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# Oral health care for Australians living with mental ill-health: unaffordable, inaccessible and invisible

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## Abstract

**Introduction:** Poor oral health is a common, but overlooked, issue among people with serious mental ill-health who experience higher rates of dental caries and periodontal disease, leading to increased hospital admissions. Despite its preventability, oral health remains largely absent from Australian mental healthcare policy and service delivery.

**Methods:** This two-phase study (1) systematically reviewed oral health integration within Australian oral and mental health policy and competitive funding mechanisms; and (2) qualitatively explored the experiences and prioritising of oral health care by individuals with serious mental ill-health, carers and healthcare professionals.

**Results:** Findings indicated that oral health is rarely prioritised in mental health policy and that it receives only 0.22% of health research funding. Eighteen participants, including health practitioners and individuals with lived experience, were interviewed. Participants described oral health as being largely ignored, personal experiences of inadequate care, financial and psychological barriers to care and systemic neglect. Recommendations for change were identified, including a need for trauma-informed, holistic approaches to care that address social determinants and promote oral health within mental health services.

**Conclusion:** Poor oral health significantly, and negatively, impacts both quality of life and hospital admissions for people with serious mental ill-health, yet remains overlooked in mental health care. Holistic, interdisciplinary approaches – integrating oral health into psychiatric assessments, education and policy – are essential. Early intervention, public health messaging, trauma-informed training and personalised care may improve outcomes. Co-produced interventions and equitable access to services are critical to reducing oral health disparities and enhancing well-being for individuals living with serious mental ill-health.

## Keywords

Priorities, serious mental illness, oral health, prevention, intervention, policy

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## Introduction

Good oral health is a critical component of overall health (World Health Organization, 2024). This reflects an individual's ability to maintain healthy teeth, gums and mouth, and seek expert care from dental practitioners regularly, and as needed. However, oral diseases remain a significant public health burden globally, affecting the lives and livelihoods of approximately 3.5 billion people (Peres et al., 2019; World Health Organization, 2024). In addition, oral diseases disproportionally affect disadvantaged populations (Watt et al., 2015), including people living with serious mental ill-health (SMI) who experience a higher prevalence of dental caries and periodontal disease.

People living with SMI are nearly three times more likely to experience complete tooth loss (edentulism) compared with people without SMI (Choi et al., 2022; Kisely et al., 2015a). Additionally, oral disease is correlated with preventable emergency department presentations and hospital admissions (Kisely and Lalloo, 2021; Kisely et al., 2015b), with Kisely et al. (2015b) reporting it as the third most common reason for avoidable hospital admissions in psychiatric patients. Early and timely access to oral health care is preventive against oral disease. Non-dental health professionals, who are often more accessible than dental practitioners, can also provide essential oral health care (Australian Dental Association, 2021).

Compounding factors for poor oral health in people living with SMI include the following: direct effects from their mental ill-health (e.g. lethargy and low motivation), medication side effects causing reduced salivary flow rate, thirst and increased consumption of caffeinated and carbonated/sugary drink, delays in seeking oral health care and high rates of smoking and substance use (Joury et al., 2023; Kisely et al., 2015a; Matevosyan, 2010). Poor oral health is detrimental to self-esteem, social interactions and job performance, all of which further reduce quality of life and well-being indicators for 'at risk' populations (Kenny et al., 2020). These inequitable oral health outcomes are often exacerbated by dental services working in isolation rather than integrated with general medical and mental health services (Nguyen et al., 2023a; Slack-Smith et al., 2017).

Oral health is included in UK guidelines for improving the physical health of people with SMI (National Health Service (NHS), 2024); a 5-year action plan that guides policy and service delivery (Mishu et al., 2024). In 2016, the Australian Equally Well National Consensus Statement highlighted that, given the high risk of poor oral health, dentistry should be incorporated into all primary and mental health care plans (National Mental Health Commission, 2016), but it is unclear how, or where, it has been integrated into Australian policies.

Improving oral health for people living with SMI is challenging, not least because their health presentations and decision-making processes are often complex, creating barriers to prioritising health needs and treatment options (Carswell et al., 2022). Ranking health needs, whether by people living with SMI, their carers or health practitioners, is not well understood. Current research suggests that insufficient training, health literacy disparities and difficulties with allocating sufficient time for discussion may mean physical (including oral) health is overlooked (Peeler et al., 2024). Given that oral diseases are largely preventable (Peres et al., 2019), better understanding is needed about whether, and how, the social circumstances of people living with SMI influence their healthcare decisions. As this population typically experiences comorbidities and complex social situations, understanding their lived experiences and mapping their support networks could help to inform best practice to integrate oral health into mental healthcare service delivery models.

This 2-phase study investigated whether/how oral health has been integrated into Australian mental and oral health policies and the extent of oral health-funded research awarded via Australian competitive funding mechanisms. In phase 2, we qualitatively explored how oral health was prioritised by people living with SMI, carers and health practitioners involved in their care.

## Method

### *Phase 1*

A systematic national and state-by-state review was conducted of all Australian oral health/dental and mental health policies and strategies initiated or concluded within the past 5 years. The review included searches for terms 'oral health/dental' and 'mental health' across state government and health websites, and national policy and health websites, to identify the extent to which oral and mental healthcare systems were integrated. Additionally, a review was conducted to evaluate publicly available data on Australian competitive funding outcomes. This analysis encompassed funding allocations from the National Health and Medical Research Council (NHMRC) since 2013, the Medical Research Future Fund (MRFF) since 2017 and the Australian Research Council (ARC) since 2017, reflecting the years that grant data sets were publicly available.

### *Phase 2*

The qualitative study adopted an interpretive descriptive approach, which is suited to investigate health and illness experiences from holistic, interpretive and relational perspectives (Thompson Burdine et al., 2021). The study was conducted according to the Standards for Reporting Qualitative Research (O'Brien et al., 2014) (Supplemental material 1); ethics approval was obtained from the host university (2023/014).

Purposive sampling was used, underpinned by maximum variation sampling (Suri, 2011) to ensure a diverse range of perspectives were explored. Mental health practitioners (including psychiatrists, psychologists and nurse practitioners), general practitioners, dentists, people with lived experiences of SMI and carers were recruited. An email about the study was circulated via the research team's extensive networks. Consent was obtained before participation in online semi-structured interviews. Interview questions (Supplemental material 2) focused on how/whether participants prioritised oral health for themselves, or for those they supported (carers and health practitioners), barriers to oral health, access and how it could be better prioritised. In addition, participants were asked to review a structured list of health needs (Supplemental material 3) and discuss which, if any, they would prioritise. All interviews were undertaken by two female authors (a lived experience researcher and a mental health occupational therapist – both experienced qualitative researchers) with no relationships with participants. The online interviews were undertaken between September 2023 and June 2025, and all participants were offered an AU$50 voucher to acknowledge their time and expertise. Interviews were recorded, transcribed and quality-checked before recordings were destroyed. Recruitment was concluded upon reaching data saturation, as participant responses became recurrent and no new insights were identified (Saunders et al., 2018).

Aligned with interpretive descriptive approaches (Thorne, 2016), reflexive thematic analysis (Braun and Clarke, 2019) was used to develop patterns of meaning in relation to the research questions, across the data set. Transcripts were read independently by the aforementioned researchers, followed by lengthy and in-depth discussions regarding interpretation. This allowed for the creation and clustering of thematic codes, which were reviewed and refined through reflective conversations as the researchers explored alternative perspectives and questioned their assumptions. Data were organised using NVivo14 software (Lumivero, 2024).

## Results

### Phase 1

The review of Australian policies and strategies (Supplemental material 3) found that people living with SMI were identified as a priority population in 50% (5/10) of oral health policy documentation (COAG Health Council, 2015; South Australia Dental Service, 2019; South Australia Health, 2021; Department of Health & Human Services, 2020; Western Australia Department of Health, 2016), but no mental health policy documents prioritised oral health care. Relevant grant funding outcomes (Supplemental material 4) identified only 50 funded oral health research grants from a total of 21,025 funded health-related projects, representing 0.22% of all awarded funding. Notably, none of these funded grants focused on SMI.

### Phase 2

Eighteen participants were recruited to the qualitative study; characteristics are summarised in Table 1. Interview data provided three main themes relating to whether, and how, oral health might be prioritised: (1) *Out of sight and out of mind*; (2) *Personal experiences of systemic failures in prioritisation and provision of oral health care* and (3) *Participant recommendations for change*. The following sections provide further detail, supported by verbatim quotes. Quotes are attributed using the following identifiers: mental health practitioners (MHP), dental practitioners (DP), general practitioners (GP) and participants with lived experience (LE).

**(1) Out of sight and out of mind.** Participants, particularly health practitioners, recounted diverse challenges regarding prioritising oral health care. Even when aware of the physical health consequences of behaviours such as smoking, they nonetheless prioritised managing mental ill-health:

> *. . . when you get someone coming in with early psychosis the primary goal is resolution of the psychotic illness, and you forget about lots of other things which contribute to a person's wellbeing . . . We all know smoking's really bad for you, but it's something we often don't bring up in conversation . . . I'm not saying we forget about it altogether, but you can see how things like this can be not prioritised even though they are a priority.* (MHP13)

> *Oral health is something I think I sort of struggle to keep on the forefront because there are usually so many more pressing issues sitting, you know, with the patient present, sitting in front of you.* (MHP5)

When provided with a list of possible health needs (Supplemental material 3), those with SMI often found it difficult to prioritise, stating that all were important, unlike health practitioner participants who more readily identified specific priorities. All participants acknowledged the interconnectedness of health with social determinants such as housing, although the importance of holistic care was articulated more strongly by people with LE of SMI.

> *Mental health, and the direct relationship between physical health and oral health, should be part of the total conversation, but they operate in three disparate worlds. In fact, they very rarely are spoken about . . . all the different times I have been in mental wards, they never once spoke about what's happening from a physical perspective . . . When I went in and talked about losing teeth, they didn't even think about doing anything.* (LE2)

**Table 1.** Participant demographics.

| Participant identifier | Gender | Age | Descriptor |
|---|---|---|---|
| **MHP1** | Male | 68 | Former chief psychiatrist |
| **LE2** | Male | 64 | Person with lived experience of SMI |
| **LE3** | Male | 63 | Person with lived experience of SMI |
| **GP4** | Female | 43 | General practitioner |
| **MHP5** | Female | 54 | Psychiatrist |
| **DP6** | Female | 24 | Dentist |
| **MHP7** | Female | 36 | Clozapine coordinator |
| **DP8** | Female | 28 | Dentist |
| **MHP9** | Female | 53 | Community mental health nurse |
| **MHP10** | Female | 32 | Mental health case manager and clinical psychologist |
| **MHP11** | Male | 49 | Psychiatrist |
| **LE12** | Male | 20 | Person with lived experience of SMI |
| **MHP13** | Male | 40 | Mental health case manager and nurse |
| **MHP14** | Male | 35 | Psychiatrist |
| **MHP15** | Female | 71 | Carer |
| **LE16** | Female | 25 | Person with lived experience of SMI |
| **MHP17** | Female | 50 | Psychiatrist |
| **GP18** | Male | 39 | General practitioner |

DP: Dental practitioner; GP: General practitioner; LE: Lived experience; MHP: mental health practitioner.

System-level factors such as appropriate and affordable housing, stable finances (and/or employment) and supportive relationships were generally considered more pressing than oral health care. Participants reported that stable mental health enabled them to engage in a wider range of life events and provided the impetus to consider adopting preventive healthcare routines, such as regular toothbrushing, which had hitherto been neglected.

Difficulties in accessing affordable, preventive and oral health care were identified by all participants, with many describing feelings of helplessness due to insufficient and/or inappropriate community resources. Lack of options meant oral health was often deprioritised or placed in the 'too hard basket'.

> *We look at the services available to our clientele group and if there's no services available . . . there's nothing worse than sitting with a client who really wants to get their teeth cleaned. But where do they go? It's very frustrating and sad.* (MHP9)

In addition, health practitioners reported that oral health was not typically included in training programmes and nor was it identified as an area of particular concern when caring for people living with SMI.

> *Mental health workers have to be better skilled in recognising and addressing physical illnesses. So instead of just saying I'll send you to your GP or make an appointment with your dentist, they've got to actually be able to navigate and help people get support.* (MHP1)

> *It's just not flagged in our training as something that you would be screening for . . . we have a General Practice Red Book,*[1] *which is kind of like the Bible for preventive health in General Practice . . . I don't even think mental health presentations are a particular risk factor for oral health in the Red Book.* (GP4)

The above quotes suggest that as oral health was rarely, if ever, the focus of clinical assessments and interventions with attention instead focused on managing presenting mental ill-health. Hence, in time-pressured clinical environments, health practitioners may struggle to find time, and right 'tone', to ask routine but sensitive questions about their clients' health and lifestyle habits.

**(2) Personal experiences of systemic failures in prioritisation and provision of oral health care.** The SMI participants who identified oral health as a higher priority described experiences of significant periodontal disease.

Narratives suggested that consequences such as tooth loss might have been prevented by timely and appropriate intervention.

> *I've lost all of or part of my five or six teeth now . . . Sadly at least some of which I don't think I would have lost if I had been able to have a regular cleaning and checkups.* (LE3)

Interviews highlighted that poor oral health negatively impacted quality of life and well-being. Participants described dental pain and tooth loss as causing and exacerbating other health-related problems. Dental pain had a detrimental effect on mental health, sleep and general functioning, while eating-related discomfort resulted in a narrower selection of food choices and a deterioration in nutritional status.

> *A lot of people that I've encountered have difficulty eating certain things because of the severity of the breakdown of their teeth, which leads to nutritional issues . . . they tend to move to things that don't require as much chewing, which may not have as much nutritional value or may be overprocessed.* (DP8)

Bad breath, discoloured teeth, speech difficulties and disquiet about physical appearance diminished self-esteem among SMI participants, exacerbating social isolation and reducing engagement in physical activity. For some participants, this relentless cycle of poor oral health impacting mental health and poor mental health impacting oral health posed a serious risk to continued living:

> *When I was losing teeth, I struggled to get out into society . . . which then made me feel more alone and isolated, which feeds into all the demons in my head, which then puts me at higher risk of suicide again.* (LE2)

Participants described delaying, or avoiding, seeking oral health care until they experienced symptoms such as toothache. Unfortunately, this frequently indicated late-stage oral disease, requiring urgent, and often complex and expensive remedial treatment. With little, or inadequate government subsidised oral health care, the financial cost of treatment in private practice was widely reported as unaffordable. *All of them say, 'Oh yeah, I should go to the dentist, but I haven't or I can't afford it' . . . I'm working with one girl who has braces that were put on when she was in her parent's care. But she's since left her parent's care. And so, she's taken the wire out. But she's still got the braces on, and they've been on for years* (MHP10).

Even when referrals for low-cost dental care were available, lengthy waitlists, difficulties navigating complex healthcare systems and previous negative encounters with healthcare professionals/services acted as effective barriers to access. Additional disincentives included participants' embarrassment about the poor state of their teeth, the unaffordability of basic commodities such as toothpaste and concerns about encountering negative attitudes, in particular being disregarded and/or feeling judged.

Health practitioners reported that experience of sexual assault in childhood could also deter participants from seeking oral health care. For those who did attend, sounds and procedures operated as triggers for re-traumatising and distress, which underscores the critical importance of trauma-informed practices in oral health care.

> *I work with a lot of the young women that have experienced child sexual assault. And so they have reported going to the dentist is really triggering and distressing for them . . . I have one client in particular who has just avoided going to the dentist because of the sound of the drills and having someone, you know, having to keep your mouth open. And yeah, that's been extremely distressing for her.* (MHP10)

Participants living with SMI who had grown up in households where oral self-care such as regular toothbrushing and flossing was not an aspect of daily life reported difficulty in adopting these routines as adults. Poor parental mental health was reported as a contributing factor in this regard.

> *The dentist said to brush my teeth more, but growing up, I had bad mental health, and my mum wasn't good at brushing her teeth because she also had bad mental health. So, I just never really got into the habit of it. And now that I'm older, I still struggle with it.* (LE12)

Accessible information on self-care was considered key to behavioural change. SMI participants looked to health practitioners for encouragement and signposting to assist them with establishing beneficial routines.

> *I was having a look at our [inpatient] notice boards, leaflets or posters about dental health, it's very hard to find anything, you know, raising awareness among patients here.* (MHP11)

Although the deleterious impact of mental health treatments on oral health was frequently emphasised by participants living with SMI, limited discussion and a paucity of information about potential treatment side effects were widely reported. A participant described the devastating impact of electroconvulsive therapy (ECT) on his teeth:

> *Probably 10 years since I went through the periods of ECT. That's when I started to have problems with my teeth. That's when they started to crack . . . started to disintegrate. So, the tops of all the teeth now have no overall covering. They're all exposed, and I've lost three at the back. I've got another three that I've only got half the teeth.* (LE2)

Symptoms of mental ill-health such as severe depression, possibly accompanied by suicidal ideation, skewed health priorities. The following quote hints at the tremendous effort required to maintain an optimistic attitude towards

personal health and well-being when deciding to survive another day was challenge enough:

> *My general health is not a priority and I think that's largely a consequence of my mental health issues and permanent suicidal ideation. Whether I die tomorrow because I've got cancer . . . or whether I die by suicide really doesn't make a lot of difference to me, particularly when I'm acutely suicidal . . .* (LE3)

**(3) Participant recommendations for change.** Participants highlighted the direct connection between mental well-being and oral health; narratives also cited failures in current government policies to acknowledge and address this link.

> *[Oral health] is also a mental health issue in one way or another, whether it's the chicken or the egg. But one way or another, they are intertwined and for the government to have policies on mental health and yet not actually do anything that would improve [oral health].* (LE3)

Services that addressed health and well-being holistically were widely viewed as ideal. Interview data, however, suggested such arrangements were aspirational as mental, physical and oral health practitioners lacked the necessary collaborative conduits to remedy deficits in provision and access. Participants living with SMI reported that mental health practitioners generally failed to enquire about their oral health, even when faced with evidence such as missing teeth or bad breath. Direct questions about oral hygiene practices from trusted practitioners were preferred and indeed viewed as positive and actionable steps for future behavioural change.

> *You know teeth, it's a more confined environment in my humble opinion . . . It's how often do you brush your teeth? How often you use your toothbrush?* (LE2)

Participants described 'touch points' in mental health care when the topic of oral health might have been raised for discussion. Routine check-ups in any area of clinical care provided openings for casual chats to discuss oral health, a topic within the remit of all healthcare providers. Health and well-being screening and/or checklists were viewed as ideal tools to prompt discussion (and follow-up) as they include items on oral health:

> *So it really does beg the question, why isn't it on a checklist somewhere where it then reminds us of when we do forget about sexual health and oral health, because those are the two important health domains.* (MHP5)

It was suggested by mental health practitioner participants that information about oral hygiene should be routinely provided across all mental health settings (e.g. hospital, community and clozapine clinics). This would enable people experiencing SMI to access pertinent information and provide timely opportunities to discuss concerns with service providers.

In the following quote, a dentist expressed that initiating conversations on sensitive topics with clients was a professional responsibility:

> *As a health practitioner, it is within our, you know, should be within our remit to discuss things like that with patients. We may not have all the answers . . . sometimes you need to go out of your way to do so.* (DP8)

SMI participants thought dentists could benefit from increased awareness and knowledge about mental ill-health and the barriers to accessing oral health care. Some reported 'shopping around' and visiting multiple dentists to find affordable care from a practitioner who understood and supported their mental health needs. Even after successfully negotiating these hurdles, lengthy waiting times were a major setback:

> *They don't know how to get into a publicly funded dentist. So you can refer them often, do the referral for them and we sit there together and do it. So at least they're on a list, but you know that they're still not going to get into see anyone for a very, very long time. At least for 12 months, probably much longer.* (GP4)

Dentists discussed needing to acquire the necessary communication skills to provide information without seeming to pass judgement or generate client discomfort/embarrassment. Training in trauma-informed care approaches was seen as important:

> *My client had a really good experience because the dentist was really understanding of her needs and took it really slowly and was very like trauma-informed, like telling her exactly what was going to happen and offering breaks, and really like supporting her through the process.* (MHP10)

While mental health practitioner participants reported having received very limited education about oral health promotion during their training, they were receptive to learning about best practice guidelines to integrate oral health in their practice.

## Discussion

This study highlights the detrimental effects of poor oral health for people living with SMI and their carers. Those who had experienced or witnessed the distress caused by severe oral disease, were more motivated, and hence, more likely, to prioritise this aspect of health. Given the progressive and cumulative nature of oral disease, it is important that all parties involved in the care of people living with SMI adopt holistic and integrated approaches to improving and maintaining health and well-being (Kemp et al., 2014; Kisely, 2016; Meldrum et al., 2018).

Some participants emphasised the importance of public health messaging to raise awareness and improve oral health self-care behaviours. Where toothbrushing and flossing had not been introduced as routine practices in childhood, they were unlikely to be easily adopted or prioritised in early adulthood – a time in the life course when the consequences of poor oral health were typically low on personal agendas. Child and youth mental health practitioners can use their trusted relationships to overcome barriers such as low motivation and poor oral health literacy to support establishing oral hygiene routines, contributing to long-term health and well-being outcomes (Robertson et al., 2025).

The severity of symptoms, including dental pain, was often a primary driver for help-seeking and discussion about treatment options; participants stressed the need for accessible information about distress and financial consequences of neglecting oral health. Improving oral health literacy was widely viewed as an essential element, not least because it is a significant and modifiable determinant of well-being (Nutbeam et al., 2018); it is also a key recommendation in the *2022 Oral health messages for Australia* (Welti et al., 2023). This emphasises the importance of strengthening oral health promotion activities which support, and ideally improve, measures of health and quality of life over the life course (Nguyen and Lin, 2023; Nguyen et al., 2023b).

While physical health, more broadly, for people experiencing SMI has gained wider attention (Firth et al., 2019), oral health and the prevention of oral disease have been largely neglected. This is in spite of a recommendation that it merits the same consideration as other comorbid physical illnesses for people living with SMI (Wey et al., 2016). Our findings suggest that the current public health burden of oral diseases in people living with SMI could be reduced by an interdisciplinary approach to care provision, whereby dentists and psychiatrists work collaboratively to ensure an enabling and facilitative policy landscape that includes strategies for accountability, resourcing and evaluating collaboration initiatives (Han et al., 2024; Nguyen et al., 2023b). Strengthening national or state mental health policies, and including oral health in all mental and primary health plans, can also support people with SMI.

In addition to interdisciplinary collaboration, there is a need to develop and evaluate innovative, low-cost, preventive interventions that improve the oral health and well-being of this population. Current evidence is limited to health promotion education, behavioural strategies (Johnson et al., 2025) and providing support to mental health consumers to attend dental appointments (Palmier-Claus et al., 2025). While biannual fluoride varnish application is an effective and cost-efficient intervention for dental caries prevention (Nguyen et al., 2020), its feasibility and impact in mental health or primary care settings remain unclear (US Preventive Services Task Force, 2023). Funding for testing such interventions is crucially needed. Our analysis demonstrated that only 0.22% of Australian competitive research funding targeted oral health, reinforcing previous findings of minimal funds being awarded (Ghanbarzadegan et al., 2023). Building a stronger evidence base will require longitudinal and cost-effectiveness analyses, and exploration of scalable models that embed oral health promotion and interventions, such as standard oral health checklists completed by non-dental practitioners, within primary and mental health services (Joury et al., 2023; Kisely, 2016).

The prevalence of oral disease in people living with SMI, and the significant health, social and emotional consequences negatively impacting their quality of life, speaks to an urgent need for effective remedial action. Health practitioners with any involvement in care provision for this priority population have a crucial role in oral health promotion (Han et al., 2024), by providing timely, relevant and best practice information and support, actively advocating for equitable access to oral health care and striving to achieve equitable outcomes for people living with SMI.

Given that strong therapeutic alliances are central to supporting people living with SMI, psychiatrists and other practitioners working in mental health are well-placed to provide oral health promotion and support. Incorporating regular oral health screening during routine psychiatric and physical assessment could assist in early problem identification; however, this screening must be linked to defined responsibilities and actionable steps to achieve meaningful outcomes (Macnamara et al., 2021). Referral pathways and implementation of evidence-based interventions could help fill important gaps in oral health care for this priority population. Programmes that combine education with other components, such as motivational interviewing, group activities and reminder strategies, have shown better results than the provision of education alone in sustaining optimal oral hygiene routines (Sharma et al., 2024). However, findings from our study suggest that mental health practitioners may need additional training in oral health promotion to effect meaningful change. Co-produced professional development programmes and preventive interventions are essential to gaining trust and ongoing consumer engagement, and ensuring that proposals are acceptable and feasible for oral health outcomes (Tabvuma et al., 2022).

Dental practitioners are often underprepared to meet the needs of people with SMI, with many lacking training in mental health awareness, trauma-informed care and effective communication (Rhoades et al., 2020). This gap can contribute to stigma, discomfort and negative dental experiences for this population (Robertson et al., 2025). Improving mental health literacy and providing co-designed, evidence-based training for dental practitioners are essential steps to improve care quality, reduce inequities and foster more inclusive and respectful clinical environments (Scrine et al., 2019).

Strengths of our study include the range of participant voices and perspectives, which contributed to nuanced and

comprehensive findings. A limitation of phase-2 is the potential for sampling bias, as the participant group may not comprehensively represent all relevant perspectives. Although purposive and maximum variation sampling were used to recruit a diverse cohort, reliance on professional and community networks may have excluded individuals with limited access to these channels. We recognise that this may influence the generalisability of our findings. Future research could employ targeted engagement with underrepresented groups, to mitigate sampling bias. Our study highlights the need for a significant and systemic re-prioritisation to improve the oral health of people living with SMI. Change is needed across multiple sectors/pathways to ensure (1) oral health is an integral component of psychiatric and physical health screening and checklists; integrated into education for health professional undergraduate, mental health specialist and continuous professional development programmes; and (2) mental health literacy is integrated into oral health practitioner training. While our findings highlight integrated oral health approaches in mental health care, we recognise that practitioners and people with SMI face competing priorities. The complexity of mental healthcare, time constraints and limited resources frequently lead to prioritisation of acute issues over prevention. Consequently, embedding oral health initiatives into existing workflows using practical tools, such as checklists or brief screening questions, will minimise additional burden. Updated health professional practice guidelines should highlight the importance of oral health for people with SMI, and a reorientation of health service structures would better support person-centred holistic care. These changes will help to ensure equitable service access and improved quality of life for individuals living with SMI.

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## Consent for publication

Informed consent was verbally obtained from each individual prior to participation including consent for data to be published.

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## Data Availability Statement

The authors had full access to the data and analysis for this study. The de-identified data that support the findings of this study are available on request from the corresponding author but restrictions apply to the availability of the data, which is not publicly available.

## Supplemental material

Supplemental material for this article is available online.

## Note

1. Royal Australian College of General Practitioners (2025) *Guidelines for preventive activities in general practice.* The 'Red Book' has an oral health section (Pg 354–358) providing advice for GPs about opportunities to *identify people who may require extra preventive care, support and education* as per Australia's National Oral Health Plan but this is not identified in the mental health section.

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