

Providing dental health services to drug users: testing a model for a community pharmacy advice and referral scheme

By Janie Sheridan, PhD, MRPharmS, Tony Carson, BSc, MRPharmS, and Mark Aggleton, BA

AIM • To investigate a model of health promotion with regard to increasing drug users' access to dental health services. To compare referral rates between drug users and non drug users.

DESIGN • Drug users and non drug users attending community pharmacies had their dental health reviewed by pharmacists and were referred if necessary for dental treatment. An audit trail was set up to monitor uptake of treatment by drug users. Satisfaction with service was measured using a self-completion questionnaire.

SUBJECTS AND SETTING • 125 drug users accessing methadone dispensing services or sterile needles and syringes, and 129 non drug users accessing prescription dispensing services or health care advice services in community pharmacies.

OUTCOME MEASURES • Referrals for treatment; uptake or referrals; satisfaction.

RESULTS • For drug users, 44 (36.1%) were referred to a dentist participating in the project, of whom 13.6% made an appointment. Only 27 (22.1%) did not require a referral, the remainder being referred to their own dentist or refusing treatment. With regard to non drug users, 63.8% did not require a referral to a dentist. Satisfaction with the service was high.

CONCLUSIONS • Differences in need for referrals were noted between the two groups, with drug users in greater need of referral. The number of drug users making appointments to see a dentist in the study was small, but not unexpected considering drug users' fear of dental treatment and prior experiences of stigmatisation. This study shows that this model of health promotion can work in community pharmacy setting and could be extended to other groups of patients.

Problem drug users have been shown to have poor dental health¹ and this is often worse than members of the non drug using population.² They also have poorer access to, and lower use of dental health services.²⁻⁴ Many reasons have been suggested for this, including lack of expendable income, the attitudes of health professionals towards drug users, a general fear of dentists and a lack of self-esteem.⁴⁻⁸

Research has shown that in the United Kingdom, community pharmacists play an important role in the management of drug misuse, in particular with regard to needle exchange and methadone dispensing.⁹⁻¹¹ In other areas of health, community pharmacists are expanding their traditional roles to encompass health promotion¹² and a greater multi-professional focus has been recommended.¹³

In Kensington, Chelsea and Westminster Health Authority, London, a two-phase project was set up in community pharmacies to review the dental health of its problem drug using population and to test a model of referral for drug users to dentists for treatment. The former has been reported in the *British Dental Journal*² and involved a dental review of 125 drug users accessing methadone dispensing services and needles and syringes from community pharmacies and an age- and gender-matched group of 129 "non drug users". Drug users self-reported a significantly greater number of

dental health problems in the previous 12 months, were less likely to access treatment for these problems and were more likely to have problems accessing dental treatment.² The project also aimed to set up and investigate an intervention designed to encourage problem drug users to access dental health services and this aspect is the basis of this paper.

The aims of this second phase of the study were to:

- To test a model of health promotion within a community pharmacy setting
- To recruit local dentists willing to provide National Health Service dental treatment to drug users
- To use the community pharmacist as a conduit into dental treatment and a source of dental health advice

- To set up a system by which drug users could be referred to NHS dental treatment
- To monitor the uptake of services offered
- To review client satisfaction with the dental health review, the advice given and the referral service

This paper, which by necessity reports the methods and some basic results from previously published work,² aims to report to a pharmacy audience the results of the intervention, and to comment on its effectiveness, acceptability and limitations.

METHOD

The methods have been described in detail in a previous publication² but, in the interests of clarity, they are also described briefly here. Eleven community pharmacies and 17 dental practices took part in this study in March–May 2000. They were recruited through the use of a letter to all community pharmacists and dentists in the health authority, describing the aims of the study. All dentists taking part were chosen for their willingness to provide an NHS service to drug users and their proximity to pharmacies in the study. Community pharmacists were trained in the use of a dental review form which was used to obtain data on the dental health of drug users and non drug users. It was also used as a referral guide.

Janie Sheridan was formerly senior research pharmacist at the National Addiction Centre, Institute of Psychiatry, King's College London. Tony Carson was community pharmacy facilitator and Mark Aggleton was formerly community pharmacy project manager at Kensington, Chelsea and Westminster Health Authority, London. Correspondence to Associate Professor Janie Sheridan, School of Pharmacy, Faculty of Medical and Health Sciences, University of Auckland, 85 Park Road, Grafton, Auckland, New Zealand (e-mail j.sheridan@auckland.ac.nz)

The instrument was designed by the research team, in collaboration with local dentists, exclusively for this project. It was designed so that responses to certain questions which fell in a highlighted area of the form required the pharmacists to intervene by offering a referral and/or providing advice. A copy of the form is available from the authors on request.

Recruitment of clients took place during March to June in 2000, with a limit of 20 pairs of drug users and non drug users per pharmacy. Pharmacists recruited drug users from patients attending the pharmacy either to obtain sterile injecting equipment or to collect a methadone prescription. If they agreed to take part they were reviewed using the referral form. A non drug using client was then recruited as an approximate match, based on gender and an estimate of age, from customers or patients collecting prescriptions or making health-related requests. Unfortunately no data were collected on refusals, or the total number of potential clients identified during the study period.

Pharmacists were remunerated £5 per pair of drug user and non drug user questionnaires. They also received a bonus payment for collecting 10 pairs (£25), a further £25 for 15 pairs and a further £50 for 20 pairs.

Pharmacists were required to refer non drug users (defined as patients accessing non-methadone dispensing services and/or purchasing any medicines) to their own dentist (or a local dentist if they were not registered with a dentist). Drug users were referred either to their own dentist or to a dentist who had agreed to take part in the study. Drug users requiring treatment were shown a list of participating dentists and asked to choose which one they wished to attend. A triplicate referral form was then completed which required the following information: dental review questionnaire number, name of pharmacist, dentist code, client date of birth, gender, pharmacy stamp and date of intervention. A further space was left for any comments the pharmacist wished to add. One copy was sent to the study co-ordinator, one remained with the pharmacist and the third was given to the client to take to the dentist.

The study co-ordinator then used the referral forms to make contact with the dentist to ascertain which referrals had resulted in an appointment being made with the dentist.

After the end of the data collection period, pharmacists asked the same drug-using clients to complete a "customer satisfaction survey" which enquired about the clients' views on the usefulness of information provided, the appropriateness of a community pharmacy for the provision of this services, the privacy provided, whether the intervention would result in a change in their oral health behaviour and any other comments. It was also used to ascertain whether or not the clients who had been referred for treatment (other than to their own dentist or a dentist in the study) had made an appointment.

The following results are based on the dental reviews of 125 drug users, and where appropriate makes comparisons with the 129 non drug user review data. (We are unable to explain the differences in the sizes of the two samples — the matching procedure was clearly open to error.)

RESULTS

The demographics of the drug users and non drug users are shown in Table 1. Of the 125 drug users in the study, information was available on 122 with regard to referrals. Of these, 44 (36.1 per cent) were referred to a dentist participating in the project, 31 (25.4 per cent) were referred to their own dentist, 19 (15.6 per cent) refused a referral and one reported already receiving treatment. Only 27 (22.1 per cent) did not require a referral. With regard to non drug users, 63.8 per cent did not require a referral to a dentist (see Table 2). Contact with participating dentists indicated that of the 44 clients who had been referred to them, six (13.6 per cent) had made appointments.

With regard to the "Customer satisfaction survey" given out to drug users who had taken part in the study, pharmacists collected data from 58 clients (46 per cent), of whom 40 (69 per cent; data missing on two cases) were male. Twelve clients (20.7 per cent) reported that the pharmacist had told them to see a dentist in the study, 35 (60.3 per cent) to see their own dentist and 10 (17.2 per cent) were given advice and no referral (data missing on one case). Of those referred to a dentist (n=47), 16 (34 per cent) reported having made an appointment. Of these 16, 12 (75 per cent) were able to provide information on dates and addresses for these appointments.

Clients were then asked for their views on the intervention. Eighty-five per cent (49/58) found the information given to them by the pharmacist was "useful" or "very useful". Further information they would have liked, but were not given (n=6 clients), included a list of local dentists (n=3), information on services that dentists provided (n=1), information on ampoules versus methadone mixture (with regard to reducing dental problems) (n=1) and brushing techniques (n=1). Clients were asked

"Do you think you have changed the way you look after your teeth after talking to your pharmacist?" — 40 per cent said "yes", 52 per cent said "no" and 5 per cent said "don't know" (data missing on two cases). The changes that were reported included: "brush teeth more often" (n=7), "make an appointment" (n=2), "get a new dentist" (n=2), "visit dentist more regularly" (n=1) and "wash teeth before going to bed and use mouthwash" (n=1).

Three-quarters of the respondents (43/58) thought that the pharmacy was an appropriate place for such information to be provided and 65.5 per cent (38/58) believed there was enough privacy, 15.5 per cent believed there was not enough and 19 per cent "didn't know".

DISCUSSION

There is a need for targeted services for drug users^{1,2,4,14} and this study has shown that it is possible to set up schemes where community pharmacists review and assess clients' dental health and make referrals to dentists. Furthermore, we have shown that it is possible to recruit dentists to provide NHS dental services to drug users — a client group often stigmatised and avoided by dentists⁶ and other health professionals.^{7,8,15} This indicates that the model of review, assessment and referral tested in the study is viable in a community pharmacy setting.

Our results indicate that it is possible to encourage drug users to access dental treatment. The percentage of clients in the satisfaction survey reporting having made appointments at either their own dentist or those signed up to the study was 34 per cent, and through the audit trail of those referred to participating dentists was 13 per cent. (Unfortunately, due to the timescale of the study, it was not possible to obtain information on whether or not appointments had been attended in all cases.)

Such results might be considered to be disappointing. However, there are a number of barriers to obtaining dental treatment such as anxiety, costs, perceptions of need and lack of access¹⁶ and this is not particular to drug users. Anxiety has been associated with non-attendance of drug users for dental appointments.¹⁴ The results could be considered in a positive light inasmuch as those making appointments may have been unlikely to have sought treatment had they not been involved in this study. Furthermore, the impact of individualised advice given to all clients should not be underestimated. The satisfaction survey results indicate that many clients had made changes to their oral hygiene after taking part. The positive feedback from clients on the provision of these types of interventions should

TABLE 1: DEMOGRAPHICS OF DRUG USERS AND NON DRUG USERS

	Drug users	Non-drug users
Number	125	129
Mean age (years)	38.2	37.7
Males (%)	72.8	67.4
Females (%)	27.2	31.0
Methadone (%)	97.0	NA
Pharmacy needle exchange clients (%)	60.0	NA

TABLE 2: OUTCOME OF DENTAL REVIEW FOR DRUG USERS AND NON DRUG USERS

	Drug users (% n=122)	Non-drug users (% n=127)
Refer to dentist in study	36.1	—
Advise to attend own or other dentist	25.4	33.1
Dentist required but refused	15.6	3.1
No intervention required	22.1	63.8

encourage the integration of such services into shared care arrangements for drug misusers.

There are aspects of this study, however, that require qualification. First, the study involved relatively small numbers of clients — a study which includes a greater number of pharmacists and dentists with the ability to recruit greater numbers of clients is needed. Subjects were not recruited randomly, and therefore might have a special interest in dental health or have greater dental health needs. Second, there is a possibility that the collection of data retrospectively might be subject to recall

bias and that those responding to the satisfaction survey may well have been those who had a more positive attitude towards looking after their teeth or were keen to provide answers which they believed pharmacists wanted in order not to jeopardise much prized services such as methadone dispensing and needle exchange. However, the audit trail did substantiate that 13 per cent had made an appointment, and this was with a dentist unknown to the client — with no opportunity for the client to build up trust and evaluate the acceptability of the service. Third, we recognise that making an appointment is not necessarily corre-

lated with attendance for treatment and future research studies would need to address confirmation of attendance and possibly obtain data on the treatment provided in order to validate the appropriateness of pharmacists' referrals.

Finally, the making of appointments was left to clients. It is possible that more use could have been made of potential pharmacist–dentist contact, with pharmacists making appointments for clients at the dental review stage. Further study is required to see whether this might enhance uptake of treatment, with pharmacists also being encouraged to follow-up clients with regard to reminding them about appointments and future treatment plans.

There is a need to raise the awareness of primary health care professionals about the dental health issues surrounding drug misuse and dentists have reported a desire for additional training.⁶ It is also important for drug services providers, dentists and pharmacists to work together to provide a co-ordinated approach to the management of the dental health of drug users in their communities. Further studies need to incorporate the views of all practitioners, as well as clients, in order to provide best quality services.

The model tested here shows potential for other health promotion issues and such a model may be considered when developing community pharmacy-based services not just for drug users, but other targeted groups or topics which have previously been suggested or researched, for example foot care,¹⁷ diabetes,¹⁸ osteoporosis in elderly women,¹⁹ coronary heart disease²⁰ and cholesterol testing.^{21,22} The study has also shown that pharmacists are able to target non medicine-related issues — even with a challenging client group.

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ALCOHOL DRUG PROBLEM?

Do you have a problem with alcohol or drugs? Do you know of a pharmacist colleague who has?

Confidential help is available through the Pharmacists' Health Support Scheme. Telephone the Royal Pharmaceutical Society's welfare officer, Mrs Beverly Nicol (tel 01323 890135), who will in confidence give the telephone number of the scheme's independent national co-ordinator or one of its regional referees.

Alternatively, you may call the national co-ordinator's direct helpline (tel 01926 315138).