IN BRIEF

- This is the first assessment of the oral health needs of single homeless adults in North and West Belfast.
- The study population had greater experience of dental caries and periodontal disease compared with adults in Northern Ireland (NI) who took part in the 1998 Adult Dental Health Survey.
- The widespread use of smoking and use and abuse of alcohol marked the study population as a high-risk group for oral cancer, with the increased risk calculated as 95 times greater than the NI population as a whole.
- Homeless people are not a homogeneous population, therefore social exclusion and psycho-social functioning should be considered when planning appropriate oral healthcare services for this diverse client group.

Oral health needs of the homeless

Homeless in North and West Belfast: an oral health needs assessment **J. Collins¹ and R. Freeman²**

ABSTRACT

Aim

The aim was to assess the oral health needs of a homeless population residing in North and West Belfast Health and Social Services Trust area, in order to determine levels of unmet need and allow recommendations for service delivery to be made.

Method

A sample of single homeless people was gathered using a snowballing sampling technique. Fourteen hostels located in North and West Belfast were visited in tandem with the homeless healthcare co-ordinator. All consenting participants were asked to complete a detailed medical history questionnaire and a questionnaire to assess their health and psycho-social needs, dental anxiety and oral health-related quality of life. All participants received an oral examination.

Results

Three hundred and seventeen homeless people consented to take part. Two hundred and sixty-seven (84%) were male. Thirty-three percent of participants had mental health problems including psychotic illness, depression and anxiety. Forty-three percent of the sample stated they were addicted to alcohol and 3% were registered injecting drug users. Five percent (16) of the sample had soft tissue swellings of which two were found to be oral cancer. The participants had a mean D3cvmFT of 16.16 (95% CI: 15.71, 17.46). Seventy-five percent of the sample had bleeding gums and calculus; however only 4% had pocket depths of 6 mm or more. Dental anxiety status was related to dental disease experience which impacted negatively on quality of life. Forty-seven percent of the participants felt at least occasionally self-conscious and/or felt ashamed by the appearance of their teeth.

Conclusions

Health and psychosocial factors associated with being homeless must be incorporated into the delivery of context-sensitive oral healthcare for this socially excluded population.

EDITOR'S SUMMARY

Perhaps one of the biggest problems faced by the homeless is that they and the issues affecting them are so often overlooked. Too often, the attitude of the public is that the homeless individual must be responsible for their situation and so they should also be responsible for getting their lives back in order. The oral health of the homeless is one of these frequently overlooked issues: how often have you passed a homeless person and wondered how and where they will be able to access dental treatment?

This paper by Collins and Freeman is a response to a 2004 BDA report calling for improvements in the delivery of dental care to the homeless, and highlights just how complex the situation is. For example, 33% of their sample had mental health problems, 43% were addicted to alcohol and 3% were registered injecting drug users. Twenty-eight percent of respondents were dentally phobic. In addition, the paper highlights the fact that the homeless are not a homogeneous population and there are complicated psycho-social factors that need to be taken into account when planning oral care services for this group. Given this myriad of issues that have to be dealt with, it is unsurprising that 75% of the sample had calculus and bleeding gums and 47% felt self-conscious or ashamed about their teeth.

Research such as this is vital if oral healthcare services for the homeless are indeed to be improved – if the many factors affecting dental care for the homeless are not highlighted, how can they be taken into account when planning these services? The authors point out that the involvement of and assistance of healthcare co-ordinators for the homeless is vital for the success of any oral health delivery initiative. By raising our awareness of these issues, this paper is a step towards making the called-for improvements a reality.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 202 issue 12.

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FULL PAPER DETAILS

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AUTHOR QUESTIONS AND ANSWERS

Why did you undertake this work?

In 2004 the British Dental Association published and launched the report entitled *Dental Care for Homeless People*. The BDA report called for improvements in the delivery of dental care to homeless people. Moreover *Dental Care for Homeless People* highlighted that little, if any, work on the oral health needs of the homeless had been conducted in Northern Ireland. At the same time the report was launched, there was growing concern about homelessness in Northern Ireland, as the number of households presenting as homeless had greatly increased in recent years from an average of 10,000 in 1995, to 17,000 in 2003/2004. Therefore it seemed the correct time to conduct a survey on the oral health needs of homeless people in North and West Belfast.

Follow-on work?

This survey highlighted that homeless people are a special needs group characterised by an increased prevalence of ill-health, chaotic lifestyles, deprivation and social exclusion. Dental fears and anxieties about appearance were real concerns for this client group and must be incorporated into planning initiatives. In addition their chaotic lifestyle means that a combination of treatment opportunities (such as mobile clinics with other health professionals in hostel localities) must be provided in conjunction with consultation and essential assistance from healthcare co-ordinators for homeless populations. Therefore future work will be to develop and evaluate an oral health service which should incorporate the psychosocial issues associated with accessibility, acceptability and availability of healthcare services for homeless people.

COMMENT

Homelessness has a wide variety of causes and covers a wide range of situations. The degree of social exclusion varies and some people are more marginalised than others. In 2004, the BDA called for improvements in the delivery of dental care to homeless people and this paper from North and West Belfast presents these needs in a Northern Ireland context.

Gaining the confidence of your target homeless groups is a key issue in this type of research. The authors were most fortunate in being accompanied by the local homeless healthcare co-ordinator, who was already known to the subjects. The study took place in hostels and drop-in centres, while some were even questioned and examined on the streets.

This study was more broad-ranging than many previous studies, as it also set individuals in context by enquiring into their reasons for being homeless as well as asking about oral health-related quality of life and levels of dental anxiety. Many respondents needed help with the questionnaire due to poor eyesight or literacy skills, while a proportion were not in a fit state to answer the questions at all.

Almost all subjects had never been employed or in paid work, while a third had mental health problems. Smoking, alcohol and drug use were very common. According to the experience of becoming homeless as reported here, in addition to the normally anticipated reasons for becoming homeless, a few mentioned paramilitary violence and feared for their safety in mainstream society.

As might be expected, the oral health status was poor, with a high oral cancer risk. More than one quarter would be classified as dentally phobic, involving relatively more of those with mental health problems. The authors have identified a clear need for an appropriate oral health service in line with one of the models described in the BDA 2004 document. Together with the prison population, this group represent a significant challenge in addressing the wider inequalities agenda for health and oral health.

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