NHS Health Scotland

Smile4life

Guide for trainers

Better oral care for homeless people

healthier scotland
SCOTTISH GOVERNMENT

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Foreword

An Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland, published by the then Scottish Executive in 2005, stated that improving the oral health of homeless people was a priority.

Last year over 55,000 households made homeless applications to their local council. Many situations can lead to individuals becoming homeless: family breakdown, domestic abuse, or unemployment. People leaving institutions such as the army or residential care and those released from prison are particularly vulnerable.

Homelessness affects an individual's ability to remain healthy and can also impact significantly on oral health. The fundamentals required to maintain good oral health include access to healthy food and the ability to carry out regular toothbrushing. For most people, this means access to basic domestic facilities such as a kitchen to cook healthy meals and a bathroom in which to brush their teeth, preferably with fluoride toothpaste. Accessing these basic amenities may be impossible for many homeless people. Keeping in touch with health providers can also be difficult when people are without a home. Little wonder, then, that in comparison with the general population, homeless people have a poor diet, poorer oral health, and are less likely to attend a dentist.

Poor oral health affects overall general health, nutrition, quality of life, communication, appearance and employability; all of which compound the problems for individuals attempting to escape homelessness.

Equally Well, The Report of the Scottish Government's Ministerial Task Force on Health Inequalities, identified the need for policies and interventions which prioritise disadvantaged and vulnerable groups (including homeless people and rough sleepers) as this approach is more likely to be effective in reducing health inequalities.

Smile4life is a training pack for staff working with people who are homeless. I encourage everyone in Scotland working with homeless people to embrace this opportunity and adopt the training offered, as we seek to help those experiencing homelessness.

Margie Taylor
Chief Dental Officer
Scottish Government

Overview and learning outcomes

About this training guide

Key message:
Improving the oral health of homeless people in Scotland is a key government priority.

Welcome to Smile4life, a training guide for all health and social care professionals to deliver training to staff working directly with people experiencing homelessness.

Why have we developed this guide?

The chaotic lifestyles and complex needs of vulnerable groups such as homeless people means that the focus tends to be on responding to presenting problems rather than addressing prevention and the underlying causes. However:

> 'At present only 4% of NHS funding is spent on prevention. Yet in 2010 the Marmot Review showed that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits.'[1]

Improving the oral health of homeless people was identified as a priority in *An Action Plan for Improving Oral Health and Modernising NHS Dental Services*.[2] In addition, *Equally Well* (2008),[3] the Report of the Scottish Government Ministerial Task Force on Health Inequalities, reported that policies and interventions that prioritise disadvantaged and vulnerable groups (including homeless people and rough sleepers) are more likely to be effective in reducing health inequalities. The *Equally Well* report recommended that a programme to improve the dental health of such vulnerable groups be rolled out. This programme should address the needs of, for example, people experiencing homelessness.

There are several reasons why the Smile4life intervention is important:

- Building capacity, through training, to meet the oral health needs of homeless people.
- Making every contact a health promotion opportunity.
- Poor oral health affects overall health, nutrition, quality of life, communication, appearance and employability.
- Poor oral health is strongly related to poverty; individuals and families who are homeless experience extreme social exclusion and deprivation.
- Homeless people are less likely to be registered with, and to attend, a dentist: they may experience difficulty in accessing dental services and often only access emergency dental care.[4]
- In comparison with the general population, oral hygiene and the maintenance of oral health can be a low priority for people who are homeless.
- Compared with the general population, homeless people tend to have more missing and decayed teeth but fewer treated or filled teeth. There tends to be a greater prevalence of dental pain and higher levels of gum disease among homeless populations.[4]
- People experiencing homelessness often have a less nutritious diet, characterised by frequent consumption of sugary foods and drinks.

Oral health promotion and prevention of oral disease

Meeting the oral health needs of people experiencing homelessness can present a considerable challenge, and requires a flexible response on the part of practitioners and service providers.

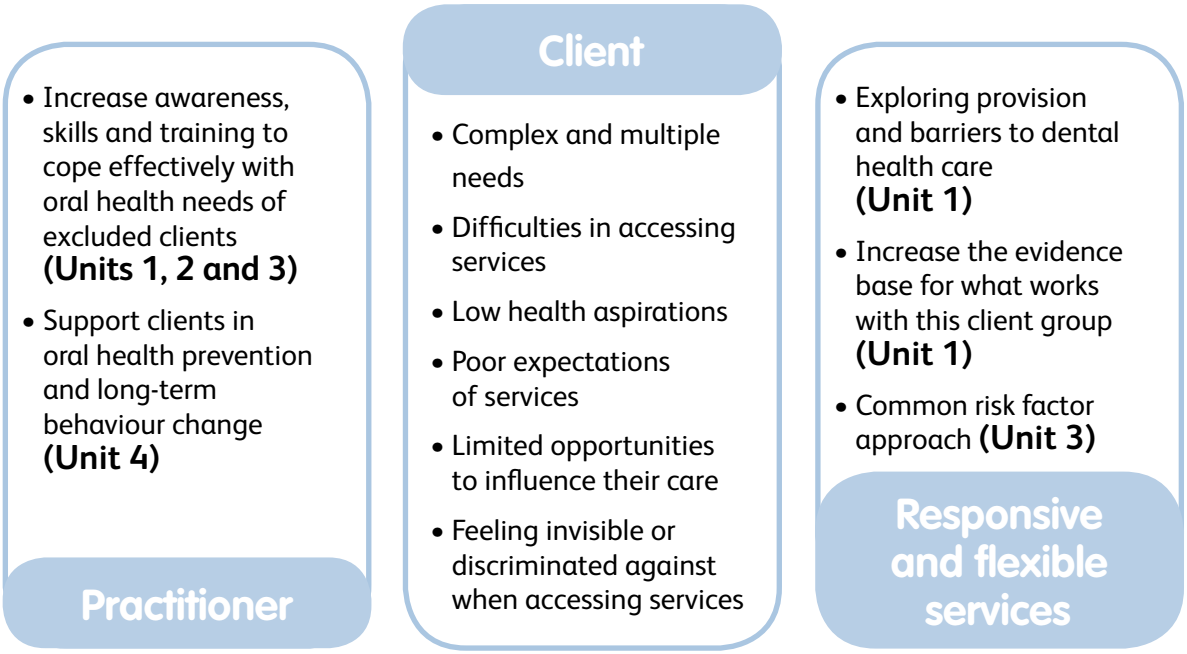


Figure 1: Challenges involved in meeting the oral health needs of homeless people (adapted from Inclusion Health)[5]

How to use this guide

The overall purpose of Smile4life is to enable health and social care staff and support workers to provide evidence-based tailored oral health messages to meet the specific and exceptional needs of homeless (roofless and houseless) people in Scotland.

The content of this training guide reflects the learning requirements and information needs of the wide variety of professionals that are involved in the care and support of people experiencing homelessness.

Consequently, this training guide has been designed to be flexible and adaptable to support trainers in developing personalised training. Trainers are encouraged to know their audience and to adapt the training to suit the local circumstances. There can also be flexibility in the order in which the trainer presents information, as knowledge might vary depending on the group being trained.

All staff (including managers) should be given the opportunity to attend training on the delivery of Smile4life. Initial training sessions should cover both key oral health knowledge and the skills required by practitioners to provide the tailored intervention to their homeless clients. It should also ensure staff are aware of the pivotal role they can play in terms of assessing client readiness to change and encouraging clients to actively maintain good oral health, making every contact a health promotion opportunity.

The guide is organised into four units:

Unit 1 gives an overview of homelessness and oral health, and examines the barriers and enablers to oral health care.

Unit 2 covers a wide range of oral health topics, including common oral health problems, access to dental services and preventive daily oral care.

Unit 3 examines the common risk factor approach to oral health, including diet, smoking, alcohol and methadone.

Unit 4 introduces the oral health promotion intervention, and includes related topics such as staff participation roles, motivational interviewing, the delivery of tailored messaging and supporting client behaviour change.

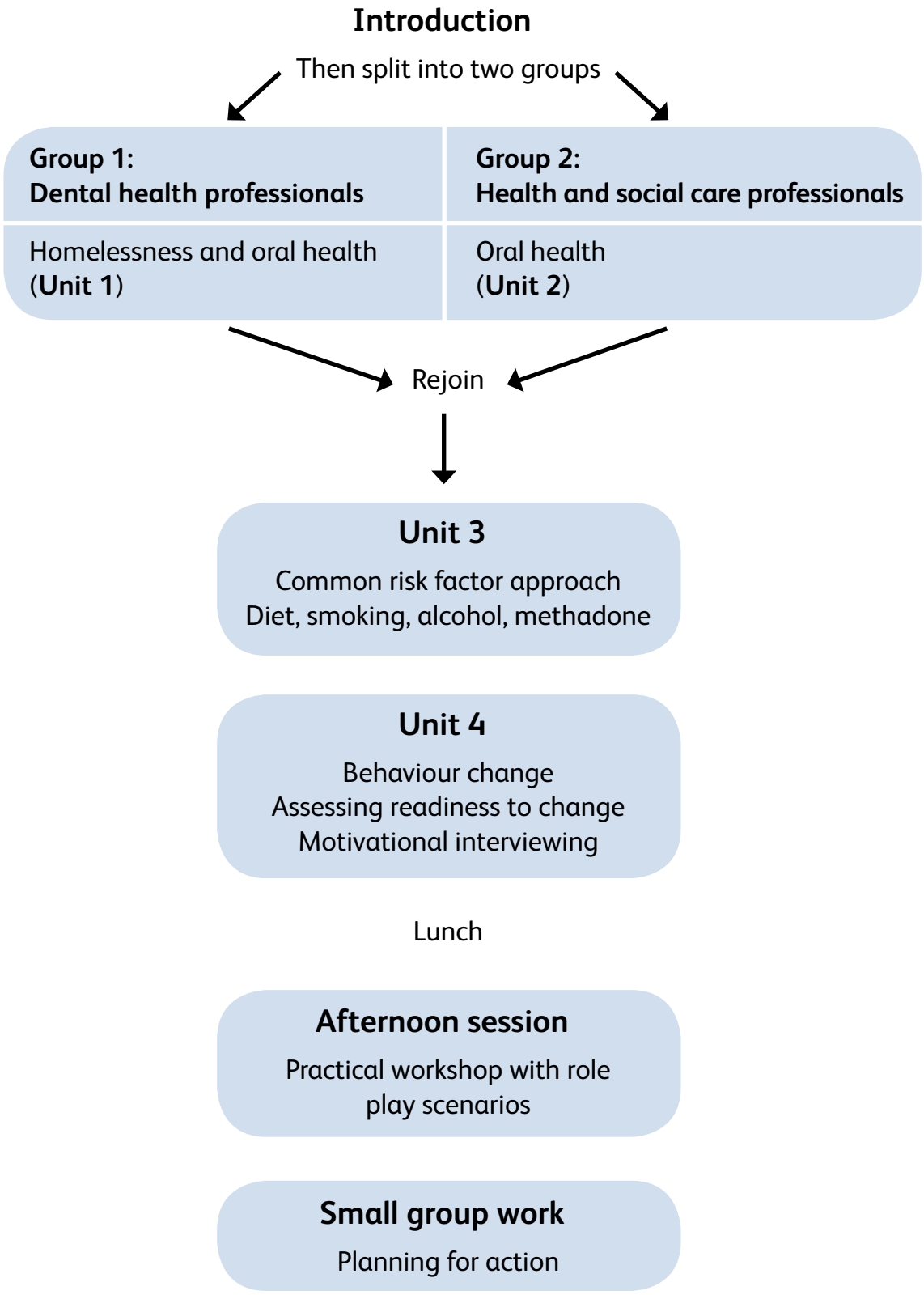
Figure 1 (shown on page 6) shows how the four training units can enable practitioners to meet the challenges involved in implementing oral health prevention for their clients experiencing homelessness.

Learning outcomes

There are eight learning outcomes (LO).

To have knowledge of the oral health issues and barriers to accessing care, as experienced by homeless people	Unit 1	LO1
To know the main oral health care messages and be competent in providing tailored oral health information to clients	Unit 2	LO2
To be familiar with the risk factors that contribute to the oral health status of homeless people	Unit 2	LO3
To be aware of how and where homeless people can access dental care	Unit 2	LO4
To be competent in giving basic health advice on diet, smoking, alcohol consumption and methadone use	Unit 3	LO5
To know the structure and application of the Smile4life intervention	Unit 4	LO6
To know how to assess client readiness to change, using the assessment tool	Unit 4	LO7
To know the basic motivational interviewing techniques when interacting with clients	Unit 4	LO8

Suggested Smile4life training outline



Key oral health messages

The following key messages are given here to view at a glance and are the essential points that participants should take home from the training.

- Improving the oral health of homeless people in Scotland is a key government priority.
- Good oral health will contribute to overall health and wellbeing.
- Toothbrushing, diet and dental visits are the three main steps towards good oral health, tailored to the needs of the individual homeless person.
- Dental decay and gum disease are preventable.
- Gum disease remains the most frequent cause of tooth loss in adults.
- Brushing teeth twice a day for at least two minutes with fluoride toothpaste is an effective way of preventing tooth decay.
- Food and drink containing table sugar (sucrose) and other added sugars are harmful to the teeth. Frequent intake of foods and drinks containing these sugars should be reduced, ideally to mealtimes.
- Every time anything sugary is eaten or drunk, the teeth are under acid attack for up to one hour. This is because the sugar reacts with the bacteria in plaque and produces harmful acid. The acid destroys the tooth enamel and, with the bacteria, causes tooth decay.
- Smoking and alcohol consumption greatly increase the risk of mouth and throat cancer. Regular dental attendance is crucial for early diagnosis.
- Smoking damages the mouth, teeth and gums – it can cause tooth staining, gum disease, tooth loss, and in more severe cases, mouth and throat cancer.
- Alcoholic drinks can cause dental erosion. Frequent consumption of alcohol can increase the risk of mouth and throat cancer.
- Drinking and smoking to excess raises the risk of mouth cancer by up to 30 times as alcohol aids the absorption of tobacco into the mouth.
- Methadone hydrochloride is an acid which attacks tooth enamel. The mouth should be rinsed with water after taking methadone.
- Chewing sugar-free gum after taking methadone stimulates saliva flow and helps reduce the plaque acid in the mouth, thus reducing the chance of tooth decay.

Preparing for training delivery

Notes for trainers

Trainer approach

NHS Health Scotland encourages trainers to continuously develop strong training and facilitation skills. Our values and beliefs, i.e. our 'trainer philosophy', means we are looking for individuals who can provide learning opportunities for others, whatever their role.

NHS Health Scotland wishes to promote an ethos of learning that is based on the following principles:

- Expose learners to the topic in advance – get them 'on side' before training actually starts.
- Make learning meaningful – link learning to real work and service improvement, connect past experiences and knowledge to new learning, and encourage learners to make these new interconnections. Help learners to realise their strengths and create positive states for learning.
- Allow time for learners to learn – include processing time between new concepts. Let them actively rehearse and apply their learning in practical ways, and encourage them to review their learning and its applications throughout sessions.
- Be clear – clearly explain the purpose of the training and provide feedback or encourage learners to give each other feedback as a routine part of the learning process.
- Create stimulating training environments – appeal to all the senses, offer a 'safe' climate where people feel free to rehearse, express opinions and take risks.
- Create learning that is natural – that stimulates positive emotions, such as excitement and curiosity, and encourages learners to review their learning and its applications.

NHS Health Scotland also encourages trainers to:

- be flexible – change what you and the group are doing if it isn't working
- vary the types and/or times of activity – provide maximum stimulation so that everyone gets something from the session
- be well prepared – lack of organisation is a major cause of anxiety. Make sure you know the training guide, equipment and resources well
- understand individual behaviours and motivations – tune into language patterns and non-verbal behaviour, to pick up clues about how people learn, what makes sense for them and where their needs lie.

Further information: NHSScotland – Health Improvement Trainers Scotland

Community of Trainers who share information and learning on health improvement.

http://elearning.healthscotland.com/course/view.php?id=2

Notes for trainers

Facts and figures for preparing presentations

The very real health care needs of homeless people, compared to the general population, were recognised by the Scottish Executive, who produced a set of Health and Homeless Standards in March 2005.[6] These comprehensive standards were aimed at ensuring that NHS Boards met the health care needs of homeless people within their Health Board areas.

An Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland,[2] (Dental Action Plan) published in 2005, emphasised this commitment when it made clear the desirability of 'NHS Boards developing and delivering oral health preventive support programmes for adults most in need, such as…the homeless'.

Earlier in 2003, the British Dental Association (BDA) published *Dental Care for Homeless People.*[7] This BDA document recognised the need to improve the delivery of dental care to homeless people, and as a first step it was suggested that a normative needs assessment be conducted in order to provide homeless people with 'accessible dental services based on local needs assessments'.

Smile4life: The Oral Health of Homeless People Across Scotland (2011) surveyed over 850 homeless people.

The findings confirmed poorer oral health among this group:

- 98 % had tooth decay
- 52 % had extracted teeth
- 23 % felt embarrassed about their teeth
- 25 % felt self-conscious about their teeth.

Homeless people face an everyday challenge to find basic elements of human necessity and comfort, such as shelter, safety and nourishment. Many homeless people have unhealthy lifestyles and use tobacco, alcohol and/or drugs to manage the situation they find themselves in. These habits are often already established prior to their homelessness.[8] An oral health needs assessment of homeless people in Scotland indicated a strong clinical need for oral health care among this population.[4]

Homelessness in Scotland is officially measured by the number of applications to local authorities by households presenting as homeless under the Homeless Persons Legislation. In the year 2009/10, 56,659 households made applications to local authorities in Scotland under the Homeless Persons Legislation.[9] This figure represents a 23 % increase in the estimated number of homeless in Scotland over the last ten years. The majority of applicants (61 %) were single people, mainly men. One-parent families, predominantly women, accounted for a further 24 % of all applications.

However, the actual number of homeless people in Scotland (including rough sleepers, sofa surfers, etc.) remains unknown, but even so the prevalence of homelessness is still likely to be underestimated.

Part I:
Setting the scene

Unit 1
Rationale

Homelessness and oral health

Key messages

A daily oral health care routine can be a problem for homeless people.

Unpredictable lifestyles and change of location can lead to difficulties in maintaining good oral health and accessing a dentist.

Check-ups may not be seen as a high priority: dental attendance is often dependent on urgent need.

Missed dental appointments and financial penalties are common among homeless people.

Some people do not go to the dentist because of dental anxiety; others may want to drop in for treatment when they are in pain.

Oral self-care may be a low priority and poor oral health may be accepted as the norm as other competing priorities take centre-stage.

People with many missing teeth may feel very self-conscious and embarrassed about their appearance and this can affect their confidence and self-esteem.

Resuming dental treatment after many years requires support.

'Unsatisfactory diet, hardly ever eats, alcohol dependency. He has suffered two heart attacks. Feels insecure and self-conscious about his teeth.' (Dental health professional, describing a homeless 46-year-old male patient)

The exceptional health care needs of homeless people in Scotland were recognised by the then Scottish Executive, which in March 2005 produced a set of Health and Homelessness Standards.[6] These comprehensive standards were aimed at ensuring that NHS Boards within Scotland and gave special consideration to meeting the health care of homeless people within their Health Board areas.

The Scottish Executive also recognised, as part of *An Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland*[2] (known as the Dental Action Plan) in 2005, that it would be desirable for 'NHS Boards to develop and deliver oral health preventive support programmes for adults most in need such as...the homeless'.

Anyone can become homeless. Despite the stereotype, it is not just the elderly man who sleeps on a park bench who falls into this category. The largest cause of homelessness in Scotland is relationship breakdown, and the majority of people who are homeless are not sleeping on the streets at all, but living in some sort of temporary accommodation – that may be a friend's sofa, a hostel, or a B&B. Whether it is one of these or elsewhere, it is somewhere that is not a permanent home, and often with no cooking facilities.

As a result of this, people who are homeless often live very unsettled lives. A healthy lifestyle can be difficult to maintain, and low on somebody's list of priorities.

In addition to this, people who become homeless with no history of substance misuse are at an increased risk of developing substance misuse problems.[10] Therefore, being homeless presents those affected with many issues that can directly impact upon health, including oral health.[15]

Smile4life: The Oral Health of Homeless People Across Scotland, an oral health needs assessment of people in homeless situations in Scotland, indicated a strong clinical need for oral health care among this population.[4] Yet most of these people are not registered with a dentist: they may experience difficulty in accessing dental services and often only access emergency care.

In comparison with the general population, they have greater levels of untreated decay and periodontal (gum) disease. This suggests that a large proportion of this population only attends for dental treatment when experiencing pain. In addition, a greater prevalence of smoking and alcohol consumption put homeless populations at an increased risk of developing oral cancer.

Many people who are homeless have difficulty complying with the main oral health messages: healthy eating, oral hygiene (with the cost of toothpaste and toothbrush being seen as luxuries), and erratic dental attendance (reducing access to oral health and information).

A qualitative study conducted as part of *Smile4life* suggested that many people who are homeless are concerned about their mouth and teeth. However, oral hygiene and dental visits tend to be low priority unless pain is experienced. The appearance of the mouth and teeth is linked to feelings of self-esteem and confidence. Access to dental treatment and regaining good oral health is associated with improving these.

Barriers and enablers

The following sections examine the barriers and enablers to dental care and the maintenance of good oral health. In general, the main barriers to attending a dentist have been identified as:[12]

- the organisation and image of dental practices
- dental anxiety
- costs: financial and time-related.

Understanding barriers to care for homeless people

Homeless people face additional barriers to those above, as the recent *Smile4life* report on oral health and homelessness in Scotland has shown.[4] These are as follows:

1. Managing oral health

Many homeless people cannot practise preventive oral health measures. Homeless people taking part in interviews about their oral health spoke about the practical difficulties of maintaining an oral hygiene routine:

> '…it was difficult then, cos there was nowhere to go to actually brush your teeth in the morning …I did try and brush my teeth as often as I could, but when you're sleeping rough, it's quite hard.' (Male, 24)

The unpredictable lifestyle can make it difficult for homeless people to manage their oral health in the face of numerous setbacks, as illustrated here:

> 'I got dentures and then I got attacked in the town, and they were all smashed up. I made an appointment with the dentist again, I had an appointment for the Tuesday and I got the jail on the Sunday.' (Male, 35)

2. Drug and alcohol addiction

Substance misuse may lead to self-neglect, and oral self-care may become a low priority:

> 'I had so many other priorities in front of that, before I would get to cleaning my teeth, and then it would be maybe three days later when you've like, a layer of scum on them, that would make you physically sick, and that's how long it would go sometimes.' (Female, 43)

Consequently, among some substance users, poor oral health was accepted as the norm, as the following comment illustrates:

> 'I used to get people saying, you know, how've you still got your teeth?…it's not the norm…addicts, especially long-term addicts, don't have their teeth, it goes along with the occupation if you like, bad diet, not caring for yourself, not looking after yourself, and teeth seem to be one of the first to go.' (Female, 43)

3. Perception of need and expectations of dental care

Homeless people face additional barriers in accessing oral health services, such as having poorer health expectations and feeling 'invisible' or discriminated against when they are able to attend.

Dental attendance appeared to be dependent on the homeless person's urgency and perception of need:

> '…it might have been as much as 10 years [since last dental visit]…I would get a bit of toothache but would just have to live with it…they were probably pretty brown, cos of smoking and general lifestyle choices, I was getting a lot of intermittent pain… I suppose it was just another issue that I just wasn't dealing with…but if you don't feel very good about yourself, you've not got it together to get a dentist.' (Male, 36)

Many of the interviewees had been registered with a dentist at some point in their lives, but few were currently registered. Interviewees reported recent registration, but because they had not attended in some time, they did not know whether or not they could go back for treatment. Others reported going back to their dentist and being told they had been removed from the register because so much time had elapsed since they had last attended.

Among those who did want to attend the dentist, missed appointments were common, partly due to unstructured lifestyles and competing priorities:

> 'I booked an appointment on the Tuesday, I missed my appointment, I was five minutes late, so I got another appointment for the following Tuesday which is tomorrow – no, today, missed it again, quarter to two I was meant to be there, know what, I'm going to have to go to another dentist, I was meant to be there today at quarter to two, I'm thinking this was Monday, but it's Tuesday.' (Male, 25)

Young homeless people in particular had difficulties arranging dental visits. They have often come straight from the family home where a parent has arranged dental appointments for them:

> 'At home I did have a dentist, I don't know if I'm still registered…but I've not had an appointment in ages. I had to go to Falkirk Royal to get a tooth out cos I had severe toothache for like three months or something, had to go to get a tooth out there, I've not been back to the dentist since like…I don't even know how to register, I don't even know how to go about it.' (Female, 17)

Many homeless people had low oral health expectations. They did not feel it was necessary to go to the dentist for a check-up if they were not experiencing any current problems with their teeth or dentures. For example, one 59-year-old female, who had worn the same set of dentures for 30 years and was unaware she needed new ones, was not registered with a dentist. She did not see the point as she had no teeth.

The following quote sums up the position that many homeless people take regarding dental visits:

> 'I only go to the dentist when I need to, I need to go the now, but I'm not in any pain, so I don't bother.' (Male, 50)

4. Dental anxiety

Many people stated that they were held back from accessing dental care by fear, even if they needed or wanted treatment:

> 'I've been scared of needles for a long time so I never went to the dentist, but my teeth were really bad…[I felt] disgusted…cos I'd left them that long, and just to have nice teeth…I was talking to people and covering my mouth.' (Female, 32)

5. Emergency dental treatment

These additional barriers, together with low health aspirations meant that many homeless people required immediate treatment when in extreme pain:

> 'I had toothache for days and days, and I says, I'm gonna have to go, gonna have to go, gonna have to go, and it took us about four days to say right, I'm going [to the dental hospital]. They [the two teeth] had holes in them, and the holes were that big, they said there's no point in filling them, we could fill them if you want but I says no, just take them out, I just want them out, so they took them out.' (Male, 25)

Yet the desire for emergency treatment, such as extractions, led to regret later on:

> 'I just didn't care…they were pretty bad, I went to the dentist and asked her to take them all out, what I had left, I only had about five left anyway…for what I had left there wasn't much point in keeping them…I had toothache, I thought I'll get them all out and that'll be…I wish I'd never done it.' (Male, 35)

Frustration arose when the required 'quick fix' was not immediately available. This suggests that drop-in services are suited to the needs of this population:

> '…it used to be when I made appointments with the dentist, can't give you an appointment for two weeks, I was like, pain will be away by then, what's the point, just leave it.' (Male, 35)

Enablers: regaining oral health

Re-establishing contact with health services was often part of the process of change, which for some meant overcoming addiction and accepting responsibility for their own health. The following statement is illustrative:

> 'Now that I'm not using any more, it's time to get my teeth back…' (Male, 35)

1. Accessing dental services

Therefore, as part of re-establishing contact, homeless people accessed services to get information as a first step to manage their own oral health:

> 'I've been back on methadone for six months and its rotting my teeth…when I went to the emergency place I got a lot of information on what toothpaste I should be using, what brushes, getting toothpaste and rubbing it over my teeth, stuff like that. I think brushing your teeth before methadone is probably the number one golden rule to preserve your teeth as long as you can, cos methadone's like a syrup, it slips off your teeth more if you brush them before.' (Male, 28)

Nevertheless barriers still existed. Some of the interviewees who took part stated that it was a big step for them to resume dental attendance after years of self-inflicted oral neglect:

> '…it's a big step, to go to a dentist, because it's embarrassing the mess you've made, I know I'm embarrassed with the mess of my teeth. You go into a dentist and you've got that, my goodness, the state of my mouth, what a mess it's in, you know, I could've done better.' (Female, 43)

2. Appearance of mouth and teeth

With improvements in self-perception and increased oral health awareness, some homeless people, particularly those with many missing teeth, were motivated to seek out dental treatment because they felt self-conscious about their appearance:

> '…when they told me about this [the homeless dental clinic], I'd stopped using, you know…I just started thinking, when I was in the town talking to people, I was hiding my mouth getting embarrassed…kidding on I'm scratching my nose to hide my mouth…so phone up here for an appointment, thought they'd tell me to go back to my old dentist, but they've been all right.' (Male, 35)

In general, it seems that the appearance of the mouth and teeth had a major impact on the confidence and self-esteem of homeless people, particularly those emerging from a long period of homelessness or substance misuse:

> '…when I first got clean, you know like your self-esteem is low and you're looking in the mirror and you're seeing bad teeth, it's not exactly the best thing for lifting that self-esteem to give you a bit of confidence and…but once I got my teeth sorted, you know, I felt better myself and it did lift my self-esteem a lot, and boosted my confidence, I wasn't self-conscious about smiling any more.' (Female, 43)

3. Reaching a turning point and resuming dental attendance

In the main, however, resuming dental attendance after a long period of non-attendance often took place when homeless people reached a turning point where they began to change and adopt behaviours conducive to good health:

> ' …it wasn't until I started to address a lot of other life issues, that I started even thinking about getting a dentist, I was prepared to go and register with somebody else when I found out about the homeless dentist.'
> (Male, 36)

Summary: Barriers and enablers to dental care

Barriers	Enablers
Difficulties in maintaining a daily oral hygiene routine	Homeless person ready to 'move on', out of homelessness
Substance misuse leading to self-neglect	Reducing or ending substance misuse
Low oral health expectations	Concerns about appearance of mouth and teeth
Lack of regular attendance	Need for oral health information
Fines for missed appointments	Taking first step to resuming regular attendance

Part II:
Oral health and oral health promotion

Unit 2
Oral health

What is oral health?

Key message:
Good oral health will contribute to overall health and wellbeing.

Oral health means more than having 'good teeth'. It is part of general health and it could be argued that you cannot have a healthy body without having a healthy mouth. It is essential for physical and mental wellbeing and is a determinant of quality of life.[13]

Oral health is defined as the:

> 'standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease or embarrassment and which contributes to general wellbeing'.[14]

The term 'oral' instead of 'dental' is used, as 'dental' usually means just the teeth. Using the term 'oral' indicates all areas of the mouth, including:

- teeth and gums
- hard and soft palate
- soft mucosal lining of the mouth and throat
- lips, tongue and salivary glands
- chewing muscles
- upper and lower jaws.

Why is oral health care important?

Prevention of pain and suffering

- A painful mouth can be debilitating and upsetting.
- Oral pain can affect mood and behaviour.

Adequate nutrition

- A painful mouth or missing teeth or dentures prevents people from eating and drinking, and enjoying food.

Quality of life and comfort

- Poor oral health can affect quality of life by lowering self-confidence and altering self-image.
- Poor oral health and reduced quality of life increases the risk of depression.[15]
- A healthy mouth gives a person dignity and should be valued.

Communication, socialisation and appearance

- Poor oral health can affect the ability to speak, smile and kiss.
- A healthy mouth can encourage confidence.
- Many people dislike or are embarrassed by their appearance if their oral health is poor.

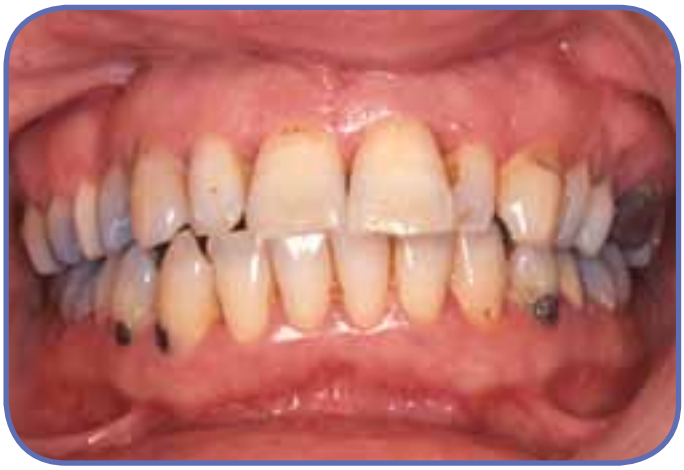
Core oral health knowledge

Key message:
Toothbrushing, diet and dental visits are the three main steps towards good oral health.

Healthy mouth, teeth and gums

What is a healthy mouth?

- Teeth are clean.
- The tooth surface is covered in enamel and free of decay.
- Gums are pink and firmly bound down.
- Minimal recession of the gums.
- Tongue is lightly coated.
- All soft tissues are pink and moist.



Healthy adult mouth

Three steps to good oral health

The term 'oral health' encompasses the mouth and all related tissues. Oral health is essential to general health and wellbeing because it enables us to eat, speak, smile and socialise without pain, discomfort or embarrassment. Poor oral health can result in malnutrition, low self-esteem and increased dental anxiety.

The following key advice must be tailored to the specific needs of the homeless person.

Dental disease is not an inevitable part of life but it still causes unnecessary pain and suffering to many. Good oral health can be maintained and poor oral health improved by following the three key messages of oral health:

1. Toothbrushing: clean the teeth thoroughly twice every day with a fluoride toothpaste

Twice-daily toothbrushing for two minutes with fluoride toothpaste is the best way of preventing both dental decay and gum disease. Toothbrushing removes plaque and adds fluoride to the tooth surface.

Brush at least twice a day, in the morning and last thing at night.

Use the correct amount of a toothpaste with age-appropriate fluoride concentration:

- Adults and children 7 years old or over: use paste containing 1350–1500 ppm (parts per million) fluoride.
- 2–6 years inclusive: use a pea-sized amount of paste containing not less than 1000 ppm fluoride.
- Under 2 years old: use a small smear of paste containing not less than 1000 ppm fluoride.

Gently scrub each tooth surface and gum margins thoroughly using a brush with a small head with soft to medium bristles. Brush for at least two minutes. 'Spit, don't rinse': excess paste should be spat out. Do not rinse the mouth with water after brushing to allow the fluoride to take effect. Replace the brush when bristles become splayed or every three months.

2. Diet: reduce the consumption and frequency of sugary snacks and drinks

The consumption of sugars, both the frequency and the amount, is important in determining the rate of tooth decay.

Food and drinks containing sugars should be limited between meals, as should acidic drinks such as fizzy drinks and fruit juices. When sugars are consumed, they should be part of a meal rather than between meals.

Snacks and drinks should be free of added sugars, whenever possible. Frequent consumption of acidic drinks (such as fruit juice, squashes or fizzy drinks) should be avoided to help prevent dental erosion. Dietary advice is summarised in Box 1.

Box 1: Key dietary advice

Restrict foods and drinks containing sugar to mealtimes.

Drink only water or milk between meals.

Eat sugar-free snacks.

Do not eat or drink after brushing at night.

Be aware of hidden sugars in some foods and the acid content of drinks.

3. Dental visits: have an oral examination every year

Everyone, irrespective of age and dental condition, should have regular oral examinations – yearly for those under 18 years of age and at intervals of no more than two years for all adults.[16] This is so that cases of oral cancer or other oral diseases can be detected early and treated.

This advice also applies to those without any natural teeth, who should still visit the dentist to ensure the mouth is healthy. Children and those at risk from oral diseases, including smokers, may need to be seen more frequently, as advised by the dentist.

Incorporation of these three key messages will help keep the mouth healthy, free from tooth decay and pain.

Oral health information

Homelessness and oral health: common problems

Key messages:

- Dental decay and gum disease are entirely preventable.
- Oral health is influenced by socio-economic factors.
- Changes in knowledge can lead to changes in behaviour.

The most common oral health problems in people affected by homelessness are:

1. Tooth decay (dental caries)
2. Gum disease (periodontal disease)
3. Oral (mouth) cancer

Poor oral health is not inevitable, however, and much can be prevented by changes in behaviour. Yet such changes require the knowledge and skills to make healthy choices and these in turn are influenced by social and economic factors. These socio-economic factors may account for the persistence of high levels of dental disease and poor oral and general health in deprived and excluded communities (see Figure 2 on page 27).

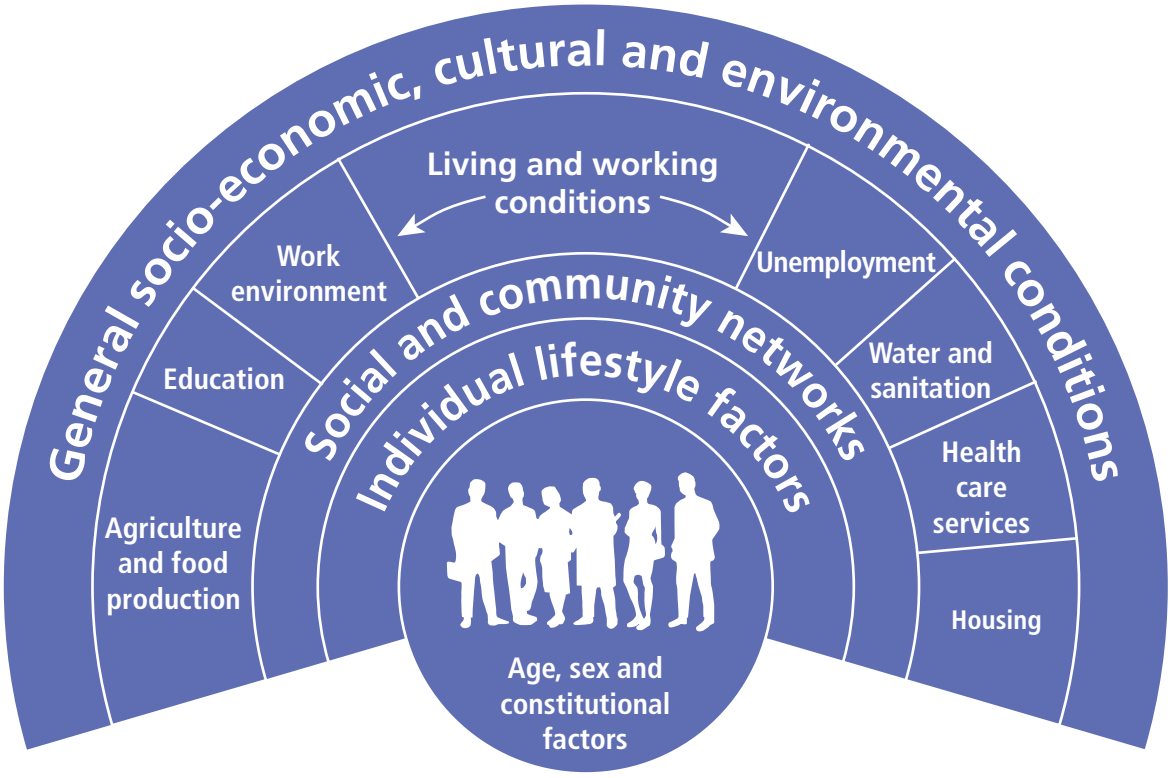


Figure 2: The main determinants of health and oral health (Dahlgren & Whitehead, 1991)[17]

1. Tooth decay

Key message:
Every time anything sugary is eaten or drunk, the teeth are under acid attack for up to one hour. This is because the sugar reacts with the bacteria in plaque and produces harmful acids.

What is decay?

It is the destruction of the enamel and dentine of the teeth.

When the enamel is weakened it can break off and form a hole (cavity) in the tooth.

When the decay reaches the dentine, it can cause pain and infection.

What is plaque?

Plaque is a build-up of bacteria that occurs naturally on the teeth and gums.

Decay

What causes decay?

The main cause of tooth decay (dental caries) is the frequent consumption of sugars, mainly in confectionery, snack foods and soft drinks, acting on the layer of bacteria (known as plaque) on the tooth surface.

Within a few minutes of ingesting sugar, the sugars are rapidly converted to acid by plaque bacteria. The build up of acid attacks the enamel tooth surface – a process called demineralisation (the loss of calcium and phosphate from the enamel) – eventually causing a cavity, and if untreated, destruction of the tooth accompanied by pain, discomfort and often infection.

Tooth decay increases with the amount and frequency of sugar in the diet: that is, how much and how often. The more frequently sugary foods and drinks are consumed, the more often the teeth come under attack from the acid produced by plaque and therefore the more likely the teeth will decay.

Saliva can replace the calcium and phosphate that is removed from the enamel surface during demineralisation. This process of remineralisation will start between 20 minutes and two hours after demineralisation. If sugars are eaten frequently throughout the day, demineralisation outweighs remineralisation and the result is decay.

How is decay prevented?

Reducing the number of times that acid attacks occur, for example, by trying to keep sugary foods and drinks to mealtimes where possible.

Using a fluoride toothpaste twice daily.

Dental erosion

Dental erosion is different from decay. Dental erosion causes wearing away of the surface of the teeth, and is becoming an increasing problem. Erosion affects plaque-free surfaces and results from the consumption of acidic foods and drinks such as diet/sugar-free drinks and fruit juices, which dissolve the enamel on the tooth surfaces.

Sipping and drinking from cans and bottles cause considerable erosion on the upper front teeth. It is recommended when drinking these drinks to use a straw.

Acids linked to erosion include citric acid and phosphoric acid, both of which are found in either fruit juices or soft drinks and have a very low pH. In order to prevent acid erosion, acidic foods and drinks should be kept to mealtimes when possible, and brushing should be avoided immediately after eating and drinking to prevent further damage to the already weakened enamel.

Gastric reflux and vomiting also brings acid into the mouth. Causes of this could be pregnancy, hiatus hernia, anorexia/bulimia, motion sickness or alcohol misuse.

2. Periodontal (gum) disease

Key message:
Gum disease still remains the most common cause of tooth loss in adults.

What is gum disease?

Periodontal (gum) disease is a group of related conditions that start off as gum inflammation (gingivitis) which may lead to periodontitis. Periodontitis involves progressive bone loss, and if left untreated can result in loosening and subsequent loss of teeth.

Gum inflammation can be diagnosed by redness, swelling, and bleeding on brushing. It can be reversed by good oral hygiene. Smoking can increase the risk of periodontitis and tooth loss.

Unlike tooth decay, which is usually a rapid process, periodontal disease can take many years to reach the stage where teeth become loose and may be lost. When gingivitis is allowed to progress, the condition may cause destruction of the bone that supports the teeth, which results in tooth loss. About 50 % of older people will have lost at least one tooth as a result of periodontal disease.

If gums recede as the result of gum disease, the roots of the teeth can come under attack and root decay occurs. This is very difficult to treat and found frequently in people affected by homelessness. Regular, more frequent check-ups would help prevent this condition through early clinical interventions.

Gingivitis

Periodontitis

What causes gum disease?

- Gum disease is caused by plaque and poor oral hygiene.
- Smoking can also make gum disease worse as it causes a lack of oxygen in the bloodstream which makes healing more difficult.
- Smoking may mask gum disease.

How is gum disease prevented?

- Effective and methodical removal of plaque by thorough toothbrushing twice daily.
- Using dental floss and/or interdental brushes to clean in between the teeth if advised by the dentist.

3. Oral cancer

Key messages:

Smoking and alcohol consumption greatly increases the risk of oral cancer.

Regular dental attendance is crucial for early diagnosis.

Early detection of mouth cancer is important, so 'if in doubt, get checked out'.

Oral cancer can affect any of the soft tissues of the mouth, head and neck: the lips, tongue, cheeks and throat. In the UK each year there are over 5,500 new cases and 1,800 deaths due to mouth cancer, a figure that is increasing.[18] The highest incidence of oral cancer, for both males and females, is in Scotland. Each year there are over 600 new cases and 200 deaths in Scotland.[19]

Risk factors

The major risk factors for oral cancer are tobacco use (all tobacco products), alcohol consumption and excessive exposure to the sun, which is linked to lip cancer.

Oral cancer is most common in those over 50 years old and those who smoke or drink alcohol. Oral cancer is twice as common among males as females.

Smoking and drinking heavily increases the risk of oral cancer by up to 30 times. This is thought to be because alcohol assists the absorption of tobacco into the bloodstream through the oral tissues. Therefore people who both smoke and drink alcohol have a greater risk of oral cancer than those who either use tobacco or drink alcohol.[20]

Oral cancer incidence is strongly related to social and economic deprivation, with the highest rates occurring in the most disadvantaged sections of the population.[21] This reflects the higher tobacco consumption and poor diet in the more disadvantaged groups. The association between deprivation and oral cancer is particularly strong for men.

Prevention

Regular dental attendance is crucial for early diagnosis of oral cancer. About half of diagnosed cases prove fatal, but survival chances are much improved with early detection. If oral cancer is diagnosed early, it will respond better to treatment and the chances of cure are increased. For this reason, it is important to visit the dentist regularly. Unfortunately, dental registration and regular attendance are not common in the homeless population.

Preventive tips are summarised in Box 2.

Box 2: Tips for prevention of oral cancer

Annual examination by a dentist.

Stop smoking.

Keep to safe drinking limits.

Eat a healthy diet with lots of fruit and vegetables to maintain mouth health.

How do you spot oral cancer?

The first sign is often a non-healing mouth ulcer or a red or white patch in the mouth. If a mouth ulcer has not healed after two weeks, or there are any unusual changes in the mouth, clients should be advised to visit a dentist as soon as possible for an examination. The number of deaths could be greatly reduced if people were more aware of the symptoms.

What to look for:

Any white, red or speckled patches.

Ulcers or sores that do not heal within two weeks.

Lumps or bumps in the mouth or on the lip.

Unexplained speech patterns or difficulty in swallowing.

See also the sections on smoking and alcohol in Unit 3.

Oral health care and daily routines

Key message:
Brushing teeth twice a day for at least two minutes with fluoride toothpaste is an effective way of removing plaque, which is the main cause of tooth decay.

Toothbrushing

Toothbrushing with a fluoride toothpaste helps to remove plaque.

Thorough toothbrushing using fluoride toothpaste, twice a day, for at least two minutes, is an effective method of removing plaque and applying fluoride to the tooth surface. This prevents gum disease and tooth decay.

Toothbrushing technique varies (clients are advised to discuss this with their dental hygienist, dentist, etc. if they are unclear). The most important advice is to ensure all surfaces are cleaned and that they are cleaned thoroughly.

Brush in a systematic order: brush all tooth surfaces, including the inside. Tilt the brush vertically and use small circular movements. Brushing the tongue will help freshen breath and will clean the mouth by removing bacteria.

Toothbrushing dos and don'ts

Do brush twice a day, for at least two minutes, using a fluoride toothpaste.

Do brush in a systematic order, ensuring that all surfaces are cleaned.

Do brush gently. Excessive pressure when brushing can increase gum recession and damage to the enamel by mechanical abrasion.

Don't rinse the mouth after toothbrushing. Fluoride in toothpaste at least 1000 ppm (parts per million) helps to harden the tooth's outer surface. However, the fluoride needs to be in contact with the surface. Rinsing the mouth out will wash the fluoride from the surface.

Don't brush the teeth straight after eating or drinking something acidic. The acid attack will weaken the enamel and may damage the enamel surface further by mechanical abrasion through brushing. Allow at least 30 minutes to 1 hour before brushing.

Don't use toothbrushes belonging to other people, as there is a risk of catching Hepatitis B, Hepatitis C and other diseases.

Types of toothbrush

The benefits of regular toothbrushing occur whether the toothbrush is manual or powered. Both types of brush can effectively clean the teeth.

Manual toothbrushes

Size: The toothbrush should be the right size for the mouth and teeth – it should not be uncomfortable to use.

Bristles: Toothbrushes are available with soft, medium or hard bristles. For most people, a soft- to medium-bristled toothbrush is the most comfortable and safest choice; hard-bristled brushes can potentially damage the tooth enamel.

Toothbrushes should be replaced every three months.

Electric toothbrushes

Rechargeable electric toothbrushes can benefit people with limited dexterity or those who find it difficult to brush their teeth. Electric toothbrushes that take batteries have been shown to lose power and are therefore not as effective as rechargeable ones.

Mouthwash

Mouthwash will help freshen breath but thorough brushing is sufficient to maintain good oral health. Mouthwash should never been used as an alternative to toothbrushing. If you choose to use mouthwash, use one that contains fluoride and does not contain alcohol, and do not use it immediately before or after brushing.

Denture cleaning

Unclean dentures can cause mouth infections (e.g. thrush) so it is important they are cleaned properly. They should be cleaned similarly to the way teeth are cleaned. Ensuring partial dentures are cleaned properly will prevent further tooth loss and inflamed gums.

Denture hygiene methods

- Poor denture hygiene can lead to a build-up of dental plaque on dentures and cause denture stomatitis (an area of redness under an upper denture).
- Ideally, dentures should be rinsed after every meal.
- Clean dentures morning and night using a toothbrush and unperfumed soap and water or denture cream.
- Clean palate, gum ridges and tongue with a soft toothbrush.
- Best practice guidance states that plastic dentures should be soaked daily in a solution of sodium hypochlorite (1 part to 80 parts cold water which equates to roughly ½ a teaspoon in a denture bowl). This should be for at least 20 minutes before rinsing and leaving in plain water for the rest of the night.
- If patients prefer their own denture soaking solution, this can be used after the 20-minute soak in sodium hypochlorite.
- Metal-based dentures should be soaked in chlorhexidine 0.2% solution.

Again these guidelines are generic and will need to be tailored to the specific needs of the homeless person.

Sugar-free chewing gum

Saliva fulfils a major protective role against tooth decay. Chewing sugar-free gum containing xylitol or sorbitol after eating or drinking may have a positive benefit for dental health by increasing saliva flow, which helps neutralize plaque acid activity. Xylitol also has antibacterial properties.

Tip:

Brushing teeth twice a day with fluoride toothpaste, and cleaning between the teeth with floss and/or interdental brushes will help protect against gum disease and tooth decay. Regular dental attendance will also help keep the mouth healthy. Finally, try to avoid snacking on sugary foods and drinks throughout the day. Keep sugar to mealtimes only.

Dental attendance

Regular dental attendance is recommended to make sure the teeth are checked for signs of early decay, allowing the dentist to restore the tooth before the decay progresses. Teeth can be restored relatively pain-free if decay is detected and treated early. Visits to the dentist also allow dentists and hygienists to offer oral health promotion advice and specialist dental advice, preventative treatments, and identify and diagnose oral health problems earlier.

Everyone, irrespective of age and dental condition, should have regular oral examinations – yearly for those under 18 years of age and at intervals of no more than 2 years for all adults.

This advice also applies to those without any natural teeth. Children and those at risk from oral diseases may need to be seen more frequently, as advised by the dentist. Smokers and drinkers have an increased risk of oral disease so may need to be seen more frequently by a dentist.

Registration

In order to receive the full range of dental treatment and care under the NHS, a patient must be registered with a dentist. In order to do this, they must give an address; however, this could include a hostel.

From 1 April 2010, when a patient registers with a dentist, they are registered for life unless they or the dentist request the registration to be withdrawn. If a patient attends another dentist for treatment and does not inform them that they are registered elsewhere, their registration will automatically transfer to that practice.

Once registered, a dentist cannot refuse to provide a registered NHS patient with any treatment they need to secure and maintain their oral health under the NHS. Clients should discuss their dental needs with the dentist – a staged approach may be necessary to ensure the restoration of full oral health.

When attending for treatment, an NHS patient will be asked to sign a GP17 form; this must be signed only in the appropriate places, particularly regarding whether the patient will have to pay. At the end of the treatment, the patient will be required to sign to confirm that treatment has been completed.

Dental services

General dental services

General dental services (GDS) provide the majority of dental services. In Scotland, general dental services account for approximately 75% of all NHS dental services. General dental practitioners (GDPs) or dentists are independent contractors who are paid through the NHS to treat patients. Some GDPs undertake only private work; many accept NHS and private patients.

Patients who are not registered with an NHS dentist but wish to register should contact their local NHS Primary Care Services department (see Local information section for further details)

NHS dental treatment charges

NHS dental examinations (check-ups) are now free to all patients resident in Scotland. There may be charges for follow-up treatment (see below).

Other UK residents visiting Scotland are also able to access free dental examinations but overseas visitors are subject to the National Health Service (Charges to Overseas Visitors) (Scotland) Amendment Regulations 2006.

Patients can get free dental treatment if:

- they are under 18 years old
- they are aged 18 and in full-time education
- they are pregnant
- they have had a baby in the previous 12 months, or have had a stillborn baby in the previous 12 months
- they are named on a valid HC2 certificate
- they are named on a valid HC3 certificate
- they or their partner are getting Income Support
- they or their partner are getting Income-based Jobseeker's Allowance
- they or their partner are getting tax credits and meeting qualifying conditions.

If patients are not entitled to free treatment or help with the cost then they will be expected to pay 80% of the cost of the treatment up to a maximum, currently £384 (as at 1 December 2010).

The following list outlines some examples of costs to patients:

Basic examination	free
Extensive examination	free
Simple scale and polish	£10.20
Two small X-rays and one small filling from	£13.32
One large filling (three surfaces) from	£17.76
Single simple tooth extraction	£6.36
Root filling front tooth	£37.36
A full precious metal crown from	£102.32
A full set of plastic dentures from	£140.28

(as at December 2010)

The total cost of NHS treatment may be different from these examples because of the number, or types, of treatment involved. However, this list gives some indication of treatment cost. Dental charges are subject to review and modification.

Help with NHS dental charges

If patients are on low incomes but are not automatically exempt from charges, they may be eligible for help. To find out, they must complete the form HC1 – Claim for help with health costs. This asks for details of individual circumstances such as the level of income, savings, etc. The claim will then be assessed.

If the application is successful, patients will receive either a HC2 or HC3 certificate:

- Certificate HC2 provides full help. The patient will not need to pay health costs.
- Certificate HC3 provides partial help. The patient will need to pay some of the costs.

Certificates are normally sent within four weeks of a claim being received. They are usually valid for six months. If individual circumstances remain unchanged after six months then, if necessary, a new claim should be made before the current certificate expires.

Patients should complete the special short claim form HC1 (SC) if either of the following applies:

- The patient lives in a care home paid for in part or in full by the local authority.
- The patient is aged 16 or 17, has recently left local authority care, and is supported by the local authority.

HC1 forms can be found at Jobcentre Plus offices, NHS hospitals, pharmacies, doctor surgeries, or dental surgeries.

More details can be found in the official information booklet HC1 *Help with health costs*.

Salaried dental services (SDS)

Salaried dental services (formerly known as community dental services) operate from a number of dental clinics in health centres and other locations within each NHS Board area. The SDS aim to complement the dental care provided by general dental practitioners.

The SDS only treats patients who, for some reason, cannot access general dental services, i.e. it provides dental care for patients who have particular medical or other special care requirements that make it difficult for some types of dental treatment to be provided in a general practice setting.

The types of patients treated by the salaried dental service include:

- children with dental anxiety or with high levels of dental disease
- children deemed to be vulnerable
- patients with learning disabilities
- medically compromised patients
- patients with a range of physical and psychiatric conditions
- pregnant and nursing mothers.

Patients are seen by appointment only. To make an appointment, or for further information, telephone the local salaried dental service office (see Local information).

Homeless dental service

In some NHS Board areas, the SDS runs a service for people experiencing homelessness who find it difficult to access mainstream dental services. The service will treat patients until they become dentally fit and will then encourage them to register with local dental practices for continuing care. See Local information for details.

Children whose families access dental services through the homeless dental service may be referred to the SDS for an appointment in a local clinic.

Emergency dental services (out of hours)

If patients need emergency treatment out of hours, and they are registered with a local dentist, then they should contact their dentist. The dentist will either have his or her own arrangements for emergency care or will be a member of the local NHS Board Emergency Out of Hours service. Whichever it is, there should be a message on the dentist's answering machine instructing the patient.

Patients who are not registered with a dentist and need emergency treatment during working hours can telephone their local NHS Board helpline (see Local information). Outside working hours, assistance is available by dialling NHS24 on 08454 242424.

Patient rights

The NHS is not bound to providing patients with an NHS dentist in the same way that they are with a doctor. However, they will help by providing names of dentists who are accepting NHS patients. It is then up to the patient to contact the dentist themselves.

If a patient is registered with an NHS dental practice, the dentist must offer the patient appropriate treatment to make him or her 'orally fit' or free from any disease by the end of the treatment. NHS treatment is guaranteed for one year and will be replaced free of charge within this time if necessary.

Cosmetic treatment that is not clinically necessary, such as tooth whitening, is not available on the NHS.

If a patient is required to pay for treatment, practices can ask that they pay at the end of treatment, after every appointment or at the beginning of treatment. It is a good idea to find out what the arrangements are at each dental practice. If the patient asks, the dentist must give them a written estimate of the cost of all treatment. The patient can refuse any treatment that he or she does not want to have.

Dentists can refuse to see a patient who has not paid for previous treatment. Dentists can charge for any missed appointments or cancellations at short notice. This is often outlined on the appointment card.

From 1 April 2010, when patients register with an NHS dentist they will be registered for life unless they or the dentist request registration to be withdrawn. Dentists can remove patients from the register for any of the following reasons:

- Regular missed appointments
- Persistent lateness
- Not paying for treatment
- Failure to follow dental recommendations
- Threatening or abusive behaviour
- Breakdown of professional relationship.

Unit 3

Giving health advice

The common risk factor approach to oral health

It is widely accepted that oral health conditions, such as those described in Unit 2, share 'common risk factors' with general health conditions such as cancers, heart disease and obesity. Therefore, in order to maintain good oral health, the mouth cannot be isolated from the rest of the body. Adopting behaviours conducive to good oral health will have a positive impact on general health.

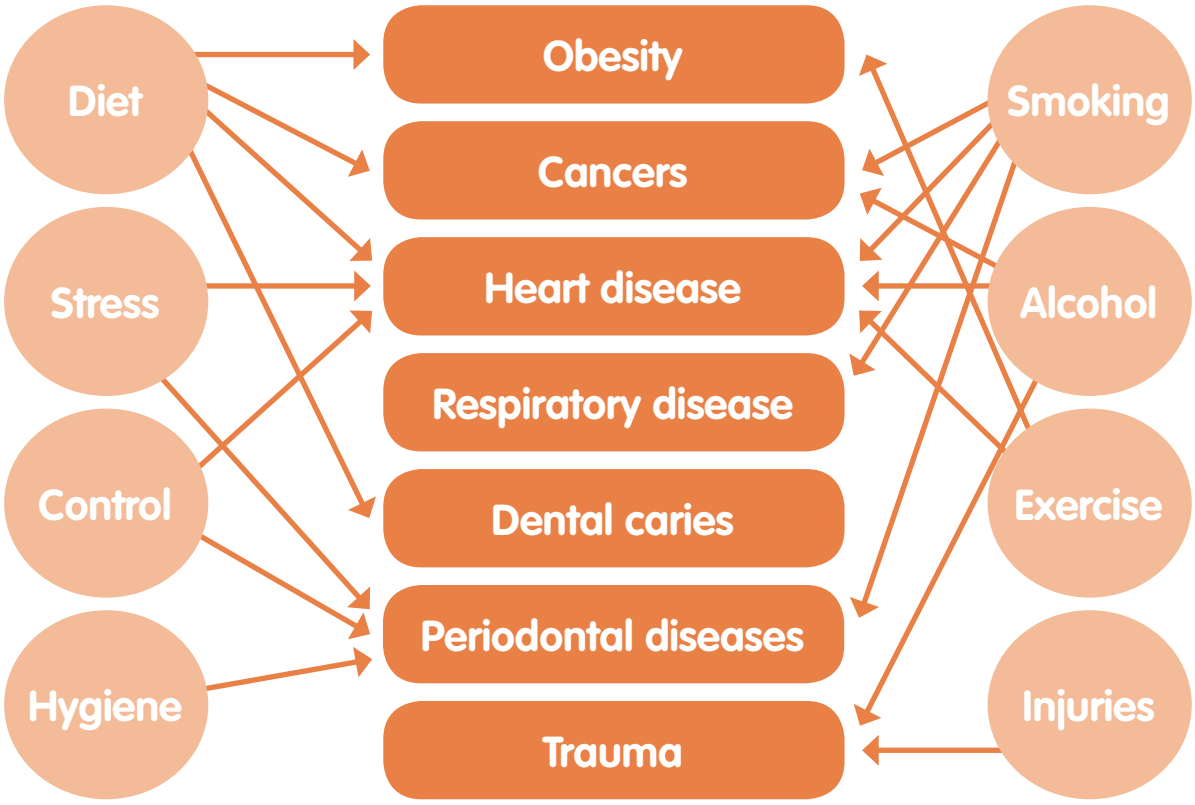


Figure 3: The common risk factor approach, modified after (Sheiham & Watt, 2000)[22]

Poor oral hygiene (see Unit 2) is the main cause of periodontal (gum) disease, and is also implicated in dental caries (decay).

A **diet** high in sugar and fat, and low in fibre and essential vitamins, is associated with conditions such as obesity, cancers, heart disease and dental decay.

Smoking is implicated in many diseases, including cancers of the lung, throat and mouth. In addition, smokers are more likely to have coronary heart disease, diabetes and periodontal (gum) disease, as well as other diseases of the soft tissues of the mouth.

1. Diet

Key message:
Foods containing sugars are harmful to the teeth, and the intake of such foods should be reduced.

Please note: the following is generic dietary information. Clearly not all of the foods listed will be available to people who are homeless so it should be adapted for training as necessary.

Sugar

Different types of sugar (partly adapted from FSA Eatwell website)

Sugar is present naturally in many foods such as fruit, vegetables and milk. These **intrinsic** sugars are less likely to damage teeth.

The **intrinsic** sugars found naturally in whole fruit are less likely to cause tooth decay because the sugars are contained within the structure of the fruit. But, when fruit is juiced or blended, the sugars are released and become **extrinsic**. Once released, these **extrinsic** sugars can damage teeth, especially if fruit juice is drunk frequently. These are known as **non-milk extrinsic sugars** and can cause tooth decay.

Sugar is added to many types of food, such as:

- fizzy drinks and juice drinks
- sweets, cakes and biscuits
- chocolate, chocolate products and chocolate-coated products
- breakfast cereals and cereal bars
- jam, marmalade and sweet spreads
- cakes, pastries and puddings
- ice cream and ice lollies.

Food and drinks containing lots of added sugars are often high in calories but equally have few other nutrients, so should only be eaten/drunk occasionally.

Sugary foods and drinks can cause tooth decay, particularly if they are consumed between meals or before bedtime. This includes fruit juice and honey. It's best to stick to having these kinds of foods and drinks at mealtimes.

It's also important to avoid sipping sugary drinks or sucking sweets too often. This is because the longer the sugar touches the teeth, the more damage it can do.

Fruit juice is a healthy choice, and counts as one of the five portions of fruit and vegetables that should be taken every day. It is best to drink fruit juice at mealtimes.

Cutting down on sugar

It's a good idea to try to cut down on foods and drinks that contain lots of added sugar, such as fizzy drinks, sweets and biscuits. This will help to keep teeth healthy. Many foods that contain added sugar can also contain lots of calories so eating less of these foods may help with weight control.

Some foods and drinks that may be perceived as 'healthy' can still contain significant amounts of sugar and thus contribute to tooth decay:

- **Dried fruit** has a high concentration of sugars so should be restricted to mealtimes.
- **Pure fruit juice** and **fruit smoothies** are not recommended between meals. Frequent exposure to the sugars and acids present when fruit is juiced can lead to tooth decay and dental erosion.
- Some **flavoured milks** and **drinking yoghurts** can contain a significant amount of added sugar.
- Some **flavoured yoghurts** and **fromage frais** can be high in sugar, particularly those containing chocolate, fudge or toffee.
- **Sugar-free/diet fizzy drinks** and **sugar-free fruit squash** are preferable to their sugary alternatives; however, due to their acidic nature, they can contribute to dental erosion.
- **Fruit squash/cordial, fruit-flavoured water** and **sports drinks** have a high sugar content and acidic nature.
- **Yoghurt-coated fruit and nuts** have a high sugar content.

When is the safest time to eat sugary foods and drinks?

If possible, sugary foods and drinks should be restricted to mealtimes. Saliva flow increases at this time and reduces the effects of plaque acid on the enamel. Avoid sugary snacks and drinks between meals or at bedtime. If snacking between meals, healthy, sugar-free snacks are best. The list below provides a number of suggestions:

- nuts
- cheese
- oatcakes or crackers
- plain yoghurt
- plain or savoury scones (avoid sugary toppings like jam)
- plain bagels, pancakes and crumpets (avoid sugary toppings like jam)
- sandwiches
- unsweetened or wholegrain cereal
- fresh soup
- raw vegetable pieces
- fresh fruit
- plain water
- tea or coffee (without sugar).

Healthy eating

The eatwell plate

This Food Standards Agency (FSA) education resource is a practical tool to help people understand and enjoy healthy eating. It shows the types and proportions of foods needed to make up a well-balanced diet that promotes good health and protects against the common diet-related diseases including heart disease, some cancers, obesity and tooth decay.

The eatwell plate applies to children over 5, young people, adults and vegetarians. The eatwell plate is widely used in a variety of settings to promote good nutrition for overall health.

The eatwell plate model is based on five food groups and shows how much of what is eaten each day should come from each group. This includes everything that is eaten during the day, including snacks.

For a balanced diet it is recommended that people should eat a variety of foods every day from the four main food groups:

- Plenty of bread, rice, potatoes, pasta and other starchy foods (yellow section of eatwell plate).
- Plenty of fruit and vegetables (green section of eatwell plate).
- Some milk and dairy foods (blue section of eatwell plate).
- Some meat, fish, eggs, beans and other non-dairy sources of protein (pink section of eatwell plate).

These provide the wide range of nutrients that the body needs to remain healthy, function properly and help prevent illness.

Foods in the fifth food group add extra choice and enjoyment to the diet, but they should form the smallest part of the overall diet:

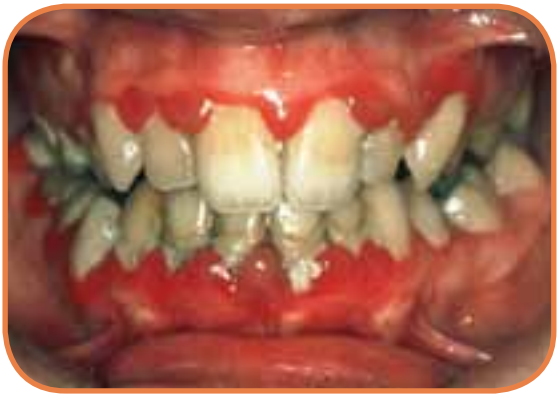
- Just a small amount of foods and drinks high in fat and/or sugar, so-called snack foods (purple section of eatwell plate).

2. Smoking

Key message:
Smoking damages the mouth, teeth and gums – it can cause tooth staining, gum disease, tooth loss, and in more severe cases, mouth and throat cancer.

How can smoking affect oral health?

Smoking stains the teeth yellow or brown due to the nicotine and tar content. It can make the teeth yellow in a very short time. The teeth of heavy smokers are often almost brown after years of smoking.



Mouth/teeth of heavy smoker

Smoking can lead to gum disease. Smoking causes the mouth to produce more bacterial plaque. As the gum becomes loose around the teeth this may lead to destruction of the root through decay, which will result in tooth loss. Infected gums are less likely to heal properly, because smoking affects blood flow to the gums. This may mask the severity of gum disease, as the gums are less prone to bleeding. Bleeding and inflamed gums are an early symptom of gum disease. Gum disease progresses more rapidly among smokers in comparison to non-smokers.

Smoking or chewing tobacco increases the chance of developing mouth and throat cancer. Every year thousands of people die from mouth cancer caused by smoking.

See Unit 2 – Oral cancer

3. Alcohol

Key messages:

Alcoholic drinks can cause dental erosion. Frequent consumption of alcohol can increase the risk of mouth and throat cancer.

Drinking and smoking to excess raises the risk of mouth cancer by up to 30 times, because alcohol aids the absorption of tobacco into the mouth.

How can drinking alcohol affect oral health?

Most alcoholic drinks contain sugar. Some are acidic and will cause dental erosion by eroding the enamel on the teeth. Drinking over a long period of time means the teeth are under acid attack for that whole period.

Drinking alcohol is the second most important cause of mouth cancer after tobacco. Frequent or excessive alcohol consumption increases the risk of developing mouth cancer. According to Cancer Research UK, 75–80% of mouth cancer patients say they frequently drink alcohol.[23] In Scotland, 35% of men and 26% of women consume alcohol in excess of the recommended number of units per week.[23]

People who smoke and drink alcohol have the highest risk of mouth cancer. Excessive smoking and drinking raises the risk of mouth cancer by up to 30 times as alcohol aids the absorption of tobacco into the mouth.[24] For non-smokers, the amount and the frequency of alcohol consumption are the most important risk factors for mouth cancer.

4. Methadone

Key messages:

Methadone hydrochloride is an acid that attacks tooth enamel.

Saliva is the mouth's natural defence against plaque acid attack and helps to reduce tooth decay. Methadone reduces saliva flow, causing a dry mouth.

Always rinse the mouth with water after taking methadone.

Chewing sugar-free gum after taking methadone stimulates saliva flow and helps reduce the plaque acid in the mouth, thus reducing the chance of tooth decay.

What is methadone?

Methadone hydrochloride is a synthesised substance that has similar pharmacological properties to a particular group of drugs often called opiates, opioids or narcotics, e.g. heroin, morphine. Methadone works by binding to receptor sites in the brain to bring about similar effects to other opiates but without the euphoric side effects. Owing to these similar properties, methadone can be used to reduce the cravings from opiates without causing the extreme highs and lows experienced with other opiates, thus making methadone a suitable therapy for treating withdrawal and dependence from opiate addiction.

Methadone is typically dispensed as a syrup formulation, which is taken orally once a day and is available in the standard (sugar-containing) formula or a sugar-free variation.

Methadone and oral health

While there is no conclusive evidence that methadone on its own can cause harm to oral health, there are some known risk factors and precautions that can be taken to reduce any harm to oral health in patients receiving methadone:

Diet: It is frequently reported that opiates will directly induce dietary changes which are typically characterised by a craving for sugary foods. These dietary changes have been linked to dental decay as a consequence of the increased consumption of sugars. High or frequent sugar intake in the diet should be avoided (see Unit 2).

Dry mouth: Opiates reduce the flow of saliva, which is the body's natural defence against acid, leading to dry mouth.

Chewing sugar-free gum after taking methadone can help stimulate saliva and reduce the chance of tooth decay. Speak to the dentist about other available products which can help reduce the effects of dry mouth.

Sugar content: some formulations of methadone contain sugar. Brushing teeth twice a day with fluoride toothpaste, and cleaning between the teeth with floss and/or interdental brushes will help protect against gum disease and tooth decay. Regular dental attendance will also help keep the mouth healthy. Finally, try to avoid snacking on sugary foods and drinks throughout the day. Keep sugar to mealtimes only.

Acidity: as an acidic compound, methadone can cause direct erosion of the tooth enamel. Always ensure the mouth is rinsed with water straight after consumption.

Chewing sugar-free gum will also stimulate saliva production as saliva acts as a buffer to neutralise the acidity in the mouth.

Tip:

Chewing sugar-free gum (containing xylitol) after taking methadone will help stimulate saliva and reduce the chance of tooth decay. If possible, also rinse the mouth with water or fluoride mouthwash, if advised by your dentist. This will reduce some of the effects of the acids. Brushing teeth immediately after taking methadone is not recommended.

Following the advice in Unit 2 will assist with maintaining good oral health and minimising the decay experience.

Note: The advice contained here does not include all the side effects that result from methadone use. It should not be used in the guidance or management of methadone use. If methadone users experience any side effects from the formulation, prescribing staff should be consulted immediately.

Part III:
Smile4life intervention

Unit 4

Behaviour change

The Smile4life intervention

In the previous Units of Smile4life you have been provided with background details of the relationship between homeless, health and oral health. We have provided information of the barriers and enablers to accessing oral health care and health education information; on what behaviours lead to good oral health; sugar as a causative factor in tooth decay; plaque as a cause of gum disease and smoking and alcohol as causative factors for mouth and throat cancer.

We have provided you with information about the common risk factor approach to put into context the causative factors for oral disease which are in common with other physical diseases. This showed you that when anyone stops smoking they will, for example, improve their gum health and reduce their risk of getting a number of cancers.

These Units equipped you with the knowledge necessary to help prevent oral diseases. Unit 4 of Smile4life is to equip you with the necessary skills to put your knowledge into action. This final Unit is in three parts: [1] information on the development of Smile4life; [2] how to support oral health prevention and behaviour change; and [3] how to tailor Smile4life to make every contact with a homeless person an opportunity for oral health promotion.

You will notice that this Unit is written in the first and second person. This is to show the interactive nature of the Smile4life intervention.

[1] **Background to the Smile4life intervention** will provide you with a summary of the Smile4life Oral Health Survey Report as well as outlining the three client-centred stages of the Smile4life intervention and staff participation roles to make every contact with a homeless person an opportunity for oral health improvement.

[2] **Supporting oral health promotion and behaviour change** will provide you with details of how to assess patient types; how to gauge your client's wishes to engage with oral health services and how to support them though a time of change using motivational interviewing. Models of health behaviour change are presented to give a theoretical basis to this section.

[3] **Tailoring the oral health message.** This part is about putting together a tailored message for your homeless client. In order to do this, we have provided two questionnaires that you may want to use to help you find out about your homeless client's wishes for engagement with oral health and to tailor oral health care to the needs of your client. The first questionnaire assesses readiness to change, and using the key provided allows tailoring of the oral health message. The decisional balance instrument allows the reasons for difficulties (barriers) in engagement with services to be raised and once more allows tailoring of Smile4life for the homeless client.

1. Background to the Smile4life intervention

The aim of Smile4life was to facilitate the development, implementation and evaluation of an evidence-based oral health preventive programme for people experiencing homelessness across Scotland. The first stage involved conducting a needs assessment: the Smile4life survey. A total of 853 people experiencing homelessness took part across the seven participating NHS Board areas. Participants received an oral examination and completed a questionnaire that covered a variety of topics including general health, dental attendance, previous treatment experiences, dental anxiety, oral health-related quality of life, and depression. The survey work was supplemented by in-depth interviews with a total of 35 homeless people in four Scottish cities.

Main findings

In comparison to the general population, the homeless participants had fewer natural teeth and around half the number of filled teeth. Ninety-eight percent had tooth decay and 58% had abscessed teeth. Fifty-two percent of the people who took part had missing teeth due to having them extracted at the dentist. The increased number of decayed and missing teeth suggested that this population of homeless people attended for dental treatment only when experiencing pain. With regard to dental treatment, three-quarters of the sample stated that they had had painful teeth extracted, but their experience of preventive oral health treatments was poor, with only 14% having had fluoride treatments.

Dental registration and attendance was low. One third of the sample stated that they were registered with a dentist, although only 15% of respondents had visited a dentist in the previous 12 months. The majority of those surveyed stated that 'pain/trouble with teeth' was the reason for their last dental visit. Only 21% had attended for a routine examination or check-up.

The poor oral health status of this client population had an impact on their quality of life. Many people felt embarrassed and self-conscious about the appearance of their mouth and teeth, while other frequently experienced impacts were painful aching and discomfort while eating. Poor oral health was also associated with depressed mood and extreme dental fear among this group: 20% of the participants were characterised as dentally phobic.

One-to-one interviews were conducted with a smaller sample of homeless people to explore what they thought about their oral health, general health and wellbeing. Many of those interviewed were aware that their teeth needed attention but often other priorities prevented them from seeking treatment. For others, dental attendance appeared to be dependent on the urgency and perception of treatment need. For those coping with a combination of urgent and immediate issues, oral hygiene and dental care tended to slip down the list of priorities, only resurfacing when pain was experienced and the need for treatment became urgent. Many people spoke about how difficult it could be to meet appointments made a long time in advance or to participate in health activities. Many were keen to access dental treatment and regain their oral health, although for some, particularly those who had not had any dental treatment for a long time, the prospect was daunting. Homeless people, therefore, face additional barriers in accessing oral health services such as low health expectations and feeling 'invisible' or discriminated against.

In summary, the survey showed that the oral health of homeless people is poor and reflects a pattern of irregular or emergency dental attendance associated with pain and discomfort. The interview findings showed that homeless people are concerned about their oral health. Support should be made available to those wishing to regain their oral health and enable them to take the necessary steps towards good oral health. This highlights the need to provide appropriate and accessible oral health care and oral health prevention for this population group.

The three client-centred stages of the Smile4life intervention (Figure 4)

Stage 1 – Basic S4L

This level of health care intervention is directed at clients who are currently not yet ready to change their behaviour. It is important to understand that healthcare professionals have a duty of care towards their clients but cannot impose their views on them. The role of the staff member here is to provide access to the educational material in the first instance, and if the client indicates that they are considering the messages, to then guide them towards a programme that they can adopt to improve their dental health, by moving towards Stage 2: Intermediate.

The basic intervention technique is designed to provide education about how the client's behaviours will have an impact on their oral health. Once the client has started to consider a change in their behaviour, adopting the motivational interviewing techniques as outlined in Stage 2 will allow staff to explore barriers to change, or costs and benefits. By working alongside clients it should be possible for staff to develop an appropriate programme that they are more likely to succeed with.

Resources for implementation

- Toothbrush and toothpaste pack
- Local information on dental services
- Units 2 and 3.

Stage 2 – Intermediate S4L

The intermediate level intervention is directed towards clients who are either ambivalent about change, preparing for change or starting to make changes. It is designed to complement the educational materials which appear at the basic level with further information that will allow the client to learn about maintaining good oral hygiene and the wider health messages that can have an impact on their oral health.

By expanding the resources to which the client has access, it is possible to build a more supportive environment whereby they can learn more about healthy choices and maintaining their new positive behaviours. Motivational interviewing will be an important component in ensuring open communication and recognising and responding to any barriers.

Resources for implementation

- Toothbrush and toothpaste pack
- Information leaflets, and local information on dental services
- Units 2, 3 and 4.

Stage 3 – Advanced S4L

The advanced level intervention is aimed at clients who have sustained a behaviour change over a significant period of time and have demonstrated an interest in improving health. Clients are encouraged to pursue and attend a course of dental treatment where necessary and appropriate.

Resources for implementation

- Toothbrush and toothpaste pack
- Information leaflets, and local information on dental services
- Units 2, 3 and 4.

Staff participation roles in the Smile4life intervention

There are three different oral health promotion roles for staff participating in the Smile4life intervention (Figure 5). These roles will be tailored to the organisational and staff resources and the degree of involvement with clients experiencing homelessness. For instance, a local authority housing officer may take on the **Information role**, whereas a key support worker may adopt the **Advocate role** and implement the three stages of the client-centred Smile4life intervention (Figure 4). The staff participation roles are:

- **Information role:** provide dental services information and dental health information.
- **Navigator role:** provide dental services information, dental health information, oral health promotion packs and assist with navigating clients to their dental appointments.
- **Advocate role:** implement the three client-centred stages of Smile4life.

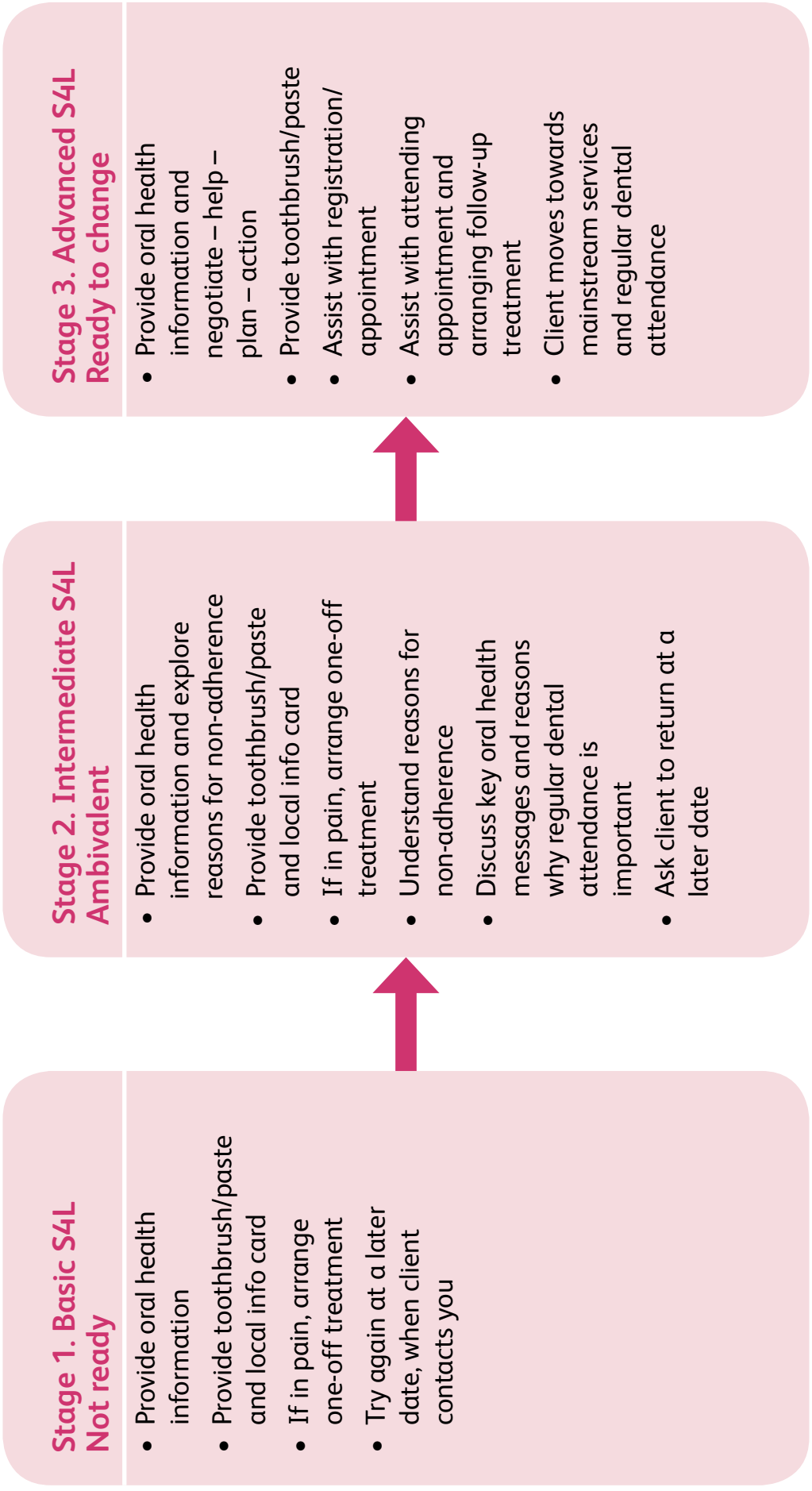
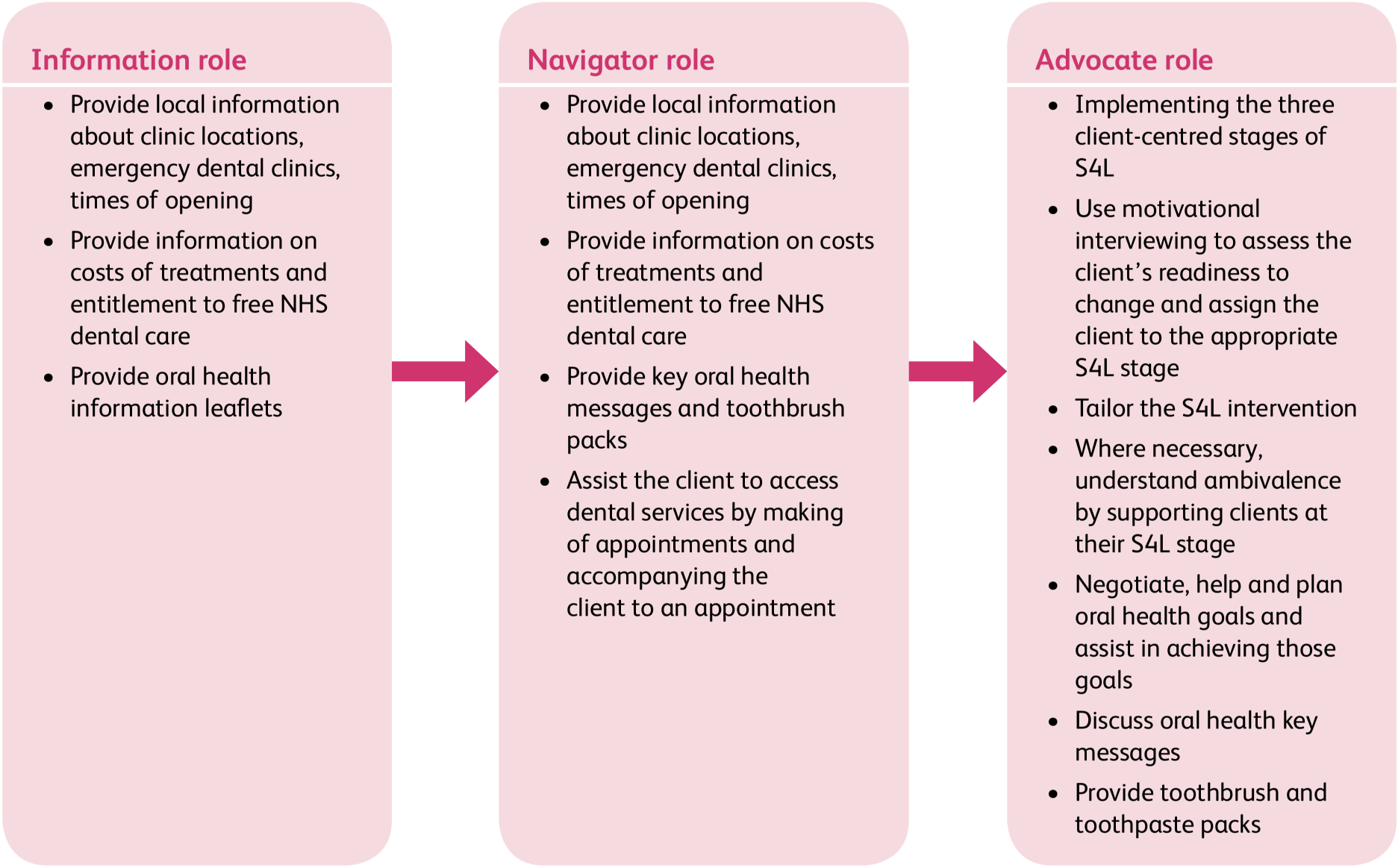


Figure 4: The three client-centred stages of the Smile4life intervention (S4L)

Figure 5: Staff participation roles in the Smile4life intervention



2. Supporting oral health and behaviour change

Clients' adherence with advice on oral health care is dependent on a range of factors such as perceived susceptibility to overall ill health, the potential severity of the oral health problem, and the 'costs' to the individual of making behaviour changes.[26] Bringing about lasting and effective changes in health behaviours is not about manipulating clients and getting them to follow health promotion advice. Rather, it is about exploring the clients' attitudes and values in relation to their own oral health and encouraging them to identify and express their own dental health needs, as well as empowering them to make any necessary changes in their own lives.[27]

Behaviour and behaviour change are complex processes. There is no simple method or strategy to predict or change behaviour. However, the more complex a process is, the more important it is to explore it from different perspectives. One role of service providers is to identify behaviours which may negatively impact on oral health, assess the client's state of readiness to change, and provide the appropriate level of help and support from the interventions available. This will enable the client to make the necessary changes.

Promoting oral health and facilitating healthy behaviour change in homeless people is a complex process, which may well be informed by behaviour change techniques. Overall, homeless people tend to have worse oral health than evident in the population as a whole (see Unit 1). Nevertheless, among this population group there are vast differences in individual oral health status as well as the readiness to adopt oral health behaviours.

Developing oral health interventions based on behaviour change models supports service providers in tailoring health messages or interventions to fit individuals or groups of people sharing the same characteristics. For example, the Precaution Adoption Process Model (Figure 6) may assist in identifying whether your clients are aware of oral health needs.

The Precaution Adoption Process Model

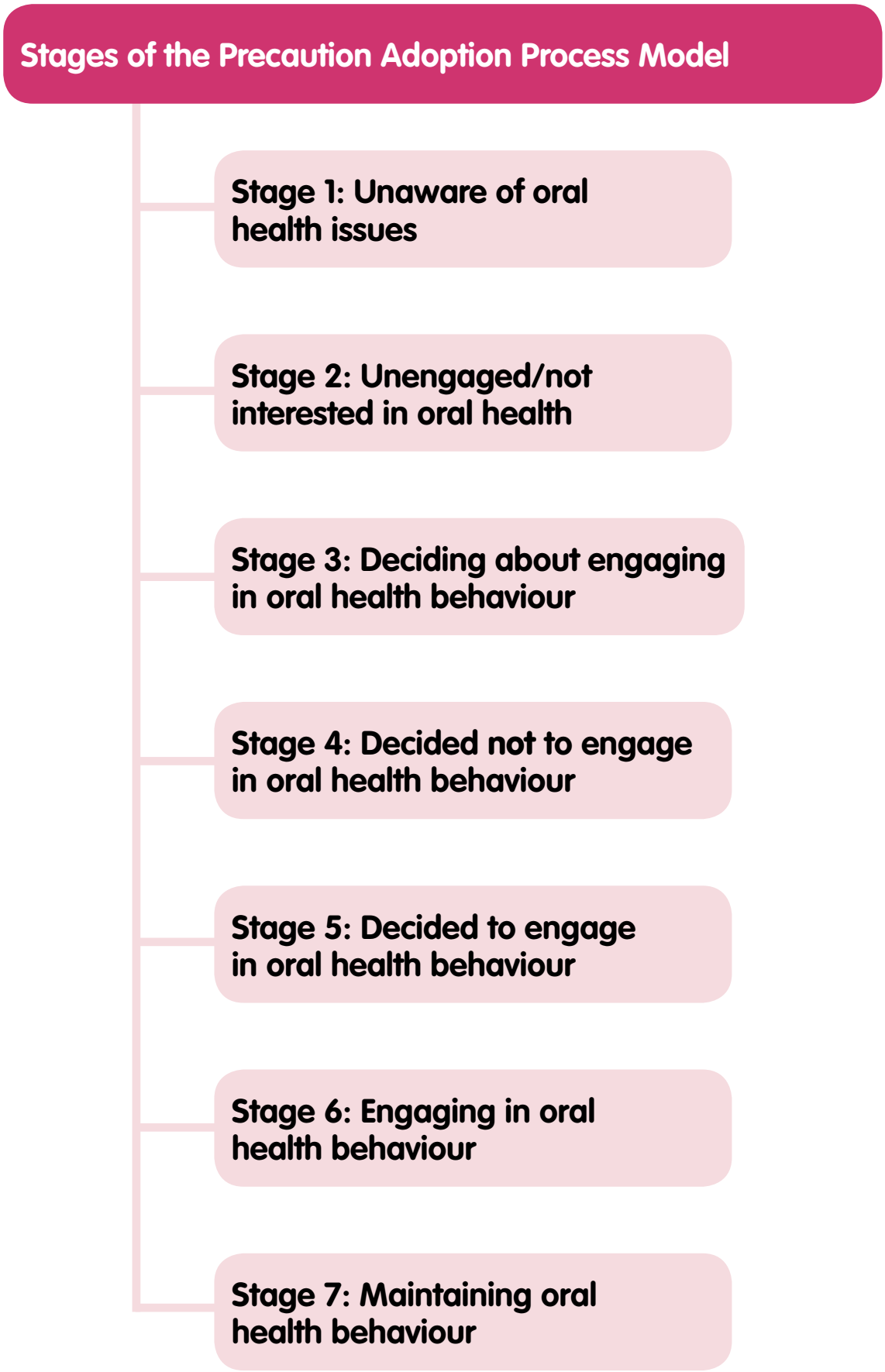
The Precaution Adoption Process Model does not rely on a client's level of previous engagement with oral health matters. Instead, using this model enables the service provider to focus on working with clients, regardless of whether clients are aware of oral health matters or whether they have stopped looking after their teeth. The Precaution Adoption Process Model (Figure 6) identifies seven stages ranging from being unaware to routinely engaging in healthy behaviours for oral health.

Depending on the stage they are at, clients show different patterns of behaviour. People at different stages also experience different facilitators and barriers to behaviour change. Clients unaware of an oral health threat (Stage 1) are likely to be unaware of their oral health needs. The first step towards adopting healthy behaviour in this client group is to raise awareness of their oral health habits. Other clients may have heard of the threats and may be starting to think about their oral health (Stage 2). At this time, however, they may not feel threatened by poor oral health. The service provider's task is to evoke in the client a sense of personal relevance of the health threat. A further group of clients is in the process of deciding whether or not to adopt preventive oral health behaviours (Stage 3). Usually, at this stage, clients have some level of personal experience of poor oral health. This stage is particularly important as clients decide either to act or not to act. The service provider's key role is to facilitate the decision-making process with effective communication and the use of available resources (see Motivational interviewing).

Good communication is essential at this stage, as the service provider needs to distinguish between clients who have not yet made a decision and those who have. Clients who have made a decision may have then considered the available information and decided not to act for whatever reason (Stage 4). They will be protective of their decision and resistant to attempts at persuasion or the provision of additional information.

Clients who decided to act (Stage 5) are usually grateful for any resources, information or advice to support taking action. Any resources or information they receive will influence the nature and extent of their oral health strategies (Stage 6). At this stage, they are usually appreciative of support. Once clients have started to engage in oral health behaviours they will be keen to turn the healthy behaviour into persistent habits, perhaps with support of their service providers (Stage 7), and, ideally, develop strategies to counter potential relapses.

Figure 6: Precaution Adoption Process Model



Supporting clients in making changes

Regardless of what stage of change readiness the client is at, the service provider is always well served by applying behaviour change methods aimed at facilitating the implementation of healthy behaviour. Two effective approaches are (i) implementation intentions and (ii) motivational interviewing.

Implementation intentions

The implementation intentions rests on the understanding that simply setting oral health goals does not necessarily mean that these are achieved. In fact, they rarely are. The implementation intentions facilitates the taking of healthy actions by providing cues to action. For example, an oral health focused implementation intention is 'before I climb into bed I will take my toothbrush, put toothpaste on it and brush my teeth for two minutes'. The more personalised the details, within reason, that can be added the better. Although very simple, this technique counters common barriers to action, including simply forgetting to act, not being aware of opportune times, having second thoughts at critical moments or relapsing into old habits.

Motivational interviewing (MI)

> 'A directive client-centred counselling style that is designed to assist clients in exploring and resolving ambivalence to increase motivation for change.'[28]

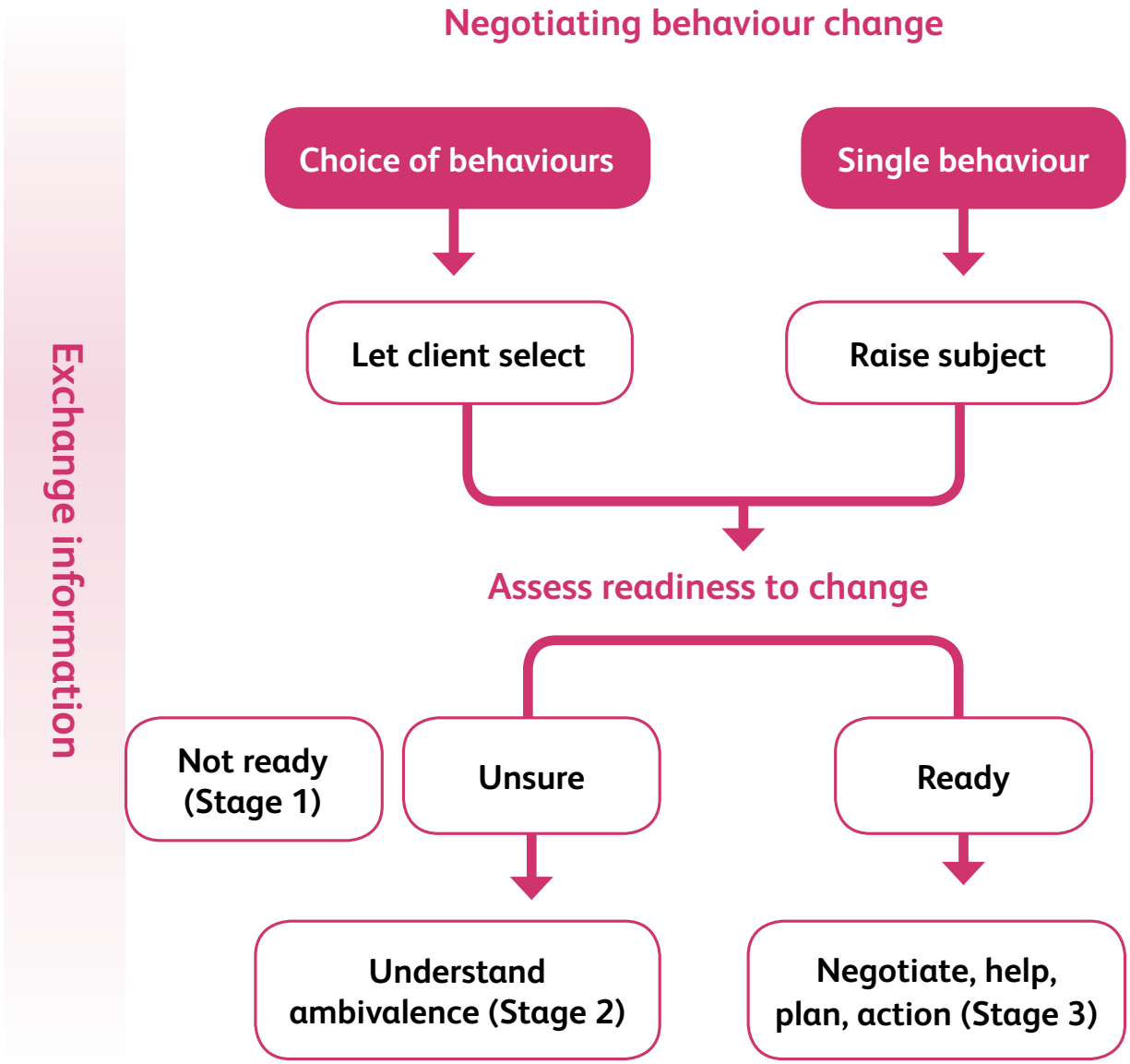
There will be times when, despite the provision of oral health information, clients will continue with their current patterns of oral health-related behaviours. One part of them may want to change while another part is quite resistant to change. They may access the health-related resources offered to them but also indicate their current dental behaviours are acceptable. These confusing messages can be described as ambivalence and are a natural occurrence in the change process, which should not be interpreted as a sign of unwillingness to change, denial or resistance.

Motivational interviewing is a method that can be employed by the service provider in order to help the client progress from feelings of ambivalence towards action and change (see Figure 7).

The MI approach is based on the general principles of:

- expressing empathy
- supporting self-efficacy
- rolling with resistance
- developing discrepancies in where a client is and wants to be.

Figure 7: Motivational interviewing



Expressing empathy

Being empathic means to 'walk in the client's shoes' or 'see the world through their eyes'. Clients who feel that a service provider understands their situation will find it easier to open up and share their experiences. The more open and honest a client is, the more information service providers will have at their disposal and the more they can anticipate facilitators and barriers to healthy behaviours. Moreover, clients who feel they are understood find it easier to explore their ambivalence about change and show less inclination to defend their beliefs and actions.

Supporting self-efficacy/affirmations

Clients may have low confidence in their ability to engage consistently in healthy behaviour. MI is used to build self-confidence and sustain client motivation, for example with the use of affirmations. Recognising and emphasising client strengths, even if unrelated to oral health, is a useful way to build confidence in clients. Affirmations allow service providers to communicate to the client that change is possible and that they have already demonstrated capable behaviours. Affirmations must be sincere or they risk damaging the relationship with the client.

'Rolling with resistance'

If a client shows resistance to any part of the process, the service provider does not address this unwillingness but, instead, rolls with it. S/he does not challenge but accepts the nature or reason for the client's resistance. However, the service provider continues to explore the client's point of view and encourages them to find their own solutions or ways forward.

Developing discrepancies

Rolling with resistance, for example, is used to identify and develop discrepancies between current behaviours and behaviours that help the clients achieve their goals. Once such discrepancies are established in a way that is not discouraging but motivating, they stop being problems and become motivators.

Communication strategies in MI

MI encourages service providers to engage in five simple but not always easy communication strategies.

1. Asking open-ended questions
2. Listening reflectively
3. Affirming client difficulties
4. Summarising periodically
5. Supporting the client in eliciting self-motivational statements.

1. Open-ended questions

Questions are open-ended if they cannot easily be answered with a simple response, e.g. 'yes' or 'no'. By adopting this questioning style, clients provide information about their current views and thoughts, which will inform further discussions. Typically, open questions start with phrases such as 'Why…' 'How…' or 'Tell me about…'

For example:

Closed question:

'How often do you brush your teeth?' Elicits a number response.

Open question:

'Tell me about your toothbrushing routine.' Elicits an open narrative.

In MI, open-ended questions are often used to review a client's typical day; to revisit past experiences or their thoughts about the future; to list helpful and problematic aspects of current behaviour, or to discuss the stages of change.

2. Listening reflectively

A key aspect of MI is being able to listen carefully to the client. There are many different levels of reflective listening. They share the aim of indicating clear interest to the client while allowing them to remain the 'driver' of the conversation. Reflective listening is particularly helpful when rolling with resistance.

Simply repeating what clients say helps to reduce resistance by acknowledging that they have been understood. Repeating client statements can be done in four ways:

- Repetition – simply repeating an element of what the client said.
- Rephrase – rewording for the purpose of clarification.
- Paraphrase – interpreting the meaning of what is said and reflecting this in one's own words, thus extending the conversation.
- Reflection of feeling – the deepest form of reflection, a form of paraphrasing that emphasises the emotional dimension through feeling statements, metaphors, etc.

Amplifying or exaggerating a client's statement is sometimes helpful in order to illicit a response. This technique should not be over-utilised as this can make the client feel mocked or patronised thus eliciting an angry reaction.

Reflection can also be used to highlight contradictions between current and past statements made by the client.

3. Affirming client strengths

As indicated above, recognising and emphasising client strengths, even if unrelated to oral health, is a useful way of building confidence in clients.

4. Regular summaries

Service providers should frequently summarise key points covered over the course of a conversation. This technique can be effectively adopted for a number of reasons, e.g. to draw attention to the key points discussed, shift attention to another topic, provide direction.

5. Eliciting self-motivational statements

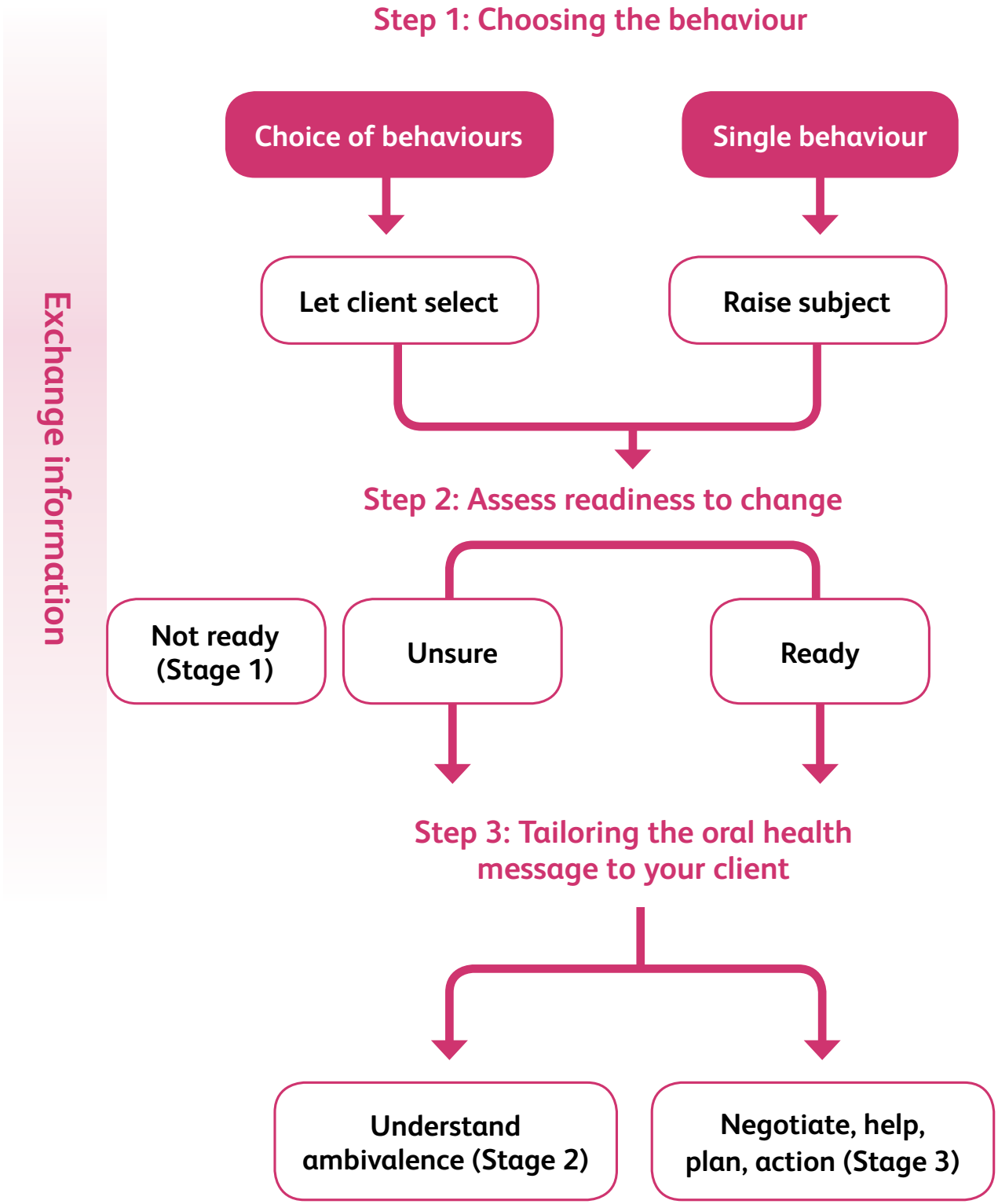
During conversations, clients are repeatedly encouraged to acknowledge and emphasise their strengths and resources. Discussing their future is a helpful tool in eliciting self-motivational statements.

Above all, the most important aspect of motivational interviewing is to ensure that good communication is maintained with the client. While interacting with clients there are some basic principles to remember:

- Allow the client to convince you of the problem behaviour and of the need for change because: 'I learn what I believe when I hear myself talk'.
- Avoid the question/answer trap as you won't be able to explore the clients behaviours or motivations for change.
- Avoid the confrontation/denial trap where your client is not yet ready to change and you may have to explore other motivators and barriers or revisit the behaviour at a later time.
- Avoid the expert trap – where you provide the direction or solution without first allowing your client to determine his or her own goals, direction and plans.
- Avoid labels – labels often carry a certain stigma and have a negative impact on the conversation.
- Avoid the premature focus trap – focus too quickly on a solution without giving your client a chance to explore the issues which matter to them.
- Avoid assigning blame – it is important that you are clear before commencing motivational interviewing that there is no blame to assign.

Further information about motivational interviewing can be found online at **http://motivationalinterview.org/clinical/interaction.html**

Figure 8: Motivational interviewing: tailoring the oral health message



3. Tailoring the oral health message

As previously discussed, the use of communication skills will allow your clients to speak of their concerns and worries about their teeth and is the basis of all tailoring of oral health education messages. Communication is an essential part of motivational interviewing. These communication techniques assist in drawing together the information needed to make the oral health improvement plan for your client. At the start this may feel like a long process but gradually it becomes quickly integrated into the care pathways for this client group.

Step 1: Choosing the behaviour

The first part of helping the client is to identify the health behaviour which they would like to or should be modified. Sometimes it will be apparent to you both what behaviour needs modifying; at other times you may want to raise the health behaviour or there may be a number of different behaviours which need to be changed and so your client may be given the opportunity to decide which one they would like to change. Pictures of different oral health behaviours may be presented to be discussed as shown in Figure 9.

Figure 9: Behaviour choice tool

Step 2: Assessing patient 'types' and readiness to change

There is a need to identify homeless clients wishing to access emergency/drop-in dental services and those who wish to access routine dental care. In addition, there is a need to provide targeted dental care provision as well as oral health promotion within a comprehensive approach.

A 'readiness to change' assessment tool can be used by staff working with homeless people to identify whether or not they are ready to change their oral health-related behaviour (see Figure 11).

Based on this assessment, one of the following oral health care strategies will be adopted:

- Clients who are **Not ready** will receive the **Basic** intervention: oral health information, toothbrush/toothpaste and local information, and one-off treatment if needed.
- Clients who are **Ambivalent** will receive the **Intermediate** intervention, where the same help will be provided as in the **Basic**, but in addition the staff member will use motivation interviewing techniques to find out why the person is ambivalent about their oral health.

The client will be asked to return at a later date to see if they are ready to move to the next stage.

- Clients who are **Ready to change** will receive the **Advanced** intervention. This includes the oral health information, toothbrush/toothpaste, etc. as in the previous levels, but additionally the staff member will work with the client to find a dentist, arrange appointments, assist with attending the appointments and arranging follow-up treatment. This will encourage the client to attend for a full course of treatment if needed, with the aim of moving them towards mainstream services and regular attendance.

The next stage is to assess if your client wants to change their behaviour. There are a number of techniques that may be used, depending on the time available. A simple, quick assessment is the 'readiness rule' (Figure 10) where the client is asked to point on the rule to indicate whether they think they are 'not ready to change', 'unsure' or 'ready to change'.

Figure 10: The Readiness Rule

Step 3: Tailoring the oral health message to your client

The identification of your client's readiness to change allows you to tailor your oral health input for your client's oral health needs.

- If your client is ready to change they will need to be supported and encouraged, and you need to negotiate their oral health goals with them. A simple way of doing this is to use the 'SMART' framework. Each health goal must be:

  S = Specific
  M = Measurable
  A = Attainable
  R = Realistic
  T = Time-related

- If your client is unsure they will need more time to come to a decision. Often people become stuck in being unsure and are said to be 'chronic contemplators' and so it is necessary to gather information, to identify and work through their feelings before any decisions may be made. It is important to understand what barriers obstruct their way in adopting new healthier behaviours. Another technique which allows the exploration of the client's ambivalence and the identification of the pros and cons of changing is the Readiness to Change instrument (Figure 11).

In some instances there will be extended periods of time over which a client's health behaviours can be explored and their ambivalence understood. However, within a homeless setting such opportunities are rare and a rapid assessment during brief contact times is a more likely situation.

The Readiness to Change instrument (Figure 11), in the form of a short questionnaire, consists of three questions and may be used to determine client ambivalence. The responses from the questionnaire can be interpreted using the key on page 75 to determine which stage of change the client is currently experiencing and which stage of the intervention is therefore most appropriate to meet their needs.

This three-item questionnaire[29] is designed to assess where clients are on the readiness to change cycle. A key based on the client's response is provided (Figure 12). This allows the support worker, service provider or health professional to place clients at a specific stage, which corresponds to their current pattern of dental attendance.

The identification of the stage the client has reached allows the support worker to tailor the Smile4life (S4L) intervention to the client's oral health needs and dental treatment requirements.

Figure 11: Readiness to Change instrument

1. How often do you go to the dentist?

- Never go to the dentist ☐
- When I feel like it ☐
- Occasionally ☐
- About once a year ☐

2. Why did you go to the dentist at your last visit?

- Never been ☐
- Had pain ☐
- Had an emergency ☐
- Check-up visit ☐
- To continue and finish a course of treatment ☐

3. In the next 12 months, do you plan to visit the dentist

- More often ☐
- About the same ☐
- Less often ☐
- Don't know/unsure ☐

Once you have completed the questionnaire (Figure 11) with your client you can start to use the key (Figure 12) to determine the appropriate Smile4life intervention stage for your client, based on their readiness to change. For example, if your client only attends the dentist when in pain and this has been their usual attendance pattern then according to the key (Figure 12) they will be offered the basic Smile4life intervention which includes assisting with attending a dentist for relief of pain, together with oral health information, toothbrush and fluoride toothpaste.

Figure 12: Readiness to Change instrument key for determining appropriate intervention based on client readiness to change responses

Responding to clients	Readiness to change	Frequency of dental visit	Reason for attending	Change in 12 months
Stage 1. Basic S4L Provide oral health info and toothbrush/paste One-off treatment if required	**Not ready**	Never	Never Pain Emergency	About the same Less often
Stage 2. Intermediate S4L Provide oral health info and toothbrush/paste One-off treatment if required **Motivational interviewing based on completion of decisional balance instrument (DBI)**	**Ambivalent**	When I feel like it	Pain Emergency	Don't know/ unsure
	Ambivalent	Occasionally	Check-up	More often
Stage 3. Advanced S4L Provide oral health info and toothbrush/paste Course of treatment	**Ready to change**	Once a year	Check-up Course of treatment	
	Maintenance	Once a year	Check-up Course of treatment	

Decisional balance instrument (DBI) (Figure 13)

An additional questionnaire which may be of help to you is called the decisional balance instrument (DBI): [29] you may use the DBI with clients who are unsure or who are thinking about preparing for change (Key: Stage 2. Intermediate S4L).

If you wish to explore your client's uncertainty in greater depth you may ask them to complete the decisional balance instrument. At first sight this seems a long questionnaire but it allows specific barriers to be explored with the client. Reasons raised in the questionnaire include travelling problems; fears of costs of treatment; difficulty in remembering to attend; feelings of embarrassment about the state of teeth and gums and so forth. The decisional balance instrument puts into action the information on barriers and enablers to oral health care you heard about in the earlier units of Smile4life.

If your client is **Not ready** to change, you must respect their autonomy, explore and understand their reasons, provide support and information on oral health as well as providing toothbrush and fluoride toothpaste. You must allow the client to make their final decision.

Once you have assessed your client's oral health needs and their readiness to change, you will be able to tailor your Smile4life intervention to the felt and expressed needs of your homeless client.

Figure 13: Decisional balance instrument [29]

Here are some possible reasons why you might decide to go, or not to go, to the dentist.

Circle the number from 1 to 5 that shows how much of each of the following reasons affect your decision to go, or not to go, to the dentist:

	Does not influence me at all	Influences me hardly at all	Influences me slightly	Influences me quite a lot	Influences me greatly
It can be difficult to get to see a dentist	1	2	3	4	5
Waiting a long time for an appointment	1	2	3	4	5
Travelling to get there	1	2	3	4	5
It makes me anxious	1	2	3	4	5
Having to make an appointment in advance	1	2	3	4	5
People at the dentist may make judgements about me	1	2	3	4	5
My teeth will look good	5	4	3	2	1
It might be painful	1	2	3	4	5

	Does not influence me at all	Influences me hardly at all	Influences me slightly	Influences me quite a lot	Influences me greatly
Difficulty remembering to go	1	2	3	4	5
To prevent tooth decay and pain	5	4	3	2	1
I can enjoy eating	5	4	3	2	1
To prevent toothache	5	4	3	2	1
Improves my self-confidence	5	4	3	2	1
Waiting in the waiting room with other people	1	2	3	4	5
Having a numbing injection	1	2	3	4	5
Having teeth drilled	1	2	3	4	5
Having teeth out	1	2	3	4	5
To prevent gum disease	5	4	3	2	1

	Does not influence me at all	Influences me hardly at all	Influences me slightly	Influences me quite a lot	Influences me greatly
Having to pay	1	2	3	4	5
Having to go back for more treatment	1	2	3	4	5
I haven't been to the dentist for a long time	1	2	3	4	5
I won't feel embarrassed about my teeth and mouth	5	4	3	2	1

Appendices

Further information

Useful websites

Smile4life
Smile4life related resources.
www.dundee.ac.uk/dhsru/smile4life

British Dental Association Patient Website
A useful website with a FAQs section that explains different types of dental treatment.
www.bdasmile.org

British Dental Health Foundation
A charity dedicated to raising public awareness of oral health and promoting good dental health practices. The FAQs section will answer most of the questions people may ask: click on the section entitled 'For the Public'.
www.dentalhealth.org.uk

Scottish Dental
Information about dentistry in Scotland. Explains the costs of NHS dental care, how to find a dentist, and how to access emergency care: click on the section entitled 'For the Public.'
www.scottishdental.org

Childsmile
National oral health initiative for Scottish children.
www.child-smile.org.uk

NHS Direct
www.nhsdirect.org

Healthy Living Initiative
www.healthyliving.gov.uk

EatWell
Hints and tips for healthy eating.
www.eatwell.org.uk

NHS Health Scotland
Information about the organisation, library service, resources and news.
www.healthscotland.com

Cancer Research UK
Mouth cancer and alcohol information page.
www.openuptomouthcancer.org/reduceyourrisk/alcohol/index.htm

British Dental Health Foundation mouth cancer information site
Mouth cancer information site.
www.mouthcancer.org/public

Motivational Interviewing
Information on motivational interviewing techniques.
http://motivationalinterview.org/clinical/interaction.html

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Local information

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