DISABILITY ACCESS AND COMMUNICATION

11th July 2025

UWA DMD2

Dr Jee-Yun Leung

BDSc(Hons) MSc(SCD) DSCD(RCSEng) DClinDent(SND) MRACDS(SND) FANZASND

Specialist, Special Needs Dentistry

Senior Lecturer, The University of Western Australia

Consultant, Maxillofacial and Dental Surgery Department, Fiona Stanley Hospital

BARRIERS TO ACCESSING ORAL HEALTHCARE

Patient-related factors

Care-related factors

Professional factors

Health system factors

BARRIERS TO ACCESSING DENTAL CARE – PATIENT RELATED FACTORS

- Perceived need for oral care
- Inability to express need for oral care
- Competing health priorities – finances, time
- Emotional, psychological, social and financial cost
- Behavioural challenges and cooperation issues
- Anxiety – difficulty rationalising fears
- Legal and ethical barriers
  - Capacity to consent
  - Need for best interest decisions or case conferences
  - Time required for referrals, sectioning, Office of the Public Advocate, consultation with third parties
- Inability to arrange or attend appointments without support
  - Reliance on others
  - Transport (ambulance, maxi-taxi, wheelchair accessible)
  - Need for domiciliary care
- Specific oral issues adding to treatment complexity (e.g. self-injurious trauma, microstomia, eruption patterns)
- Number of appointments / amount of treatment required to maintain oral health
  - Sweet snacks used as rewards
  - High calorific diet / sugary medications required
  - PEG feeding → calculus accumulation
  - Inadequate oral hygiene and substantial dependence on others for daily oral maintenance

BARRIERS TO ACCESSING DENTAL CARE – CARER RELATED FACTORS

- Lack of awareness of need for oral care
- Knowledge, experience and skills of carers
- Attitudes towards oral care
- Value placed on oral care
- Overwhelmed with burden of complex medical and day-to-day care
- Lack of staff rostered to take patient to dentist and provide daily oral hygiene
- High staff turnover and contractual agency staff (responsibility, familiarity)
- NDIS regulations on restrictive practices if client refuses toothbrushing, scale & cleans
- Relatives requiring time off work
- Age/frailness of family members (e.g. parents who are primary carers)

BARRIERS TO ACCESSING DENTAL CARE – PROFESSIONAL FACTORS

- Lack of dentists with adequate skills and training
- * Lack of dentists willing to treat people living with disability
- Lower renumeration relative to other aspects of dentistry
- Discrimination and attitudes towards disability (lack of patience)
- Oral health problems failing to be recognised, discussed or considered by medical or other allied health practitioners (‘**diagnostic overshadowing**’)
- Increased commitments and financial responsibilities with specialty training

BARRIERS TO ACCESSING DENTAL CARE – HEALTH SYSTEM FACTORS

- Strict eligibility criteria
- Cost of dental care
- Lack of funding for services
- Long waiting lists for public dental care or specialised SND services
- Not all buildings/surgeries are disability accessible
- Equipment required: hoist, wheelchair recliner, bariatric chair, portable dental equipment
- Lack of clear and specific public health policy addressing dental needs for those with disability

CONSEQUENCES OF BARRIERS

- Localised problems
  - Decay, gum disease, attrition, fungal/bacterial infections, pain, poor appearance, loss of teeth
- Unwanted outcomes
  - Extractions instead of fillings, increased severity of periodontal disease, lack of functional replacement of extracted teeth
- Functional difficulties with eating, drinking, smiling, speech
- Aesthetic concerns, loss of self-confidence and dignity
- Complications related to dental procedures
  - Bleeding, post-op infections, ONJ, aspiration
- Urgent, systemic health issues
  - Sepsis, compromised airway, swallowing difficulties, malnutrition, dehydration, aspiration pneumonia
  - Crisis point with behaviour
- Complications related to sedation and GA
- Psychological trauma from invasive dental procedures undertaken without adequate preparation
- Increased financial burden on individuals, families and the health system

ACCESS

UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITY (CRPD) 2006

- Ratified by Australia in 2008
- Aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
- **Article 25** addresses health and commits State Parties to provide:
  - PwD with the same range, quality and standard of free or affordable health care and programmes as provided to other persons;
  - Health services needed by persons with disabilities specifically because of their disabilities
  - Health services as close as possible to people's own communities
  - Require health professionals to provide care of the same quality to persons with disabilities as to others, including
    - on the basis of free and informed consent
    - through the use of ethical standards
    - training to raise awareness of the human rights, dignity, autonomy and needs of persons with disabilities.

ACCESS

- Four key areas:
  - Access to the **building**
  - Access to the **dental surgery**
  - Access to the **dental chair**
  - Access to the **mouth**

ACCESS TO THE BUILDING

- Disability Discrimination Act 1992 (Cth)
  - Makes it against the law to discriminate against a person because of disability when providing goods, services or facilities, or access to public premises.
    - Direct discrimination (e.g. refusal of entry)
    - Indirect discrimination (e.g. staircase is only entry way)
  - Requires businesses to make **reasonable adjustments** to enable a person with disability to access goods, services or facilities

ACCESS TO THE BUILDING

- It is not against the law to discriminate in providing access to goods, services or facilities if it can be demonstrated that making the required adjustments would cause '**unjustifiable hardship'**
- Before claiming that adjustments will create unjustifiable hardship, businesses should:
  - thoroughly consider how an adjustment might be made
  - estimate the cost of making the adjustment and whether any financial or other assistance is available
  - consider the potential benefit or detriment of the adjustment for
    - any specific person concerned
    - the business
    - the community
  - discuss this directly with any person involved
  - consult relevant sources of advice.

ACCESS TO THE BUILDING – REASONABLE ADJUSTMENTS

- Reasonable adjustments
  - Parking, ramps, mindful of kerbs
    - Gradient, well-lit and signposted, parking space dimensions
  - Improving signage and lighting
  - Simple rails and ramps
  - Entrance: door width, level threshold, door opening, position and design of door handles
    - Above ground floor: Installing stair lifts or wheelchair lifts
  - Making appointments and communication:
    - Allowing longer for an appointment
    - Providing interpreter support, writing things down – or providing written information orally
    - Communicating in an accessible way – producing information leaflets in large type/font, audio information, or texting/emailing/writing appointment times.
    - Contact details of reliable taxi company with wheelchair-accessible cars

Fig. 2 A simple grab rail can improve access

Fig. 3 A stairlift

ACCESS TO THE SURGERY – REASONABLE ADJUSTMENTS

- Reasonable adjustments
  - Reception and waiting room
    - height of reception desk
    - clear signage
    - non-slip flooring
    - appropriate seating (chairs with arm rests, space for wheelchairs)

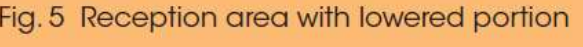
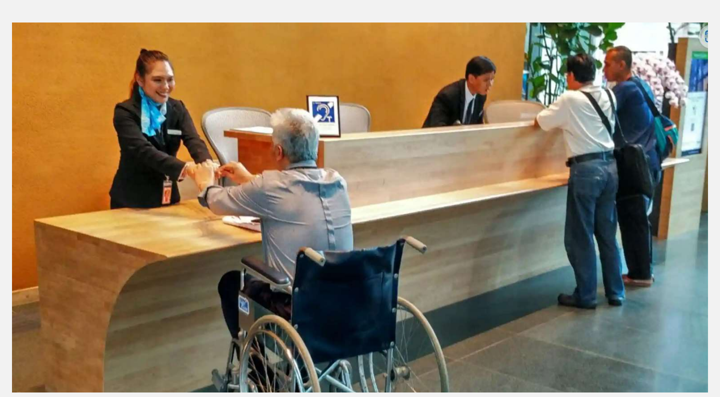


Fig. 5 Reception area with lowered portion



  - Corridors:
    - no clutter
    - width

ACCESS TO THE SURGERY – REASONABLE ADJUSTMENTS

Surgery:
- wheelchair access and spacing for manoeuvrability

Facilities:
- Toilet
    - Picture of toilet on blue door
    - Space
    - Transfer bars
    - Raised seat
    - Alarm
- Emergency escape
    - Signage
    - Visual alarms,
    - Accessible exits

Floors:
- Matte, even-coloured flooring

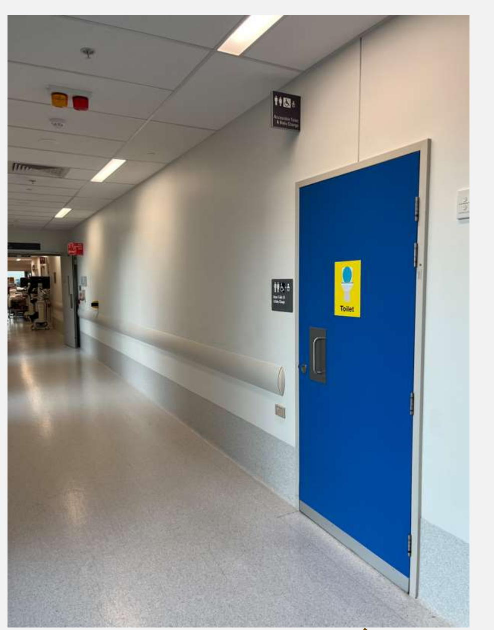


Fig. 4 An accessible toilet

ACCESS TO THE DENTAL CHAIR – REASONABLE ADJUSTMENTS

- Reasonable adjustments
  - Arrange room to allow for wheelchair to be brought alongside dental chair to aid easier transfer
  - Treat patient in their own wheelchair
    - Use headrest attachment
    - some wheelchairs recline
  - "Banana board" to allow transfer
    - only 5% of wheelchair patients use wheelchair 100% of the time, many can transfer independently

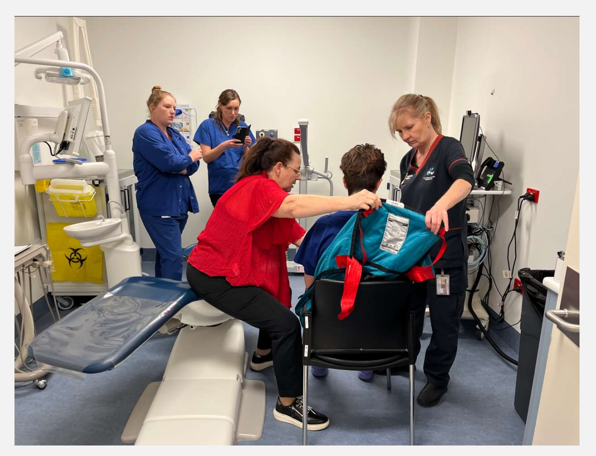
DISCUSS WITH PATIENT/CARER/RELATIVE

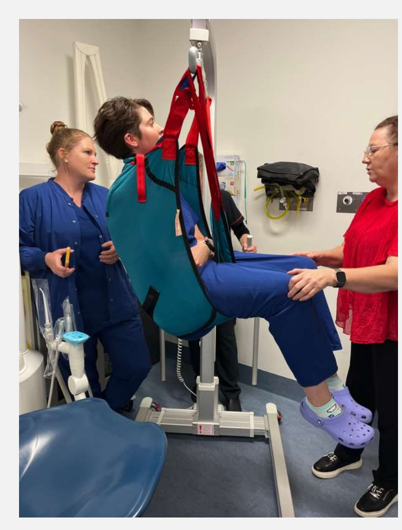
Fig. 7 A banana/transfer board used to 'slide' into the dental chair

Fig. 1 A manual chair, a powered chair, a powered chair with reclining function. Reproduced with permission from Sunrise Medical

ACCESS TO THE DENTAL CHAIR – EQUIPMENT IN SND FACILITIES

Equipment in SND facilities
Hoist

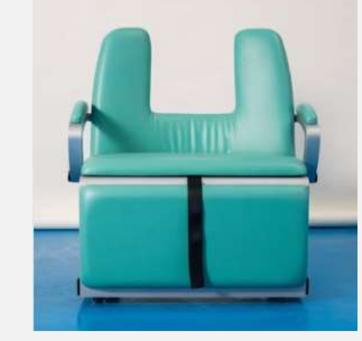




ACCESS TO THE DENTAL CHAIR – EQUIPMENT IN SND FACILITIES

- Equipment in SND facilities
  - Wheelchair recliner / tipper
  - Bariatric chair

Fig. 10 A wheelchair recliner by Design Specific



ACCESS TO THE DENTAL CHAIR – EQUIPMENT IN SND FACILITIES

- Equipment in SND facilities
  - “Break-leg” facility to ease transfer
  - Portable turntable

Figs 8a and b A portable turntable for transfer of a patient with good upper body strength

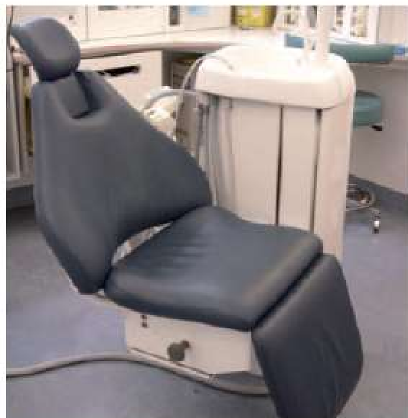


Fig. 5 A break-leg chair allows easy access for people with mobility issues

ACCESS TO THE DENTAL CHAIR

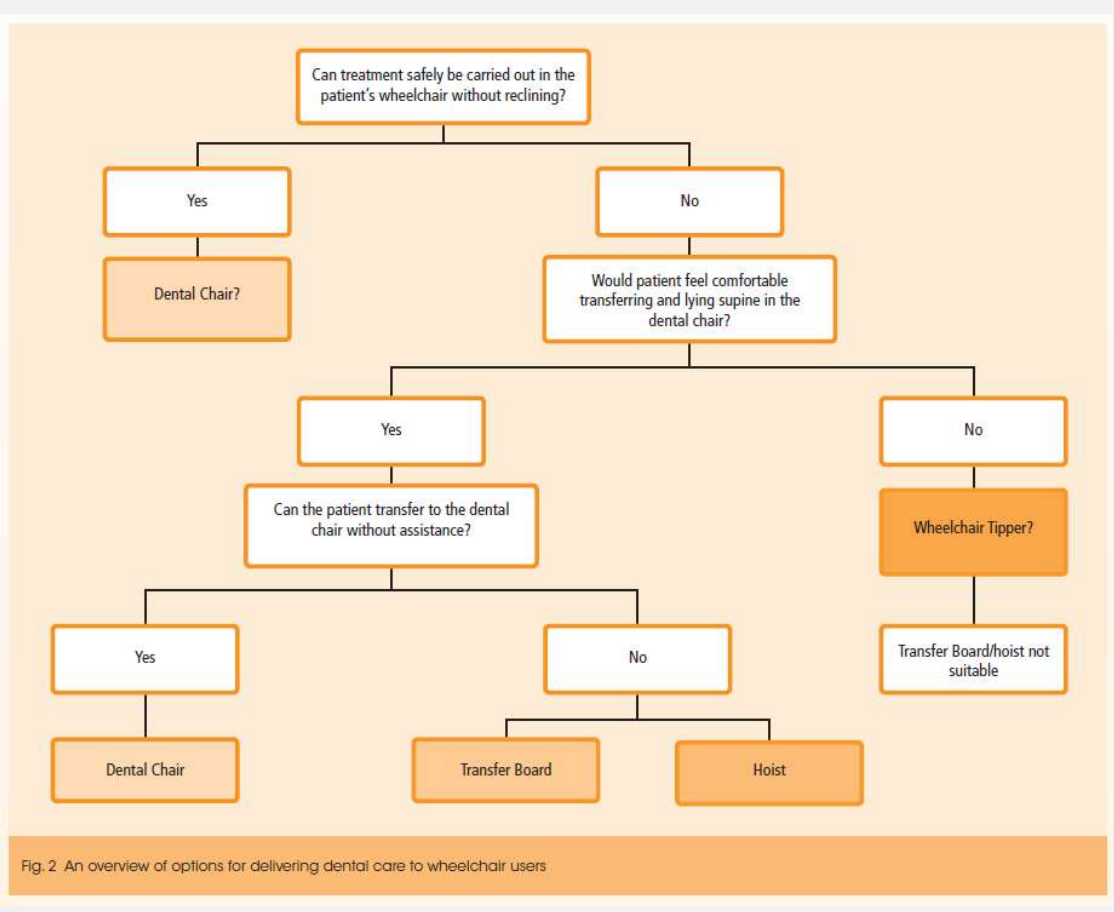


Fig. 2 An overview of options for delivering dental care to wheelchair users

Ramirez L, Dickinson C. Wheelchair users: A guide. B Dent J. 2018;224(6):408-12

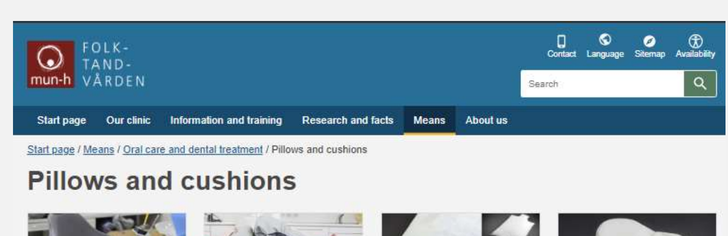
ACCESS TO THE MOUTH

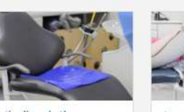
- Key barriers:
  - Intellectual disability or challenging behaviour
  - Muscle tone or control (frailty, spasticity, hypotonia, dystonia)
- Strategies:
  - Acclimatisation and behavioural techniques
  - Empathy
  - Use of headlight if dental chair light unable to reach mouth (e.g. wheelchair / bed / domiciliary setting)
  - Semi-upright position: chronic obstructive airway disease and congestive cardiac conditions.
    - Ask how many cushions patient uses to sleep at night, and adjust chair to similar position.

Fig. 6 Examples of a standard headlamp, and an LED light mounted to dental loupes

ACCESS TO THE MOUTH

- Create body postures that ensure body is well-supported, with joints and muscles in rest position.
  - Spasticity: chin should be as close to chest as possible, hips and legs flexed and separated to achieve maximal relaxation
  - Cushions or beanbags if difficulty achieving above posture (eg. RA, MS, cerebral palsy)
  - Mun-H-Centre (Sweden) = National Resource Centre for oro-facial aids → set of 4 cushions to provide non-steady anatomical support





Anti-slip cloth

The anti-slip cloth prevents the patient from slipping out of the chair.

Leg relaxer, Tumle dental pillows

The pillow is there to relieve the hip and knee joints.

Fastening straps for leg relaxers, Tumle Dental pads

The strap holds the leg slap in place.

Head pillow, Tumle dental pillows

Bowl- and wedge-shaped head pillow used to stabilize the patient's head against the operating table.

Circumference, Tumle dental pillows

The pillow is placed behind the neck, around the shoulders, back and arms.

Extender for Circumference, Tumle Dental Cushions

Extender for Surrounded with Velcro. With the help of the extender, the pillow can be connected.

Neck pillow, Crescent, Tumle dental pillows

The pillow provides support for the neck. The pillow has nibs to pull out at the sides of the head for increased stability and comfort.

Neck pillow, Cheese bow, Tumle dental pillows

The pillow is an alternative to the Half Moon neck pillow. It is slightly larger and provides higher padding in the neck pit.

Neck pillow, Tempur

Headrest that can be attached to the treatment chair.

Seat cushion, Kids, Tumle dental pillows

The pillow is a combination of seat cushion and back cushion and distributes the support evenly under the body surface.

Lower leg cushion, Tumle dental pillows

The lower leg cushion supports the calves and feet and is used together with the leg relaxer.

ACCESS TO THE MOUTH

- Uncontrolled movements (exaggerated bite reflex, uncontrolled muscle spasms):
  - Place equipment in a position will not get knocked
  - Finger bite support / rubber spatula
  - OpenWide® foam mouth rest
  - Unbreakable mirror heads, plastic mirrors
  - Cheek retractor
- X-ray arm able to reach mouth
- Suction able to reach mouth (extended piping tube length)
- Spittoon – if unable to reach, use kidney dishes or cups

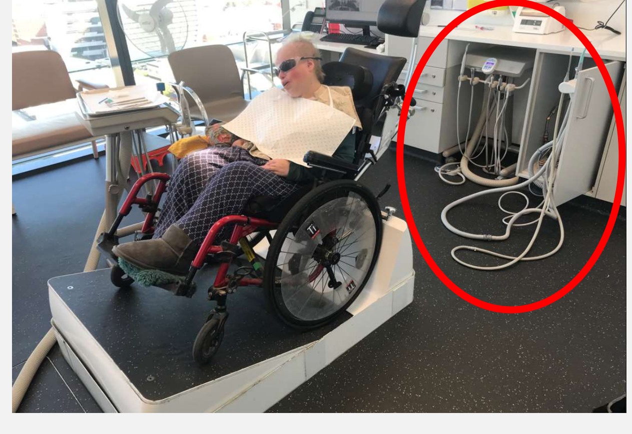


Fig. 13 Using a photographic cheek retractor to hold the soft tissues away from the teeth to improve access

ACCESS TO THE MOUTH

- Assess risks to your own health and take necessary precautions
  - Avoid prolonged periods in positioned conferring stress to spine
  - Seated dentistry
  - Standing: Footstool, bend at knee (c.f. waist)
  - Four-handed dentistry

- Occupation hazards
  - Manual handing
  - Poor posture

COMMUNICATION

COMMUNICATION

- **Definition**: A complex system of sending, receiving and interpreting messages.
  - A two-way process, involving a sender and receiver
- **Effective communication**: Signals sent = signals received
- **Importance**: Fundamental to good clinical practice
  - Informed consent
  - Provide appropriate preventive advice
  - Facilitate patient rapport and trust
  - Minimise misunderstanding and complaints

ELEMENTS OF COMMUNICATION

- **3 Elements:**

Words (VC) + tone of voice (NVC) + body language (NVC)

BUT if: **VC ≠ NVC → NVC believed**

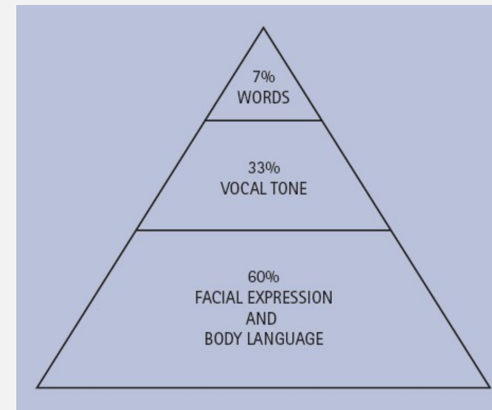


Fig. 1 'The communication triangle' denoting the percentage value of elements of communications. Source: reference 1

BARRIERS TO COMMUNICATION

COMMUNICATION DIFFICULTIES

- Difficulty when communicating verbally, visually or in writing
- Difficulty interpreting the speech and actions of others
- Difficulty expressing one's own thoughts and feelings

CONDITIONS WITH COMMUNICATION DIVERSITY

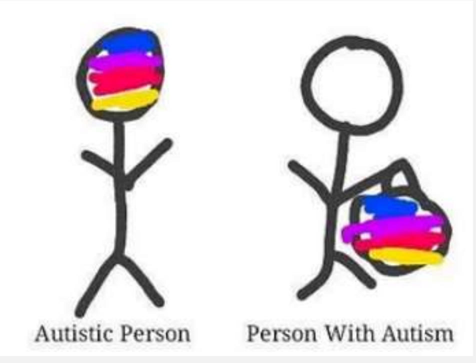
- Developmental and cognitive disorders
  - Intellectual disability
  - Autism spectrum disorder
  - Dementia
  - Neurological disorders (e.g. ABI, stroke/TIA, Huntington's Disease, MND)
- Communication disorders
  - Speech and/or language delay, disorder or impairment
  - Expressive and/or receptive language disorder
  - Stuttering or dysfluency
  - Semantic/pragmatic disorder (affects individual's use of language for social purposes)
  - Central auditory processing disorder (affects individual's listening and understanding of language)
  - Dyslexia
- Sensory impairment
  - Hearing, visual impairment
- Poor control over vocal apparatus or muscle movements needed to speak clearly/quickly (verbal dyspraxia)
  - E.g. Cerebral palsy, Parkinson's disease, laryngeal surgery, stroke/TIA
- Difficulty focusing / paying attention
  - E.g. ADHD, anxiety
- Intoxication/overdose or drug withdrawal
- Lack of experience, stimulation or opportunity to talk to other people

COMMUNICATION DIVERSITY

PERSON FIRST LANGUAGE

↓

PERSON CENTERED LANGUAGE

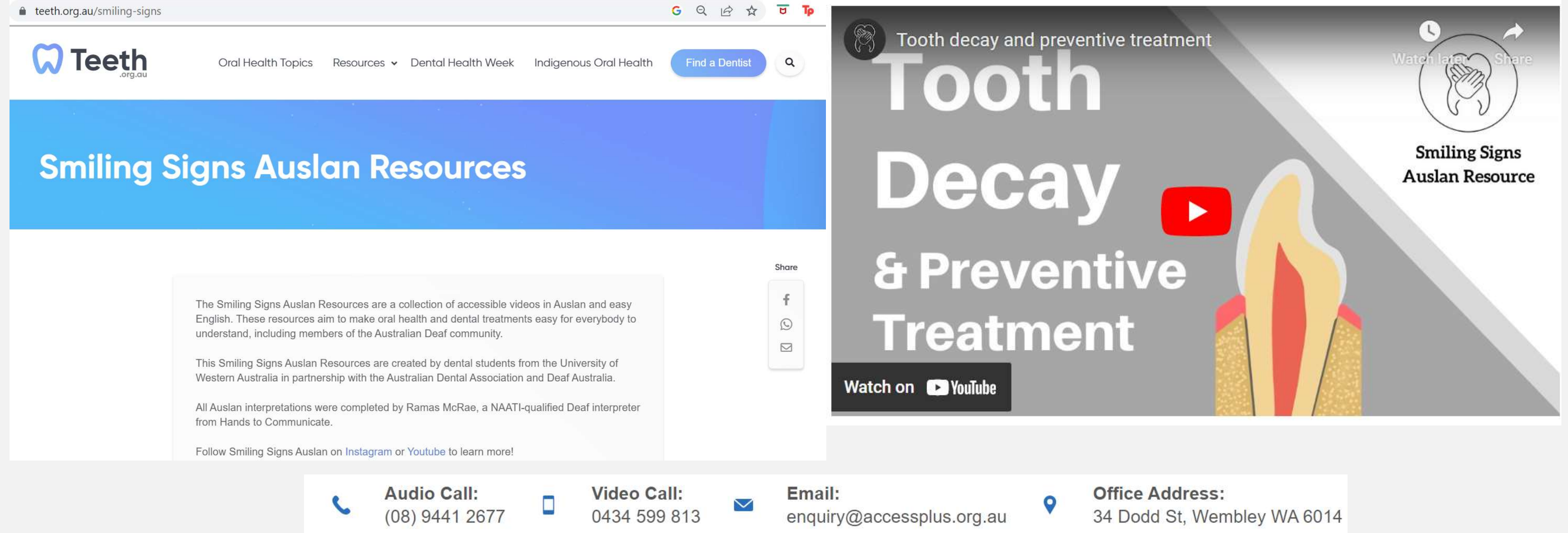


INCORRECT	CORRECT
HANDICAPPED OR DISABLED PEOPLE	PEOPLE WITH DISABILITIES
HE IS MENTALLY RETARDED OR A MONGOLOID	HE HAS A DEVELOPMENTAL OR INTELLECTUAL DISABILITY
SHE IS WHEELCHAIR-BOUND	SHE USES A WHEELCHAIR
HE IS A CRIPPLE	HE HAS A PHYSICAL DISABILITY
MIDGET OR DWARF	A PERSON OF SHORT STATURE
HE SUFFERS FROM HEARING LOSS	HE IS HARD OF HEARING
NORMAL OR HEALTHY PERSON	PERSON WITHOUT A DISABILITY
HANDICAPPED PARKING OR BATHROOM	ACCESSIBLE PARKING OR BATHROOM
HAS OVERCOME THEIR DISABILITY OR CHARACTERIZED AS INSPIRING	PERSON WHO IS SUCCESSFUL OR PRODUCTIVE
THE BLIND OR SUFFERS FROM VISION LOSS	PERSON WHO IS BLIND OR VISUALLY IMPAIRED

SENSORY IMPAIRMENT

- Affects:
  - Access to dental care
  - Communication and interactions within the dental setting
  - Can result in dental anxiety
- Includes:
  - Hearing impairment
  - Visual impairment
  - Deafblindness

HEARING IMPAIRMENT



HEARING LOSS

- deaf vs Deaf
  - Deaf = people who have been deaf prior to learning to talk (pre-lingual).
    - Sign language tends to be first language
    - Strong and close Deaf community with its own culture and sense of identity
  - deaf = "hard of hearing", "hearing impaired"
    - People who do not hear very much
- Level of deafness is defined by the quietest sound a person can hear
- Can be congenital, inherited, or acquired (accident, disease, ageing)
- Affects 1/6 of the Australian population

HEARING IMPAIRMENT – COMMUNICATION METHODS

- Identification: hearings aids, pre-typed note or card, speech
- Ask preferred method of communication
- Ideally communicate directly to make appointments
  - C.f. National Relay Service
- Hearing aids:
  - Do not assume patient can hear you
  - Ensure are switched on for communication
- Language service providers
  - Lip-speakers
  - Auslan interpreters (c.f. family member)
  - Preferred interpreter?
- Communication aids
  - Text machines, iPad/laptops, SMS (c.f. phone calls), pen & paper, cue cards
- Lip-reading
  - Speak clearing in normal cadence and tone

HEARING IMPAIRMENT

Table 2 Hearing impairment – tips for improving communication
• Position yourself with your face to the light so you can be seen clearly and face the patient so they can read your lips. Remove your facemask or wear a clear face shield to facilitate lip reading
• If you are using communication support always remember to talk directly to the person you are communicating with, not the interpreter
• Minimise background noise (such as music), distractions and interruptions
• Allow extra time for the person to respond
• If what you say is not understood, do not keep repeating it. Try saying it in a different way instead
• Speak clearly but not too slowly, do not exaggerate your lip movements, and use natural facial expressions and gestures
• Avoid jargon and unfamiliar abbreviations
• Resist the urge to shout – it will not help, is uncomfortable for a hearing aid user and looks aggressive
• Lower the pitch of your voice – it is more effective than raising the pitch as people lose high pitch hearing first
• Use gestures for visual feedback, such as a thumbs up for 'you are doing well'
• Be prepared to write down what you have to say or have pre-prepared written prompts to save time
• Check that the person you are talking to can follow you. Be patient and take the time to communicate properly
• Make appointments and communicate with the patient through texting

Stealth Clarity FFP3 Transparent Face Mask x 5 PK

DEAF CULTURE

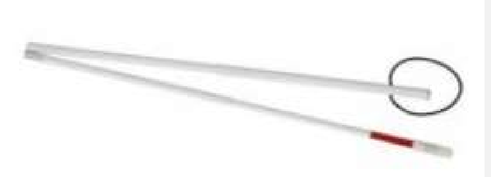
- People must face each other to have a conversation
  - Eye contact is essential
  - Extra room for signing space
- Lighting is important (visual language)
- Pointing is a regular and necessary way of referencing (not rude/abrupt)
- Is normal to lightly tap someone’s shoulder or upper arm to get their attention

VISUAL IMPAIRMENT

- Legal blindness = cannot see at 6m what someone with normal vision can see at 60m, OR field of vision is <20 degrees in diameter
- Low vision = permanent vision loss that cannot be corrected with glasses and affects their daily functioning
- 2016: 384,000 people in Australia → 2030 projection: 564,000 people

VISUAL IMPAIRMENT

- Identification: specialised glasses, carry white cane, guide dog
- Ascertain how much residual vision they have, and their preferred method of communication
- Provide tactile feedback: handshake on meeting, guiding by offering patient to hold your elbow, warning if any steps coming (and how many).
- Guide dogs: ask if will remain in waiting room or accompany into surgery
- Speaking: face patient, ensure no strong back lighting that interfere with residual vision
- Keep patient informed of each step: anticipate sudden noises or sensations, describe procedures in terms of sound/feel/taste/smell
- Printed material (letters, appointment cards, information sheets): matte paper, font size 14+, text in mixed case (c.f. capitals)



DEAFBLINDNESS

- Combined sight and hearing loss
- Causes: Rubella, Ushers syndrome, CHARGE syndrome, ageing
- Two distinct cultural groups:
  - Born blind, lose hearing as adults: tend to continue to use speech as their main communication and have a variety of hearing devices
  - Born deaf and lose sight as adults: use sign language to communicate

DEAFBLINDNESS

- Most common forms of communication:
  - Speech, oral and aural communication
  - Sign language / Auslan: including a variety of ways of receiving sign language (close range, visual frame/field and tactile)
  - Deafblind fingerspelling
  - Alternative and augmentative communication e.g. touch cues, pictographs, key word signs
  - Print or braille, including print on palm, computer, SMS text and email

DEAFBLINDNESS

- Identification: carry white and red cane
- Ask preferred method of communication: may have residual hearing or sight
- Approach gently, tap arm to inform you are there, do not walk off leaving patient stranded
- Additional communication support required will depend on when the dual sensory loss was developed

NEUROLOGICAL CONDITIONS

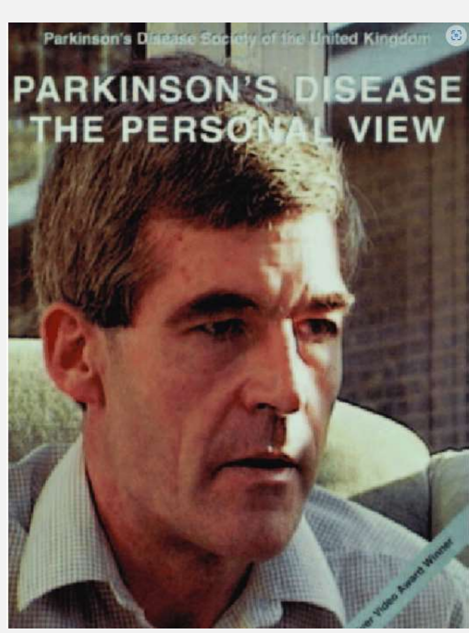
- Affects communication in different ways depending on the area of brain affected
- Almost any acquired brain injury may cause memory problems → language, spatial-perceptual and retention span difficulties
- Commonly occurring neurological communication impairments:
  - **Dysarthria** = weakness/lack of control in muscles required to produce speech (motor speech disorder)
  - **Dyspraxia/apraxia** = difficulty or impossibility of making certain voluntary motor movements (neurological condition)
  - **Aphasia** = difficulty comprehending speech

APHASIA

- Damage to portion of brain responsible for speech → impaired ability to process language
- Usually occurs after stroke, head injury, brain tumour
- Does not affect intelligence, but can affect all 4 modalities of language (reading, writing, comprehension, expression)
- Affects each person differently, and communication difficulties can change from day to day or hour to hour

DYSARTHRIA

- Group of speech disorders resulting from neurogenic disturbances in muscular control → paralysis, weakness or uncoordination of speech musculature
- Often occurs in neurological conditions (e.g. cerebral palsy, MS, MND, stroke)
- **Parkinson's Disease** associated with "hypokinetic dysarthria"
  - Reduced respiratory support for speech and rigidity of respiratory muscles → reduced volume and monotone, breathy, whispery, harsh voice quality.
  - Distinctive features: difficulties initiating speech, lack of fluence, frequent pauses, word blocks, repetition of syllables followed by short rushes of speech
  - Easier during "on periods" when medications (levodopa) working
  - Masked facies



DYSARTHRIA AND APHASIA

- **Avoid being condescending** - treat them as the mature adult (s)he is
- Ensure patient only doing **one thing at a time** (e.g. not walking and talking)
- Reduce **distractions and background noise**
- Ensure **eye contact**, so facial expressions / gestures can provide clues about the message
- Speak with a normal voice, but **slightly slower speed** than normal
- Give only **one piece of information** at a time
- Give patient **time to reply**
- **Watch** person as they talk, and avoid writing notes simultaneously
- **Do not finish the person's sentences** for them. However if they get stuck for words, help them search for words
- Ask **direct questions** (e.g. "do you want a cup of tea" vs "what would you like to drink?")
- **Closed "Y/N" questions** are easier to answer than open questions requiring a full answer
- **Augment speech** with gestures (e.g. thumbs up/down) or visual aids. Pen and paper can be useful if person finds it easier to read/write/draw than speak.
- Check you have both **understood (do not pretend**). Repeat the part you did understand so the speaker does not have to repeat entirely.

ALTERNATIVE OR AUGMENTIVE COMMUNICATION (AAC)

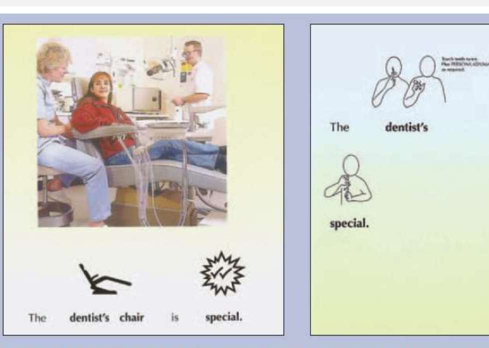
- **AAC** = any type of communication strategy for people with a range of conditions who have significant difficulties speaking
- Help alleviate the pressure to speak → allows person with speech difficulties to be more relaxed and come across in a more intelligible manner
- Two main types:
  - **Unaided AAC** = do not require use of an external aid.
    - Gestures (e.g. blinking, pointing, raising head, thumbs up/down), facial expressions, Auslan
  - **Aided AAC** = external aid used
    - High technology systems = iPad, tablet, speech generating device, switch
    - Low technology systems = real objects, communication books, pen & paper, pictures

ALTERNATIVE OR AUGMENTIVE COMMUNICATION (AAC)

Fig. 7 A lightwriter used as a text to speech communication aid by people with speech loss

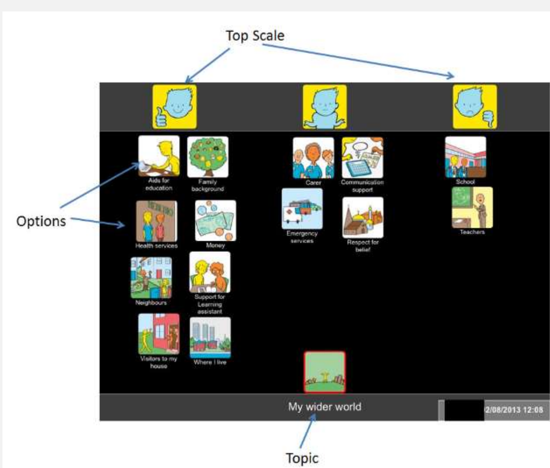
Fig. 6 Individual using a mouse to operate the computer for communication by e-mail

Proloquo2Go



Figs 2a and 2b A double-page spread from *Going to the dentist*[44] showing how Makaton utilises pictures, symbols, signs and words

Makaton



Talking Mats

This guide is about dental care. This is about looking afte your teeth by keeping them clean and by going to the dentist.

It is important for people's health and happiness that they look after their teeth. Problems with teeth can hurt a lot.

Some people with learning disabilities may need help with keeping their teeth clean.

Some people with learning disabilities are anxious about going to the dentist.

Easy Read

INTELLECTUAL DISABILITY

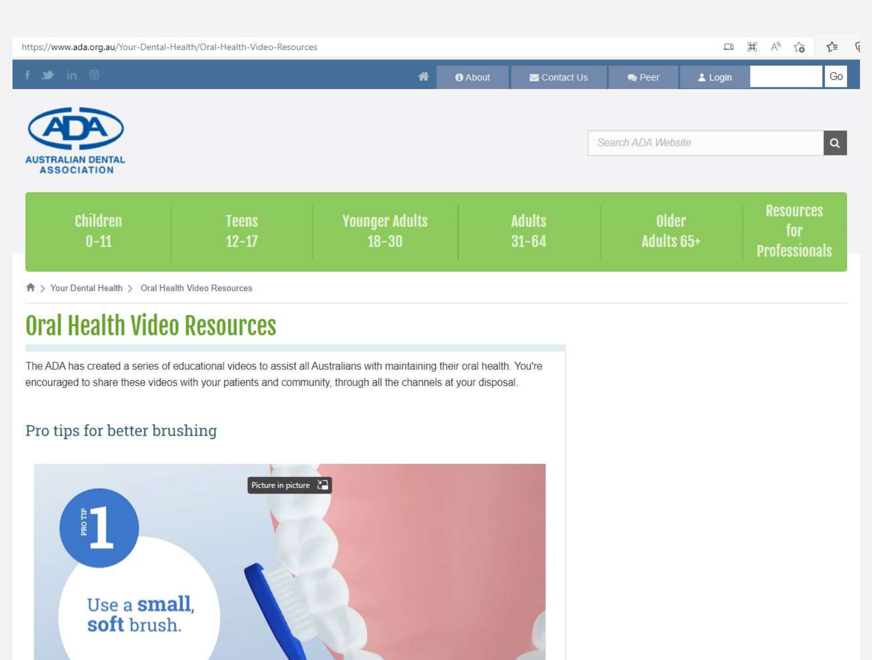
Three aspects to good communication with patients with complex communication issues:

- Use communication techniques
- Communicate with key support professionals and family members
- Recognise that "behaviours of concern" or "challenging behaviour" is better viewed through the lens of communication

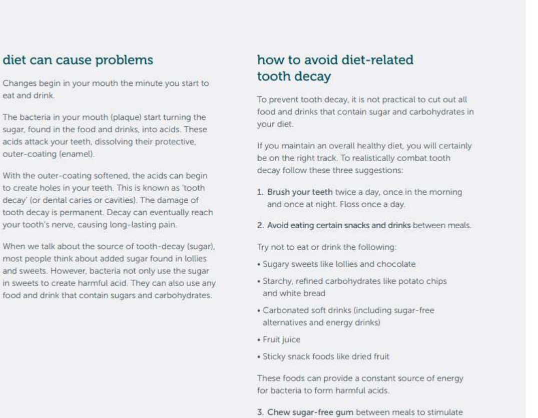
INTELLECTUAL DISABILITY

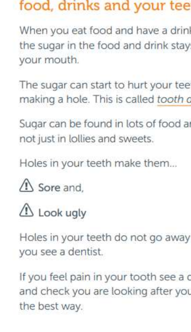
- Communicate using the style patient/carer has identified as their **preferred style**
- **Communicate directly** with the patient, and provide opportunity for accompanying supporters to be involved
- **Do not speak down** to people with ID, or refer to their IQ or "mental age"
- Spend a **few minutes conversing** in their preferred communication style before the clinical assessment/treatment. Invite feedback.
- If procedure is lengthy, **take breaks.** Involve patient/support person in deciding how to keep patient comfortable.
- Use a portable device or tablet, show videos, or use pictures to **explain procedures**.
  - E.g. Your Dental Health – Oral Health Video Resources
  - Dual Read Guide

INTELLECTUAL DISABILITY



https://www.ada.org.au/Your-Dental-Health/Oral-Health-Video-Resources



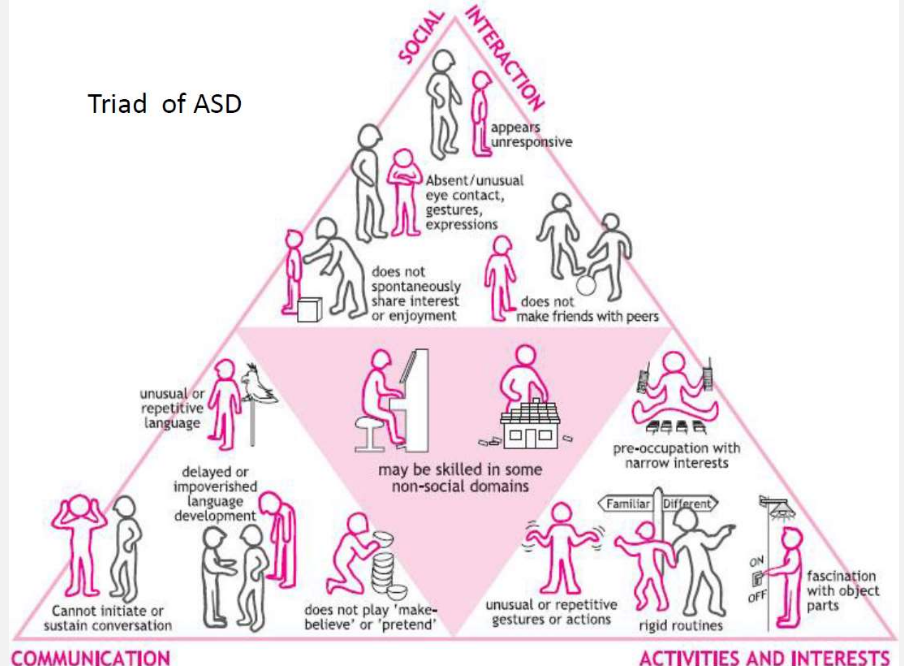


Dual Read Guide

AUTISM SPECTRUM DISORDER

AUTISM SPECTRUM DISORDER

- Definition: Spectrum of pervasive developmental disorders that usually begins in the first 30 months of life. Three characteristics:
  - Poor social skills
  - Ritualistic and compulsive behaviour
  - Abnormal speech and language (communication)



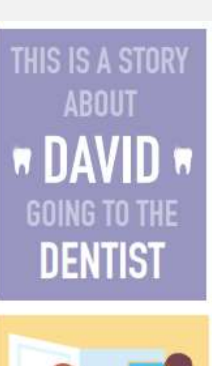
AUTISM SPECTRUM DISORDER

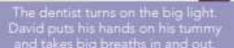
Difficulty in Social Communication	Love of Routines	Sensory Sensitivity
• Facial expressions or tone of voice • Jokes/sarcasm • Common phrases and sayings • Metaphors • Avoid eye contact • Appear deaf • Start developing language, then abruptly stop talking	• Rules can be important • May be difficult to take a different approach once they have been taught the 'right' way to do it • Practice repetitive actions	• Can affect any of the 5 senses: smells, textures, tastes, loud noises, bright lighting • Hypersensitive (cry out in pain to slight things) or hyposensitive (need to look for toothache that may not feel) • Radio, steriliser, handpieces (sound / vibration), light (room / chair / loupes), suction, perfume, taste (prophy, MW, alginate) • Moving dental chair • Cannot always tell where it hurts

AUTISM SPECTRUM DISORDER

Preparation:

- Personal profile
  - “About me” information – likes, dislikes, topics of interest, means of communication, behaviour management
  - Behaviour Support Plan or Consistent Approaches documents
- Social story
  - Steps at dentist introduced prior to appointment by carer
  - Personalise
  - Photos of actual room, equipment, staff
- Appointment time
  - Avoid peak hour, waiting

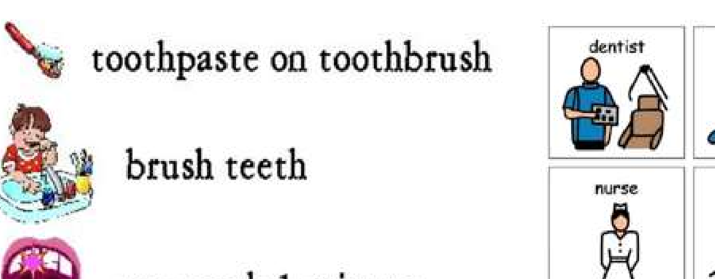


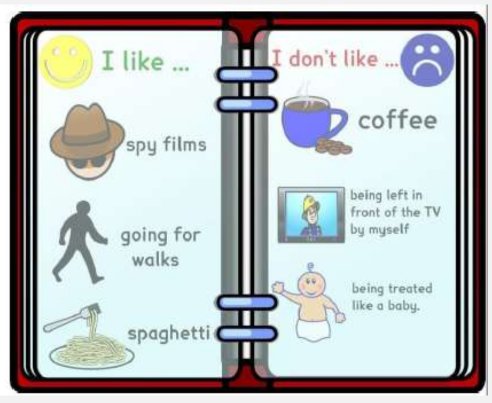


AUTISM SPECTRUM DISORDER

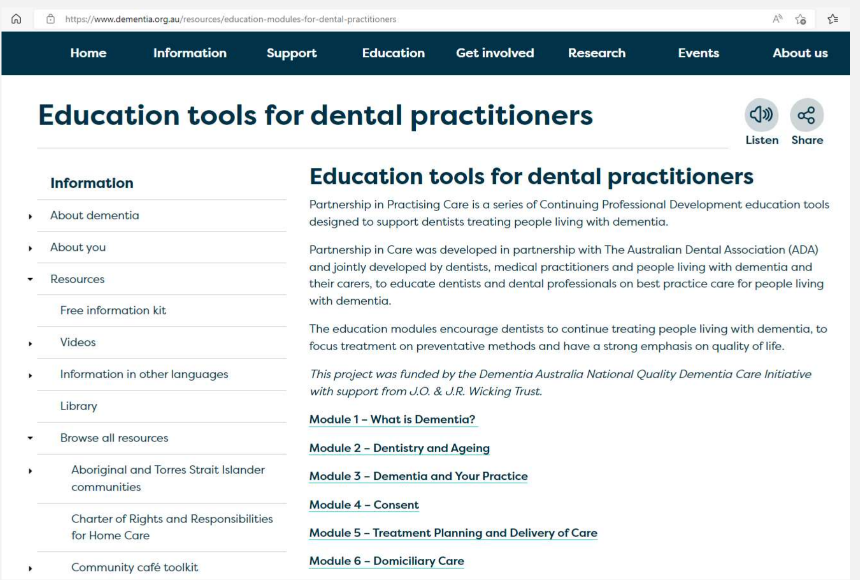
Communication:

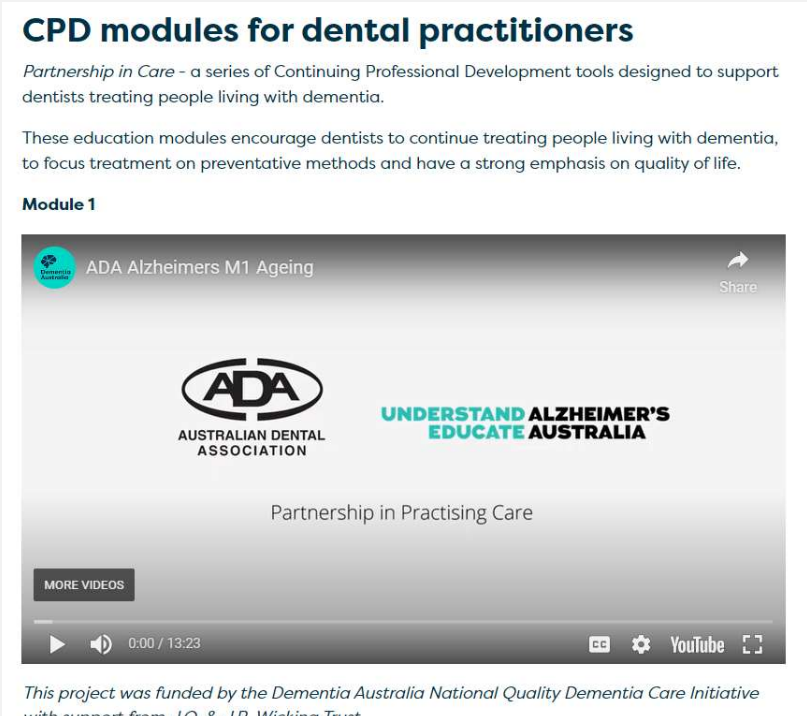
- **Stages** broken down
- "**Tell-show-do**" approach
- **Speak directly** and **no metaphors**
  - Short, precise and literal instructions
- Communication tools and visual supports (augment with **visual aids**):
  - Photos
  - Pictures/symbols
  - Written words, flow charts, lists
  - Communication passports
  - Show visually as well as verbally
- **Allow time** to process and understand instruction
- **Avoid distractions**
  - "single mindedness"
  - One activity at a time
  - Discuss only one topic at a time
- **Echolalia**





DEMENTIA





DEMENTIA

DEMENTIA

- **Definition**: Progressive neurodegenerative syndrome, in which there is deterioration in memory, thinking, behaviour, and ability to perform everyday activities.
- **Clinical Manifestations**:
  - Memory loss
  - Language impairment (some revert to mother tongue)
  - Disorientation and confusion
  - Personality changes (mood, aggression)
  - Psychiatric symptoms (apathy, depression, psychosis)
  - Sight and vision problems (reading, judging distance, shiny/patterned objects)

DEMENTIA

- Appointment time:
  - Ideally morning, but not too early
  - When less likely to wait
- Appointment reminder, possibly involving relative/carer
- Signage: dental clinic, names of dental staff
- Noise reduction
- Familiar carer to remain in sight

DEMENTIA

- Understand preferences of patient:
  - Preferred name
  - Previous hobbies/interests/occupation
  - Carer who knows them best
  - Things that make them worry/anxious
- Find out what was popular when patient was in their early 20's (talking point)
- Keep language simple and to the point
- Yes/No questions
- May revert to first language

DEMENTIA

- Be kind and reassuring. Do not talk down or be patronising.

- Maintain their respect and dignity
  - Good verbal and non-verbal communication
  - Eye contact
  - Be relaxed/calm
  - Gently hold hand or put arm around shoulder to comfort them
  - Give verbal cues (“I am your dentist” vs “do you remember who I am?”)
  - Constant reassurance

DEMENTIA

If unable to voice pain/discomfort → **possible indicators of dental problems**

BEHAVIOURAL

- Refusal to eat/drink (especially hard/cold foods)
- Frequent pulling at face or mouth
- Leaving previously worn dentures out
- Increased restlessness, moaning, shouting
- Disturbed sleep
- Refusal to partake in daily activities
- Aggressive behaviour
- Bruxism

PHYSICAL

- Drooling
- Redness
- Swelling
- Ask carers if have spotted any "holes"

OTHER SOURCES OF INFORMATION

Pro-Tip Videos

Factsheets

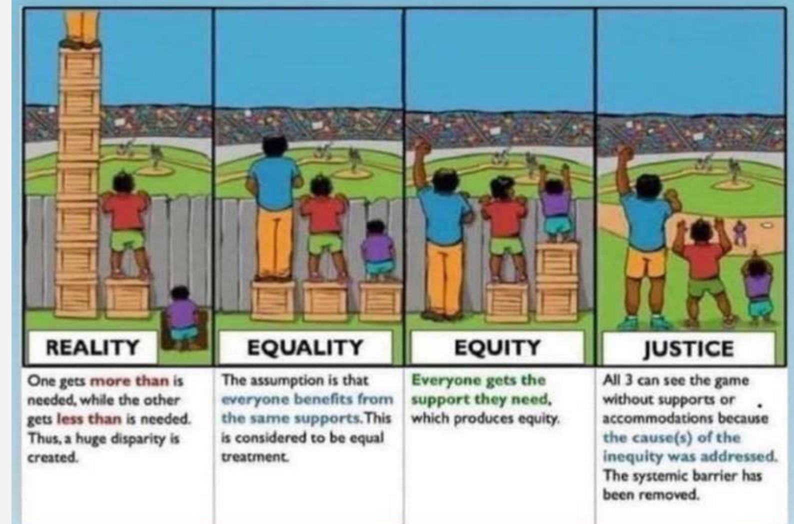
Watch Your Mouth podcast

SUMMARY OF COMMUNICATION METHODS

- Gesture – hand gestures, facial expression
- Signing – Makaton, Signalong, British Sign
- Language, individual methods such as blinking
- Symbols – pictures which represent word e.g. Widget Software
- Photographs – to depict a subject
- Objects – to depict a subject or action
- Drawings – used to illustrate what needs to be communicated
- Writing –used to relay information
- Alternative and Augmentative Communication (AAC) devices – e.g. communication boards, light writers, computers or voice output devices
- Speech – it is essential to speak to the individual, (even if they have no speech) in addition to using other communication methods as appropriate

CONCLUSION

- Communication is important! Do not pretend that you **understand**.
- Ask your patient their **communication preference**
- **Do not assume** intellectual disability
- Communicate **directly** to the patient
- Speaking **louder usually does not help** → aggressive
- Take the **time** to communicate well
- **Explain the procedure beforehand**, the more information the better
- **Minimise distractions**
- Consider **holistically** what would make the patient feel included (understanding vs condescending)
- Person may not consider their impairment a "disability", but rather a cultural difference or societal issue



REFERENCES

- Ramirez L, Dickinson C. Wheelchair users: A guide. B Dent J. 2018;224(6):408-12
- Dougall A, Fiske J. Access to special care dentistry, part 1: Access. Br Dent J. 2008;204:605-16.
- Dougall A, Fiske J. Access to special care dentistry, part 2: Communication. Br Dent J. 2008:205(1);11-21
- British Society for Disability and Oral Health, Royal College of Surgeons of England Faculty of Dental Surgery. Clinical Guidelines and Integrated Care Pathways for the Oral Health Care of People with Learning Disabilities. London. 2012.
- Breslin M, Cook S. No turning back: posture in dental practice. Vital 2013;10:23-25.

THANK YOU!

Any questions?

Jeeyun.leung@uwa.edu.au