Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

The future of Special Care Dentistry in Ireland ?

Annual Scientific Conference ISDH 2019, Naas Co Kildare

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7/06/19

Conflict of Interest Disclosure

I do not have any financial interests that would create a conflict of interest or restrict my independent judgment with regard to the content of this presentation

Global burden of disease

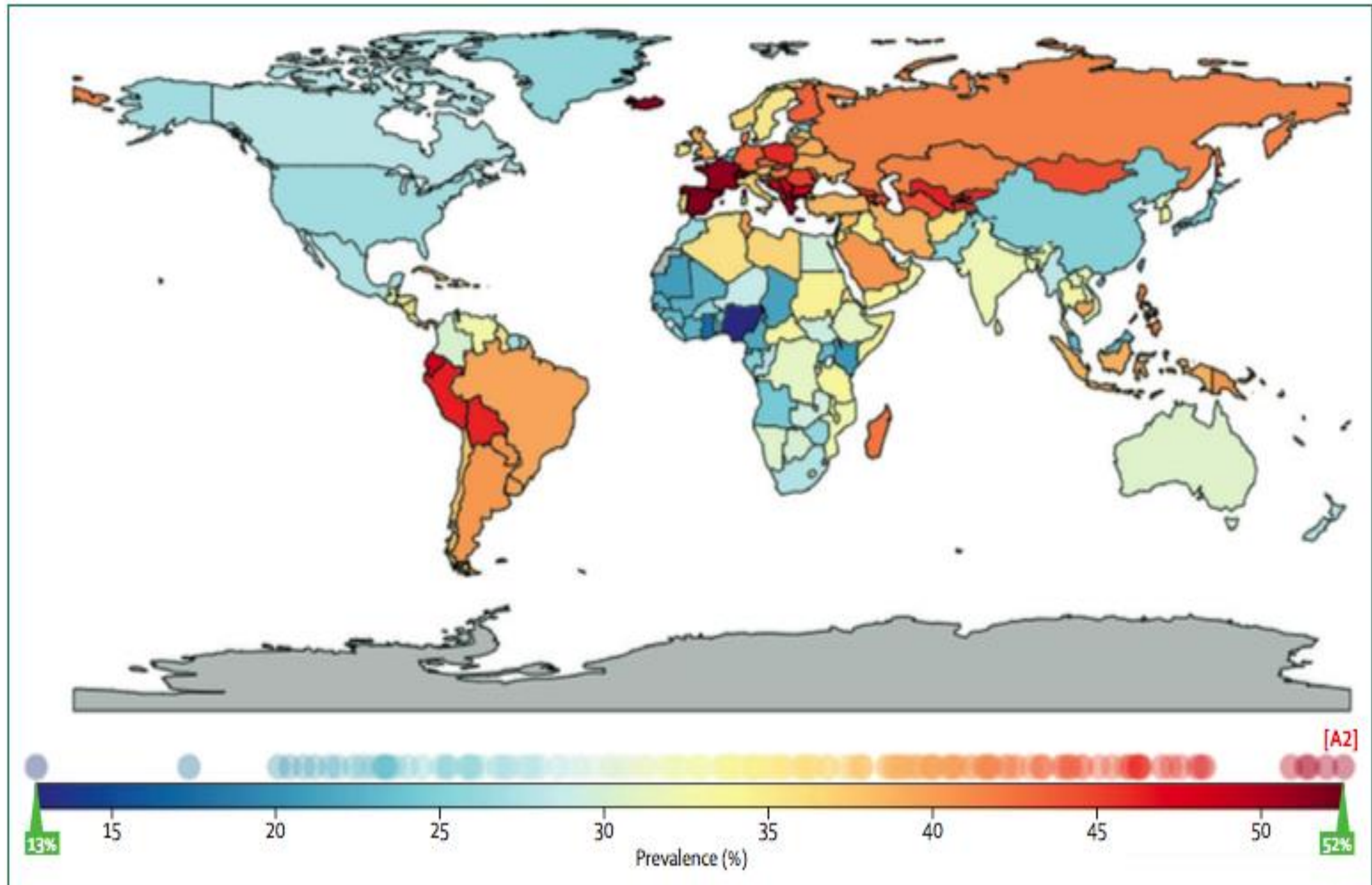

Figure 1: Estimated global prevalence of untreated dental caries in permanent teeth for 2017

Peres et al 2019

Global burden of disease

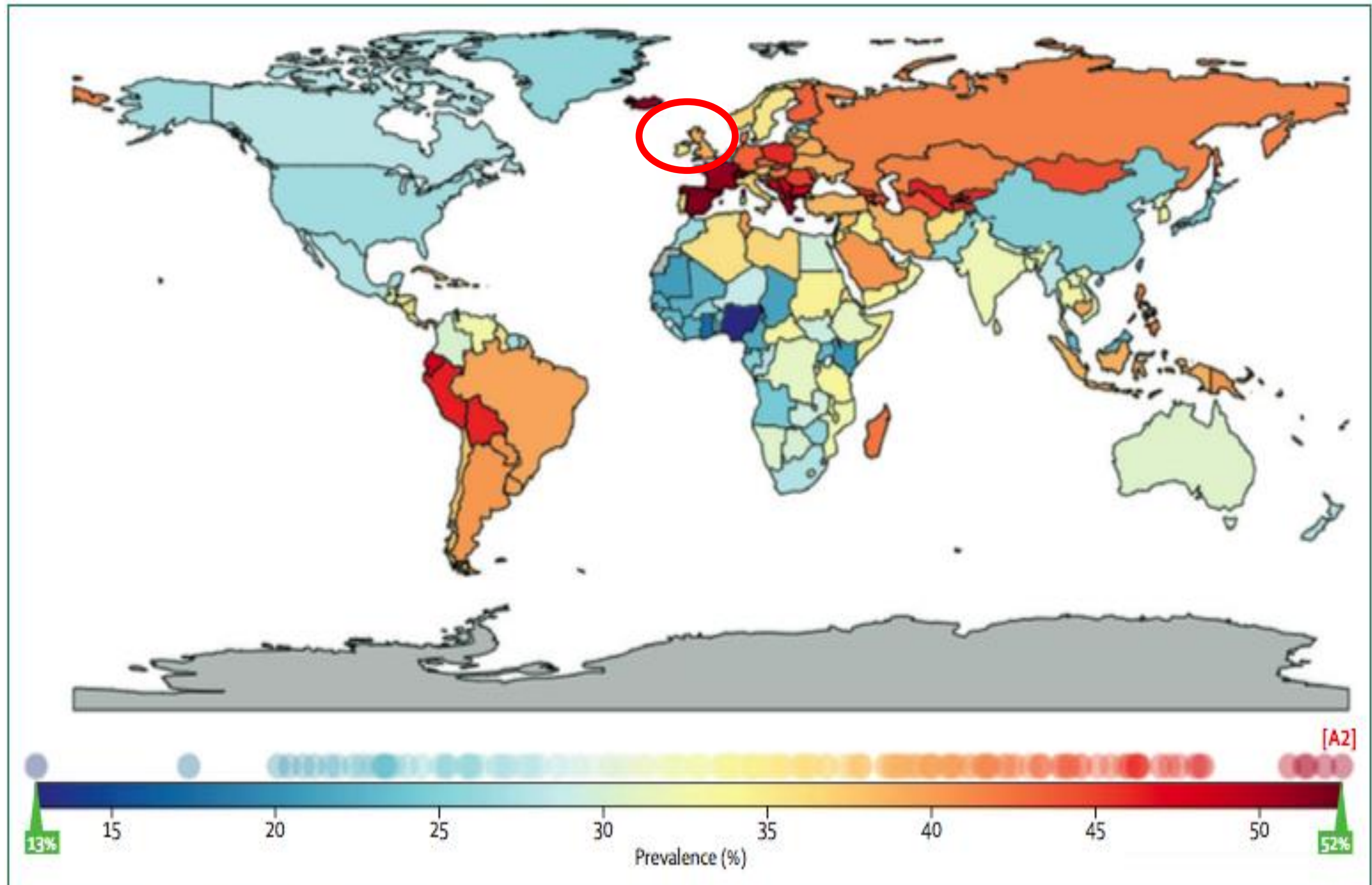

Figure 1: Estimated global prevalence of untreated dental caries in permanent teeth for 2017

Peres et al 2019

Impact of poor oral health

Impacts

- •Physical heath
- •Quality of life
- •Social functioning
- •Self esteem

Clinical home

Impact of oral diseases

Treatment costs (societal and individual)

Functional limitations

Impaired growth in children

Impact on general health

Impact on aesthetics / reduced self esteem

Social isolation

Pain and discomfort

Fear / anxiety

Time off work / school to attend clinics

Reduced productivity of the workforce

Impact on educational attainment

Sleepless nights

Figure 1. Impact of oral diseases.

Watt et al 2015

Impact of poor oral health

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- Quality of life
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Thomson 2010

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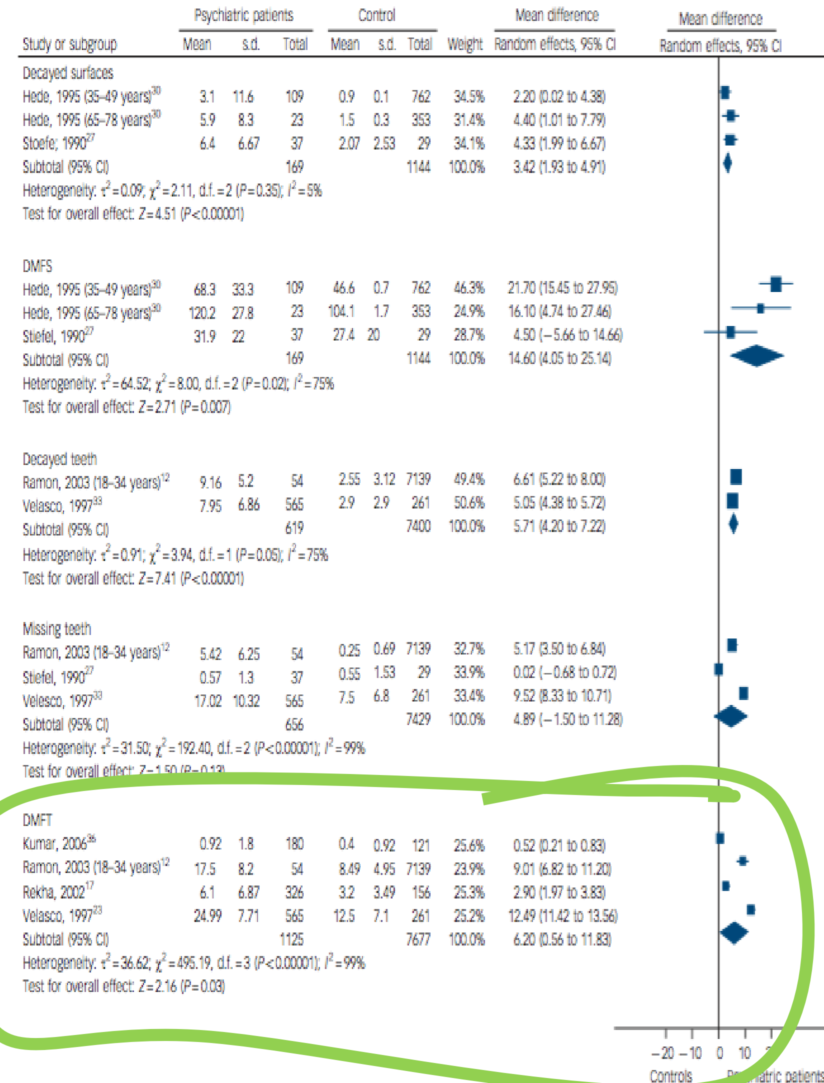
Figure 1. Impact of oral diseases.

Watt et al 2015

Severe Mental Illness (SMI)

- Poor nutrition
- Oral hygiene
- Sugary drinks
- Comorbid substance use
- Dry mouth
- Barriers to dental care



Study or subgroup	Psychiatric patients Mean	Psychiatric patients s.d.	Psychiatric patients Total	Control Mean	Control s.d.	Control Total	Weight	Mean difference Random effects, 95% CI
Decayed surfaces								
Hede, 1995 (35–49 years)[30]	3.1	11.6	109	0.9	0.1	762	34.5%	2.20 (0.02 to 4.38)
Hede, 1995 (65–78 years)[30]	5.9	8.3	23	1.5	0.3	353	31.4%	4.40 (1.01 to 7.79)
Stoefe; 1990[27]	6.4	6.67	37	2.07	2.53	29	34.1%	4.33 (1.99 to 6.67)
Subtotal (95% CI)			169			1144	100.0%	3.42 (1.93 to 4.91)
Heterogeneity: $\tau^2=0.09$; $\chi^2=2.11$, d.f. $=2$ ($P=0.35$); $I^2=5\%$								
Test for overall effect: $Z=4.51$ ($P<0.00001$)								
DMFS								
Hede, 1995 (35–49 years)[30]	68.3	33.3	109	46.6	0.7	762	46.3%	21.70 (15.45 to 27.95)
Hede, 1995 (65–78 years)[30]	120.2	27.8	23	104.1	1.7	353	24.9%	16.10 (4.74 to 27.46)
Stiefel, 1990[27]	31.9	22	37	27.4	20	29	28.7%	4.50 (−5.66 to 14.66)
Subtotal (95% CI)			169			1144	100.0%	14.60 (4.05 to 25.14)
Heterogeneity: $\tau^2=64.52$; $\chi^2=8.00$, d.f. $=2$ ($P=0.02$); $I^2=75\%$								
Test for overall effect: $Z=2.71$ ($P=0.007$)								
Decayed teeth								
Ramon, 2003 (18–34 years)[12]	9.16	5.2	54	2.55	3.12	7139	49.4%	6.61 (5.22 to 8.00)
Velasco, 1997[33]	7.95	6.86	565	2.9	2.9	261	50.6%	5.05 (4.38 to 5.72)
Subtotal (95% CI)			619			7400	100.0%	5.71 (4.20 to 7.22)
Heterogeneity: $\tau^2=0.91$; $\chi^2=3.94$, d.f. $=1$ ($P=0.05$); $I^2=75\%$								
Test for overall effect: $Z=7.41$ ($P<0.00001$)								
Missing teeth								
Ramon, 2003 (18–34 years)[12]	5.42	6.25	54	0.25	0.69	7139	32.7%	5.17 (3.50 to 6.84)
Stiefel, 1990[27]	0.57	1.3	37	0.55	1.53	29	33.9%	0.02 (−0.68 to 0.72)
Velesco, 1997[33]	17.02	10.32	565	7.5	6.8	261	33.4%	9.52 (8.33 to 10.71)
Subtotal (95% CI)			656			7429	100.0%	4.89 (−1.50 to 11.28)
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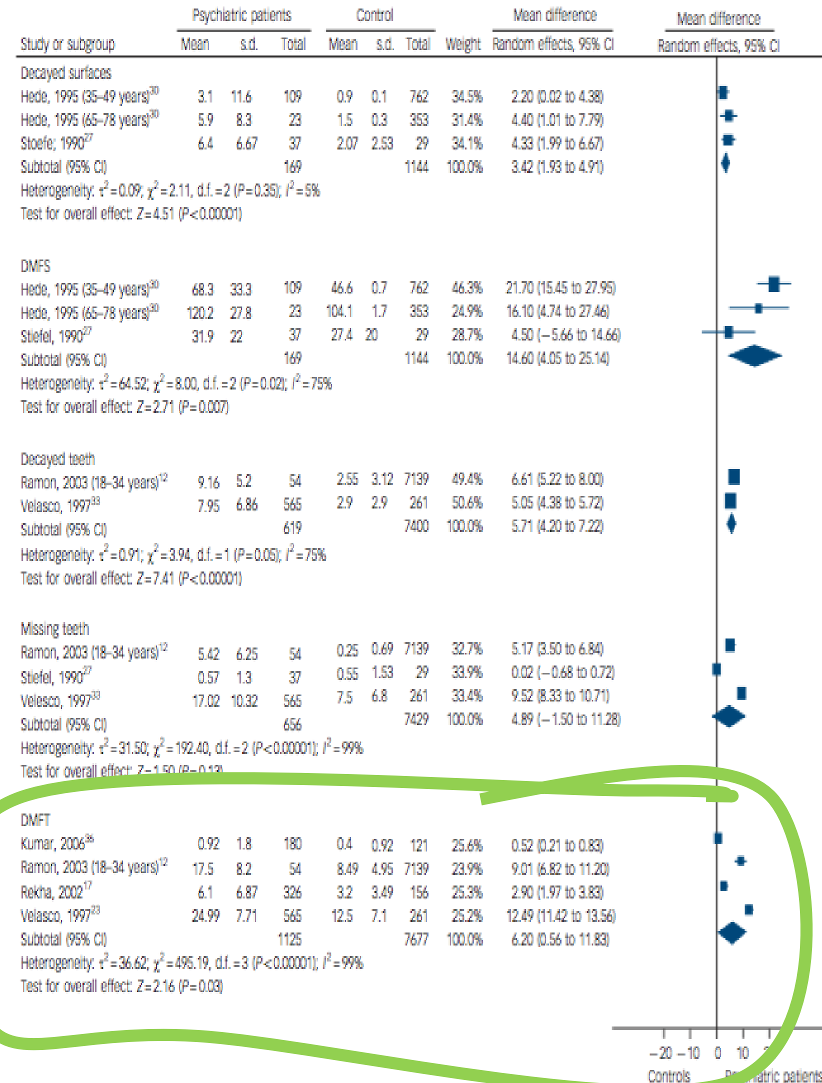
DMFT								
Kumar, 2006[36]	0.92	1.8	180	0.4	0.92	121	25.6%	0.52 (0.21 to 0.83)
Ramon, 2003 (18–34 years)[12]	17.5	8.2	54	8.49	4.95	7139	23.9%	9.01 (6.82 to 11.20)
Rekha, 2002[17]	6.1	6.87	326	3.2	3.49	156	25.3%	2.90 (1.97 to 3.83)
Velasco, 1997[23]	24.99	7.71	565	12.5	7.1	261	25.2%	12.49 (11.42 to 13.56)
Subtotal (95% CI)			1125			7677	100.0%	6.20 (0.56 to 11.83)
Heterogeneity: $\tau^2=36.62$; $\chi^2=495.19$, d.f. $=3$ ($P<0.00001$); $I^2=99\%$								
Test for overall effect: $Z=2.16$ ($P=0.03$)								

Severe Mental Illness (SMI)

- Higher experience of untreated disease
- More Missing teeth
- Fewer Fillings
- 3.4 the odds of losing all their teeth



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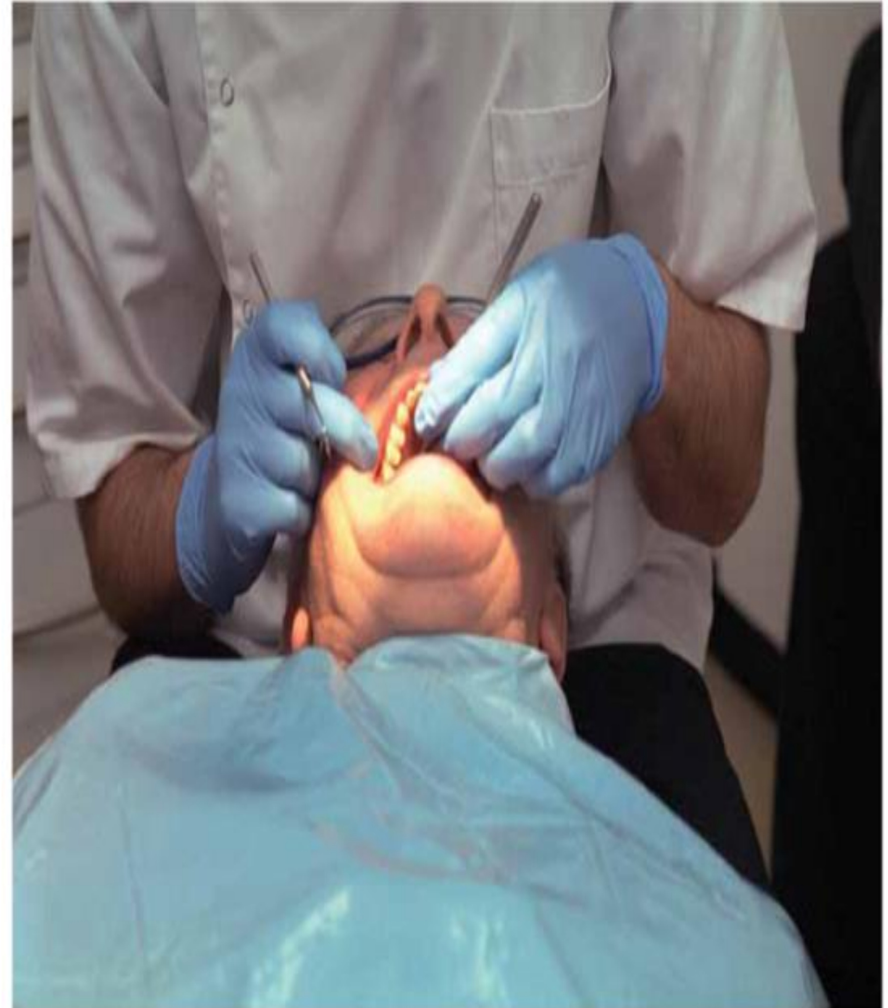
Intellectual Disability

Compared to general population

- Higher prevalence of periodontal disease

Anders & Davis 2010, Camaro et al 2014



Intellectual Disability

Compared to general population

- Higher prevalence of periodontal disease

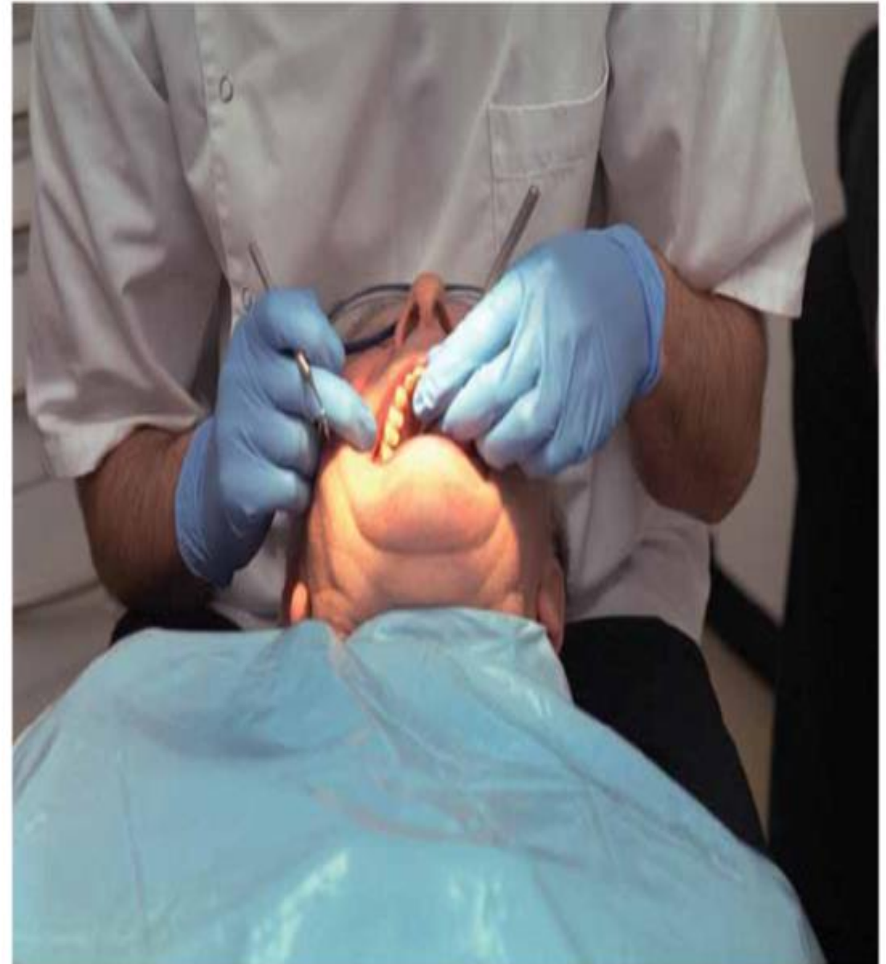
Anders & Davis 2010, Camaro et al 2014

- Similar prevalence of caries

BUT

- More untreated caries, more missing teeth and fewer restorations

Olivieira et al 2013, Morgan 2012, Catteau et al 2011, Anders & Davis 2010 De Jongh 2008 Crowley 2005, Hennequin et al 2008



ORAL HEALTH

The importance of oral health for people with intellectual disabilities.

IDS TILDA Research is informing us about the importance of oral health for people with intellectual disabilities as they age in Ireland.

x2 — If an older person has an intellectual disability they are X2 as likely to be edentulous

x12 — When an older person loses all their teeth they are x12 less likely to have a complete denture if they have an intellectual disability

73% had some teeth

19% had no teeth or dentures

8% had no teeth and wore complete dentures

Background:

The population is ageing and so too are people with ID. There is a need to study how they age so as we can design and assess policy and practice.

- x3 Soft/Liquidised diet
- x3 Difficulty eating
- x2 Constipation
- x1/2 Overweight / Obesity

CMacGiollaPhadraig 2016

Inequalities in oral health of vulnerable people

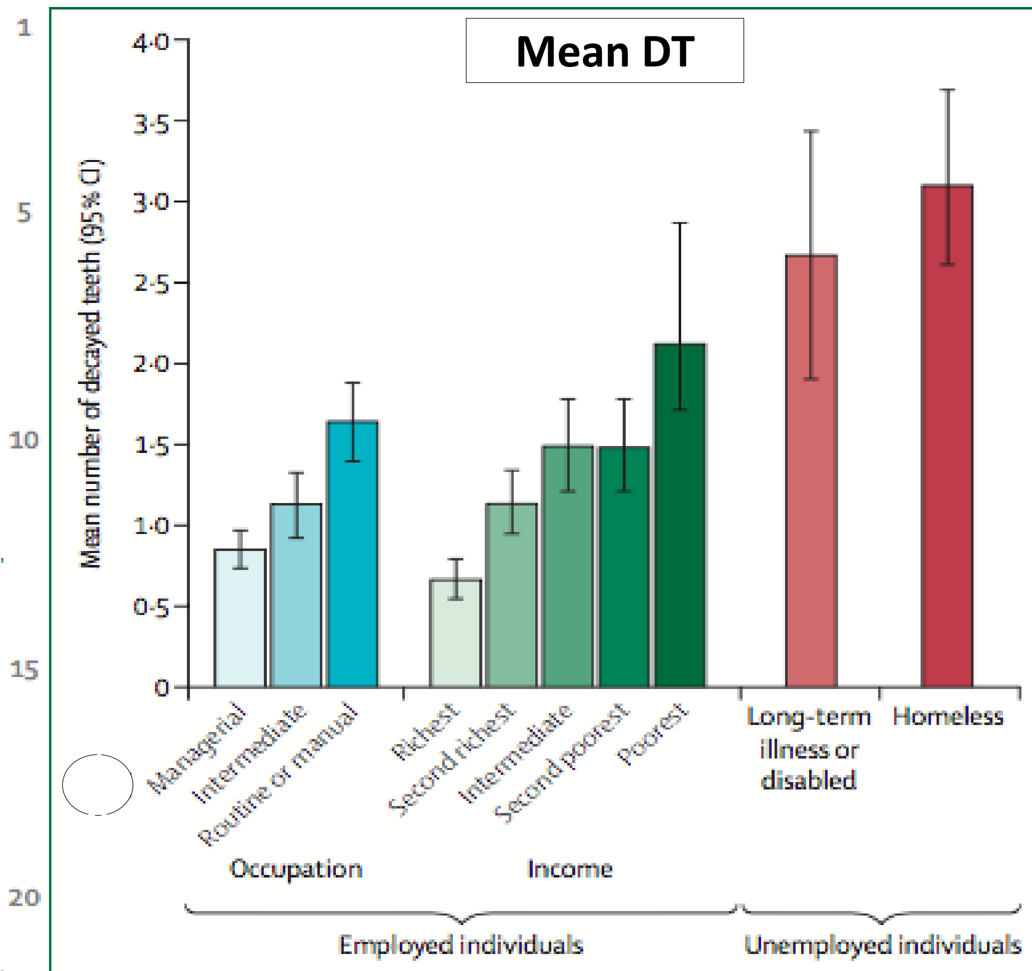
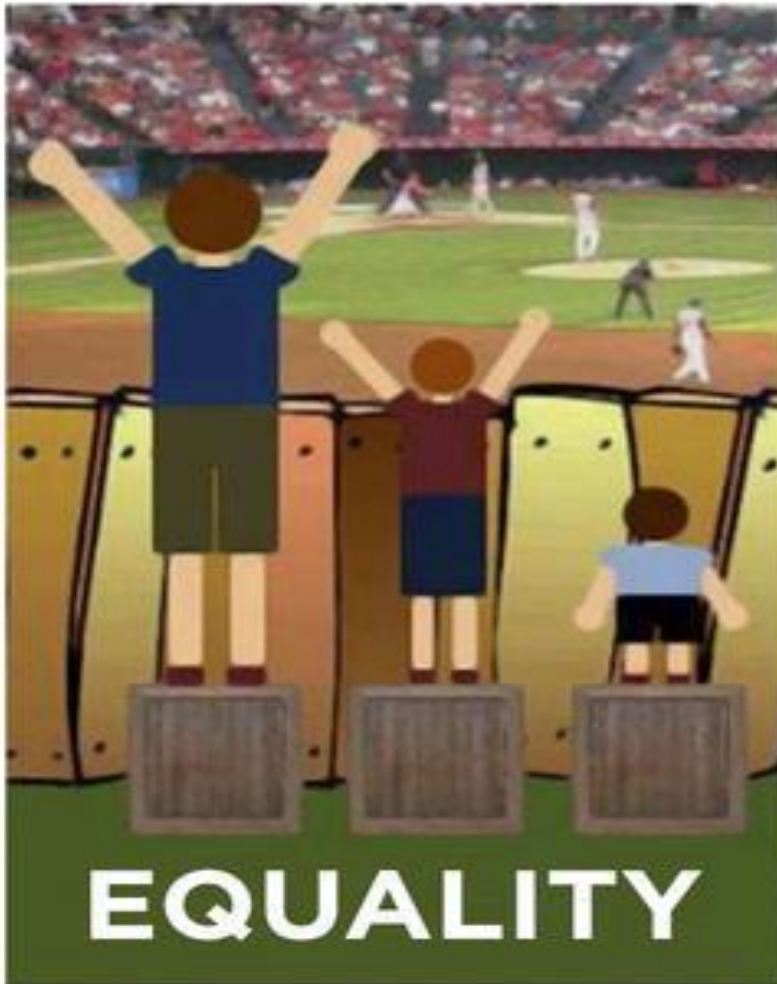


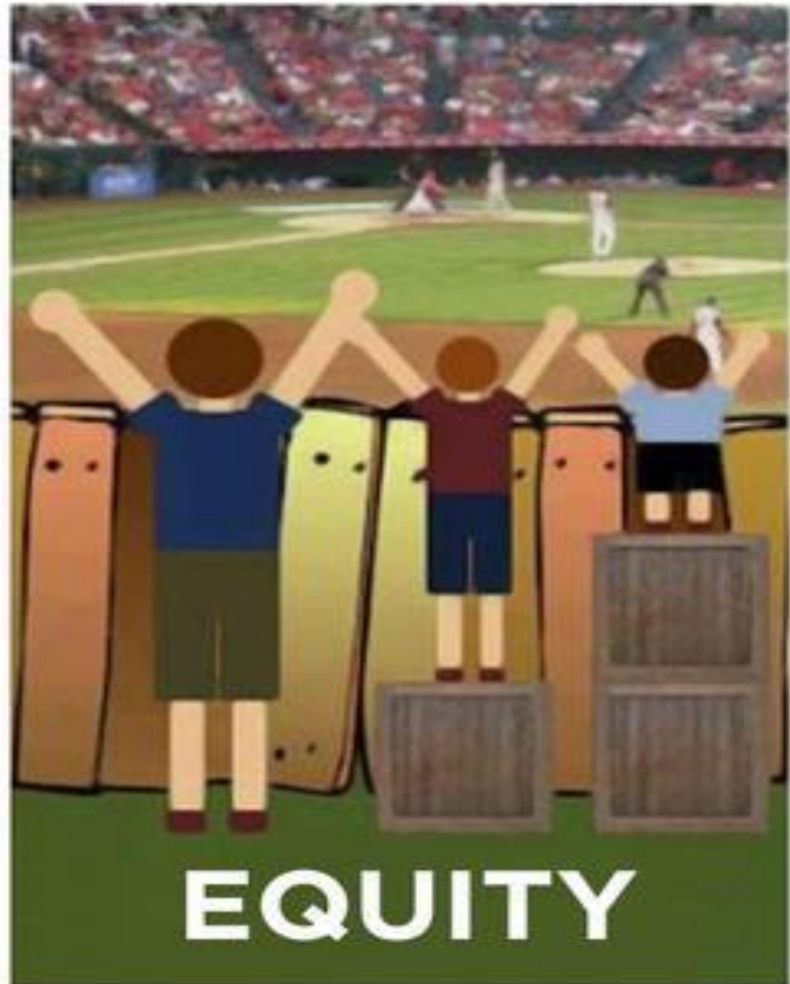
Figure 2: **Mean number of decayed teeth among male adults aged 16–65 years in England, Wales, and Northern Ireland**

Inequalities

- Unjust
- Unfair
- Unnecessary
- Unacceptable

Inequality and inequity





Action on determinants of health

Structural determinants
(Socieconomic, political, and environmental context)

- Macro-economic policies
- Social and welfare policies
- Trade policies
- Overseas development policies
- Globalisation
- Urbanisation

Intermediate determinants
(Social position and circumstances)

- Social class
- Income
- Education
- Gender
- Ethnicity

- Material circumstances
- Social relationships
- Psychosocial factors
- Health service availability or use
- Environmental setting

Proximal determinants
(Behaviours and biological factors)

- Diet
- Alcohol consumption
- Tobacco use
- Physical activity
- Hygiene

- Inflammation
- Infection
- Immune response

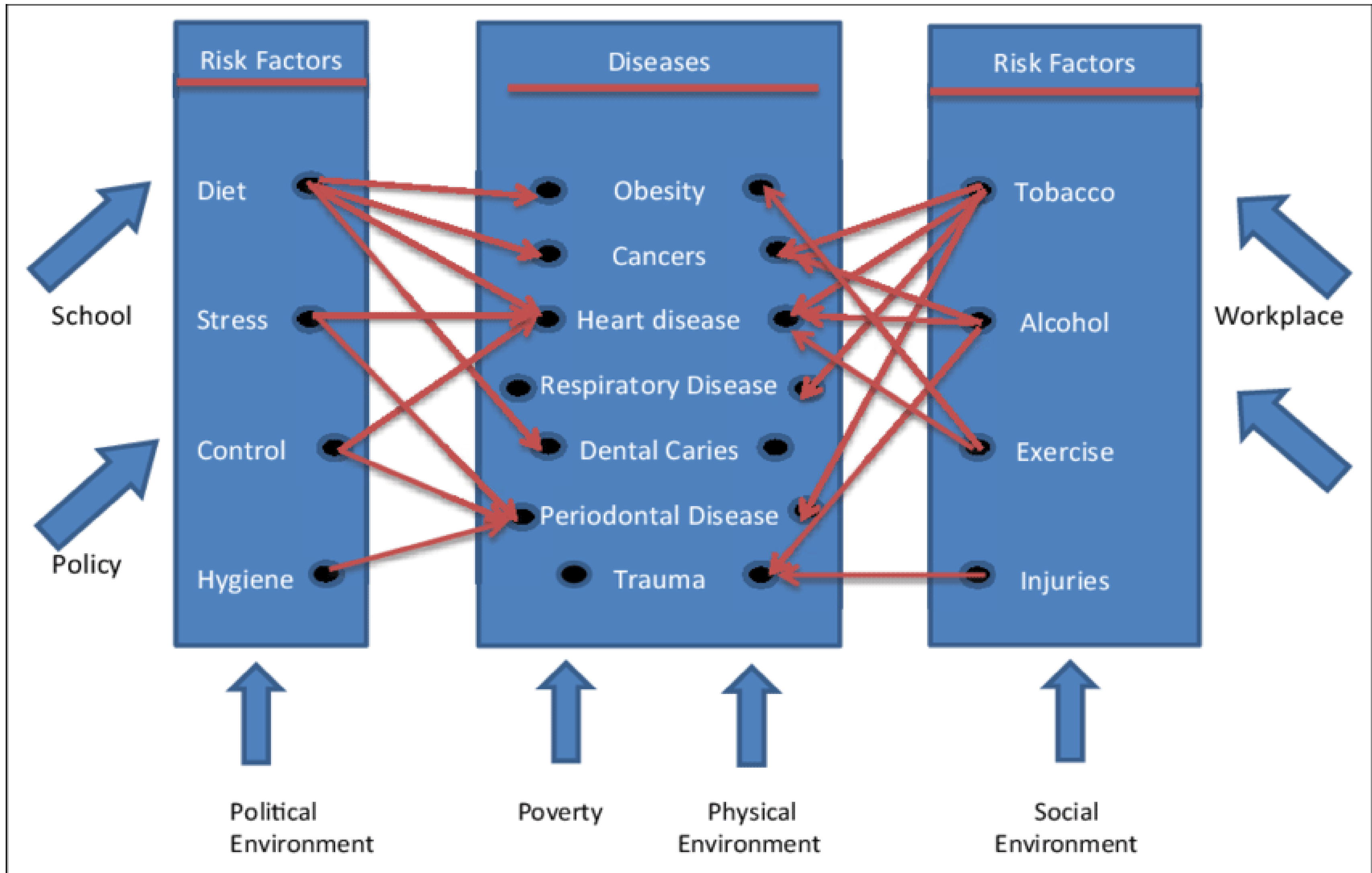
Outcomes

Oral disease and contribution to NCD burden

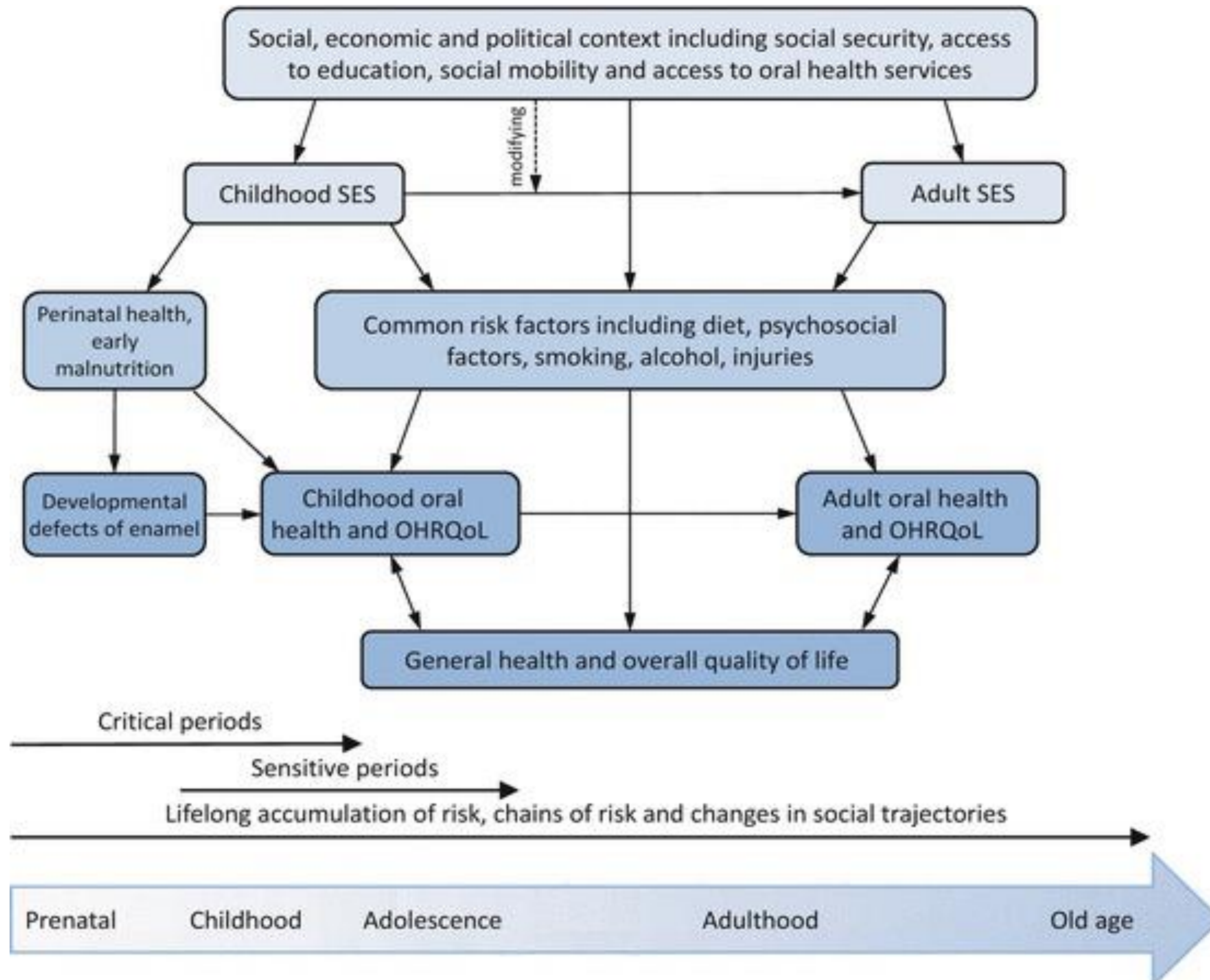
Commercial determinants—corporate strategies

- Political and economic power and influence
- Lobbying to influence policy
- Corporate citizenship
- Targeted and tailored marketing and promotion strategies
- Influence on research agenda
- Influences on social norms and local policies
- Media influence to distract attention and cause confusion
- Influence on consumers' choices and behaviours

Common risk factor (PREVENTION)



Life course (Clinical Home and Transition)



‘If nothing changes….. nothing will change’

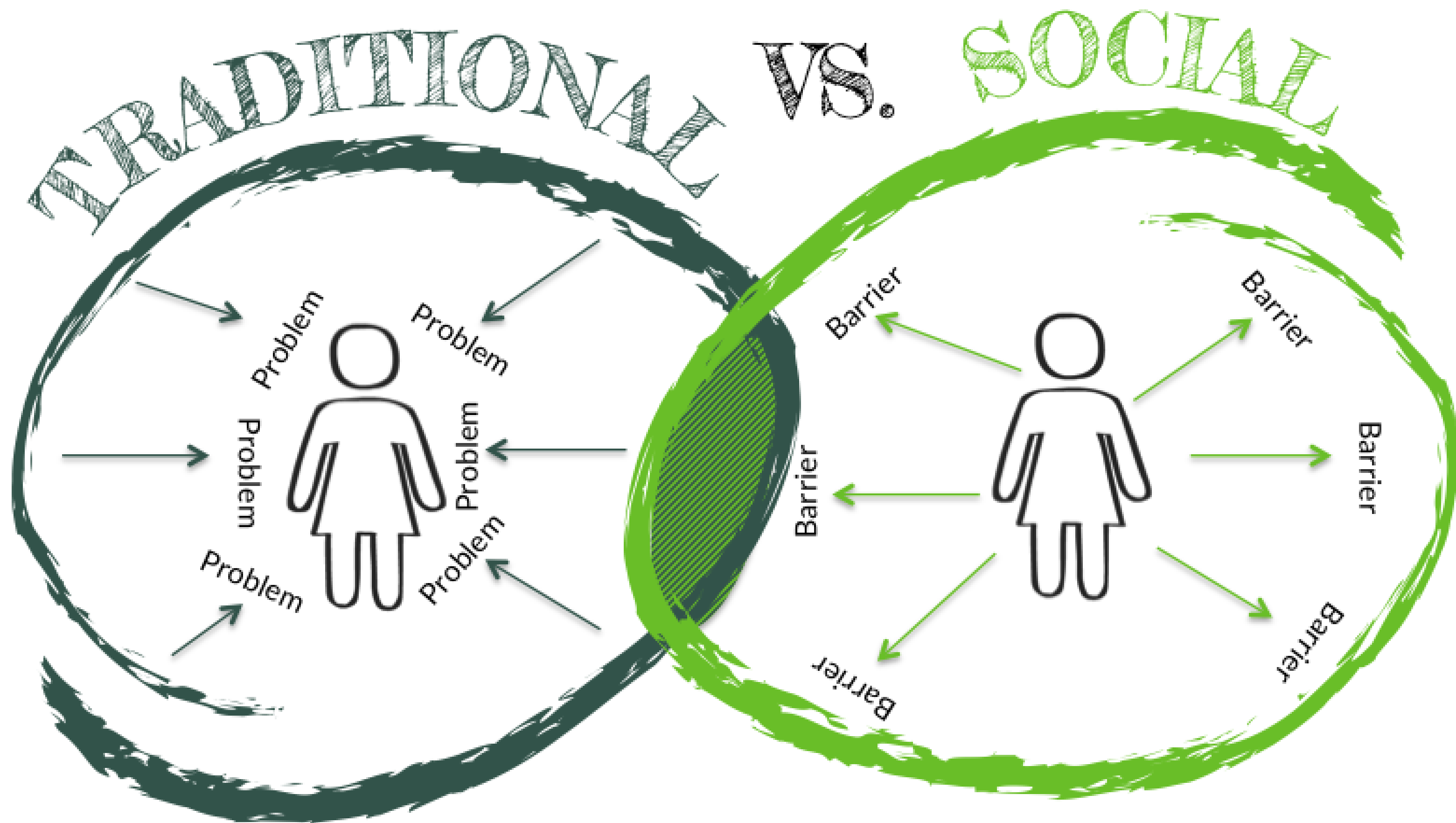
Theory and paradigms (Disability)

Concept of disability

- Scope is broad, umbrella term
- Physical, sensory, intellectual, mental…. emotional or social impairment or disabilities
- Often a combination of these factors
- Conditions from birth or acquired [change in demogrphay)

[Lifecourse/ transition]

Defining Terms and changing concepts



Effects of Disability - Social Oppression

Disability is created by barriers in society

1. **The environment – including inaccessible buildings and services**

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2. **People's attitudes – stereotyping, discrimination and prejudice**

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4. **Reduced educational opportunities**

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5. Reduced employment opportunities

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3. **Organisations – inflexible policies, practices and procedures**
4. **Reduced educational opportunities**
5. **Reduced employment opportunities**
6. **Increased levels of poverty and inequality**

Scambler 2015

Disability Rights Movement

- Disability rights movement (1970s)
- UN Convention on the Rights of Persons with Disabilities (CRPD) 2006……
- CRPD Adopted in Ireland in 2007…..Ratified (2018)

Grace, N 2018

UN Convention on Rights of Persons with Disabilities: A Paradigm Shift

Persons with disabilities are not **"objects"** of charity, **medical treatment** and **social protection**; rather as "subjects" with **rights**, who are capable of claiming those rights and **making decisions** for their lives based on their **free and informed consent** as well as being active members of society.

The Convention gives universal recognition to the **dignity of persons with disabilities. (Ireland 2018)**

Convention on the Rights of Persons with Disabilities 2006

Empowerment makes changes in education

Down Syndrome Ireland: Extra month of education can make real difference - Google Chrome

https://www.irishexaminer.com/breakingnews/ireland/down-syndrome-ireland-extra-month-of-education-can-make-real-di...

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HOT TOPICS: ELECTIONS 2019 DONALD TRUMP VISIT BREXIT

HOME » IRELAND

Down Syndrome Ireland: Extra month of education can make real difference

Wednesday, January 30, 2019 - 02:09 PM

Oireachtas members will be asked today to resource schools and teachers to ensure students with Down Syndrome are given a level playing field.

Down Syndrome Ireland have today said without adequate provision, people with Down

Up to 90 children with autism in Dublin 15 have no school places - Google Chrome

https://www.irishtimes.com/news/education/up-to-90-children-with-autism-in-dublin-15-have-no-school-places-1.3881742

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THE IRISH TIMES

Wed, Jun 5, 2019 Dublin 10°C

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Up to 90 children with autism in Dublin 15 have no school places

Parents say their children are being denied the right to appropriate education

Sun, May 5, 2019, 17:34

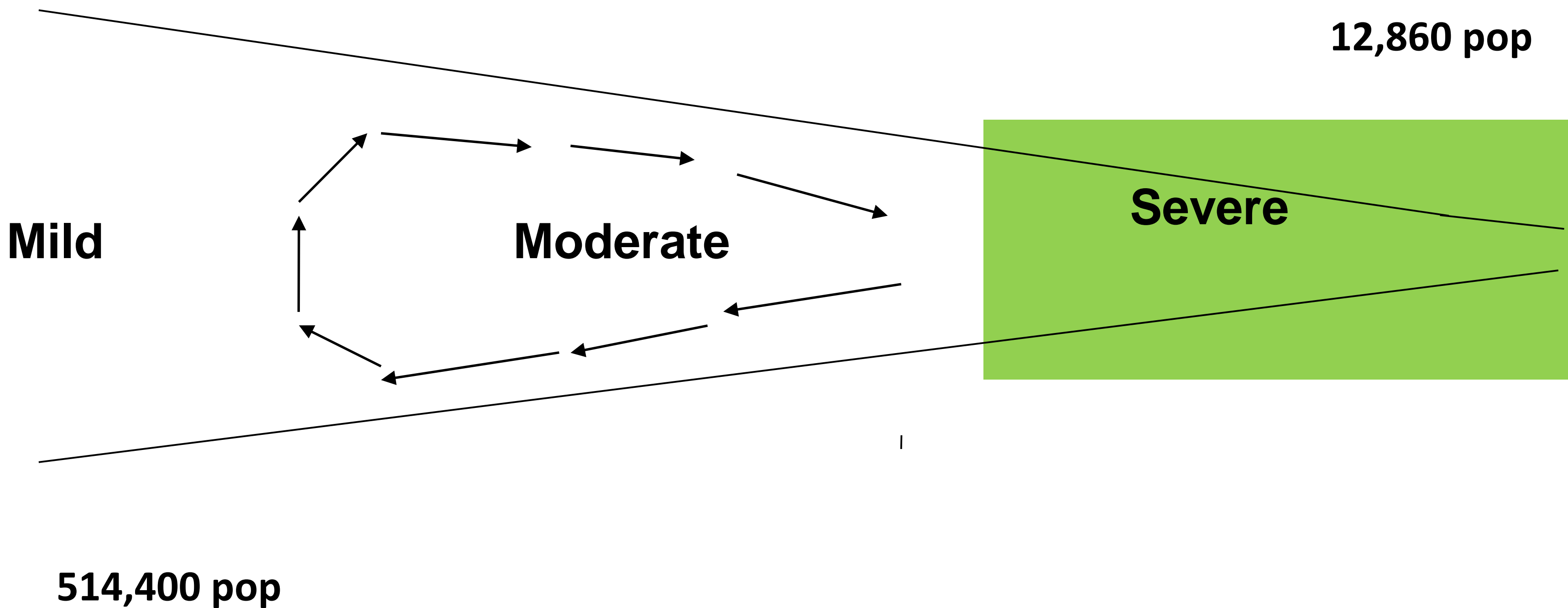
Carl O'Brien Education Editor

CAO Countdown

The latest news, tips and advice on navigating the CAO process in 2019

Category	Volume of Need	Source
Physical impairment	1/5 adults live with diseases related to arthritis affecting (1,000,000-740,000) 262,818 difficulty with physical activity (5.5% pop)	www.arthritisireland.ie Census 2011; 2016
Sensory impairment	Visual : 54,810 (1.2% pop) Hearing: 103,676 (2.2% pop)	Census 2016 Census 2016
Intellectual impairment /disability	66,611:	Census 2016
Mental impairment or disability	Psychological or emotional 123,515 Mental Health problems 32,000	Census 2016
Social impairment/disability	Autism spectrum disorders 1.5% prevalence	DoH 2018
Development impairment /disability	DS 1/546 births Edwards syndrome 17 births per year Cerebral palsy rates 1.5 to 4 per 1000 live births	DS
Older people	128,000 over 80 years	Aois agus Eolas 2019
Marginalised groups	Homeless people 10,000 ; Drug users 30,000; Asylum seekers 12,900	Smile agus Slainte 2019
Total Disability	**643,000**	**Census 2016**

Spectrum of Disability Ireland



(Total disability 643,000 Census 2016)

Modelled on JACSCD 2003 p 54,

What is Special Care Dentistry (SCD)

-Label

-definition gone for the activity ‘restriction’ perspective rather than the label

-

What is Special Care Dentistry?

Special Care Dentistry (SCD):

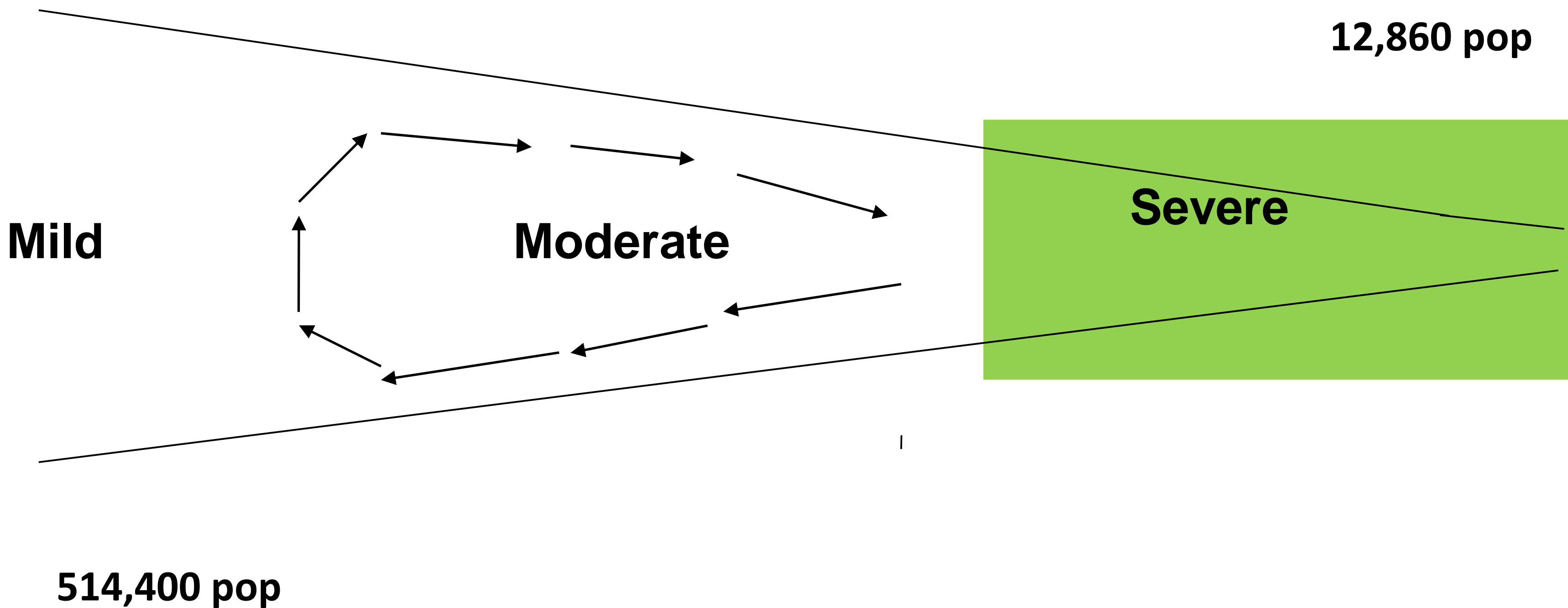
SCD takes a comprehensive, holistic approach to the care of patients, sometimes referred to as a group of people with 'special needs'.

Groups may include but are not limited to people with intellectual, sensory and/or physical impairments, those with mental health issues and/or complex medical conditions and includes frail older people.

'a disability or activity restriction that directly or indirectly affects oral health and is impacted by the personal and/or the environmental context of the individual'

Faulks et al 2007, FDI/IADH 2017

Spectrum of Disability Ireland



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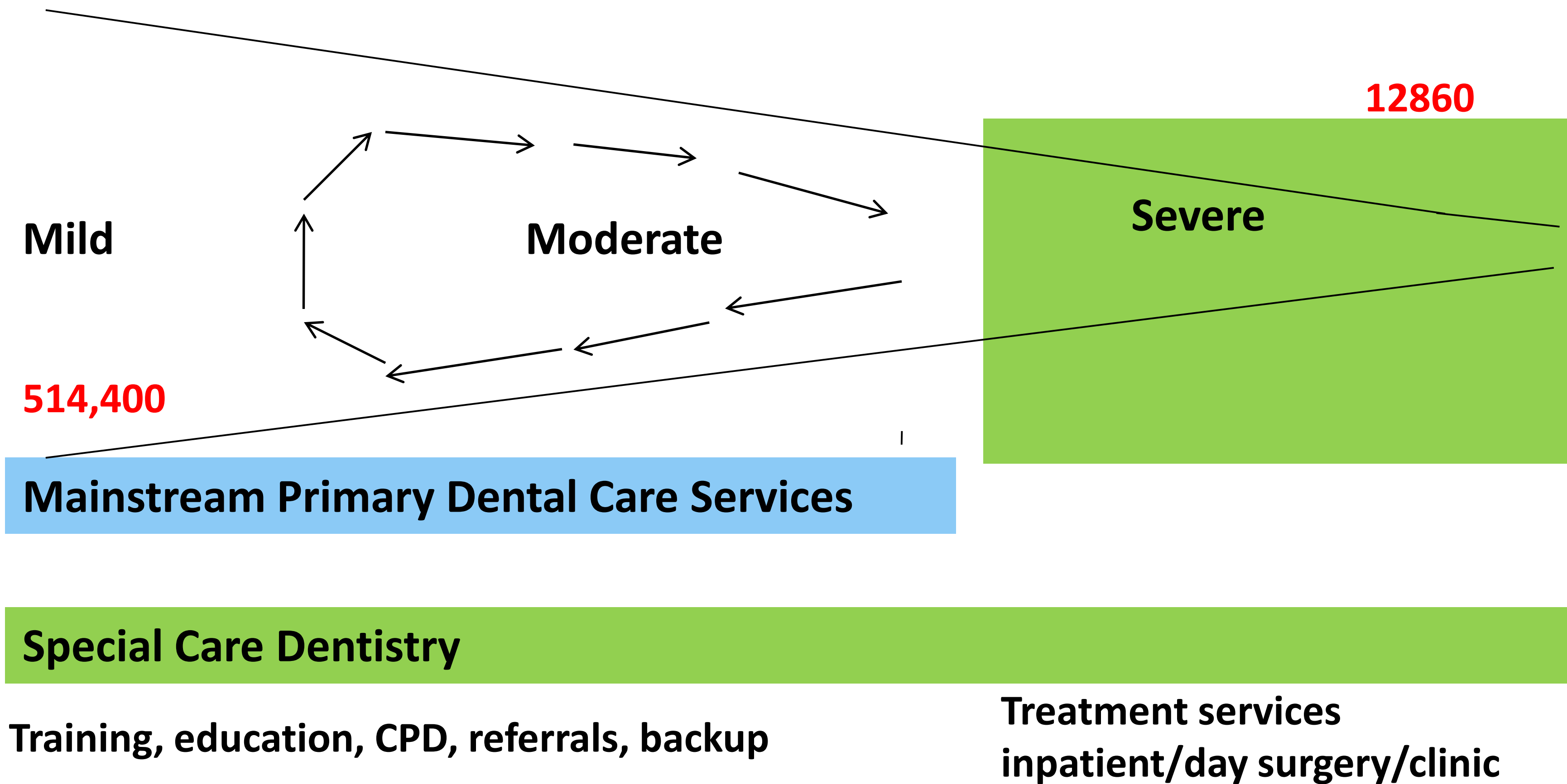
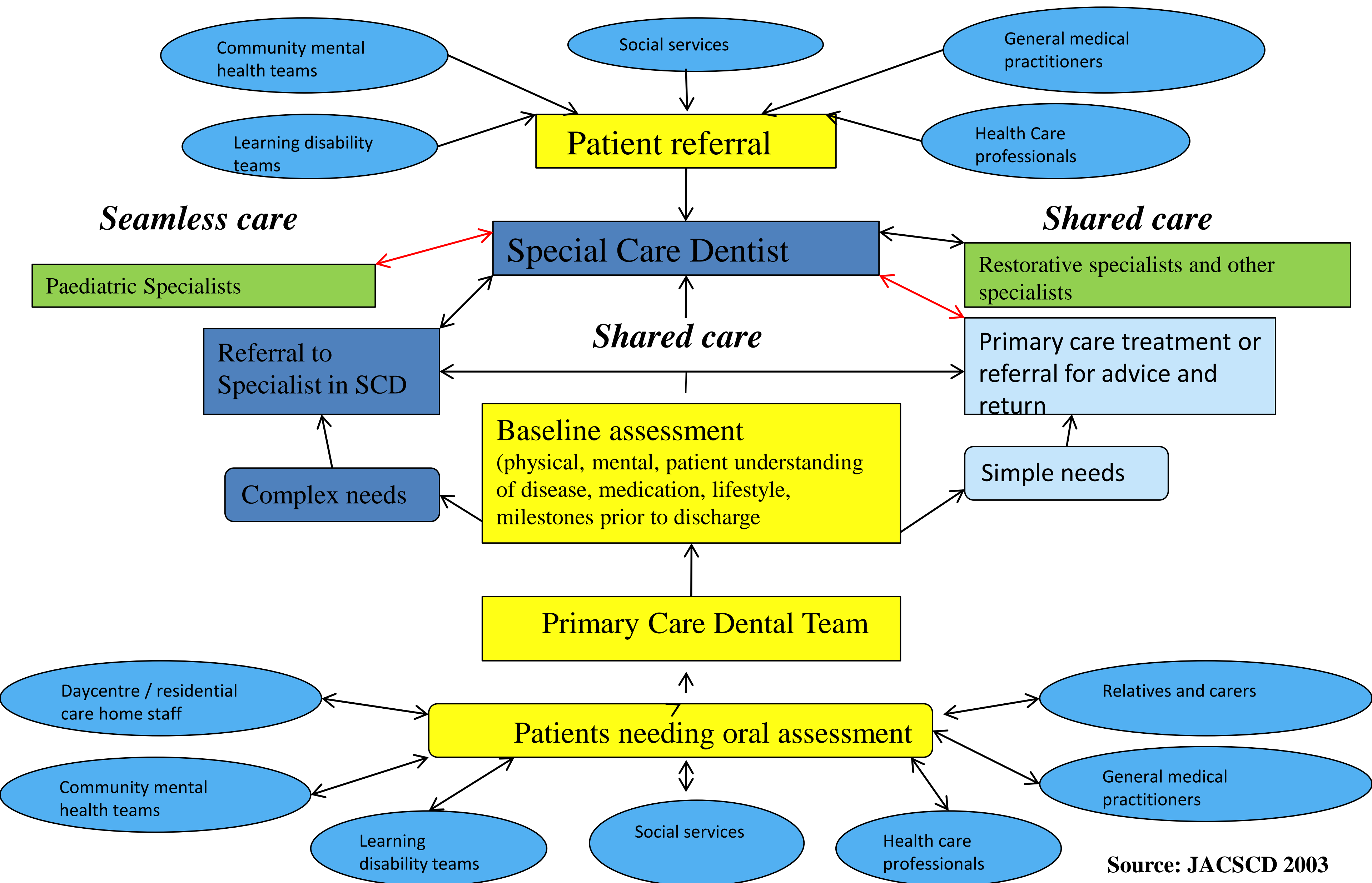
Location of Care in Ireland



Source: JACSCD 2003 p 54,

Integrated model of best practice



Source: JACSCD 2003

SCD grand challenges

- **Complexity & disparate group of individuals and groups**
- **Conditions from birth & acquired (get lost to follow-up)**
- **Spectrum of need versus disability**
- **Whose Job is It (~ complexity)?**

Whose business is it (CASE MIX)

Related to Complexity of the PERSON (BDA case-mix parameters)

- **Communication**
- **Co-operation**
- **Oral Health factors**
- **Medical Status**
- **Access**
- **Legal/ethical**

NOT THE DENTISTRY

Provisional weighting

In order to facilitate analysis, the criteria have been assigned weightings based upon the opinion of a group of experienced clinicians in the BDA working group. In the field trial both quantitative and qualitative analysis of the main data demonstrated some validity to these provisional weightings. It can however be anticipated that with the introduction of electronic data capture and analysis, widespread use and benchmarking between services, future evidence may demonstrate a need for some adjustment.

	0	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

Banded total score

The weighting scores across all six criteria are summed to give a total score for each course of treatment. These are then allocated to one of the bands below, and the case mix can subsequently be analysed by calculating the numbers and percentage in each band, split into different cells as appropriate e.g. whole service; different age groups; different clinics; different operators.

Score	Band
0	Standard patient
1 - 9	Some complexity
10 - 19	Moderate complexity
20 - 29	Severe complexity
30+	Extreme complexity

Communication

Ability to communicate

Reflects issues of communication between the dental team and the patient/parent/guardian/carer while in the surgery. (Note: communication regarding appointment etc. is covered under Access). Such communication may be direct between staff and patient/parent/guardian/carer, or may require the need for a third party to act as interpreter, advocate etc.

0	Free communication with adequate understanding between patient, parent, guardian, carer and dental team.	0
A	**Mild restriction** • Some difficulty in communication but can overcome • Patient / parent / guardian speaks English but not as first language • Patient/ parent/ guardian can communicate for themselves without intervention of 3rd party • Patient/ parent/ guardian has mild learning difficulty • Very young child with limited verbal communication	2
B	**Moderate restriction** • Non- verbal communication necessary • Child/ parent has autism or other communication impairments • Child/parent has moderate learning difficulty • Limited communication only possible	4
C	**Severe restriction** • No ability to communicate due to impairment • Multiple communication aids required • Interpreter/ 3rd party required to communicate	8

Co-operation

Ability to co-operate

Reflects circumstances wherein patient co-operation affects the delivery of dental care. It may be expected that clinicians with differing patient management skills may score an individual differently in respect of this criteria, or patients may vary between appointments. The grade given should reflect the average experience over a course of treatment. The definitions regarding length of appointment and behaviour modification are intended as guides only. The highest grade, C, is reserved for cases involving general anaesthetic as this reflects also the greater numbers of staff necessary to provide care in these instances.

0	Patient will accept all restorative care and simple extractions with LA +/- routine behavioural management techniques	0
A	**Some difficulty in co-operation** Full examination and/or simple treatment possible, but requiring additional support or behaviour management techniques	3
B	**Considerable difficulty in co-operation** • Limited examination only possible • Clinical holding required • Patient will accept limited restorative care with difficulty • Patient requires multiple acclimatisation visits to accept treatment	6
C	Patient requires general anaesthetic, sedation or other advanced management techniques to accept treatment	12

Medical status

Medical Status

Reflects circumstances where modifications have to be made to provision of dental care due to the patient's medical history and issues where a patient's medical history is not readily obtainable at a dental appointment.

0	• Adequate medical history obtainable at appointment with no significant relevance to this course of treatment • No additional investigations required	0
A	**Some treatment modification required** • Medical history unable to be obtained at first appointment • Further information required in order to complete medical history	2
B	**Moderate impact of medical or psychiatric condition on provision of care** • Medical or psychiatric status complex or unstable, affecting the provision of treatment • Child in need	6
C	**Severe impact of medical condition on provision of care** • Multidisciplinary review required to treat • Multidisciplinary appointment for medical reasons	12

Oral risk factors

The technical complexity of the dentistry provided is not relevant in assessing oral risk. Rather it reflects the specific risk factors which require a higher than average resource be allocated to their care. Examples include working with carers or patients themselves in mitigating risk factors, the amount of treatment necessary to maintain oral health, or specific oral issues making provision of dental care more complex.

0	**Minimal risk factors** • Stable oral environment; teeth brushed twice a day with fluoride paste • Can comply with all aspects of 'Delivering Better Oral Health' advice	0
A	**Moderate risk factors e.g.** • Can comply with most aspects of 'Delivering Better Oral Health' advice • Child unable to brush effectively themselves • Good Oral Hygiene hindered by malocclusion /manual dexterity • Course of treatment following a period of neglect	3
B	**Severe risk factors e.g.** • Extensive support to achieve some aspects of 'Delivering Better Oral Health' advice • Oral hygiene relies on 3rd party to maintain • Child uses non-fluoride toothpaste • Cariogenic diet resulting in uncontrolled caries • Molar Incisor Hypomineralisation with symptoms or post-eruptive breakdown • Altered salivation • Access to oral cavity severely restricted • Children with severe dental or craniofacial developmental abnormalities	6
C	**Extreme risk factors e.g.** • Unable to comply with any aspects of 'Delivering Better Oral Health' • Unable to brush effectively due to challenging behaviour or limited co-operation • High calorie supplementation • Regular sugar-containing medication • Severe xerostomia • PEG feeding • Immunocompromised	12

Access to oral care

Reflects complexities surrounding patient access to care at any point during the course of treatment. The criterion takes into account any obstacles created by the patients themselves that would hinder their access to dental care, e.g. persistent failure to attend. Grade 'C' is reserved for provision of care in a domiciliary setting or equivalent.

0	**Unrestricted** • Patient can access surgery without additional requirement • Child accompanied by a parent	0
A	**Moderately restricted** • Patient who fails to attend, or cancels at short notice, more than once in a course of treatment • Child who is not brought to an appointment more than once in a course of treatment • Patient requires support to access the surgery eg carer attends; administrative support	2
B	**Severely restricted** • Specialised equipment required to attend the surgery (eg ambulance, hoist, wheelchair tipper, slide board) • Child whose parent (or vulnerable adult whose carer...) repeatedly cancels, giving concern about possible disguised compliance	4
C	**Domiciliary care required***	8

*This criteria is intended **ONLY** for patients seen on a "domiciliary" basis in a hospital or nursing home. Do not use for operating theatre cases

Legal and ethical barriers to care

Reflects other barriers to care not otherwise covered in the previous 5. Two of the most common are the time spent in consultation with 3rd parties to obtain consent to treat, and the difficulty identifying the financial status of some patients and thus eligibility for free treatment. This criterion should also be used when resource is necessary for other reasons to consult with guardians, advocates, or seek the opinion of a court of law for example. The highest grade, C, is reserved for case conferences or equivalent where a multi-professional team needs to be consulted before care can proceed.

0	No legal or ethical issues affecting care; e.g. No problems with consent or parental responsibility.	0
A	**Some legal/ethical difficulties may arise** • Best interests' decision not requiring additional correspondence • Child in need	2
B	**Moderate legal/ethical difficulties may arise** • Fluctuating capacity to consent • Best interests' decision requires additional correspondence with carers/ relatives • Financial responsibility requires further clarification • Child who is subject to a care order • Child who is the subject of a child protection plan • Parental responsibility requires further clarification • Looked after child	4
C	**Severe legal/ethical difficulties** • Multi-professional consultation/ case conference required including but not limited to, child protection meeting • Referral to an IMCA • Safeguarding referral made	8

Sample 1

The Presidential Dental Practice
Whitehouse,
3 Main Street,
Medium Sized Town,
Ireland.

Re: ***Treasa May*** Aged 46

7 June 2019

Dear consultant,

Could you please assess and treat as you see fit. Treasa has a number of medical issues. She is in need of routine dental care: fills and scale/polish. She has a profound gag reflex and cannot take medication orally as she gets sick. Her specialist says she should have antibiotic cover for her VP if she's having a surgical procedure. Please note she is a wheel chair user.

RMHx : Hydrocephalis
Epilepsy
VP shunt
Cerebral palsy
Visual impaired
autistic

Medications : Melatonin 6mg at night
Prozac 20mg
Trileptal 450 mg x 2

Yours sincerely,

Donald Trump.

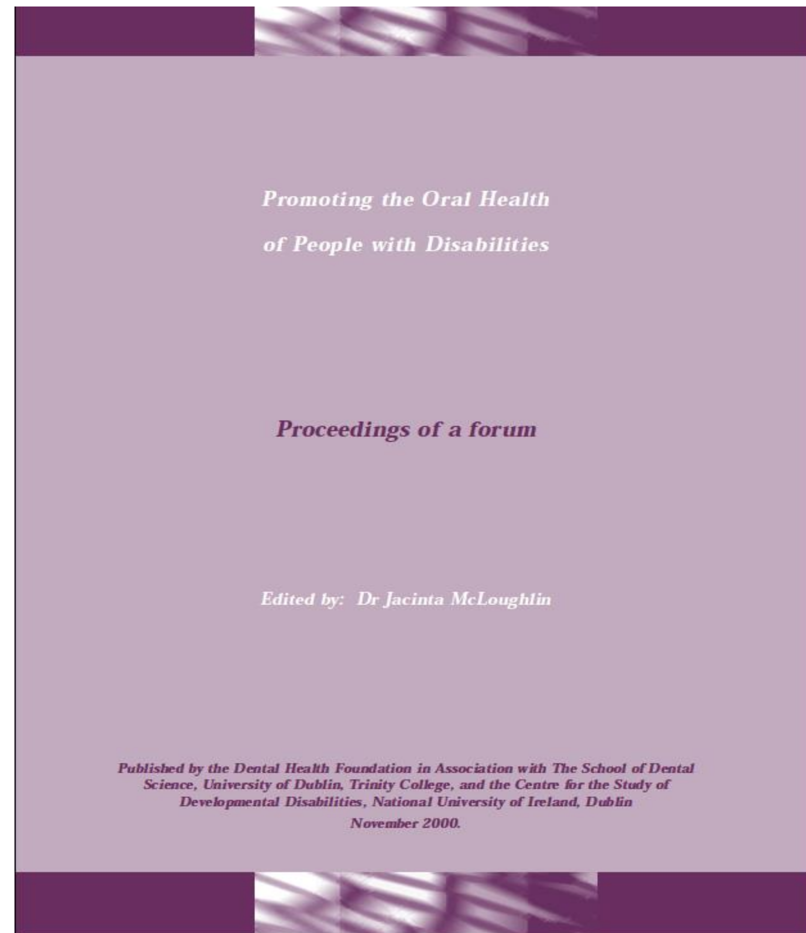
D Trump
Dentist

Where are we?

- **What has gone before (Disability forum, the way forward, ISDH submission, New Oral health Policy)**
- **Demography**
- **What do people want ?**

Promoting the Oral Health of People with Disabilities

- Forum 2000
- Representation: DHF, Health Boards, DoH, UCD, TCD, UCC
- Mapped the baseline
- Identified challenges



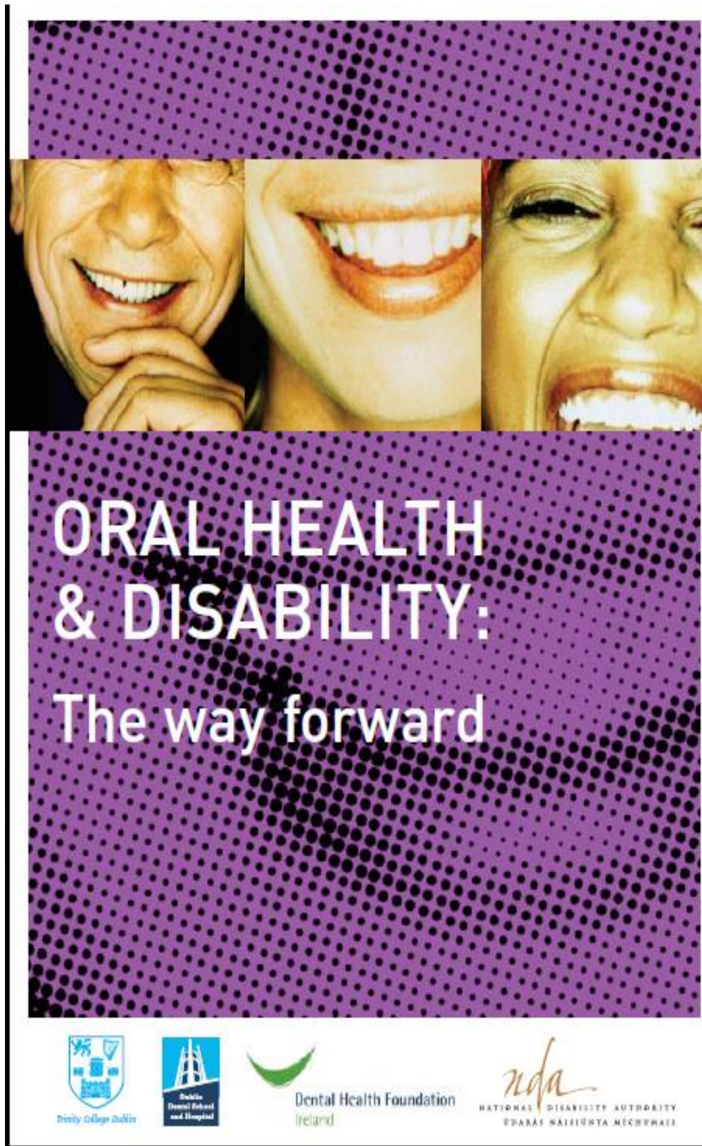
Promoting the Oral Health of People with Disabilities

Proceedings of a forum

Edited by: Dr Jacinta McLoughlin

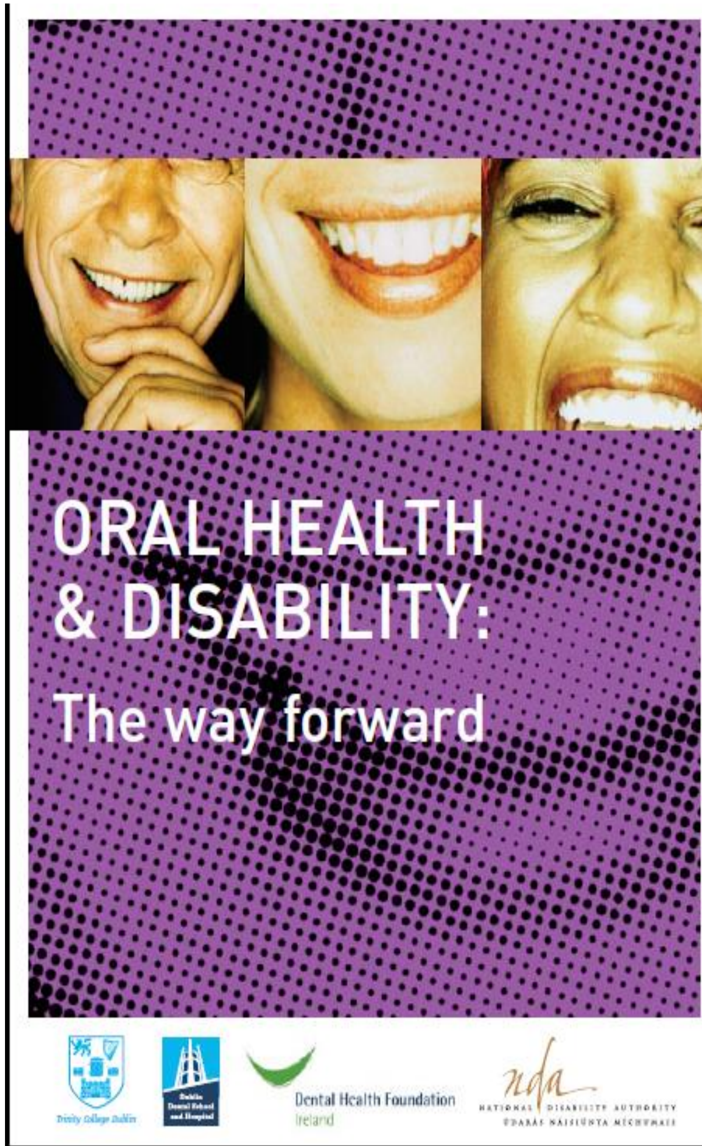
Published by the Dental Health Foundation in Association with The School of Dental Science, University of Dublin, Trinity College, and the Centre for the Study of Developmental Disabilities, National University of Ireland, Dublin
November 2000.

The way forward (2005) 10 Steps



- Reframed and defined special needs and SCD
- Establish definitive training pathways
- Adjust skill set within the dental team
- Mainstreaming , while valuing specialism
- Accessibility and Equity
- Early intervention
- Acknowledge competence appropriately
- Information clearing house
- Person centred research
- Capacity and consent

The way forward (2005)



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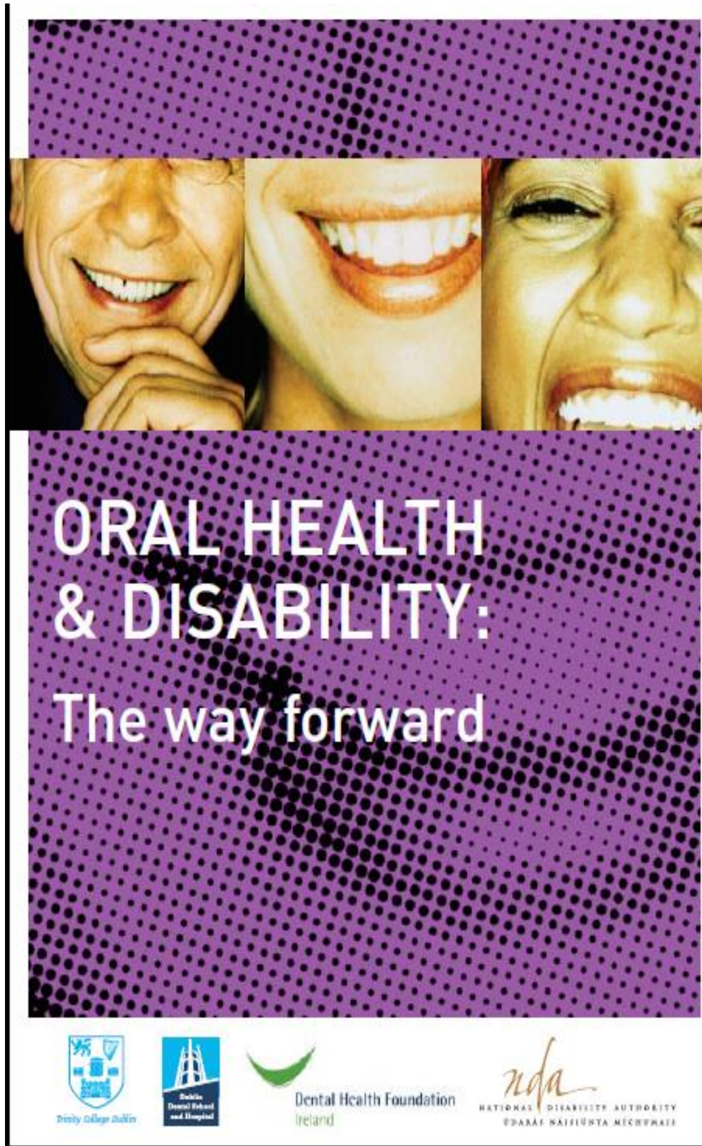

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- Capacity and consent

ISDH submission to DoH 2018

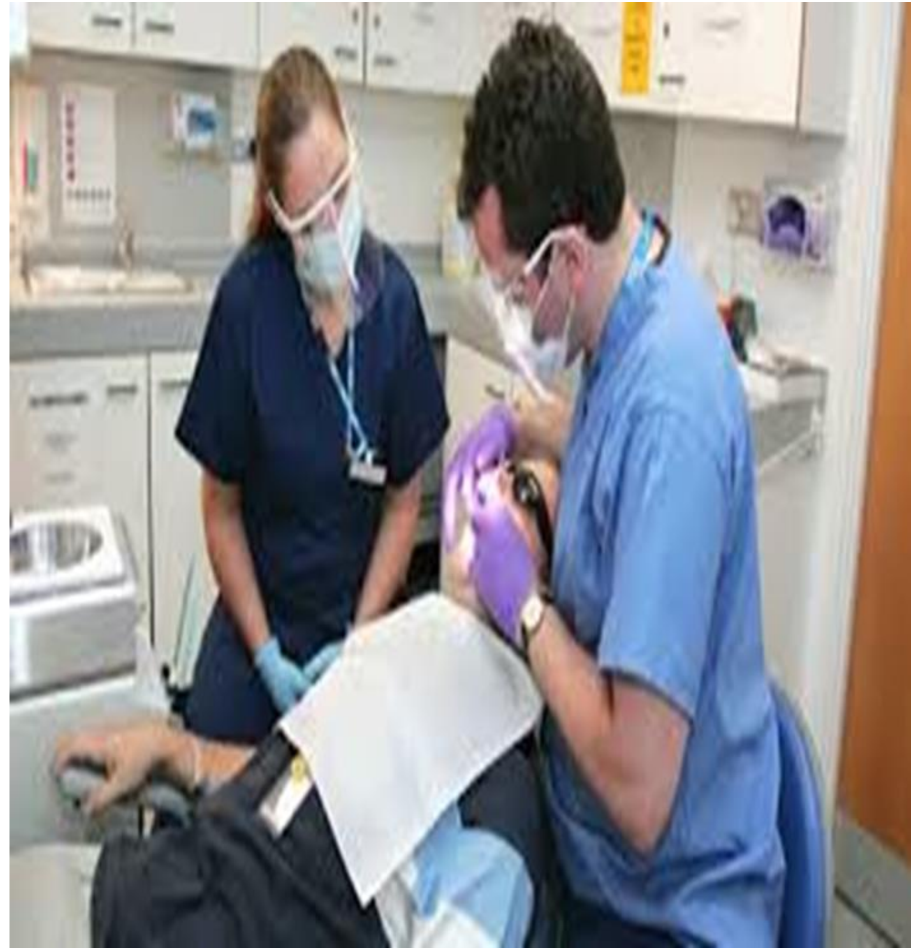
- **Lack of resources (GA and other facilities)**
- **Inconsistent and variable targeting of SCD groups**
- **Embed disability and oral health into national policy**
- **National framework for SCD with local flexibility**
- **Early engagement with health care and Lifecourse approach**
- **Workforce needs addressed and remunerated**
- **Services evaluated for optimal outcomes**

Wants of people?

McGiollaPhadraig et al 2014

Outcomes: how have we done ?

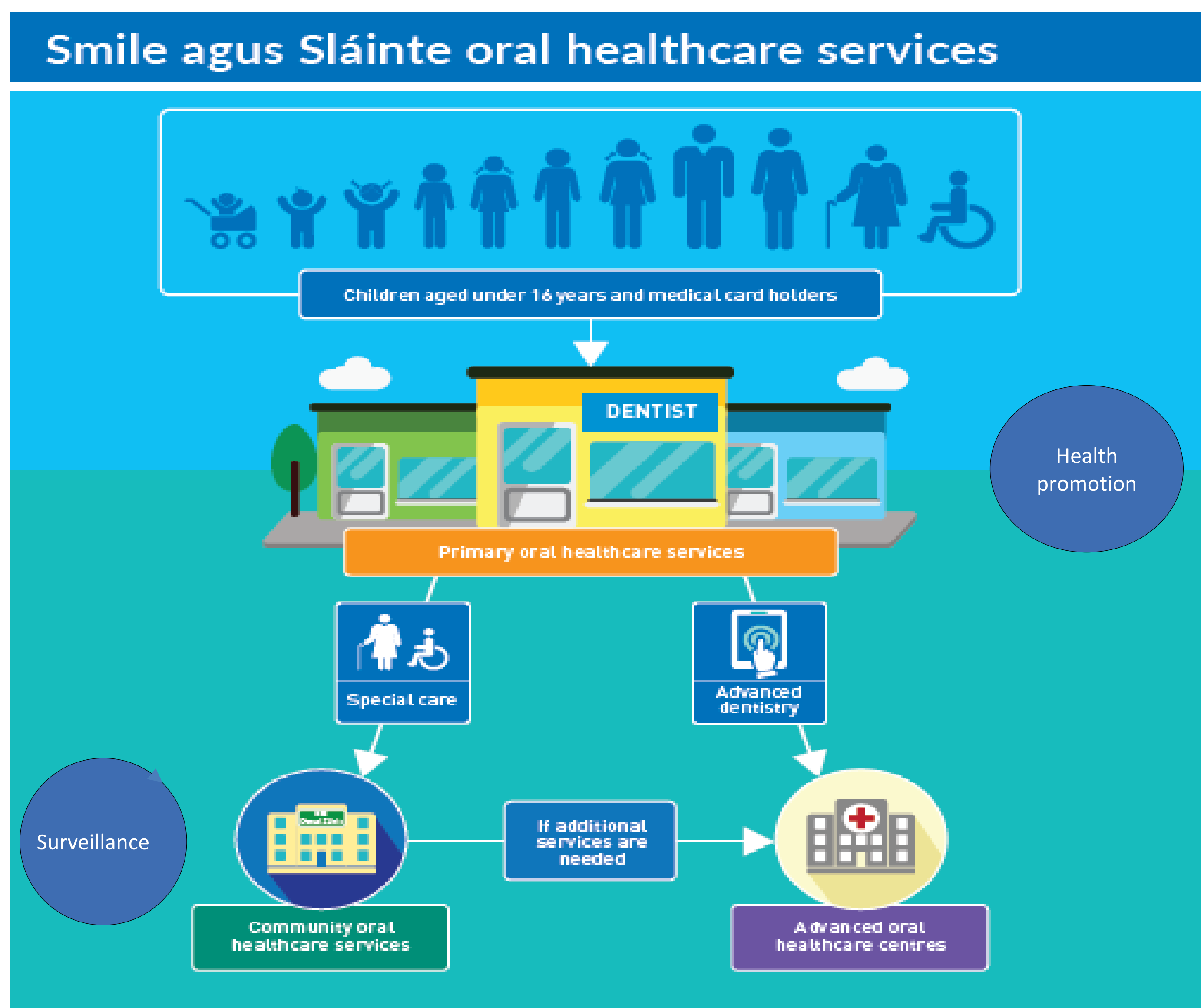
- **Limited**
- **Results conflicting**
- **72% of ID in TILDA IDS go to the dentist but 33% are edentulous!**
- **5 year post later active caries and treatment need …**
- **Need for Prevention and wider health & social care team**
- **Restricted coverage for SCD**
- **Remit?**



D McGeown 2019

CMacGiollaphadraig

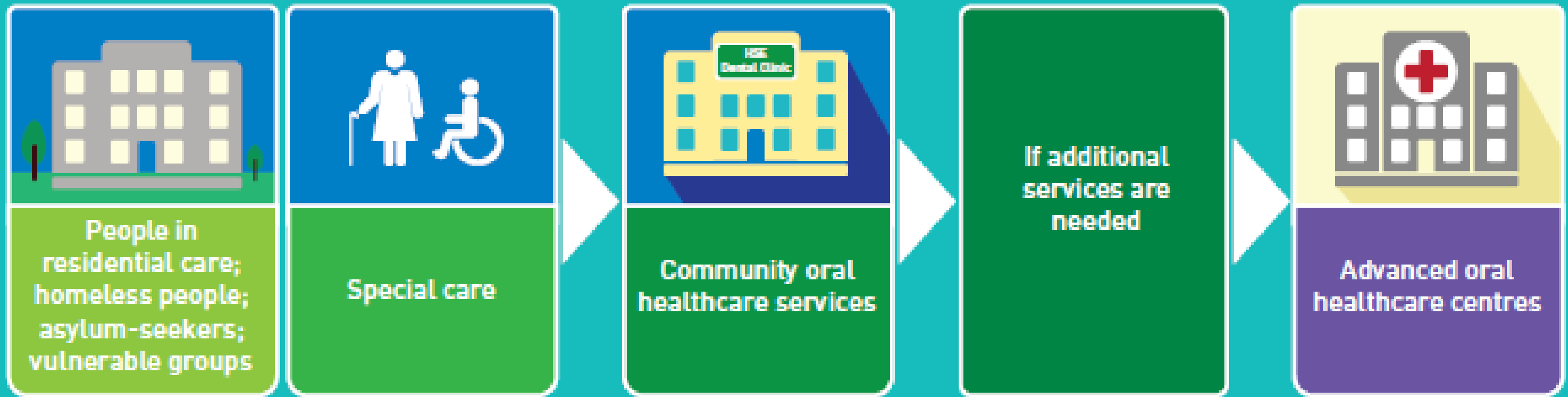
Oral Health Policy 2019



Health promotion

Surveillance

Oral Health Policy 2019 – Care Pathway



RECAP

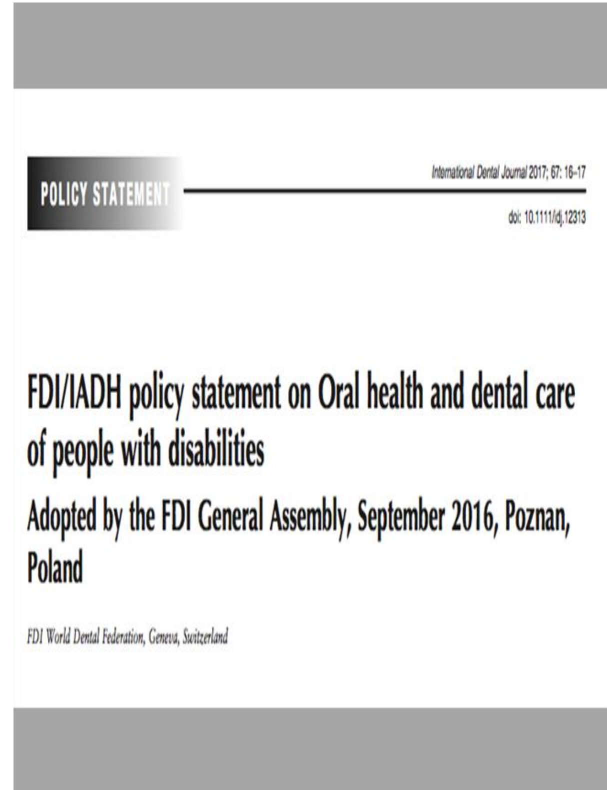
- **Huge and extreme oral health inequality experienced by vulnerable people that is unnecessary**
- **An empowered community of vulnerable people who want services 'just like everyone else' and in primary care**
- **A 'known demographic' of disability and marginalized groups; change in demographic to also include frail older people**
- **Recognition that what is done in under resourced, areas of good practice and experience , but pathway unclear and not working for PWD**
- **Unclear up to now whose remit or role the business of SCD is.**

‘If nothing changes….. nothing will change’

SKU NO.:340356
P/O NO.:82785
ST.LOUIS, MISSOURI
C/NO.:86
MADE IN CHINA

Principles/Ethos

- All have a right to health
- Equity & Dignity
- Participation & Inclusion
- National care pathway (flex/needs)
- Mainstream & Life-course
- Early intervention and focus on prevention (CRF)
- Right things Right (reasonable adjustment) & Resourced & EBP
- Choice
- Integrate


POLICY STATEMENT

International Dental Journal 2017; 67: 16–17

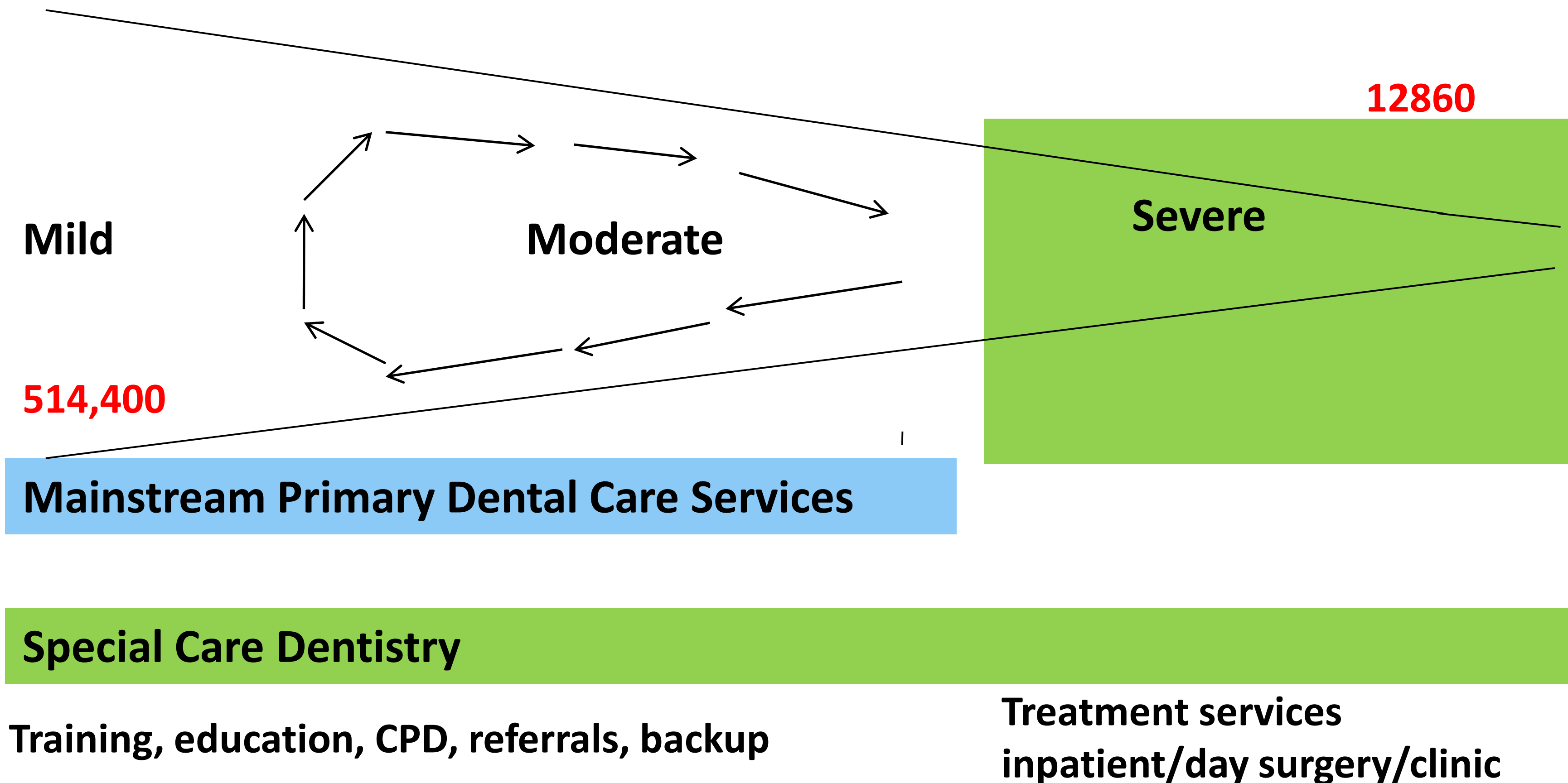
doi: 10.1111/idj.12313

FDI/IADH policy statement on Oral health and dental care of people with disabilities

Adopted by the FDI General Assembly, September 2016, Poznan, Poland

FDI World Dental Federation, Geneva, Switzerland

Location of Care in Ireland

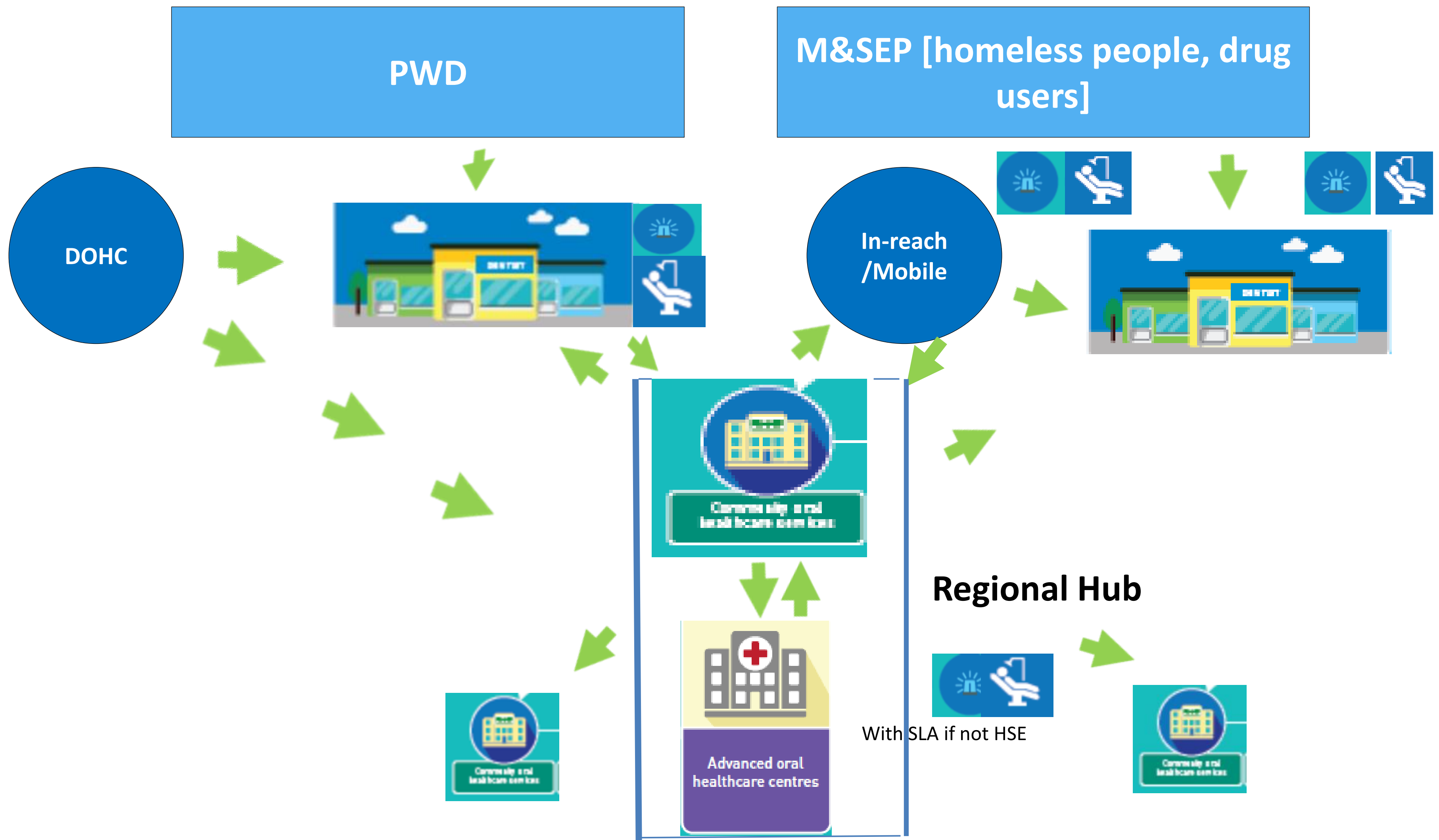


Training, education, CPD, referrals, backup

Treatment services inpatient/day surgery/clinic

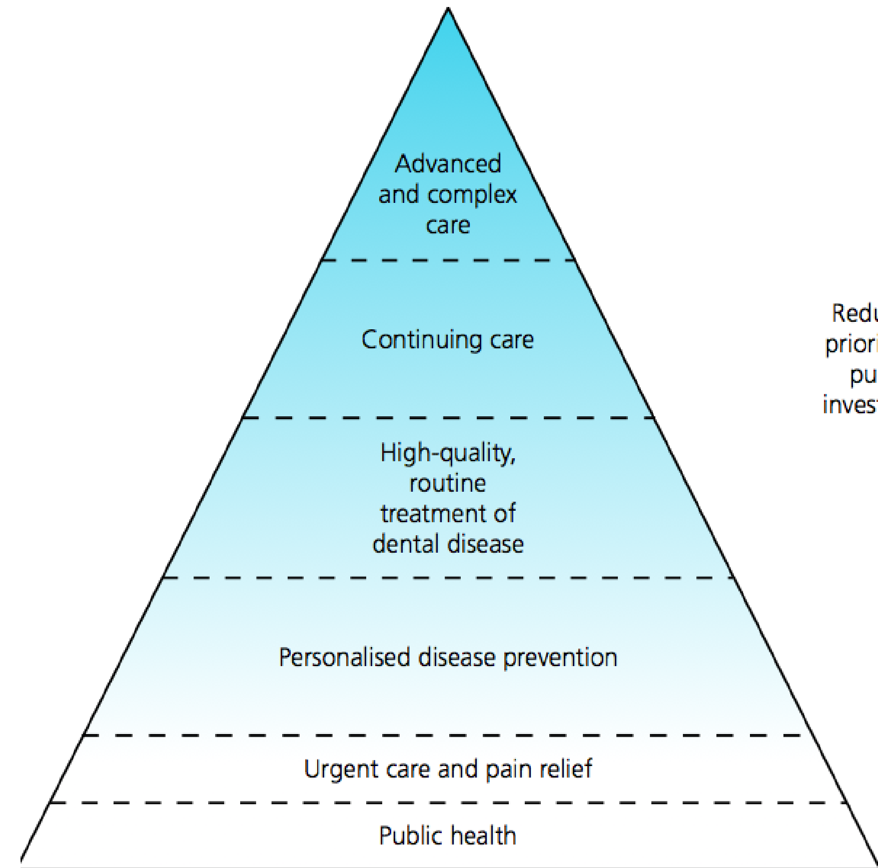
Source: JACSCD 2003 p 54,

National Care Pathway (local commissioning)



Patient Oral Health Needs Assessment

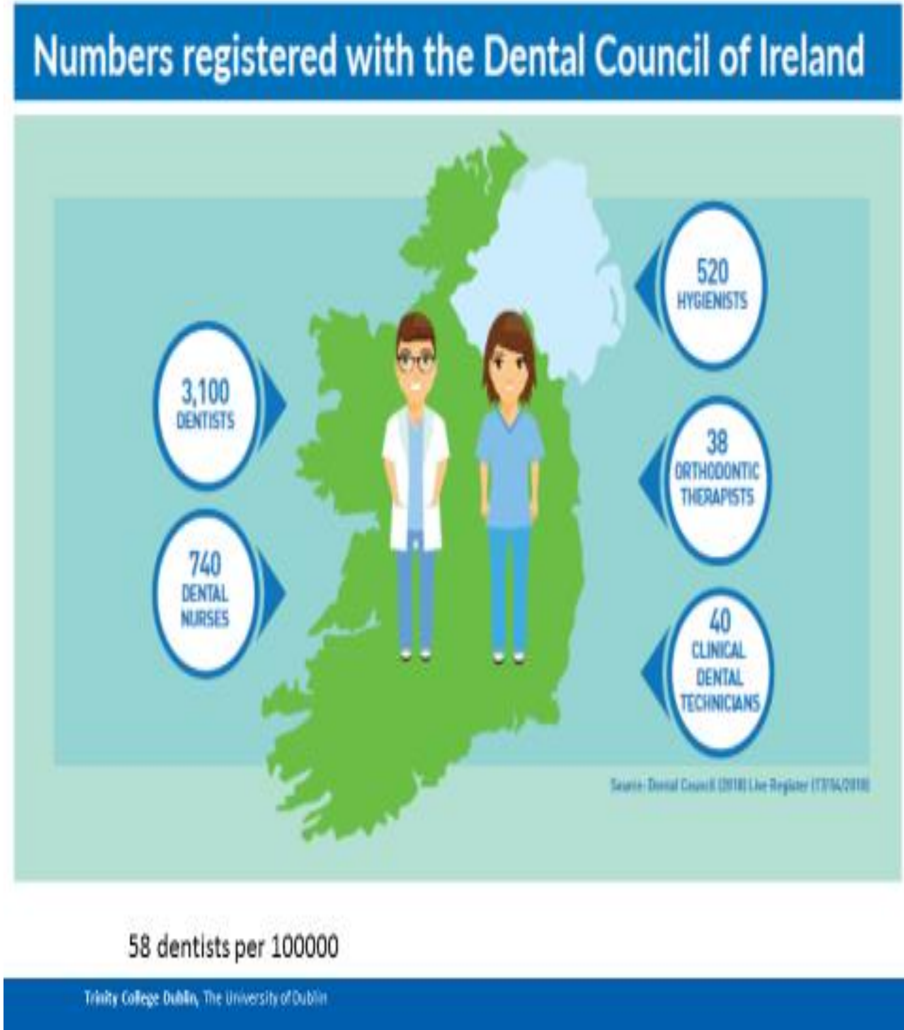
- Full Oral Health Needs Assessment
- Social & Medical History
- Risk assess [caries, periodontal disease, etc]
- Previous Dental History (cooperation and toleration)
- Assign risk category and protocol (implement)
- Assess Complexity (Communication, Co-operation, access, medical complexity, oral health factors, legal/ethical
- Assign setting (s) care & Treatment plan (adjuncts)
- Review/Recall



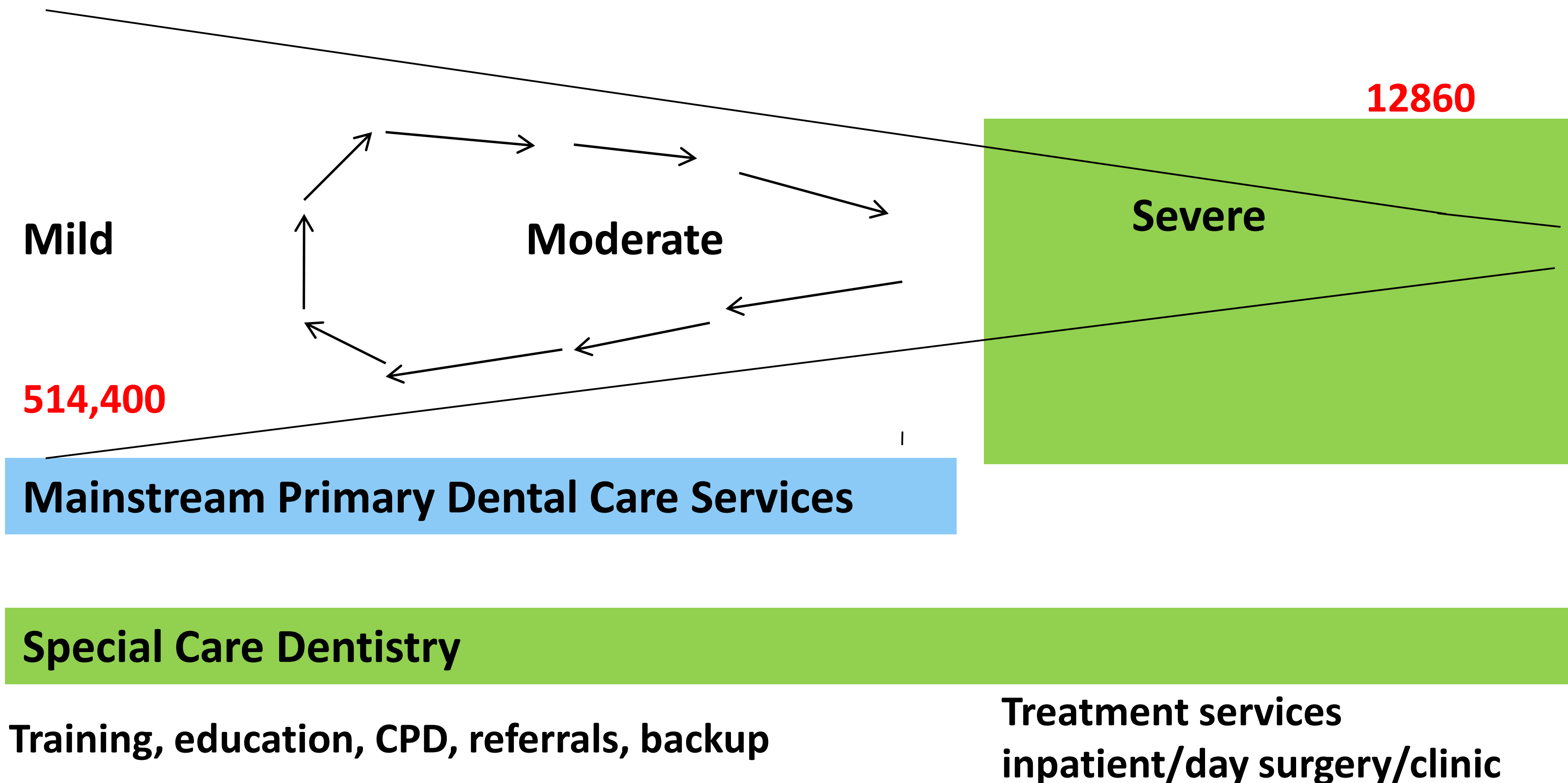
Pyramid DoH Steele Review 2009

Workforce

- **Harness potential of the Dental team**
- **Skill-mix**
- **Expanded duty dental Nurse**
- **Incentivise training**



Location of Care in Ireland



Source: JACSCD 2003 p 54,

Numbers needed (SCD)

- **Caseload of 800-1500 per year (Gallagher & Fiske 2006). To meet the current need projection based on average caseload in primary care (800-1500) would require between 8.5 to 15**
- **Average dentist population ratio in Ireland 44/100,000 (Smile Agus Slainte) applied (2272) would require 5.7**
- **SCD specialists would have parallel in both systems as they will provide ongoing care for complex needs BUT also support a referral base for some with mild and moderate complexity**
- **Based on a population approach of 4 specialists per 1.5 million population would require (4.85 million 2019) would require 13**
- **Regional Hubs (2 at least)**

Mainstream (ROCS model) Sheffield

GDPs, CDS and DPH

Offer annual screening visit as DOHC or surgery

Referral to CDS for SCD

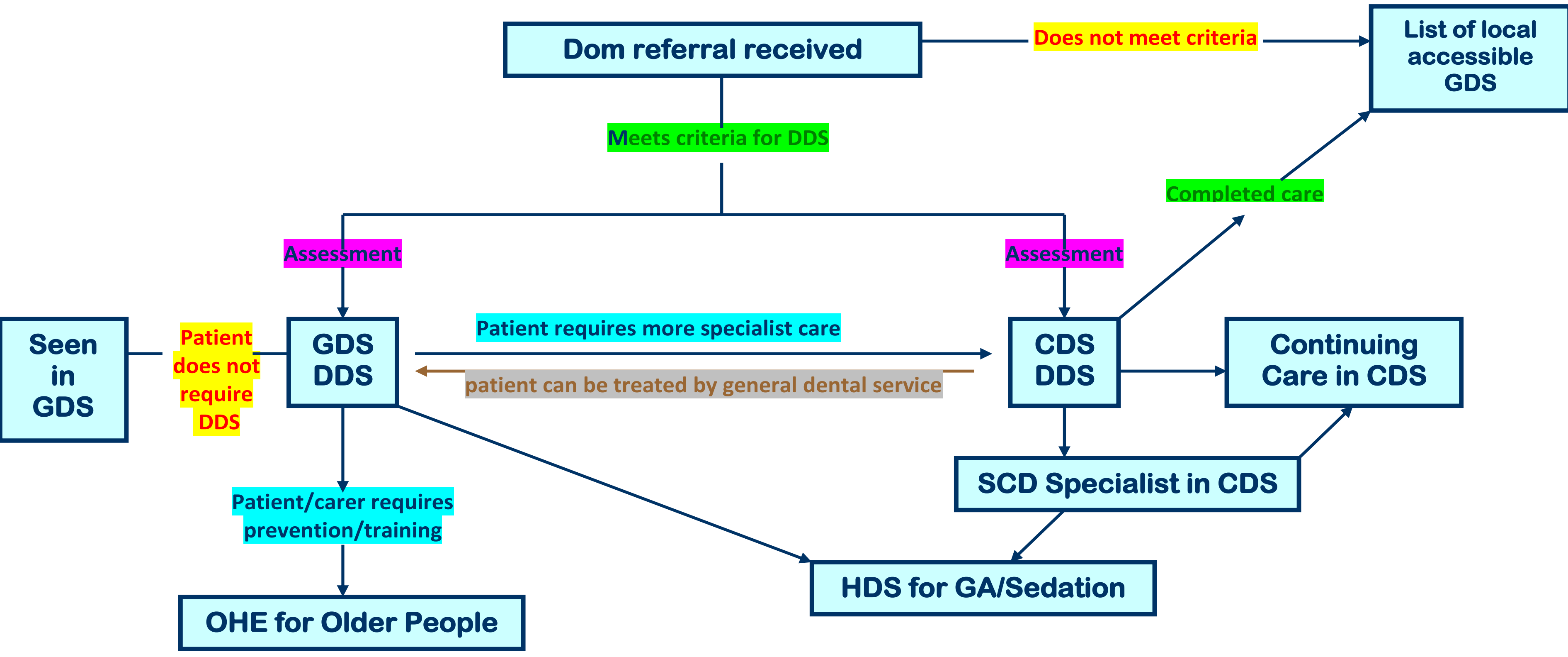
50% care homes

Adopting OHNA based on DBOH, supported by Colgate

The ROCS process is relatively simple and consists of the following stages:

1. Contact is made by the GDP with the home to be covered and an appointment arranged with the care-home manager.
2. A meeting is convened to explain the details of the dental package. The ROCS charter is explained - what the home can expect from the dentist & vice versa. The residents are all offered a screening & appropriate information, and payment status is collated by the home
3. At the screening visit(s), data is collected and forwarded to DPH consultant for use. in needs-assessment exercises
4. Information is recorded in the patient care plans
5. Treatment visits are planned and provided, with referral to the Salaried Dental Service if appropriate
6. Input from the Oral Health Promotion department on regular basis
7. Meeting with care-home manager to report on recommendations

The 'Gwent Model'



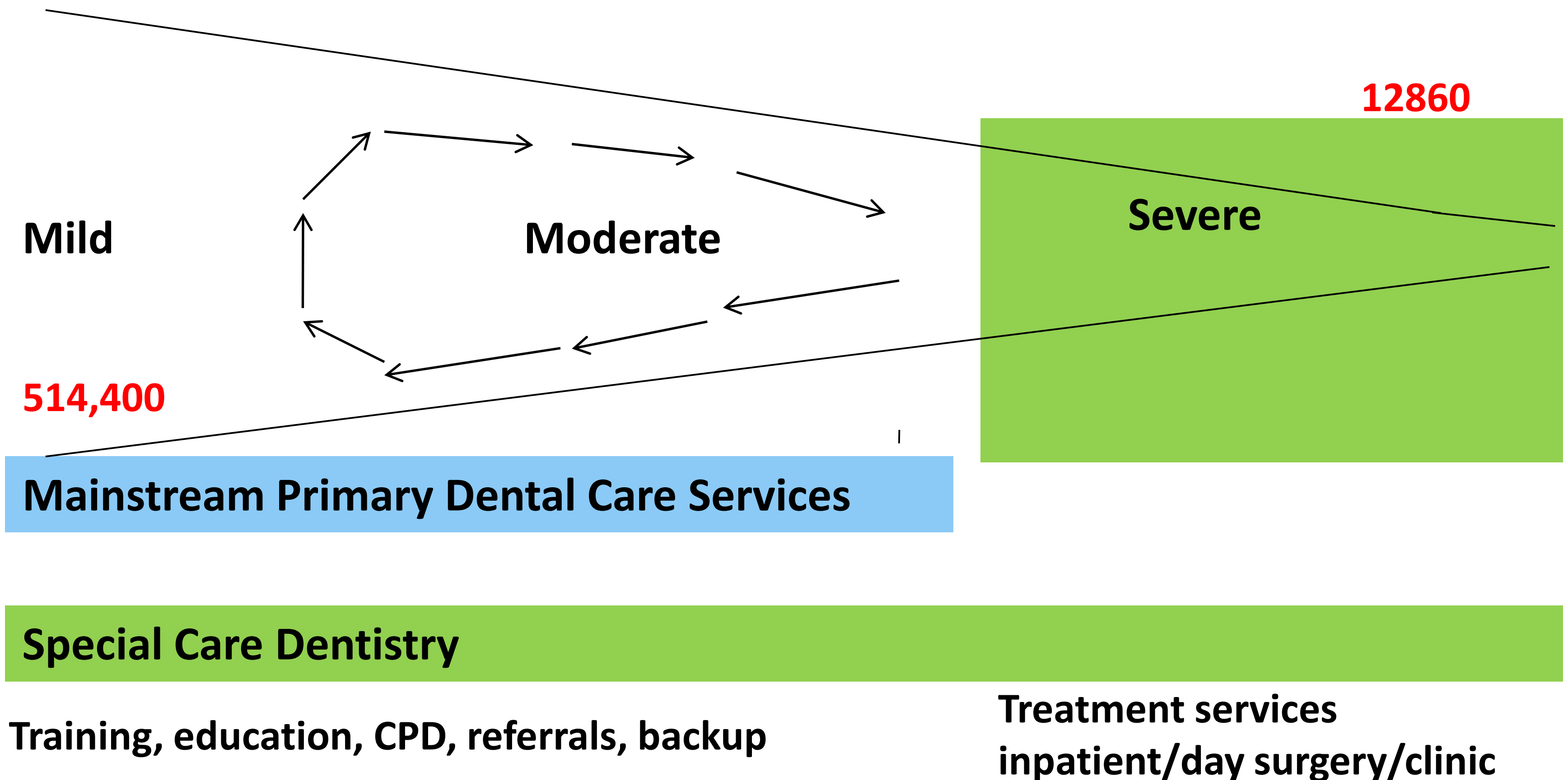
DDS – Dental Domiciliary Service
CDS = Community Dental Service
GDS = General Dental Service
SCD = Special Care Dentistry
HDS = Hospital Dental Service

GWENT: triage for access

- **Mobility, how are GP & Hospital appointments attended**
- **Does patient have someone to attend with them**
- **How are other social and activities attended**
- **Does carer ‘come in’**
- **Last time left house**

Research in Disability and Oral Health

Training needs, organisation, inclusion



Source: JACSCD 2003 p 54,

Opportunity window is small

Dog travels to Dublin alone on the train - Google Chrome

https://www.rte.ie/news/player/2019/0403/21534524-dog-travels-to-dublin-alone-on-the-train/

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Dog travels to Dublin alone on the train

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Broadcast on: April 03rd, 2019

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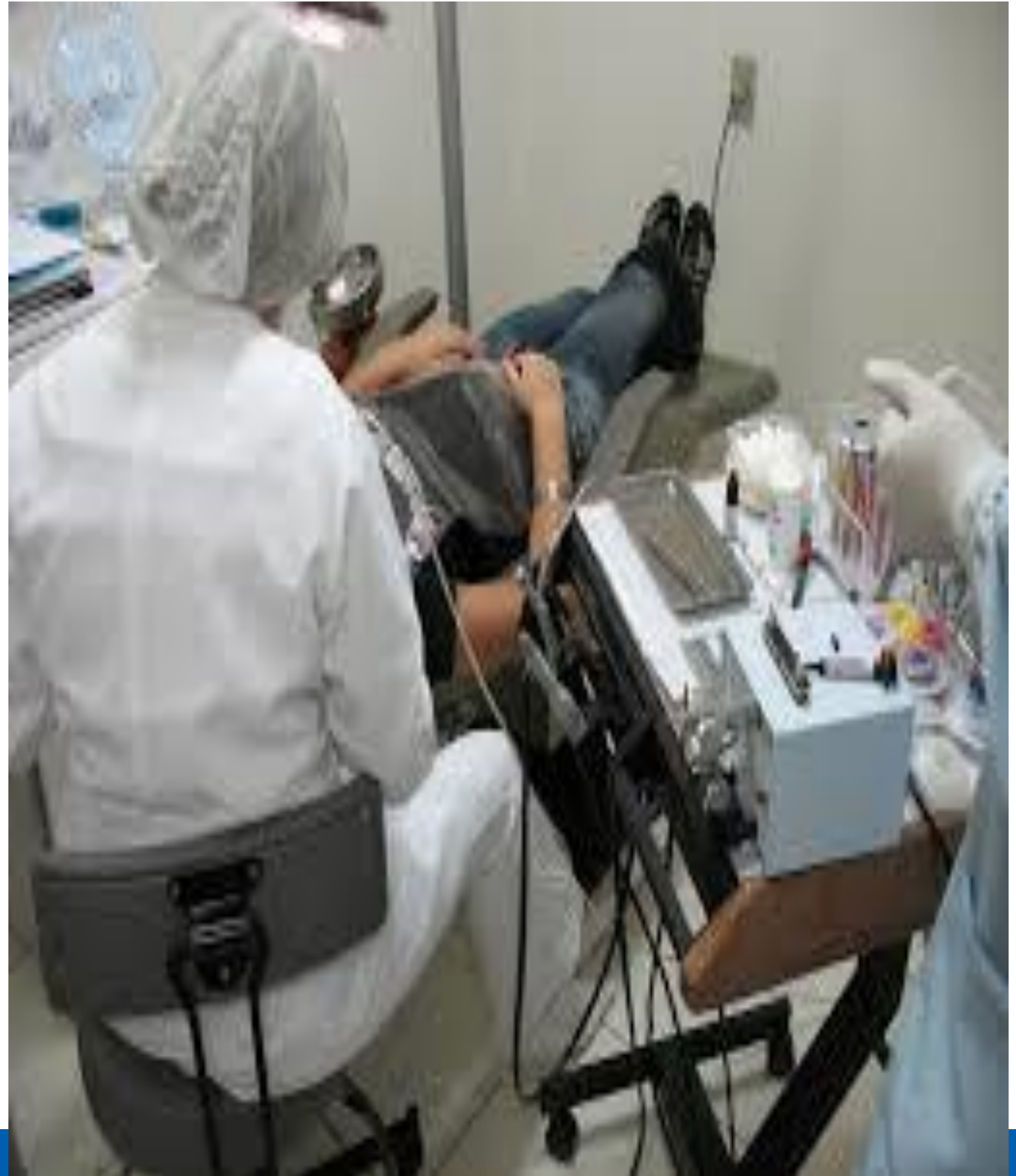
Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Thank You

Disability and oral health

Remit varies



Special services versus Mainstream versus Nothing?

Underserved and oral health inequality

Approaches to providing care for people with disability

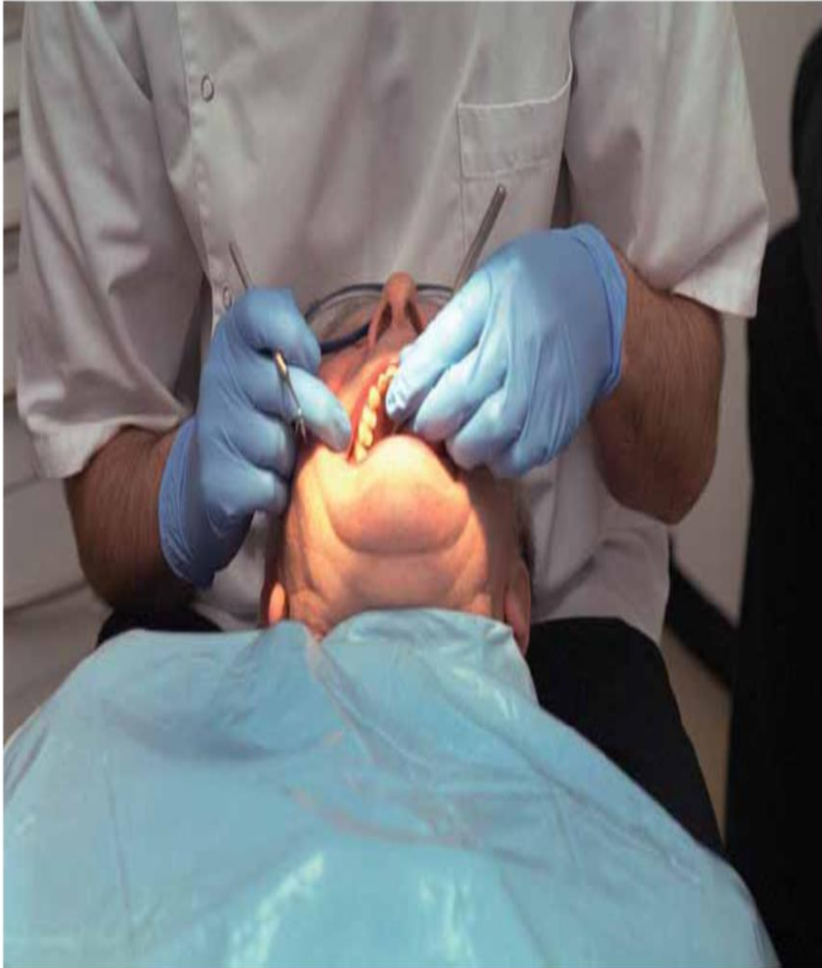
Enable access

- **Domiciliary oral health care**
- **Outreach dental care**

Managed care networks

- **Community/primary dental care**
- **Secondary settings for complex care**

Evidence Base?



- **Absence of academic recognition of oral health and disability**
- **Research community not sure where research in oral health and disability fits?**