BDS MFDS RCPS(Glasg), Clinical Fellow in Restorative Dentistry, Deputy Director of Engagement, School of Dental Sciences, Newcastle University, Framlington Place, Newcastle upon Tyne, NE2 4BW

Patient and public engagement

I co-authored a *BDJ* article[2] highlighting the need for further research based on the dearth of evidence in the UK currently. From my primary care experience, I felt that there was opportunity to develop a research question around oral health care and substance dependency with people who are engaging with substance recovery services, to enable improved engagement with primary dental health services.

In order for me to develop a research question I wanted to engage with those at the 'coal-face', gain an understanding of their perspective of dental health and explore appropriate research methods pertaining to this particular cohort. An opportunity arose where I was successful in being awarded funding from Newcastle University's Faculty of Medical Sciences Tilly Hale fund to develop a creative, co-productive patient and public engagement (PPE) project.

I contacted a local charity-run substance

© 2020 British Dental Association. All rights reserved.

recovery support service called Change Grow Live who were very keen to take part in my PPE project.

Getting creative

From a brief literature search prior to this project I discovered that there may be barriers to engagement of this cohort; for example, literacy amongst people with substance dependency has been found to be poorer compared to that of the general population.[8] There is also some evidence that suggests people with substance dependency are aware of issues and risks surrounding their dependence and therefore provision of written information is of limited value.[9] There is evidence to suggest that media-literacy is increased for those with alcohol/smoking dependencies[10] implying that it would be beneficial to use innovative methods to ensure maximal engagement of this cohort.

In light of this I created a storyboard poster (Fig. 1) to recruit participants alongside a conventional Patient Information Sheet (PIS). I did this to assess whether potential participants preferred a certain method of recruitment. I attended an informal breakfast club and encouraged them to chat about what they liked/disliked about the information provided; I also gave them felt pens to write on the posters to maximise engagement. They really liked the posters and much preferred them to the PIS; they felt that the poster could be used as a stand-alone method of recruitment as they felt it provided enough information to give valid consent to participate. Ten people decided they wished to participate in the project.

This is a good learning point that can be applied in primary care: avoiding over-superfluous written information and providing information in a more accessible format.

Group perceptions

In order to understand what this group of people felt about oral health, I attended the breakfast club again, but this time to ask the group questions. I spoke to the participants individually [most were voice recorded with permission] to ask them about their thoughts on the importance of oral health and their general feeling towards oral health care.

This was extremely interesting and I gained a lot of insight from their discussion. The main issues discussed were that when someone is in the midst of their addiction, although they are aware of the importance of oral health, it is not a priority. Also there was a great sense of embarrassment that they know they have caused their oral problems

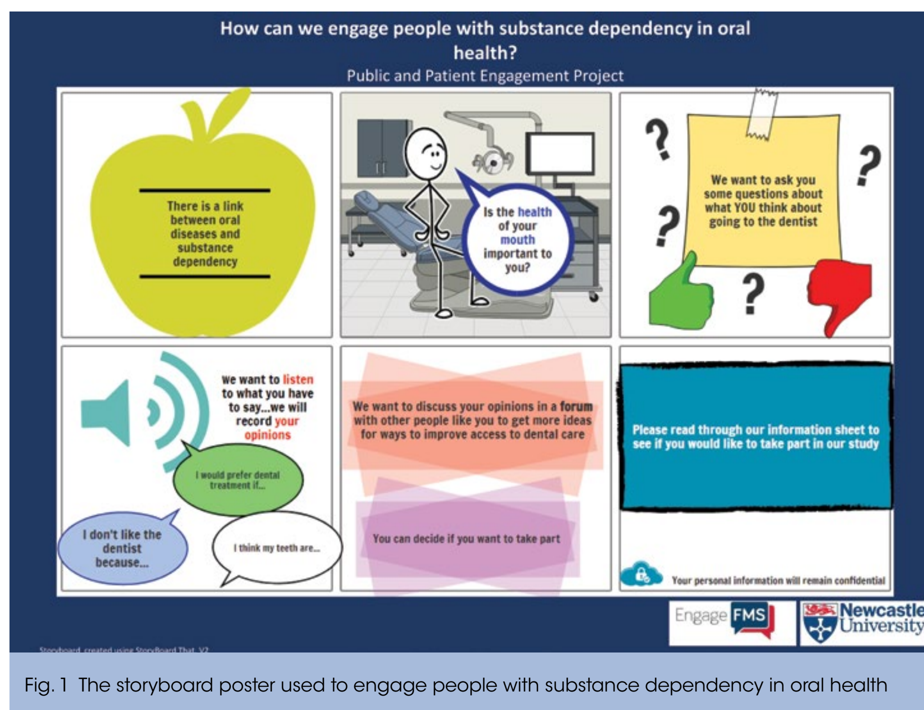

Fig. 1 The storyboard poster used to engage people with substance dependency in oral health

'I found the discussions extremely eye opening as I had not appreciated the full extent of dental and health problems experienced by people with substance dependency.'

and they don't want to share that with a dental professional. During this session I brought along oral hygiene aids also and gave some brief oral hygiene advice to engage participants further, which is something they were extremely grateful for.

Dental perspective

I found the discussions extremely eye opening as I had not appreciated the full extent of dental and health problems experienced by people with substance dependency. I spoke to several people in their 40s who were edentulous due to previous alcohol dependency and were embarrassed to speak unless they covered their mouth with their hand. They also did not wear dentures as they were so embarrassed of going to the dentist and asking for dentures for fear that they would be stigmatised. The main reason for attending dental appointments was for pain compared to regular check-ups, due to the chaotic nature of their lives. Another interesting point was that people who were in recovery for alcoholism replaced alcohol with high sugar drinks and for example, would drink multiple bottles of cola daily; this has a significant impact on dental health, such as caries and tooth wear.

Getting creative

Drawing upon the information participants disclosed during discussions, I worked with a student film-maker from Newcastle University to try and creatively disseminate the information back to the cohort. I showed the film to participants but also to other people with substance dependency who had not participated in discussions. They engaged really positively with the film and felt that it was representative of their views and that they enjoyed the way it was presented.

Dental care for people with substance dependency

In an ideal world, dental care would be

© 2020 British Dental Association. All rights reserved.

provided within a recovery centre as part of a holistic approach to care. Due to limited NHS funding, it is difficult to see a dental service providing care within a recovery service. However, service-users found me going to talk to them and delivering brief oral health education and signposting to local dental services very useful. They said it would be beneficial for a dental professional to 'drop-in' to the recovery services and offer tailored oral hygiene advice; this would allow them to build a relationship with a dental professional and feel more comfortable in attending a signposted primary care setting.

Next steps

As staff-lead of BrushUp (Newcastle Dental School's volunteer oral health education group) and having an established connection with this substance recovery service, I aim to introduce regular visits to this service and other substance recovery services to ensure dental care is part of a holistic, multi-disciplinary service. This will also improve dental undergraduate experience in delivering oral health education to a wide diversity of people, and increase Newcastle Dental School's civic approach.

I aim to apply for further funding to undertake research in the area of dental care and substance dependency. I aim to undertake this whilst working part time in a community dental setting. My research aims to not only have a positive impact on my practice but also the wider dental team.

Learning points for the dental team

- Be understanding and empathetic to the dental problems of people with substance dependency- they already feel like it is their fault
- Find out what they want from a dental appointment
- Don't be afraid to let them know of the effects of alcohol and other substance abuse on their dental health- sometimes they don't know and are desperate for advice
- Give tailored oral hygiene and diet advice
- Use posters and other creative media to engage this cohort.

'It would be beneficial for a dental professional to "drop-in" to the recovery services and offer tailored oral hygiene advice; this would allow them to build a relationship with a dental professional and feel more comfortable in attending a signposted primary care setting.'

References

1. Shekarchizadeh H, Khami M, Mohebbi S, Ekhtiari H, Virtanen J. Oral health status and its determinants among opiate dependents: a cross-sectional study. *BMC Oral Health* 2013; **19:** 5.
2. Bowes C, Page G, Wassall R, Lloyd C. The need for further oral health research surrounding the provision of dental treatment for people with drug dependency. *Br Dent J* 2019; **227:** 58-60.
3. Sheridan J, Aggleton M, Carson T. Dental health and access to dental treatment: a comparison of drug users and non-drug users attending community pharmacies. *Br Dent J* 2001; **191:** 453-457.
4. Binks S, Hoskins R, Salmon D, Benger J. Prevalence and healthcare burden of illegal drug use among emergency department patients. *Emerg Med J* 2005; **22:** 872-873.
5. Palepu A, Marshall B, Wood E, Kerr T. Addiction treatment and stable housing among a cohort of injection drug users. *PLoS ONE* 2010; **5:** e11697.
6. Lloyd C. *Sinning and sinned against: the stigmatisation of problem drug users.* London: UK Drug Policy Commission, 2010.
7. Robinson P G, Acquah S, Gibson B. Drug users: oral health-related attitudes and behaviours. *Br Dent J* 2005; **198:** 219-224.
8. Yates R. Bad mouthing, bad habits and bad, bad, boys: an exploration of the relationship between dyslexia and drug dependence. *Mental Health and Substance Use* 2012; **6:** 184-202.
9. Dermota P, Wang J, Dey M, Gmel G, Studer J, Mohler-Kuo M. Health literacy and substance use in young Swiss men. *Int J Public Health* 2013; **58:** 939-948.
10. Bergsma L, Carney M. Effectiveness of health-promoting media literacy education: a systematic review. *Health Educ Res* 2008; **23:** 522-542.

https://doi.org/10.1038/s41407-020-0234-z

© 2020 British Dental Association. All rights reserved.