Multi-agency Working for Inclusive Dentistry

Health and Homelessness Conference
Edinburgh 2018

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WHO Response for Oral Health Challenges

• Public health solutions for oral diseases are most effective when they are integrated with health and health promotion programs.

• Health promotion sessions enable people to increase control and make decisions over their own health.

• It covers a wide range of interventions that are designed to benefit and protect people’s health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure.
Oral health and psychosocial needs.
The evidence base of Smile4life.
The aim: to conduct an oral health and general needs assessment as the first stage of the programme.

Produced data on:
- Demographic profile;
- Health and health behaviours;
- Degree of patient management complexity;
- Psychosocial health.
853 homeless people took part

- **Demography**
  - age range 16 to 78 years
  - largest age groups 16-24 years (29%) and 25-34 years (30%)
  - 75% male
  - 78% single

- **Living status**
  - 32% living in hostels
  - 20% in short-term temporary accommodation
  - 7% in longer-term supported accommodation
  - 2% rough sleepers
• Reasons for homelessness included:
  • relationship breakdown
  • eviction/loss of tenancy
  • substance misuse

• The participants had experience of a diverse range of poverty; social exclusion and marginalisation
Health Status
54% of people stated that they were receiving medical treatment in primary or secondary care

Health Behaviours
85% reported being smokers: 20 cigarettes smoked/day
30% reported to drink alcohol daily
29% reported to use street drugs
(81% of those reporting to use drugs stated they were IDUs)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of patients taking prescribed medication (n=472)</th>
<th>Percentage of patients taking medication</th>
<th>Percentage of total sample (n=853)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-depressants</td>
<td>153</td>
<td>32.42</td>
<td>17.94</td>
</tr>
<tr>
<td>Methadone</td>
<td>153</td>
<td>32.42</td>
<td>17.94</td>
</tr>
<tr>
<td>Chest/asthma medication</td>
<td>128</td>
<td>27.12</td>
<td>15.01</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>96</td>
<td>20.34</td>
<td>11.25</td>
</tr>
<tr>
<td>Analgesics</td>
<td>64</td>
<td>13.56</td>
<td>7.50</td>
</tr>
<tr>
<td>Anti-psychotics</td>
<td>51</td>
<td>10.81</td>
<td>5.98</td>
</tr>
<tr>
<td>Vitamins</td>
<td>43</td>
<td>9.11</td>
<td>5.04</td>
</tr>
<tr>
<td>GIT medication</td>
<td>30</td>
<td>6.36</td>
<td>3.52</td>
</tr>
<tr>
<td>Anti-epileptics</td>
<td>29</td>
<td>6.14</td>
<td>3.40</td>
</tr>
<tr>
<td>Anti-hypertensives</td>
<td>27</td>
<td>5.72</td>
<td>3.17</td>
</tr>
<tr>
<td>Anti-inflammatory</td>
<td>24</td>
<td>5.08</td>
<td>2.81</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>23</td>
<td>4.87</td>
<td>2.70</td>
</tr>
<tr>
<td>Cardiac medication</td>
<td>15</td>
<td>3.18</td>
<td>1.76</td>
</tr>
<tr>
<td>Muscle relaxant</td>
<td>14</td>
<td>2.97</td>
<td>1.64</td>
</tr>
</tbody>
</table>
Oral health status:

- **27%** of decay experience was due to decayed teeth
- **52%** by missing teeth and
- **22%** by filled teeth.

This suggested that people had their decayed teeth extracted rather than filled.
Figure 30: Percentage of participants who report dental anxiety by MDAS items
Oral health-related quality of life

Oral health impacts

- pronouncing words
- sense of taste
- painful aching
- uncomfortable eating
- self-conscious
- tense
- diet poor
- interrupt meals
- hard to relax
- embarassed
- irritable
- unable to do a lot
- life less satisfying
- unable to function

% of respondents

- occasionally
- fairly often
- very often
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Psychological health and social well-being: depression

Two percent of men and 2.5% of women in the UK are said to suffer from depression. In this homeless population, 58% of respondents who completed the CES-D scored at least 16, which suggested that they were suffering from a depressive illness. This compared unfavourably with the 38.9% of people in north London who were identified as being depressed by the CES-D in a previous general population study [28]. The mean score for depression among the homeless sample was 21.71 [95% CI: 20.60, 22.83].
Depression and oral health

Decayed and missing teeth (DM) indirectly influence depression through oral health-related quality of life (OHIP), and to a lesser extent, dental anxiety (MDAS)

\[
\text{Total Effects of DM} \rightarrow \text{Depression} = 0.44 = 19\%
\]

Deconstruction to reconstruction formulation of homelessness:

[1] Pathways into homelessness
[2] Deconstruction of the life before homelessness
[3] Construction of the homelessness identity
Reclaiming life appeared to be underpinned by a trajectory of basic social processes that defined a journey through homelessness.

This journey was conceptualised as a ‘deconstruction – construction – reconstruction’ trajectory which reflected the homeless person’s means of solving their internal world problems, externalised as ‘homelessness’.

Preceding the construction of the homeless identity, a period of deconstruction emerged. Associated with social or external world difficulties, it was theorised that this deconstruction formed part of the trajectory which emerged as deconstruction to reconstruction.

The trajectory therefore included the determinants of the homeless identity, from the deconstruction of the pre-homeless identity, the construction of a homeless identity, and the reconstruction of a post-homeless identity.
Reclaiming Life

**De-construction**

**Revolving**: spiralling away from family and friends: loss of love and support: being abandoned: experiencing violence: choosing

**Sleep walking**: a slow walk to homelessness: becoming involved with the ‘wrong crowd’: woke up and were homeless: vagueness: forgetfulness

**Construction**

**Resistors**: People resisting the homeless identity were those who were early in their homeless career and tended to be either younger or older people who were experiencing homelessness for the first time

**Sleepers**: tended to sleep walk into homelessness: remained in a sleep-like state: sleep allowed an escape from violent experiences: unbearable thoughts: emotional pain and feelings of emptiness.

Like sleeping beauty, sleeper constructors could be awakened with the realisation of passing time and the wish to engage with services

**Decayers**: people who had experienced dreadful trauma: emotionally damaged and unable to function: remained in a state where the maintenance of their homelessness allowed a type of life to reclaimed

**Re-construction**

**Ready to move on**: recognition of need for change and reclaiming a sense of responsibility for self: awareness of lost time

**Oscillating**: positive steps to reclaiming interspersed with destructive behaviours: key worker and relationship building

**Consolidating**: consolidating life style choices: taking control of their own lives and accessing health care
Construction of a neglected dentition

De-construction of oral health

Loss of routines:
Loss of facilities to toothbrush
Loss of regular mealtimes & snacking on cariogenic foods
Loss of attendance for dental care

“All I was interested in was getting my drugs, that was my main priority, teeth were the last thing I ever thought about, until I got toothache...when I was eating, bits of them were breaking off, so the ones I had left were getting really bad...when I was mad with it I just didn’t care whether I had them or not” (M, 35).

Accepting the norm:
Unawareness of need for dental treatment
Increased pain threshold
Toothache part of everyday living
Emergency attendance and tooth extraction

“I had toothache for days and days, and I says, ‘I’m gonna have to go, gonna have to go, gonna have to go’, and it took us about four days to say right, I’m going to the dental hospital. They [the two teeth] had holes in them, and the holes were that big, they said there’s no point in filling them, we could fill them if you want but I says no, just take them out, I just want them out, so they took them out” (M, 25).

Re-adoption:
Oral health behaviours
Awareness of dental treatment need and accessing treatment

“I started to address a lot of other life issues, that I started even thinking about getting a dentist. I’m a lot happier with them...I’m quite grateful, and a lot happier about the appearance of them since I’ve had the treatment. Before they were probably pretty brown, cos I had smoking and stuff like that, just general lifestyle choices, they were pretty manky looking, there’s a big difference with that. And I was getting a lot of intermittent pain and that’s all gone. I’m really grateful for the service [homeless dental clinic], glad to have found it” (M, 36).
Trust building and social engaging with service users. Adopting a multidisciplinary approach across sectors...
- Joint work across sectors
- Multi-agency working
- Community engagement
- Service User Involvement
- Co-production
- Co-design of services
- Participatory research methods
In practical ways what does it mean?

- A recognition that one field of knowledge/expertise will be not enough to face the complexity of homelessness and health fields

- A real joint effort to build trust and relationship between partners through a meaningful interaction and communication around a common agenda

- Implies mutual respect for the expertise and lived experience of others

- A desire to become part of an active and mutual learning process
“In the homelessness context oral health is not always seen as an immediate priority”
<table>
<thead>
<tr>
<th>Periods of time</th>
<th>Situations faced</th>
<th>Services available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early intervention</td>
<td>Conflicts at family environment, death of family members, divorce, women and children victims of violence, addiction, unemployment, mental problems</td>
<td>Conflict resolution, advice and information, health and psychosocial wellbeing,</td>
</tr>
<tr>
<td>Crisis moments</td>
<td>Rough sleepers, People discharged by health treatments, Sofa surfing</td>
<td>Hostels, supported accommodations, food banks</td>
</tr>
<tr>
<td>Sustained tenancy</td>
<td>Repeated cycles</td>
<td>Life skills, training and education</td>
</tr>
</tbody>
</table>
Pathways of a research experience using a multidisciplinary and participatory approach
Youth homelessness
• In Scotland 28% of total homelessness applications were from people aged between 16 and 24 years old (Scottish Government, 2016).
• Hidden Homeless
• Group in high-risk to present complex needs as physical and mental health conditions (Harleigh-Bell, 2016; MacInnes, 2015; Malley et all, 2004; Fitzpatrick, 2000; Ferran & Sabatini, 1985).
• There is a need of a holistic approach
• Group has being seen as difficult to engage
• Frontline staff fell difficult to address health and psychosocial needs of their clients
• Health education activities are cited by young people as “especially important” because they could not get the appropriate health advice from their families or peers (Ensign, 2004)
The research project aimed to strengthen a culture of health promotion and citizenship within organizations working directly with young people experiencing homelessness to jointly discuss sensitive issues related with their life experiences being homeless and their perceptions on health.
Pilot Project

- Rock Trust (Edinburgh)
- Young participants (16 to 25 years old)
- Supported accommodations

- Partnerships:
  NHS Lothian; NHS Forth Valley; NHS Education for Scotland
  Cair Scotland; Cyrenias
Methodology

- Direct observation of the context
- Building trust and relationship
- Pedagogical Workshops (2 phases)
- Semi-structured Interviews (staff and young participants)
Topics covered by the Workshops

- Homeless trajectory
- Oral Health
- Mental Health
- Youth Homeless
- Future
- Stigma

Youth
Homeless
Oral
Mental
Future
Stigma
Learnt lessons in terms of engagement

- Adopting elements of Critical Pedagogy (Freire, 1991) the workshops (Candau, 1995) intended to be a way to build knowledge, with an emphasis on reflection and action.

- We need to valuate different forms of knowledge, values, interests, needs and experiences to encourage life changing processes and improving professional practices.

- Allow time and a safe space for mutual learning and meaning interaction; an active process of mutual transformation between facilitator and participants.
Lessons learnt in terms of engagement

Engaged participants or service users start with engaged practitioners...

The emphasis is not on outcomes, but on processes...
**Workshops Structure**

**Creative approach:** the use of drawing, photographs, films, collage and drama

**Structure:**
- Shared meal
- Ice breaker
- Introduction (capturing previous knowledge and experiences)
- Providing information on health and homelessness issues
- Group discussion
- Interactive production
- Group agreement
Social interaction
Capturing previous knowledge and experiences
Providing information
Group discussion and collective production
Group discussion and collective production

TREAT PEOPLE AS INDIVIDUALS
NO STIGMA
RESPECT
NO JUDGEMENT
ACCEPTANCE

We’re all different in lots of ways. Why focus on one?

See beyond first impressions.

WE ARE WHO
WE ARE - AMAZING
INDIVIDUALS WITH
A LIFE AHEAD OF US
Group Agreement

**Group agreement on Oral Health**

“Brushing my teeth differently”

“Using mouthwash at different times”

“Not use water when brushing my teeth”

“Put just a pea size of my toothpaste”

“Using a straw to drink any juice”

**Group agreement on mental health**

“Exercise more to benefit my mood”

“Think positive”

“Share with people when I am very worried or upset”

“Spend more time with friends”

“Improve my listen (more listen, less talk)”
Feedback from participants

The best part of the workshop:

Welcoming and Informal environment,

The learning process,

Information provided,

Safe space to share ideas and experiences,

The discussions on topics related with their lives,

The material produced
Feedback from staff

“I liked to see the interaction between them, young people being comfortable about sharing experiences”

“I know that the young people which came along took something away with them at each session. They were rather sad to hear that the group was coming to an end, and have already mentioned to me that they’re planning on coming along to the second phase sessions”
Preliminary Conclusion

We need an specific (cross sectors) agenda to work with inequalities

We need to work better with the civil society, policy makers, social movements, advocacy groups, communities

We need to develop new forms of partnerships with different sectors

We need to re-think the meaning of ‘public engagement’

Fundamentally, we need to assume a political engagement with what we do