Yang and colleagues' (2018) have conducted an important and timely meta-analysis indicating that patients with psychosis are more likely to have missing, decayed or filled teeth, than general population samples. This health disparity is staggering and clearly unacceptable, and yet it has received very little attention in research and clinical arenas, evidenced by the identification of only nine eligible studies in this meta-analysis. It was revealing that none of the studies were conducted in the United States or United Kingdom, areas with otherwise strong psychosis-related research outputs. Interesting was also the absence of any research exploring oral health outcomes in younger first episode samples. Understanding the development and course of oral health difficulties in their early stages could help to facilitate more timely interventions preventing emergency dental appointments and more intrusive treatments (e.g. extractions).

The authors highlight the possible causes of poor oral health in psychosis, pointing to both individual and systemic factors. Particularly worrisome are the possible iatrogenic effects of antipsychotic medication on oral health, which, in our experience, are rarely discussed with service users when selecting medication. Greater awareness of these effects could help to protect against the poor outcomes seen in chronic psychosis. For example, there is some evidence that high fluoride toothpaste is effective at protecting the teeth of populations at high risk of oral health problems (Public Health England, 2017), which could be prescribed alongside psychotropic medication.

In addition to the risk factors identified in the paper, substance misuse, dental anxiety and practical barriers to dental visiting (e.g. understanding complex information on eligibility for free care) might also contribute to the poor oral health outcomes observed in psychosis. Sadly, it is likely that these patients also encounter obstacles arising from the dental system itself and policies which aim to balance access and efficiency sometimes do so at the expense of equity (Laverty et al., 2018). A prominent lead of the British Dental Association recently labelled homeless people as 'no-hopers', extremely time-consuming, and a reason why dental practitioners might miss their health service targets (The Guardian, 2018), revealing a certain reluctance in many practices to embrace potentially

challenging and time-consuming patients. It is clear that changes are needed both within mental health care, but also within dental care, to improve and foster greater integration between services, and this should be a priority for commissioners, policy makers and service providers.

Even with the knowledge of poor oral health outcomes in psychosis, there is currently very little understanding of what can be done to address this problem. The Three Shires Trial (Adams et al., 2018) represents the largest study in psychosis to date and indicated that monitoring alone may be insufficient to change oral health outcomes. We have recently worked with service users, mental health professionals and dental staff to develop resources to empower service users to take steps to protect their own oral health (www.rightfromthestartmatters.com), the uptake and utility of which requires further evaluation. To effectively instigate change, the development, implementation and evaluation of complex interventions addressing multiple barriers to optimal oral health care is surely necessary.

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