TOP TIPS

Top tips for managing people who experience homelessness and social exclusion in primary care

By Natalie Bradley[1]

There is no national figure for how many people are homeless across the UK because homelessness is recorded differently in each nation and many homeless people do not show up in official statistics at all. Crisis estimates that on any given night, over 200,000 households in England alone are at risk or living without stable housing. Homelessness has risen over the past five years, from a peak just before the pandemic of 219,000, and in 2021 this had risen to 227,000.[1]

There is also an unknown number of 'hidden homeless' which are more difficult to quantify as well as other socially excluded groups who have unstable or inadequate housing (Box 1). For example, it is estimated that there are over 50,000 asylum seekers and refugees being housed in temporary accommodation across the country.[2]

While traditionally seen as an urban problem, in fact homelessness affects all areas of the United Kingdom, as described by the charity Shelter.[3] Their figures show that there are high concentrations of homeless people not only in London and the South East, but also South coastal areas, northern cities such as Manchester and Newcastle, as well as the South West and East of England.[3]

There are many reasons why people become homeless. This can be because of social reasons, such as lack of affordable housing, poverty and unemployment which can lead to eviction. Many people are forced into homelessness as a result of a breakdown of a relationship, escaping domestic violence or abuse or having nowhere to go when they are released from prison, care or the army. Other life events can also be the trigger for homelessness, such as mental health issues, addictions, poor physical health or even disasters such as fire or floods. In almost all of these cases, homelessness is preventable.[1]

Box 1 Description of homeless and socially excluded groups

- Rough sleepers
- People in emergency accommodation/night shelters/B&B
- Hostel dwellers
- Women in refuges
- Asylum seekers/vulnerable migrants
- People released from prison/institutes
- Squatters
- People living under the threat of eviction/violence
- Gypsy travellers
- Sex workers
- People living in severe overcrowding/unfit housing
- The 'Hidden Homeless' eg sofa-surfers

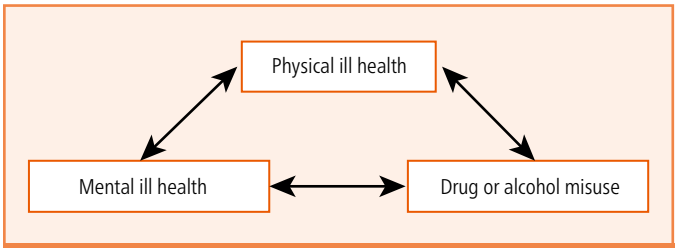

Fig. 1 Tri-morbidity in homelessness

The general health of people who experience homelessness

Chronic homelessness is characterised by 'tri-morbidity', demonstrating higher levels of physical and emotional ill health than the general population. This means that individuals are more likely to be living with mental ill health, physical ill health and substance misuse, and at the same time are less likely to access the health services they need[4] – see Figure 1. This can lead to frailty where homeless hostel residents with an average age of 56 are comparable to those aged 89 in the general population.[5] There are therefore high rates of mortality where average ages of death in the homeless population are 44 for men and 42 for women. This is compared to 76 for men and 81 for women in the general population.[6]

Tri-morbidity not only directly impacts oral health status, but also creates challenges when planning safe and appropriate dental care for this group.

The oral health of people who experience homelessness

Recent research has shown that people who experience homelessness have an inequitable burden of oral disease, with 90% of rough sleepers having had problems with their mouth since becoming homeless and 40% in dental pain at the time of questioning.[7]

Their oral health needs are therefore high, with one service reporting that 99% of homeless people require dental treatment in some form.[8] High levels of all forms of dental diseases are prevalent due to comorbidities, dental neglect, a chaotic social situation as well as difficulties in accessing dental care. See Table 1.

Access to dental services

People who are homeless can find accessing dental care difficult which can be due to a number of factors such as finances, anxiety, stigma, lack of knowledge of how to access services and communication problems. Failure to attend rates in this population have ranged from 36.7–49.8%[9] which has resulted in many questioning whether this population is suitable to be seen within the General Dental

[1]Clinical Director at Dentaid the Dental Charity, Totton, UK

Services; in fact 56% have been unsuccessful when trying to sign up with a dentist.[10] As a result, people who experience homelessness have had to resort to alternatives when they have a dental problem: 36% have accessed Accident and Emergency departments for dental problems and 15% have pulled their own teeth out.[7]

The impact of poor oral health and lack of access to dental services is profound for these groups and can perpetuate the cycle of homelessness. Poor oral health can lead to:

- Exacerbation of systemic health issues
- The medication of dental pain with drugs and alcohol, and therefore prevent effective engagement with substance misuse programmes
- Low confidence and self-esteem
- Poor function and nutrition.

Recommendations from the Smile4Life Survey have outlined that health services aimed specifically at homeless groups should be provided in a safe environment which is a 'comfort zone' in order for patients to build trusting relationships with dental professionals without fear of judgement or stigma. This approach should not be limited to those who aim to care for people who experience homelessness, but in fact all dental services including those in primary care. The survey outlined that homeless people should have access to comprehensive dental care, consisting of three 'tiers' of service:

1. Emergency dental services for those unable to take advantage of routine dental care
2. Ad hoc or single item treatments that can be accessed without the need to attend and full course of treatment
3. Routine dental care and full courses of dental treatment.[11]

Although there are dedicated dental services that provide this comprehensive care, all of the above tiers can also be addressed by services in general dental practice.

Table 1 Oral health problems experienced by people who experience homelessness

Oral health problem	Causes
Caries	Lack of access to oral hygiene aids Lack of motivation to care for dentition Diet – sporadic mealtimes, high sugar intake from what food is available/donated Substance misuse – leads to food binges when 'coming-down', effects of methadone, sugar in alcoholic beverages Dry mouth from methadone use, other medications eg antidepressants and immunosuppression eg HIV
Dental trauma/ missing teeth	High incidence of trauma when sleeping rough eg assault, accidents, intoxication leading to falls Those at risk of violence or victims of previous violence, often trauma to head and neck region Often only care people can access is emergency ie extraction only
Periodontal disease	Lack of access to oral hygiene aids Lack of motivation to care for dentition Substance misuse or immunosuppression increasing risk of periodontal conditions eg necrotising gingivitis High prevalence of smoking leading to periodontal disease
Soft tissue pathology	Mucosal perforations in cocaine use Burns and other soft tissue pathology from substance misuse High risk of oral cancer due to smoking and alcohol use Manifestations of malnutrition such as anaemia or scurvy
Tooth surface loss	Drug use can lead to bruxism and tooth surface loss Alcoholism and repeated vomiting leading to erosive tooth surface loss
Sepsis	Untreated caries and periodontal disease progresses and can lead to infections as difficulty in accessing dentistry or do not prioritise dental needs Immunosuppressed or comorbidities predispose to spreading/ severe infections eg HIV IV drug use increases risk of infective endocarditis

Top tips

1. Clarifying payments and dental exemptions

While there is often confusion about dental exemptions for the general population, many people who experience homelessness will be exempt from dental charges. Obtaining a valid dental exemption, most specifically if a HC1 form is required, can be a significant barrier to care for someone who is homeless; especially if they have poor literacy or a language barrier.

Support should be provided to help fill in the relevant forms, including NHS forms. HC1 forms could for example, be left with homeless drop-in centres or hostels to facilitate confirmation of exemption (HC2 form) if a resident is not on the appropriate benefits. Forms are also available online. Groundswell, an example of a peer advocacy charity, provides a free to download poster which explains dental charges and costs which can be distributed to homeless services to be displayed. This can be accessed at https://www.transformationpartnersinhealthandcare.nhs.uk/resource/healthy-mouths-posters-and-guidance/.[12]

Support with dental charges and travel costs to clinics is sometimes offered by Peer Advocacy services and other homeless charities. Support from a charity or council might also be required to help confirm a dental exemption for people who have No Recourse to Public Funds (NRPF). NRPF means that the person is subject to an immigration control as defined by section 115 of the Immigration and Asylum Act 1999 and cannot claim for public funds such as benefits or housing.[13] They can however, claim full (HC2) or partial (HC3) help with dental charges.[14]

Dentists are not required to ask for proof of identity, address or immigration status and therefore anyone with NRPF can access NHS dental care; in fact dental practices cannot turn down an applicant for NHS treatment if a person cannot show evidence of a valid exemption – the relevant box to say that exemption has not been seen should instead be ticked and the NHS Business Service Authority (BSA) Dental Exemption Checking Service will confirm a valid exemption.[15]

2. Obtaining reliable contact details

Obtaining reliable contact information can be a challenge for people without a fixed address and whose contact details might change. NHS services have a duty to ask patients how they would like to be contacted and information given to them. This might be by email, text message or phone calls if someone doesn't have a fixed address.[16] Patients may also have an address where they are able to pick up their post from, for example a homeless day centre, where correspondence can be sent to. Patients might also have a support or key worker who could be used as a contact on behalf of the patient with the patient's consent.

When transmitting courses of treatment for NHS treatment (FP17 forms), the NHS BSA recommends the use of a dental practice's address should a patient have no fixed abode.[17]

3. Missed appointments

With fluctuating priorities, attending dental appointments can be challenging for homeless and socially excluded groups and therefore flexibility with appointments is key in caring for this group. This can be a challenge in General Dental Services (GDS) where remuneration is by Units of Dental Activity (UDA) and staff are self-employed. Homeless advocacy groups call for flexible appointments with lenient missed appointment policies,[7] yet this has to be balanced with running the business of a dental practice.

Some strategies to help reduce FTA [failure to attend] rates in GDS include:

- Reminders – telephone calls, appointment slips, text messages
- Engaging with key workers, peer advocacy and other reliable contacts (such as a good friend) to motivate, remind and escort patients to their appointments
- Offering a fixed appointment slot per week for a hostel or drop-in centre which can be populated by any service user, rather than a named person slot
- Double booking appointments
- Updating contact details of the patient at every appointment
- Sharing information with patient consent with their keyworker, hostel or day centre manager
- Always making follow up appointments in person.

4. Managing tri-morbidity

Some people who experience homelessness have additional needs that might need input from special care dentistry, but many can be treated by a Level 1 practitioner in primary care.[18] Shared care arrangements could also be employed.

Substance misuse:

- Be aware of the oral manifestations of recreational substance misuse such as tooth surface loss as a result of stimulants which promote bruxism, soft tissue lesions and perforations and periodontal disease[19]
- Poor oral health is often multifactorial in these patients. They may have caries because of neglect, suffer from xerostomia because of opiate use or have poor dietary habits associated with periods of intoxication and altered taste. Higher rates of tooth loss could also occur because of trauma. Alcoholism also promotes erosive tooth surface loss as a result of instrinsic and extrinsic acid and substance misuse also increases the risk of oral cancer[19]
- Assessment of a patient's capacity to consent is required if a patient shows signs of intoxication. If there is acute intoxication, a patient's behaviour could become challenging and the clinician must ensure appropriate risk assessment to ensure patient and staff safety.

Mental health:

- As stated above, consent and capacity can be an issue not only from substance misuse, but also from other mental health issues. Patients should be assessed at the beginning of each appointment as it should not be assumed a person lacks capacity just on the basis of consumption of drugs or alcohol. Should a patient be likely to recover their capacity, any non-urgent decisions should be deferred until they regain their capacity to consent. If they are unlikely to regain capacity, or the treatment is urgent, a decision should be made in their best interest[20]
- Some medications prescribed for mental health conditions will have oral side effects such as xerostomia that can impact caries risk and people with mental health conditions often have poorer oral health than the general population[21]
- During acute or manic episodes of poor mental health, patients' behaviours can become unpredictable or they will not be motivated to engage with dental practitioners. Engagement with these patients might fluctuate and therefore, teams must be flexible and willing to engage when the patient is ready.

Physical health:

- Long term alcohol use, or hepatitis from Blood-Borne Viruses (BBV) can cause liver cirrhosis and therefore increase the risk of bleeding post-dental extractions. Liaison with appropriate medical practitioners might be required or preoperative blood tests to check clotting function if extractions are required. Local haemostatic measures might be required together with staging of treatment should multiple extractions be required
- Patients who are frail or have mobility issues might need adjustments such as being seen in a ground floor surgery, or given longer appointment times at times of the day which are best for them. Dental teams have a legal requirement to make reasonable adjustments for patients who need them[22]
- Patients who use IV drugs are at higher risk from infections such as BBVs or Infective Endocarditis (IE). Universal cross infection measures should be implemented and these patients usually do not require antibiotic cover prior to their dental treatment, unless they have already had IE or fall under the other special consideration groups according to guidelines.[23]

5. Tailoring prevention advice

Oral and general health promotion should be delivered for all patients according to *Delivering better oral health*,[24] but messages need to be adapted to the specific needs of people who experience homelessness.

- Dietary advice. There might be limited autonomy over diet for people who experience homelessness. Nutrition might be poor, particularly if they also use drugs or alcohol. Many will rely on soup kitchens or donated foods which could be high in carbohydrates and therefore be cariogenic. Advice given needs to take this into consideration
- Oral hygiene. Access to oral hygiene equipment such as toothbrushes and toothpaste might be difficult so if possible, a practice could donate or offer these. Advice should also be tailored, for example, that there is no need for running water to brush their teeth.
- Making every contact count. It is also within the dental team's role to deliver general health messages, such as smoking cessation and alcohol reduction. Teams should be aware of where to signpost patients onto, such as local drug and alcohol services and general practitioners (GPs) where necessary.

6. Treatment planning

Depending on what stage a person is at in their life, the dentistry they might wish to access can vary between the three tiers of care described above.

Dental teams should engage with patient-led treatment plans which meet the expressed needs of the person, for example getting someone out of pain, fixing a front tooth which could improve

their self-esteem, or improving function. While elements of their lives remain unstable, such as employment, housing and addiction, patient-led treatment plans may be more suitable to address their immediate needs. Trust can then be built so a patient can choose to engage with more routine care and comprehensive treatment planning when they are ready. Phased courses of treatments have been advocated in high needs patients such as this population, in a letter 'Avoidance of doubt' from the Chief Dental Officer.[25]

7. Trauma-informed care

Socially excluded groups can face stigma from professionals when trying to access services. The dental team should be inclusive and non-judgemental when caring for all patient groups, including people who experience homelessness. Care should be patient-centred and the whole dental team should treat patients with understanding and friendliness. Principles of trauma-informed care should be applied, and there are resources available on the training of inclusion health for the whole team.[26]

8. Improving dental access

Accessing NHS dental care has become increasingly challenging for many people since the COVID-19 pandemic. There have been reports that show that the pandemic has disproportionately affected the mental, social and healthcare needs of excluded groups,[27] including those who experience homelessness. Services that this group might have accessed pre-pandemic, such as walk-in clinics may no longer be operating in the same way because of changes in infection prevention and control. Inequalities in oral health are therefore set to widen.

Improving access to care for vulnerable groups, including those who are socially excluded, across all dental settings is therefore a priority. Conveniently located services for people who experience homelessness have been shown to be an important factor in access, as many cannot travel long distances to access care.[8] Dental practices that are convenient locations to services that homeless people already access could be 'buddied up' to create pathways. Training and appointing an Oral Health Champion within the buddy service, such as a hostel manager, could help promote the service, assist with paperwork and facilitate appointments. These methods could reduce FTAs and therefore make it more financially viable to see these patients in primary care settings.

Conclusion

People who experience homelessness and social exclusion have poor oral health which can impact on their quality of life and face barriers to accessing dental care. Recommendations have been made for dental services to create a comfort zone for patients so that dental teams can build trusting and non-judgemental relationships with this group, which includes general dental practitioners.

While there are specific challenges in providing dental care for this group within the current NHS contract, such as overcoming high FTA rates, managing comorbidities, and clarification on dental charges, there are strategies to ensure those patients who can be seen in primary care are able to access dental care. ■

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