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Short Communication

From Recovery in Mental Health to Recovery in Oral Health: Empowerment of People with Schizophrenia

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Abstract

In recent years, patient partnership has gained traction with regards to physical healthcare, while recovery has become the guiding principle of transformative action plans throughout the world, this time in terms of mental healthcare. Recovery-oriented mental health policies and systems seek to support the individuals with mental illness to live and remain active in their community that is to remain partners in, and of the community as a whole. In this paper we suggest the idea of applying patient partnership in combination to recovery values and principles; from mental health to oral health.

ABBREVIATIONS

CBPR: Community-Based Participatory Research; SMI: Serious Mental Illness

INTRODUCTION

In recent years, the British Medical Journal called for a "patient revolution" [1] and launched an innovative strategy to promote patient partnership [2]. Partnering with patients, their families, caregivers and support communities is more and more seen as an imperative for improving the quality, safety, value, and sustainability of health systems. This trend is also present in the field of mental health, as the contemporary recovery paradigm is now the guiding principle of progressive transformational action plans throughout the world. Much effort is going into the transformation of services and systems to achieve recovery-oriented outcomes [3]. Beyond reduction or remission of psychiatric symptoms, recovery-oriented mental health policies and systems seek to support the individuals with mental illness to live and remain active in their community, that is, so to speak, to remain partners in, and of the community as a whole. This claim derives from the Mental Health Consumer/Survivor Movement, and refers to a person's rights to self-determination and full inclusion in community life, regardless of disability status and with roots in the civil and social rights movements of the 1960s and 70s. It has recently been suggested that the idea of applying recovery values and principles not only to mental health but also to physical health might be promising [4]. In terms of trans-sectoral continuity, can recovery also apply to oral health?

In this paper we introduce a new program of therapeutic education which not only "focuses" on patients with schizophrenia but is being developed in close partnership with, and thus at least partly, by them. Groups of patients who meet the diagnosis of schizophrenia (Diagnosis: F20-F29) as defined in the International Classification Diseases-10th edition will be offered this health literacy module, which will hopefully encourage them to improve their oral hygiene by themselves and in partnership with a range of providers like dentists, psychiatrists, pharmacists, nurses, physicians, psychologists, caregivers, specialists in therapeutic education, and other persons with schizophrenia. Partnership among persons with the lived experience of mental illness might be the key for successful navigation across and beyond a multiplicity of sectors and stakeholders groups (e.g. mental health, chronic physical illness, dentistry, informal self-help, or family medicine).

MATERIALS AND METHODS

Indeed, the poor physical health faced by people with mental illness has been the subject of growing attention [5], but there has been less focus on the issue of oral health. This is nevertheless an important part of the overall physical condition of a person. In their original review on this topic, Kisely et al. report the reasons for poor oral health in persons with Severe Mental Illness (SMI, e.g. schizophrenia) and its impact on general health [6]. For persons

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with SMI, one of the most visible elements is edentulousness, with large numbers of missing or decayed teeth (leading to pain, infection, and masticatory and digestive problems). Dental caries and periodontal or infectious diseases, as well as metabolic disturbances induced by antipsychotic treatments (diabetes, obesity), poor diet and lifestyle behaviors (diet rich in sugar, use of psychoactive substances, such as tobacco, and inadequate oral hygiene) all contribute to poor health and diminished sociality, thus impacting self-esteem and mental health. Compared to patients with other types of mental illnesses (e.g. anxiety or depression), antipsychotic drugs taken by patients with schizophrenia can cause xerostomia, which is associated with several dental disorders, including caries, gingivitis glossitis, stomatitis, parotiditis, fissured tongue and tongue atrophy, and oral ulcers [7]. The consequence of the resulting hyposalivation is the worsening of periodontal diseases and rapid development of caries, and this is aggravated by dry mouth (xerostomia), which is a common side effect of many psychotropic medications [8]. Moreover, patients with schizophrenia visit dentists less frequently, compared to healthy people, because of their difficult financial conditions and a lack of motivation in the maintenance of dental hygiene due to the illness [9]. We would add that difficult relationships with professional care givers due to fear of mental illness or lack of training, and obstacles related to the health system in general in terms of access to private practice care, and the cost of dental care, also contribute to poor oral health. Kisely and colleagues make recommendations for management at the patient and the system level. Their recommendations are most relevant especially those regarding the importance of reconciling knowledge of the psyche, somatic disease, dentistry and medicine within the scope of a global care approach, and to promote prevention. Effective prevention in patients with schizophrenia requires the training of people who frequently interact with them, especially the family circle, community, medical and social services personnel, private nurses and general practitioners [10,11]. But this training must foster better understanding not only of the person's symptoms, but also of the person's challenges in terms of access to opportunities in order to avoid misunderstandings regarding their behavior. However, health beliefs are often not studied among this population with high medical and oral needs. A rational presentation of the causal links between health and inappropriate behavior is sorely needed if we wish to treat patients successfully over the long term [12] and to improve their overall quality of life and life expectancy.

Excess mortality rates due to the complications of a chronic physical illness in such patients are two or three times higher, corresponding to a 10-25-year reduction in life expectancy in comparison with the rest of the population [13]. Studies have shown that even when accepted for the treatment and management of a chronic physical illness, patients with a psychiatric condition are less likely to have comprehensive reviews. There is also a greater delay for medical and surgical interventions when compared to the general population [14], and this is also true in terms of oral health. The possible explanations for this disparity include: unhealthy habits like smoking or lack of exercise; side-effects of psychotropic medication; delays in the detection or initial presentation of a symptom leading to a more advanced disease at diagnosis; and inequity of access to services partly due to a lack of thorough investigation and poor patient-doctor and doctor-patient communication skills [15,16].

A joint France-Canada project has led our group to conduct a cluster randomized controlled trial to assess the effectiveness of a therapeutic educational program in oral health for persons with schizophrenia. The trial is in progress (Trial registration: Clinical Trials Gov NCT02512367), with the aim of supporting patients to take care of themselves and to improve empowerment and their oral health related quality of life [17]. This educational program is not only patient-centered but is being developed in close partnership with them and, shall we emphasize, by them. In this model, the person is in the best position to know how the disease interferes with his/her overall wellbeing.

This program was built using a multidisciplinary approach (dentists, psychiatrists, nurses, doctors, psychologists, caregivers, specialists in therapeutic education, and persons with schizophrenia). Groups of patients will be offered a health literacy module, which will hopefully encourage them to improve their oral hygiene, to present themselves to their primary care dentists, and to follow recommendations they understand. Expected outcomes would be an improvement in oral health (e.g. less decays). A dental panoramic film (orthopantomogram) will detect periodontal disease, fractures, tumors and bone disorders from teeth and conditions that may affect the jaw and sinuses.

The main objective of this study is to evaluate the effectiveness of a therapeutic education program in oral health for patients with schizophrenia in the context of a multi-site randomized controlled cluster study using a population with schizophrenia sample recruited from out- or in-patients in psychiatric hospitals in France. Therefore, 12 hospitals are being randomly allocated to four clusters (a cluster is composed of three hospitals) where benefiting from the program is available or not. It will be necessary to include 202 patients (101 per group) with a power $\beta = 80\%$ and a risk $\alpha = 5\%$. Assuming that approximately 10% of patients will discontinue the study prematurely (withdrawal of consent, lost to follow-up), we have estimated that we need to include 230 patients in total (115 per group, 23 per institution on average). These patients are being recruited and randomly allocated with a ratio of 1:1 to one of two conditions: control without intervention versus the group benefitting from the program. All participants at the twelve sites will be interviewed and clinically examined by the co-investigators. Each participant will undergo a clinical oral examination in the dental surgery of the hospitals participating in the study. Pre-packaged and disposable instruments will be used and cotton rolls will be used to remove plaque. Among other procedures (see Denis et al, 2016 [17] for further methodological details), periodontal disease will be evaluated by the Community Periodontal Index of Treatment Needs [18] to detect changes.

RESULTS AND DISCUSSION

In a previous study, Pelletier et al. confirmed the feasibility and acceptability of partnerships with patients with SMI in order to develop an interactive guide to improve access to primary care providers for the management of chronic diseases and health promotion [16,19]. This Interactive Guide for Medical Appointments was used to report, in this Journal, multiple chronic physical illnesses among a sample of patients with

schizophrenia in Montreal, Canada [4]. The new program of therapeutic education which is hereby introduced consists of enlarging the scope of such an approach in order to also include oral health with a Community-based Participatory Research (CBPR) approach. CBPR involves persons of primary interest in all aspects of the process, from conceptualization to data collection, through interpretation and dissemination of findings. Involving people about whom the research is conducted as research partners is a fundamental tenant of CBPR, and speaks to CBPR's roots in social justice and social change movements. With roots in feminist and postcolonial theory, CBPR is founded on the premise that knowledge is created in collaboration and that no research should be conducted on people under study without them as research partners for that study (Nothing about us without us). In addition, co-learning, a strengths-based approach, and acknowledgement of privilege and power are hallmarks of CBPR.

A life-course and inter-sectoral approach is warranted to go beyond a typically curative approach to mental, physical, or oral illness by which the professionals are the authority. Patients remain the best placed persons to incarnate a holistic approach to health in order to transcend these historic silos, which are artificial from their own daily life-course perspectives and trajectories. New strategies for navigating the complexities between multiple sectors need to be explored to address iniquity of access to services for this vulnerable population [20]. We suggest that partnership among persons with the lived experience of recovery, for mutual and organized self-support, will help to not limit a strategy in a particular sector, but to position this partnership in a trans-sectoral manner to support the person in its own individual recovery journey towards health and well-being. Can dentistry be revolutionized, too, by benefiting from the empowering recovery values and principles which are now becoming the norm in mental health?

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