ORAL HEALTH CARE RELATED PERCEPTIONS AND EXPERIENCES OF HOMELESS ADULTS IN VANCOUVER’S DOWNTOWN EASTSIDE

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(Population and Public Health)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

December 2015

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Abstract

Background: Oral health problems are particularly prevalent among homeless adults in Vancouver. The extensive unmet oral health care needs (both clinically evaluated and self-reported) indicate the importance to understand homeless adults’ perceptions and attitudes towards use of oral health care to improve their oral health. The purpose of this research was to explore homeless adults’ perspectives on oral health and oral health care services through their experiences with the access to and use of oral health care services.

Methods: A qualitative approach was taken and 25 semi-structured interviews were conducted with homeless adults in Vancouver in regards to their self-perceived oral health status and to their experiences of access to and use of oral health care services.

Results: For the majority of the homeless participants, maintaining good oral health was important while they perceived their oral health to be poor. Participants reported a high need in oral health care and that many past experiences with oral health services were disappointing. As such, they described their unwillingness to visit dentists regularly because they feared that they would not receive appropriate oral health care services. In addition to the cost of care and lack of adequate public oral health services, the main concern of homeless adults’ were the indifferent attitude by dentists, and lack of information about the available oral health care resources.

Conclusion: The study participants ranked oral health as important and perceived high need of oral health care services. The past experiences with dentists influence the participants’ behavior towards future use of oral health services. The study results suggest that the current state of affairs between oral health service providers and homeless adults is a divisive one filled with distrust, disrespect, and at times professional irresponsibility.
Preface

This thesis is an original, intellectual, and independent work by the author, Anjali Mago. The ethics approval for the research was received from the University of British Columbia’s Behavioural Research Ethics Board (H14-01169).
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BC</td>
<td>British Columbia</td>
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<td>BCDA</td>
<td>British Columbia Dental Association</td>
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<td>BMVP</td>
<td>Behavioral Model for Vulnerable Populations</td>
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<tr>
<td>CDCs</td>
<td>Community Dental Clinics</td>
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<tr>
<td>CHMS</td>
<td>Canadian Health Measures Survey</td>
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<tr>
<td>DTES</td>
<td>Downtown Eastside</td>
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<tr>
<td>GVRSC</td>
<td>Greater Vancouver Regional Steering Committee</td>
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<tr>
<td>NIHB</td>
<td>Non-Insured Health Benefits</td>
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<tr>
<td>U.S.</td>
<td>United States</td>
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<td>U.K.</td>
<td>United Kingdom</td>
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Acknowledgements

I offer my enduring gratitude to my supervisor, Dr. Jim Frankish, for his wonderful guidance and continuous support, feedback, kindness, and confidence that I could complete this study. I thank Dr. Mario Brondani and Dr. Michael MacEntee for supervising my work and providing me their in-sight and knowledge into oral health related issues. They challenged me in different ways to think critically and enlarged my vision.

I am thankful to the homeless men and women who participated in this study. Their descriptions allowed me to be inserted into their lives so that I could look at the topic through their eyes. The staffs at the Lookout Emergency Aid Society were supportive and enthusiastic about this study including the site managers: Michelle Raufeisen, William Oksanen, and Linda Fox.

I owe particular thanks to the program manager, Beth Hensler, for her continuous support, friendship, and kindness. I am also grateful to Dr. Claudia Krebs who helped building my self-confidence and forget any stress.

Special thanks are owed to my family, Vijay, Mehar, and Subhi, for their tremendously valuable support throughout this academic journey. I would also like to thank my parents, in India, who continually encouraged me to work hard.
1. Introduction

This chapter reviews the perspectives and experiences of oral health care by homeless people, which this research was designed to address. The chapter introduces the phenomenon of interest, the objectives of the study, the research questions, and the significance and implications for oral health care research, practice and policy.

1.1 Problem statement

The report on the Canadian Health Measures Survey (CHMS) 2007-2009 states that the government of British Columbia (BC) is committed to focusing on the vulnerable members of the society to help them achieve and maintain excellent dental health (1). The provincial government has been supporting the development of not-for-profit dental clinics for those who have limited access to private clinic dental services [page 8] (1). Still the low income Downtown East Side (DTES) residents of Vancouver, specifically homeless adults, have poor oral health and exhibit significant unmet oral health care needs (2). Therefore, it is necessary to understand the perspectives and experiences of oral health care by homeless adults in order to define treatment goals and outcomes as part of the need for improvement in their oral health.

1.2 The phenomenon of interest

This thesis examines the oral health related perspectives and experiences of a sample of homeless adults in the city of Vancouver. The Canadian Observatory on Homelessness defines homelessness (3) as a situation when a person is: 1) unsheltered i.e., living in a place not intended for human habitation; 2) emergency sheltered i.e., staying in overnight shelters; and 3) provisionally accommodated i.e., lacking security of tenure or the accommodation is temporary, and 4) at Risk of Homelessness i.e., the current economic and/or housing situation is precarious.
The definition of health care related experiences includes three concepts (4): 1) incidents that happen across the continuum of care; 2) the concept of satisfaction with a focus on individualized care and tailored services according to needs while engaging patients as partners in their care; and 3) past experiences are strongly associated with future expectations. Moreover, people’s expectations may not be limited to health outcomes. Health experiences are also defined as reporting on actual care received, perceived accessibility to health care, sense of continuity with a specific practitioner, availability of services, and coordination of different types of services in a given health care setting (5).

Some studies have examined the perspectives and attitudes of vulnerable people such as well-fare recipients, homeless people with mental illnesses, and low income people living in the remote regions, towards oral health care (6–8). In general, these studies have found the participants’ self-reported need of oral health care, resentment towards dental professionals, self perceived barriers to access oral health care, and coping strategies to manage oral health problems. An Australian study on the oral health of homeless people found that the self-reported prevalence of untreated oral health problems was significantly higher than in the general population (9). That study also showed that fewer homeless people had visited the dentists within the past year and the visits were due to oral problems rather than the regular check-ups.

1.3 Objectives of the study

The aim of this study is to describe what oral health means to, and what it is like to experience the oral health care by homeless adults in Vancouver’s eastside district. The study offers an examination of dental approaches and practice from the perspective of the homeless people who participated in the study. It is hoped that the description of homeless adults’ perceptions and experiences will be used to inform oral health research, practice and policy in Vancouver, BC and elsewhere in Canada.
1.4 Research questions

1. What are the self-reported perspectives on oral health and oral health care providers among the homeless adults in Vancouver?

2. What were the experiences by homeless adults in Vancouver in using oral health care services?

3. What are the perceived barriers (if any) to access oral health care among the homeless adults in Vancouver?

1.5 Significance and implications of the study

This thesis may contribute to a better understanding of how the current oral health care system influences the experiences of access to and use of the comprehensive oral health care by the vulnerable, homeless adults in Vancouver. Homeless adults may include people with low socio-economic status, persons with psychiatric, cognitive, and developmental disabilities, and persons who have been abused, substance abusers and mentally incompetent (10). High burden of oral diseases and unmet oral health care needs among homeless people may relate to sociocultural determinants such as poor living conditions and low education level; psychosocial determinants such as the lack of social support and feelings of loneliness and isolation affect the mental health and well-being of homeless people (11). Similarly, health care system and oral health services also influence people’s oral health outcomes (11). The current study helped in understanding these influencing factors as explained through the self-reported experiences of homeless people with the oral health care system. Investigating the topic may be helpful to conceive strategies to promote oral health among homeless adults.

The topic is relevant to many stakeholders such as homeless adults, policy makers and health care administrations, dental and medical health care providers, staff at dental clinics, and homeless support societies.
2. Literature Review

2.1 Introduction to the review of literature

This chapter is based on narrative reviews of the literature (12). Key words such as homeless, oral, dental, and health were defined and articles were located using various databases such as PubMed, MEDLINE, and Google Scholar. Based on the title, 418,000 studies appear on Google Scholar, which are related to the general health of homeless people, only 8970 studies have devoted attention to the oral health among this population. The focus of the studies related to the oral health of vulnerable populations has been more on quantifying the unmet oral health care needs and barriers to access oral health care and less on describing their experiences with service utilization. Research on the perspectives and experiences in providing services to vulnerable populations by oral health care providers is more prevalent than from the recipients’ perspective.

The review in this study frames recent understanding and knowledge from theoretical and contextual points of view in oral health care experiences by homeless adults. The literature review was conducted with the emphasis on two areas of investigation: 1) studies on homeless people and their oral health; and 2) studies related to service providers’ perspectives on homeless and other vulnerable people in oral health care. The review also includes studies in policy efforts in reducing the challenges to access oral health care by vulnerable people in BC in particular, and in general within Canada. The literature review includes quantitative and qualitative studies conducted in the fields of dentistry, medicine, public health, and social sciences.

2.2 Homeless people and oral health

2.2.1 The concept of homelessness

The Canadian Observatory on Homelessness terms (unsheltered, emergency sheltered, provisionally accommodated, and those at risk) depict the level of accommodation experienced by people who live
without suitable, secured, and permanent housing (3). Unsheltered homeless people are individuals who do not have access to housing except during extreme weather conditions. They live in public and private spaces such as parks, sidewalks, lane ways/alleys or vacant buildings. Emergency sheltered homeless people temporarily access related support systems. Emergency shelters provide basic emergency or immediate services including safe accommodations, food, information, and referrals to other support services. Provisionally accommodated homeless people access temporary housing arranged by themselves independently or with the help of government and not-for-profit (e.g., charitable) organizations. Provisionally or interim housing may allow persons to stay longer compared to the temporary shelter arrangements. Persons at risk to homelessness live in unstable or unsecured housing situations and are at risk of becoming homeless.

Until 1977, Canada had no significantly identified or recognized homelessness rates except for a small number of people living in cheap rooming houses (13). By the 1980’s homelessness started becoming a common social problem in Canada as more and more people faced lowering incomes and deeper poverty levels to the point they could not afford even poor quality housing (13).

A recent scenario regarding homelessness as presented by the Greater Vancouver Regional Steering Committee (GVRSC) is as follows (14):

- There were 2,777 homeless people in Vancouver in 2014; 4% higher than in 2008.
- Vancouver has the largest concentration of homeless people in the Greater Vancouver Region; ~65%.
- In 2014, 72% homeless people in Vancouver were in the age range of 19-54.
- Men represented about three quarters of the people identified as homeless.
- About one third of the total homeless populations were identified as Aboriginals (Aboriginal peoples in Canada are First Nation, Métis and Inuit peoples).
2.2.2 Homelessness and oral health

Dental diseases such as caries and periodontitis are the most common oral health problems and slowly lead to tooth loss. These diseases can have a significant impact on physical and mental well-being influencing how people appear, chew, taste food, communicate, smile, and enjoy life (15). Low socio-economic status has been one of the most important influencing factors for developing oral diseases (16). The Canadian Academy of Health Sciences reported that untreated dental and gum diseases, missing teeth and dental pain are more prevalent among low-income Canadians who do not own a home (17).

The prevalence of untreated dental caries and missing teeth in Downtown Eastside (DTES) Vancouver residents, with a high concentration of homeless people, is twice as much as in the Canadian low-income population (2). Poorer oral health in homeless people than in the general population has been reported in UK (18), USA (19), Canada (17), Australia (9), Hong Kong (20), and other locations (21). These studies demonstrated that homeless individuals exhibit high rates of dental infections, dental caries and emergency treatment needs and the tremendous need of health care services, including regular oral health care. The GVRSC on Homelessness reported in 2014 (14) that the oral health care services ranked 11th among 19 types of services used by homeless people. 19% of homeless people in 2014 were reported to have used the dental services compared to 26% in 2011. It was also noted that 22% of sheltered homeless people used dental services in the past 12 months compared to 16% of unsheltered homeless people. The data indicates that having a place to stay may influence the utilization of oral health care services. The difference in oral health care service utilization pattern between sheltered and unsheltered groups of homeless people may reflect the fact that sheltered people become more visible to the service providers, and hence more likely to have the health care needs identified and addressed appropriately (22).

Homeless adults also exhibit a higher prevalence to other common risk factors in poor oral health such as poverty, mental illness, smoking, alcohol and substance use, musculoskeletal disorders, diabetes, HIV
infection, and poor nutritional status (23). Substance abuse and mental illness are found to be more prevalent among the homeless people than the general population (24). Homeless persons have high rates of methamphetamine usage that is associated with extensive tooth wear known as “meth mouth” (25). The higher prevalence of alcohol and tobacco use increase the risk of oral cancer among homeless adults (26). Lack of access to proper diet, consumption of convenience food having high sugar content, lack of access to water, tooth brush, tooth paste, and regular preventive care contribute to poor oral health among homeless individuals (23).

2.2.3 Homelessness, oral health, and general health and social well-being

Oral health is an integral part of general health. Oral health and general health are intertwined because of the common risk factors for non-communicable chronic diseases and oral diseases. The evidence suggests that periodontal diseases are associated with heart diseases, respiratory diseases, and diabetes through common bacteria and pathologic changes in the tissues (27). These pathological associations between oral cavity and body are demonstrated in many studies linking the periodontal diseases with coronary heart diseases and stroke (28), although no direct causal link has been identified (29).

Oral health is also associated with mental health and social well-being and also closely associated with homelessness (30). Palma and Nordenram (31) reported homeless people regained their self-confidence, social function, and courteous reception after they received oral health care. Locker, Clarke et al. (32) suggested that homeless people who perceived their oral health to be poor also had a lower morale, more stress and less life satisfaction as compared to those who perceived their oral health to be good.

Homelessness affects one’s ability to form stable ties with family, friends, and community, leading towards social disaffiliation and powerlessness (33). Homeless peoples’ identity may be influenced by illicit drugs, illness, and exclusion more so than the general population (33). Homelessness carries with it the feelings of stigmatization. Homeless people are stereotyped and stigmatized as people who are drug addicts, dirty, poor, alcoholic, mentally ill, strange, dangerous, scary, unemployed, and abused.
The overwhelming poverty reifies concept of homelessness. It leads to the way that oral health care providers see the homeless adults.

### 2.2.4 Homeless people’s experiences with oral health care

Much of what has been written in relation to the oral health of homeless people in North America is primarily based on questionnaire-based survey research that lacks the descriptions in actual experiences from homeless adults with their use of oral health care. Most studies focus on the burden of oral diseases among homeless people and consistently reported substantial need for oral health care due to dental pain, infections, grossly decayed or missing teeth.

My review of health services literature was limited since the experiences of homeless individuals with oral health care utilization came mostly from studies conducted in Sweden and Scotland (31,35). Palma and Nordenram’s 2005 study (31) involved the provision of oral health care to homeless participants and captured their experiences with service utilization. The focus of this study was to examine the effects of dental treatment on homeless people and the results suggested that the oral health care was not a priority while they were actively using illicit drugs; whereas taking care of oral health became a source of regaining dignity and general health when participants started rehabilitative treatments for drug addiction. Coles and Freeman 2015 study (35) focused on examining oral health care awareness and socio-economic and psychosocial issues that influenced homeless individuals’ decisions to utilize oral health care. The study results showed that oral health care experiences were constructed in three different stages influenced by the phases of homelessness. In the first stage, the factors associated with homelessness deteriorated oral self-care, in the second stage oral health continued to be neglected and in the third stage, oral self-care was regained when the individual exited the homelessness situation.

### 2.2.5 Affordability for oral health care

In Canada, oral health care delivery is mostly private. There are a few public oral health programs for adults in Vancouver offering limited oral health services to low income people, and persons with disabilities - $1000 per 2 years as of 2014 (36,37). Aboriginal peoples also receive dental benefits.
through the Non-Insured Health Benefits (NIHB) by the Government of Canada (38). A single person on welfare was eligible to receive $658 -$906 per month (as of 2015) depending on whether they were disabled or had multiple barriers to employment benefits (39). As of 2007, the estimated monthly food cost and basic rent for an adult were approximately $200 and $374 respectively (40). Consequently, the costs of food and shelter leave little room to cover the cost of dental services. Moreover, there is an approximate 24% financial gap between the fee schedule of the Ministry of Social Development and Social Innovation and the fee guide of British Columbia Dental Association (41), which is often beyond the ability of welfare clients to pay. Dentists may often refuse to treat such clients if they cannot afford to pay the difference in dental fees (42).

Under these circumstances people who do not have access to comprehensive oral health care plans, try to cope with their oral health problems in a number of forms. The literature shows that without conventional access to dental care, homeless adults often rely on the emergency departments of hospitals, alcohol, illegal drugs, home/self-remedies, and over-the-counter medications for oral health problems (6,43). Visiting emergency departments to receive treatment for preventable dental problems is a marker in poor access to dental services and is more often seen among vulnerable populations (44)

2.3 Oral health among other vulnerable populations

The review of literature on oral health in other vulnerable communities, such as those with low incomes, immigrants, older people, and welfare recipients suggested that these people suffer greatly from oral diseases, decayed, broken and missing teeth than the average Canadians (17). Financial accessibility and acceptability is seen as major barriers to access oral health care among vulnerable populations in Canada (6). There also exist other barriers, such as language and cultural factors as noted among older Punjabi and Chinese immigrants (45–47).

A number of studies have focused on the attitude and behavior towards oral health care in people who were on social assistance in Quebec (6,48,49). The results suggested that public coverage for welfare recipients had major gaps, and Francophones in these studies were strongly critical of the dental
profession. Robinson, Acquah et al. (50) explored the oral health related attitudes and behavior of drug users in the United Kingdom. The study showed that there existed both drug related and non-drug related barriers to oral health care. The drug related barriers included homelessness, prolonged usage of drugs, low self-esteem and the lack of responsibility and commitment to obtain dental treatment. The factors not directly linked to the drug usage were reported to be the lack of availability in dental care and a fear of dentists.

Similarly, a study conducted on low-income British Columbians living in remote regions suggested associations between socio-economic disparities, access and oral health care (8). The study explored access to oral health care services in relation to the availability, acceptability, and affordability of oral health care based on the Penchansky’s model of access to health care (51). Their results suggested that people on social assistance perceived high needs of dental treatments. The study participants identified dentistry as an expensive service and believed that public insurance programs were inadequate as the allowed coverage was not enough to complete the recommended treatment. Participants also thought that there were not enough dentists available who were willing to accept them. The study results also posed that drug addictions, mental illness, and homelessness among social service recipients were the major issues to tackle for dentists.

In summary, there is evidence that links the close association between homelessness and poor oral health, along with perceptions and behaviors in vulnerable populations with oral health care. Oral health care related perspectives and experiences in access to and use of oral health services among homeless adults is lacking.

2.4 Oral health care providers’ perspectives

The objective in this section of the literature review is to provide the opinions of dentists in administering treatment to homeless adults. This review uncovered beliefs and perceptions that could affect the provision of care.
2.4.1 Attitudes and behavior of dentists

Several studies have addressed the providers’ perspectives and experiences in delivering services to poor people including homeless adults (52–56). In general, the studies have reported the resentment of service providers regarding poor patients and patients on social assistance, but others suggest an empathic attitude by dentists towards poor patients. The study conducted in France to understand dentists’ perspectives on poverty and their experiences with people on social support, suggested that dentists had major problems when such patients missed their appointments (53). The dentists related missed appointments to: i) a *therapeutic failure* as an inability to provide treatment; ii) a *system failure* as renouncing the oral health care opportunities offered by the public oral health system; iii) a *relationship failure* as the lack of recognition between dentist and patient; iv) a *financial failure* as dentists could not earn money when the patients missed appointments; and v) a *personal failure* as dentists felt discouraged to treat such patients. The dentists who experienced such failures repeatedly tended to avoid administering care to poor people on social assistance. In another study, eight dentists working in poor areas in Montreal were interviewed about their approaches for treating people living in poverty and addressing their needs (55). The study showed that dentists developed a socio-humanistic approach in order to understand patients’ social context, took time with patients and showed empathy, avoided moralistic attitudes, overcame social discrimination, and favored direct contact with patients.

A recent study in Montreal also showed that dentists had negative experiences with people on social assistance (56). These bad experiences were related to organizational issues such as appointment scheduling, and inability of dentists to provide adequate treatment because of the limitations of the public insurance; poor patients opted for extractions that were covered. The study concluded the dentists were frustrated with such a system. Moreover, the perceived lack of motivation among people on social assistance towards improving oral health was another perceived disappointing issue for the dentists. The study also suggested that the dentists did not perceive people on social assistance as lucrative patients.
because the government payment rates did not follow the fee guidelines established by the professional organizations.

Another study in Montreal showed that the dentists could have two different perspectives about people on social assistance (54). One perspective nurtured empathy towards poor patients and was explained as a socio-life-course perspective. According to this perspective, the dentists acknowledged that the poor people became distressed and powerless due to structural rather than individual factors. The other perspective emphasized an individualistic and dominating perspective among the dentists. According to this perspective, the dentists felt that the present situation of poverty for an individual was due to his lack of capabilities and negative attitude towards work. This study emphasized that the care relationship between dentists and vulnerable patients can be either enhanced or impeded depending on the kind of perspective dentists hold towards vulnerable patients.

### 2.4.2 Policy makers’ efforts

During the past 30 years, Canada has experienced a continuous decrease in expenditures for publicly financed oral health care (57). BC has responded to the challenges in access to oral health care by initiating limited public dental programs and supporting non-government programs in the areas of greatest needs, specifically among children of families receiving income assistance (36,37). As of 2014, the Ministry of Social Development and Social Innovation in B.C. provided $1000 over two calendar years for persons with disabilities; $1400 over two calendar years for children of families receiving income assistance; and emergency dental services to relieve pain for the adults receiving income assistance (36). In addition to the provincial dental programs, the Vancouver’s Public Health Dental Program provides some limited dental services and education to pregnant women and adults with developmental disabilities (58). This program offers dental hygiene program externships and student public health rotations through Vancouver Community College. Through this program, the agencies working with people with developmental disabilities provide resources on oral health to dental
professionals. All other adults are referred to either reduced fee dental services or private dental services.

The reduced fee dental services are offered by community dental clinics (CDCs). Community dental clinics have emerged in BC to serve oral health care to those with low incomes (37) and provide basic and emergency dental services to poor people by scheduling appointments and offering emergency walk-in services. Many CDCs are managed by local non-governmental organizations, which also provide other services such as shelters, food, employment services, among others. Therefore, CDCs are sometimes integrated with other health and social services. There are two models of oral health care delivery by CDCs: volunteer charitable clinics and not-for-profit clinics (59). While the volunteer services offer services limited to teeth extractions, not-for-profit clinics offer treatments that are more comprehensive. However, there are concerns about the sustainability of these clinics under an extensive demand for care with limited financial support from health authorities or government strategies (59).

At a national level, the office of the Chief Dental Officer provides policy directions in the field of oral health care across Canada (17). In 2007, the President of the Canadian Medical Association (CMA) suggested that Canada’s health policy should include universal coverage for oral health care (60). The Canadian Dental Association (CDA) has also recommended a “dental safety net” for all disadvantaged Canadians (17). The CDA urged the federal government to pay attention to dental health care by improving its traditional policy direction of only targeting specific vulnerable groups, particularly children (17). Many public and private oral health care policy stakeholders have been publishing reports related to access in oral health care in Canada and question the future of oral health (61). In a report by the Canadian Centre for Policy Alternatives, it was queried that, “a strange truth of Canadian public policy: the care of our lips, tongues and throats is fully covered by public funding, but not our teeth and gums” (61). The Canadian Academy of Health Sciences recognized that the existing public resources for oral health care may not be enough to meet the current needs and may not be directed towards those in the greatest need (17).
2.5 Summary

The scholarly literature related to homeless people reviewed in this chapter provides evidence regarding oral health and oral health care among homeless adults, the attitudes and behavior of the oral health service providers, and the policy efforts towards addressing the issue of access to oral health care. It is limited in terms of homeless adults’ descriptions of their experiences with the oral health care system, particularly their viewpoints on those experiences. Review of the literature illustrates major inequities in oral health and oral health care among vulnerable groups in Canada. Compared to the rest of the population, homeless people exhibit a greater need in oral care amidst all the challenges associated with homelessness. Other vulnerable populations, such as low income people, people on social assistance, immigrants, and drug users are also less likely to have dental insurance, more likely to consult dentists only in emergencies, and more likely to have oral problems such as gum diseases, dental decay, dental pain and missing teeth. The literature review indicates the challenges for homeless people to access and practice oral health care and there remains a lack of studies that address homeless adults’ self-perceived oral health experiences. An opportunity exists to add to the body of knowledge related to homeless adults’ perspectives and experiences with access to and utilization of oral health care.
3. Conceptual Framework

The aim of this chapter is to present the theoretical framework used in my study. The aim is not to generate a new theory or to modify the existing theory, but to advance the knowledge about the oral health care related perspectives and behavior of homeless people by applying the existing theory in the oral health care scenario.

3.1 The theoretical framework

The Gelberg-Andersen Behavioral Model for Vulnerable Populations (BMVP) served as a general guiding framework for this study (62). The Behavioral Model of Health Services Utilization was developed with the aim to understand why people use health care services, to measure access to health care, and to assist in the development of policies that can promote the access to health care (63). This behavioral model has been revised to address the needs of vulnerable populations. The model is based on Andersen’s theory of health service utilization and is a function of three domains: 1) predisposing factors (e.g., familial and individual characteristics such as substance abuse, mental illness, etc.); 2) enabling factors (e.g., the resource distribution such as public benefits, transportation, etc.); 3) need factors (e.g., the perceived and evaluated need for professional health care).

Figure 1 shows the concise version of the BMVP to represent the conceptual framework used in this study. It is the heuristic tool used to develop the interview guide used for prompting the description of oral health care experiences by the homeless participants.

The BMVP has been used in several studies that have examined access to health care services among homeless adults (64–66). Results from those studies indicate that the different factors under the domains of predisposing, enabling, and need factors facilitate or hinder access to health care services and determine the utilization of health care. These factors also influence the experiences of homeless adults...
while accessing, and during the time of actual utilization of oral health care services. The enabling factors in the BMVP were related to a more general concept of an access to health care system (51).

Figure 1. Conceptual framework of oral health care related behavior adapted from the Gelberg-Andersen’s BMVP

Access to health care resources was defined as a ‘fit’ between people and a health care system and those similarities also apply to the oral health care system (51). There are the five ‘A’s of access defined by Penchansky: availability, affordability, accessibility, accommodation, and acceptability (51). These ‘A’s are related to the enabling factors defined in Gelberg-Andersen’s model. According to Penchansky, “It [access] is related to but not identical with the enabling variables in the Anderson model of the determinants of use, a model which includes variables describing need, predisposing factors, and enabling factors” (51).

The five “A”s are defined as: i) access to health care in terms of availability of health care providers was conceptualized as the willingness to administer treatment to vulnerable patients. There can be a presence of many dentists in a particular area but it is important from an accessibility point of view whether these dentists accept or refuse service provision to vulnerable patients; ii) affordability is understood in terms of whether a patient has enough finances or insurance to cover the costs of dental treatment; iii)
accessibility refers to the ease in access and availability of services in oral health care in the area. Accessibility takes into account transportation resources, travel distance, cost and time; iv) accommodation is understood as the organizational issues such as appointment scheduling, hours of operation, walk-in facilities, telephone services etc.; and v) acceptability refers to the relationship between patients’ attitudes towards providers’ characteristics, as well as the acceptable characteristics of patients to the providers. Provider attributes refer to the age, sex, type of facility, or religious affiliation. For example, the literature showed that Punjabi older immigrants and Chinese immigrants do not accept the western oral health care system due to cultural reasons and their belief in traditional herbal medication (45–47,67) In turn, providers may have preferences for certain attributes or financial mechanisms and may be unwilling to provide services to certain types of people such as welfare patients (56).

3.2 My theoretical assumptions for the study

My approach to this study begins with recognizing my presuppositions about the topic of this research. By presuppositions, I mean my beliefs and my attitudes towards experiences in oral health care by homeless adults. As a practicing dentist, I had been engaged in community-based volunteer oral health care services to poor people including homeless adults for about ten years. My close association with such vulnerable people influences my observations and interpretations of those observations. As a researcher, I seek to locate these interpretations within the dental literature and the theories of use of oral health care.

Assumptions based on the review of the literature and personal experiences as a dentist highlight that:

• Health service utilization is a function of a predisposition by people to use health services, factors that enable or hinder such use, and people’s need for care (63).

• The factors that make homeless people vulnerable might also affect their use of health services and their health status (63).
- Homeless people with more competing needs are less likely to have a regular source of care and are more likely to perceive barriers to obtaining care (63).
- Homeless people have more self-perceived oral health care needs as contrasted with persons who are not homeless (68).
- Health inequity is unfair and systematic, it is produced socially, and yet, it is modifiable (69).

Other assumptions:

- The study participants gave accurate information during the interviews.
- The interview protocol used in this study elicits responses appropriate to the objectives of the study.
4. Methods

4.1 Introduction

This chapter discusses the methods used to conduct this research. The information starts with brief sections on the settings for the interviews, the sample size, the time of the study, and the ethical approval. It is followed by the sections describing the data collection procedures such as the recruitment of participants, inclusion and exclusion criteria, obtaining informed consent, and conducting interviews. The last section discusses the data analysis including the general qualitative approach and the steps in generating themes.

4.2 Description of the preparation

4.2.1 The settings

The Downtown East Side (DTES) area of Vancouver was chosen to recruit the study participants because most of the homeless adults of Vancouver reside in this area. The study was conducted during the September to December 2014.

4.2.2 Participants

There were 25 homeless men and women, including Aboriginal peoples, chosen as a purposeful sample out of the homeless population in the DTES area.

4.2.3 Ethics

The study was approved by the Behavioral Research Ethics Board of the University of British Columbia. The study was conducted in the ethical way and for that reason the following challenges were addressed: Vulnerable populations: It was acknowledged that the label ‘vulnerable’ could be patronizing and insulting. Homeless individuals might be vulnerable because of their mental problems or situational characteristics. The research relationship could be unequal, but it was admitted that the homeless adults have unique strengths because they might be survivors of difficult situations. I tried to be polite and
sympathetic and did not restrict responses and spontaneity. The participants’ concerns were listened with sincere interest and concentration.

Informed consent: The participants were provided information about the study objectives and the potential risks and benefits to the individuals, groups, and community of homeless adults. Each participant was required to sign a written consent before taking part in the interview. There was no imposed rush on the participants to make any decision regarding participating in the study. The participants were free to pose any questions and discuss the study before they considered whether or not to participate.

Harm to the participants: There were no known physical or social risks for the participants involved in this study. Psychological distress might have occurred among the participants who had a negative experience with the oral health care services. The participants were given time to express significant emotions and such responses were acknowledged sympathetically. The protocol was to terminate the interview if the participant felt too distressed.

Assuring optimal confidentiality: Participants were assigned codes, like A-Y, to identify them. Once the study analysis had been completed, the audio-recordings and all electronic and paper forms of data were secured by the research supervisor at UBC.

Harm to myself: The literature suggests that there are often chances of researchers getting burned out by the lives and experiences of their research participants (70). It was ensured that I had a network of compassionate service providers who were working with the homeless individuals and could support me as well.

Also considering my physical safety, I planned to conduct the interviews inside of a controlled, and safe institutional setting such as a meeting room in the Yukon Shelter and in the Living Room of the Look-Out Society outreach office in Vancouver (See Section 4.3.1 for details).
4.3 Data collection

4.3.1 Recruitment of the participants

My research project was interviews based, therefore I was the main instrument of data collection. It was difficult and a challenge for myself as a female student to approach homeless adults on streets, parks, or other undesignated areas. Therefore, both homeless men and women were recruited with the help of an identifiable and distinguished outreach agency within the DTES. This agency, the Lookout Society, was informed about the study objectives. The Lookout Society’s core services of programs include crisis intervention, counseling, outreach, food and temporary housing. These programs are offered at the three places - The Living Room, the Al-Mitchell Place, and the Yukon Shelter. The Living Room Drop-in services include medications administration program, food and clothing supplements, and social activities such as games and trips. Al Mitchell Place Shelter and Yukon Shelter provide temporary beds and find sustainable housing options for its clients.

I met with the managers at the Living Room, the Al-Mitchell Place, and the Yukon Shelter and provided them a written information sheet about the study objectives and methods, interview guide, and ethical considerations including the consent form. I was informed about the rules and regulations to use their facilities, the bug control protocol, and the strategies to communicate with the vulnerable clients.

The intention was to recruit the study participants based on the purposive sampling, and the purpose was including participants of different age groups, of all sexes, having aboriginal status, and having different dental insurance status, but due to the complex behavior and multiple barriers such as drug abuse and mental illness, homeless people tend not to engage in case management or outreach services (71). As such, the recruitment process was initiated with the convenience sampling technique. As the data were collected, the sampling strategy changed from largely convenience to a more purposeful framework to include variables such as age, gender, Aboriginal status, and the dental insurance status. I changed the sampling strategy after first few interviews as many participants were available with the help of staff at the Lookout Society. Age and gender were considered in order to include the data of a range of
demographics. Aboriginals might have different perspectives and experiences influenced by their dental coverage. The dental insurance status differs among homeless adults depending on their disability status and eligibility for the Pensioners' Dental Services Plan (PDSP) (36).

The inclusion criteria for participating in the study were that the participants: a) be 19 years of age or older, b) are homeless, c) have the ability to communicate in English, and d) are oriented to time, place and person at the time of the interview as assessed by the pre-interview communication with them. During this communication, the participants told their names and talked about the Look-out Emergency Aid facility where we were present at the time of interview. Their orientation to time was judged based on the fact that they showed up at the time of their appointments for the interviews.

With the consent of the Lookout Society, I posted the posters containing information about the study (Appendix A) at the three study sites. Interested participants contacted the staff at the selected sites. Some of the participants provided their phone numbers so that I could contact them to discuss their availability for the meeting. The staff made a list of the interested participants and informed them that I will be visiting the Living Room Drop-in Center every Monday and Thursday and the Yukon Shelter every Wednesday. I collected the information about the interested participants from the staff and visited the facilities on the designated days. I met with the interested participants and informed them about the study objectives. The time and place of interviews were fixed as per our mutual agreement. Only one woman was excluded from interviewing because she could not communicate in the English language.

Before starting each interview, the participants were provided detailed information about the study objectives. They were given a consent form (Appendix B) to sign indicating that they understood the information about the researchers, the study objectives, the interviews, and the related ethical considerations. All the participants gave informed consent and received $30 upon completion of each interview. The remuneration of $30 was meant to compensate the participants for their time. Each interview lasted 20-45 minutes and was audio-recorded for the purpose of assistance in the analysis process.
4.3.2 Interviews

The study is based on the individual interviews with 25 homeless participants who were interviewed within one and half month of their recruitment in the study. I conducted all the interviews. To stay focused and not deviated from the study objectives, an interview guide (Appendix C) was prepared considering the Gelberg-Andersen’s Behavioral Model for Vulnerable Populations, and other studies addressing similar research questions (8,31), e.g., the questions “How important to you is taking care of your dental/oral health?” and “How do you maintain your dental/oral health?” were conceived considering the ‘Health Behavior’ characteristic in the model. Similarly other questions were prepared considering the other characteristics of the model such as ‘Predisposing, ‘Enabling’, and ’Need’ factors. The interview guide was discussed with the research supervisor before starting the actual interviews. The interviews were started and progressed according to the information provided by the participant in each question. During the entire period of each interview, careful attention was paid in listening to the participant, maintaining eye contact and responding sympathetically to his/her concerns.

4.4 Data analysis

A method of thematic content analysis as has been described by Philip Burnard (72) was used to develop a detailed and systematic documentation of themes and linking these themes together under a reasonably exhaustive system of sub-themes. The analysis process started with transcribing the first interview which revealed that the information provided by the first participant contained uncertainties and need more information on certain aspects e.g., what is it that restricts the participant to communicate with dentist. Therefore the interview guide was modified for the next interview through a process of constant comparison (73) to explore this new information that emerged from the preceding interview. Modification to the interview guide was carried on constantly after each interview and led to the purposeful selection of participants in further interviews. Repetition in participant responses appeared
after twenty interviews; therefore it was decided to conduct a few more interviews to make sure that the state of saturation was achieved (74). The data collection process was terminated with 25 interviews. The process of data analysis is outlined as a step-by-step method as follows:

Step 1. I made short notes after each interview to memorize myself what were the main concerns talked about in that interview and how those concerns were linked to or deviated from the study’s theoretical assumptions. e.g., Among many other concerns, the first participant asked me about the place where the oral health care services be accessed beyond what the free dental clinics offer. I wrote down in my memo after this interview:

“The felt need to access the extended oral health care services indicates person’s perception of limiting current oral health and lack of knowledge about the available oral health care resources.”

Similarly other memos helped me think about the other major categories such as impact of oral health, communication with dentists, fear of visiting dentists, etc.

Step 2. I read the transcripts thoroughly and made notes on general themes. the examples of such notes are:

“There are some positive and lots of different kinds of negative experiences with the oral health care being described in these interviews,

“A major theme of experiences with oral health service utilization seems to be emerging out of these descriptions”

Step 3. I read through the transcripts again and wrote down codes for all the meaningful aspects of the descriptions in all the interviews. By meaningful aspects, I mean I excluded the issues that were unrelated to the topic of oral health and oral health care. Table 1 shows an example of such free generation of codes or open coding from the interview transcripts.
Table 1. Example of open coding

<table>
<thead>
<tr>
<th>Interview Transcript</th>
<th>Open coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need to access services. I realize that I need help, well I realize that I need extended services beyond just the free clinic, because I already got my teeth checked at the free clinic, but I need services beyond that. They [Dentist] couldn’t provide me a whole lot of information and I was unsure too what kind of question to ask. It was kind of ‘in one door and out the other. They just examined my teeth and told me what needs to be done, what I should do and then that was it. I would like you to look if you could provide me more information about where I could go for partials where could those be made up, to see how often I am covered</td>
<td>Need extended services.....</td>
</tr>
<tr>
<td></td>
<td>Couldn’t provide me a whole lot of information.....</td>
</tr>
<tr>
<td></td>
<td>Where I could go.....</td>
</tr>
<tr>
<td></td>
<td>How often I am covered.....</td>
</tr>
</tbody>
</table>

Step 4. I contemplated the list of open codes and looked for the similar codes. I grouped them together to reduce them under higher order themes and sub-themes. For example the following codes were collapsed into one sub-theme entitled ‘Lack of Knowledge’

- I don’t know where to go.
- How often I am covered.
- I wouldn’t know right now.

Step 5. I requested my supervisor to generate themes and sub-themes independently. We discussed the two lists of themes and found that my thematic analysis was reasonably complete and accurate. We made some adjustments and devised a finally agreed list of themes and sub-themes. This process helped the system of analysis having some internal validity.

Step 6. I read the transcripts again in order to make sure that my list of themes cover all the aspects of the interviews.

Step 7. Each transcript was coded according to the themes and subthemes. These headings were identified on a computer using a coding scheme with the help of a word-processor as shown in Table 2.
Table 2. Thematic scheme of each transcript

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Sub-theme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oh man, it is really important. Because if you lose your teeth, you can’t eat properly. You will have to get dentures, you will have to go through pain.</td>
<td>Importance and Impact</td>
<td>Perspective on oral health and oral health care</td>
</tr>
<tr>
<td>As far as I can think that far back I haven’t had any experience like that as yet. It’s always been good so far. My experience and everything has been good. I haven’t had any bad so far, keep my fingers crossed.</td>
<td>Positive</td>
<td>Experiences with oral health service utilization</td>
</tr>
</tbody>
</table>

Step 7. Each coded section of the interviews and all items of each theme and sub-theme were collected together for a direct reference during writing up the findings.
5. Findings

This chapter describes the demographic information of the study participants and the outcomes of the thematic analysis in the oral health care related perspectives and experiences of homeless participants.

5.1 Demography

The participants in the study (Table 3) ranged in age between 31–64 years, with a mean age of 55 years and 18 were males. Within the 25 people participating in the study, eight participants identified themselves as Aboriginals of Canada. Seventeen participants reported they had been receiving disability benefits.

Table 3: Specific characteristics of 25 homeless participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>25-54</td>
<td>13</td>
</tr>
<tr>
<td>55-64</td>
<td>12</td>
</tr>
<tr>
<td>Aboriginal</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
</tr>
<tr>
<td>Disability status</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>17</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
</tr>
<tr>
<td>Self-rated oral health</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>4</td>
</tr>
<tr>
<td>Fair or Poor</td>
<td>21</td>
</tr>
<tr>
<td>Accessed emergency departments for oral health</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
</tr>
</tbody>
</table>
Twenty-one participants rated their oral health as poor or fair, and four participants rated their oral health to be good. Eight participants reported to have used emergency departments for oral health problems

5.2 Themes

The findings of the study are presented within the four themes that emerged from the participants’ descriptions of their experiences in accessing and using the oral health care system while being homeless. Examples of participant statements are provided with corresponding themes as a means to describe the decision trail leading to the development in the conclusions from the study.

The themes that emerged from the analysis are: 1) Experiences With the Oral Health Service Utilization, 2) Perspectives on Oral Health and Oral Health Care, 3) Perceived Barriers to Access Oral Health Services, and 4) Suggestions for Preventing Oral Health Problems and Enhancing Access to Oral Health Care. There are several sub-themes in relation to the above themes. All the themes and sub-themes are shown in a pictorial view in Figure 2. The themes are represented in four white boxes and the sub-themes are represented in the yellow boxes.
Experiences with oral health service utilization

Positive

Negative: Distrust Disrespectful Greedy Cruel Discriminatory Incompetent

Cost of Care

Disabilities

Lack of motivation

Lack of availability of dentists

Lack of knowledge

Lack of contact information

Perspectives on oral health and oral health-care

Importance and impact

Coping strategies

Perspectives on accessing dentists versus accessing physicians

Regular dental visits

Current state of oral health and unmet needs

Suggestions for preventing oral health problems and enhancing access to oral health-care

Diet

Communication with dentists

More generous public oral health insurance

Dental outreach programs

Promoting knowledge of community dental clinics

Figure 2: Thematic map
Theme 1. Experiences with oral health services utilization

This theme describes the experiences of the study participants while using oral health care services under the following sub-themes.

a. Positive: Some participants described positive experiences in the past, but also believed that they should not be critical of dentists because dentists are the professionals. When asked to describe the dental visit that did not go well, one of the participants explained,

“As far as I can think that far back I haven’t had any experience like that as yet. It’s always been good so far. My experience and everything has been good. I haven’t had any bad so far, keep my fingers crossed. We can’t actually go and start questioning them because it depends on who is the dentist than anything else. I just said could you do my teeth? I just keep it to myself, stuff like that. Hearing me questioning them because they are doing bad job type of stuff. But it’s just not very fair. But I always say that just don’t say anything because it is better because that way that person gets respect especially the doctor or nurse, whoever is doing my teeth.” [Participant W]

Another participant explained,

“They are pretty professional there. They couldn’t provide me a whole lot of information and I was unsure too what kind of question to ask. It was kind of ‘in one door and out the other’.” [Participant A]

b. Negative: Most of the participants experienced disappointment with their use of oral health care services. These negative experiences were described from several perspectives including dentists being cruel, disrespectful, distrustful, discriminatory, greedy, and incompetent. Apart from their descriptions about the negative experiences with the dentists, many participants were also disappointed with the attitude of service providers in the emergency departments of hospitals.

Cruel: Many participants recalled being treated with non-caring and cruel attitudes by dentists. According to one participant,
“No anesthetic, no, nothing, just, “Oh, you got a sore tooth, okay, come in, and let me rip it out” and then they say “oh, go, cry somewhere else.”.” [Participant B]

Another participant alleged,

“You know if you say it’s not enough freezing, they are like, “oh no no don’t worry,” they just pull the tooth out, you know? They say, “Don’t worry, quit being like a baby.”.” [Participant Y]

**Disrespectful:** Participants felt they were not treated respectfully when they visited dentists for dental problems, as one participant put it,

“I had an abscess and I went to my doctor first and he called the dentist right next door and the receptionist was like, “Oh! You people only come in when your teeth are hurting.” And she said, “Well! Probably [we should] pull out all your teeth.” She was not nice and I walked out. I told my doctor she was not very nice and that was just the receptionist. So I did go back and she was like little bit better. She already wrecked it by saying, ‘you people’, and the dentist wasn’t any better than her. He was like, “We are just gonna pull out all your teeth, not today, two or three at a time.” They didn’t tell me why, and then when he pulled out the three and told me to come back next week and I never did.” [Participant J]

Another participant explained his resentment,

“There is a stigma attached to the way we look after our teeth but the whole history of teeth and gums is not asked or explored by dentists sometimes and sometimes a doctor would just go, “Oh! Crooked tooth, look.” They judge us by the teeth they look outside. They don’t look at other features that may include as to what is the reason. It’s frustrating” [Participant H]

**Distrustful:** Many participants reported having distrustful experience with the dentists. One participant said cautionary,

“I went there once, he ripped that out, ripped that out. I left. I just got up and walked out. I had big ball stuffed in my mouth. I just got up, grabbed my jacket, and walked out. Hey! Come back, come back. I said, go hell with you, I am not coming back. You have to be careful because when
they clean your teeth, they get x-rays, and now suddenly might want to do something. The guy in a chair [sound of a running machine], and now before you know and you are sitting in a chair, blood is coming out and you get your teeth ripped. They have to be honest.” [Participant F]

**Discriminatory:** Being discriminated was another facet of disappointment described by the participants. Mostly people on disability or the members of First Nation reported suffering from dentists’ discrimination. One participant suffering from AIDS put it,

> “Some dentists don’t like it (to see patients with AIDS), I understand that. The bottom line is that, that is their trade. HIV used to be life for anyone but now it’s chronic and controllable. It is scary and I can’t blame them.” [Participant E]

Another participant who had been suffering from cancer said,

> “They won’t take you, they just flat out tell you, “no, no, we don’t accept people on disability.” I would do the phone book pretty hard to find someone who would take someone on disability. Some people would but they would charge you more, other people just flat out, you know? They might want to laugh at you on phone, “Uh! What?”.” [Participant K]

Some Aboriginal participants thought that they had been discriminated by dentists because of prejudicial comments and actions towards them. One of them expressed,

> “Dentists should treat everybody equally, no matter what color, what kind. If they are purple, treat them like they are blue instead of categorizing.” [Participant J]

Another First Nation participant stated,

> “She [the dentist] is prejudice. She looks down on everybody, “you don’t have white skin, you are not good enough”. But the old Chinese guy, he has been there, so he doesn’t look at skin color.” [Participant C]

**Greedy:** Some participants’ experiences with dental services constituted greediness exhibited by the dentists. One participant felt that his dentist had a business first attitude,
“He had very cold manners, like business first. He insisted on paying first before they work. I don’t know but he did.” [Participant H]

Another participant explained,

“Just doing their job and pushing you out of the door, you know what I mean? Counting their money” [Participant Y]

**Incompetent:** A high number of the participants experienced inappropriate services rendered by dentists. Their experiences included: improper anesthesia, erroneous treatments, and negligence. One of the participants recalled her dissatisfaction,

“It takes a long time for freezing to work for me and they are impatient, time is money, so they just froze me more and I ended up being frozen down here and here and then it froze like Calgary ice. I flew all the way home from that freezing that he [dentist] gave me because he was in hurry. If he would have waited for 10 minutes, the first freezing would have worked just fine.” [Participant K]

Another participant perceived his experience related to improper anesthesia as,

“In the past one time the dentist gave me freezing and hit the nerve with needle and my whole face went on fire like that caused me a lot of anxiety while I was at the dentist. So this is the thing that I don’t like, just don’t like dentists.” [Participant S]

The experience related to the erroneous treatment was described by one of the participants as,

“They hastily did it, because, you know why I know it was hastily done? Because the lower part they did in such a way that they left chips in my mouth. I had to go back for it. I told them, “before you fit me a denture, there are still chips in my mouth and they are starting to grow around nerve in the chips. They said, “Oh my Goodness! Look at this.” The students need to do more practice. The students didn’t do it right.” [Participant H]

Another participant explained her experience due to dentist’s negligence,
“I got my teeth pulled out, I still have chunks of teeth left in my mouth. My dentures, they gave me wrong, somebody else’s dentures. Actually, I asked him [dentist] to fix them [my own denture] and when I went back to get them, they gave me somebody else’s. So it caused a bone infection in my mouth and it went through right into my throat….. My mouth looked like a monkey. It was so swollen. Oh! It was terrible. So I don’t know what to expect anymore.” [Participant N]

Most of the participants believed that their disappointing experiences with dental services were related to the dentists being inexperienced or just graduated. The descriptions were put as follows,

“They got one [dental clinic] at the Native health but those were the students, learning or something…..I went to check it out. They have actually done no right.” [Participant L]

“The dentist did not remove my teeth. He had student working on my teeth…..They hastily did it, because, you know why I know it was hastily done? Because the lower part they did in such a way that they left chips in my mouth. I had to go back for it. I told them, “before you fit me a denture, there are still chips in my mouth and they are starting to grow around nerve in the chips. They said, “Oh my Goodness! Look at this.” The students need to do more practice. The students didn’t do it right.” [Participant H]

Many participants reported that they had visited emergency departments in hospitals for dental problems where they received palliative treatment. Some of them were also disappointed with the attitude and the services received in the hospitals. A respondent suffering from a chronic disease described his experience as,

“They looked at my mouth, oh! The guy was like, “look at that mess in there”, I said, “Excuse me, why are you saying like that besides you don’t care about me.” He said, “You don’t care about your teeth.” I said, “Excuse me, you don’t know where I am going to and what’s going on.” He said, “We cannot help you here with this. We can help you with pain, that’s it and we will give you that.” That was not good. It was good for four hours and then I waited over four
hours in hospital just to get out of there. I felt like I didn’t mean anything to them.” [Participant H]

In summary, this theme related to homeless participants’ experiences with the actual utilization of oral health care services describes the nature of their resentment with the dentists and the services provided by them. The next theme presented is related to homeless participants’ experiences at the point of accessing oral health care services—described barriers to access oral health care services as perceived by the participants.

**Theme 2. Perceived barriers to access oral health services**

Almost all of the participants experienced difficulties accessing oral health care services at one or more times in their lives. The main barriers to access oral health services as perceived by the participants were classified under six sub themes as follows:

a. **Cost of care:** Majority of the participants felt that the oral health care services were costly and they could not afford them. They perceived that going to a dentist would mean they would have teeth extractions and they did not wish to lose their teeth. Participants wanted to keep their teeth for as long as possible. They also determined having minimal financial resources they could not get the appropriate treatment but only extractions. One participant who currently had no dental insurance and waiting for his disability status to be approved said,

    “It is hard, very-very hard. You go there and see if you don’t believe me. It’s very hard. I experience this because there are not lots of resources here. You don’t find in church people coming with good quality voice that sings for free, same is with dental, you won’t find a good dentist, good quality, educated doing service for free, do you see? So it is hard, I can’t afford to go [to the dentist].” [Participant O]

According to another respondent,
“There is no financial way that I can save them what’s left in there, it is just coverage is not there. I would need caps and all kinds of things are expensive.” [Participant S]

The participants who currently have dental insurance also reported problems accessing dental services in terms of restricted services allowed to them. Neither the Aboriginals nor other participants who had dental insurance (currently on welfare) were contented with the scope of oral health care services accessible to them. A First Nation person alleged,

“They [service providers] say I am only allowed three extractions a year because I am First Nations and the government says you can only do so much and…, that was really up to the government what happens.” [Participant B]

Another participant reported,

“Its just coverage, the coverage is not enough. Like years ago I had root canal, but I could not finish it because I finished my limit of coverage and I was losing my tooth.” [Participant S]

b. Lack of motivation: Participants were also not interested in visiting a dentist. There was a description about lack of the desire to do so. One participant said,

“It’s my motivation, I know I’ll get around to it.” [Participant L]

Another participant described,

“I am very able to go. The access is available, it’s only my hindrances that stop me, yeah, personal hindrances.” [Participant R]

c. Lack of contact information: Participants reported having problems accessing oral health services while being homeless; they also experienced miscommunication. One participant reported,

“There were some skips of the appointments which I didn’t know about. At that time I didn’t have phones or no contacts. By the time, I got the letter, it was too late. Everything gave up on me. I went there to try to straighten everything up. They said they don’t want to see me anymore because due to miscommunication.” [Participant C]
d. Lack of availability of dental services: Lack of availability of dentists in general and of emergency oral health care services outside regular dentist office hours in particular were also reported as a hurdle to getting proper oral health care. According to one older adult participant,

“Dentists only work Monday to Friday. If you have bad tooth ache or abscess on week-end, you go to St. Paul or VGH [Vancouver General Hospital], they have dentists there. I guess they are better than the dentists down here. They have to be because they are needed seven days and 24 hours.” [Participant F]

A participant suffering from a chronic disease reported:

“I know dentists going to communities and offering free services and there are some places we can go but this is minimal, you know this is not the general population. I mean there is parents living in the British properties, in West Vancouver, in the north, the upper middle class area where their children are getting treated properly, sure their parents can afford it, so it is the expense [money] they (dentists) want to have.” [Participant T]

e. Disabilities: Disabilities were described as another facet of impediment for some of the participants. One participant suffering from a mental illness mentioned,

“My mental health gets in the way a lot. The anxiety from when I have an episode about to start. That’s all about it.” [Participant R]

Another participant requiring a wheelchair raised mobility issues when asked about what was it that made it hard for him to see a dentist.

f. Alcohol abuse: Abusing alcohol hindered the participants from accessing oral health services. A middle aged participant reported,

“Because I drink a lot. I drink usually to excess every day. I drink till I am drunken and pass out and then wake up and then do it all over again.” [Participant B]

Another participant explained,
“I drink too much. That’s the truth. I mean I was too hung over, I might puke or I am busy partying. That’s an issue for different parts of my life. That’s why I kind of missed my last appointment.” [Participant K]

g. Lack of knowledge: Other participants did not know where to go to attend to dental problems because they did not have a regular dentist and some were afraid of entering a dentist office others have had a bad experience in. One participant explained,

“I don’t know unless I have some better place to go, I’m gonna look into that and see if they can work with me and if they can’t then I’ll be looking for another place to go, right? Because I got to talk to people first and say this is my situation and I am n disability, I have low income, I can’t afford too much and if they can work with me then I can get the dental work done. If they are like, “oh no, no, no”. Then I will be like, oh forget it, I’ll walk and I’ll find someone else.” [Participant U]

In summary, the above two themes provided the participants’ experiential descriptions about their access to and use of oral health care services which shaped the way they perceive oral health and oral health care.

Theme 3. Perspectives on oral health and oral health care

This theme emerged as a description on homeless adults’ perceptions in the current status of oral health and unmet needs, the importance of oral health to general health, the coping strategies in dealing with oral health problems, the perspectives on visiting dentists regularly and on accessing dentists compared to accessing physicians. This theme was classified under the following sub-themes:

a. Importance and impact: The majority of the participants reported that oral health was really important for them but not when they were younger. As such, they did not look after their oral health. One participant sounded regretful to not acknowledge its importance earlier,
“It hasn’t been important to me, it cost me. Now I am like this, this is really important because you can actually get diseases. I was not taught to take care of my teeth. If I would have cared of my teeth and didn’t do bad jobs, but I can’t change that, that makes me sad.” [Participant J]

Some participants had a viewpoint that their current behavior towards oral health was related to the behavior they learned during childhood. According to one participant suffering from cancer described,

“Probably my mom started that and gave me the braces before when she didn’t have a plan to cover. She paid cash, right? I think you learn those lessons when you are little. Because even when I had no money and I had nothing, I still made a point of going to see a dentist, so I think you learn that stuff when you are little.” [Participant J]

In response to the question regarding the importance of oral health, participants commented on a variety of entities, such as eating, smiling, talking, comfort, and general health. One of the respondents said,

“I experience pain and there is lot of food that I can’t eat or chew….. I am insecure about it. I feel insecure. I don’t smile as much as I used to.” [Participant S]

Another respondent put it,

“It is hard to eat stuff … I can’t chew on things and I can’t bite things off. I got to rip up food to eat it. I feel shy, I don’t talk to lot of people because I have no teeth in my mouth. I know I make different sounds and miss some. I am kind of embarrassed about it.” [Participant V]

Another young adult said,

“I realize that I need to concentrate severely on my dental health because it can give me heart attack. If you don’t keep your dental health at the highest level, it can lead to even cancer of mouth, tongue and also the throat.” [Participant H]

For some of the respondents, keeping good oral health was not important because of other stressful conditions and circumstance in their lives. One person responded,

“Not very important, because my son died and I gave up. I quit living.” [Participant B]
b. Current status of oral health and unmet needs: Most participants perceived having poor oral health and felt the need for better oral health care services. According to one woman,

“Very bad. Oh yeah, I still have chunks of bone coming out (after extractions)” [Participant N].

Another participant described,

“I get dryness of my mouth all the time and I don’t know what’s causing it. When I try to brush the bottom part..., they bleed a lot. I got sensitive gums. There are no teeth on the top, they all got pulled out.” [Participant C]

There was a perceived need for oral health care services by many of the participants. One Aboriginal participant described,

“I need to access services. I realize that I need help, well I realize that I need extended services beyond just the free clinic, because I already got my teeth checked at the free clinic, but I need services beyond that.” [Participant A]

A woman participant put it:

“I think my gums are okay, but my teeth are not because I have three very large fillings which are put in by dentist when I was quite young. They are all out. So I haven’t good bunch of my teeth from those fillings coming out and I have one that I can tell that the filling isn’t there or I can feel the gap in between my filling and my tooth.” [Participant X]

Another participant reported,

“My dentures are sore. I got dentures, I don’t wear them because it is sore” [Participant Q]

c. Coping strategies: The majority of homeless participants seem to experience poor oral health and need oral health care services. They tend not to visit a dentist. In order to cope with poor oral health and lack of oral care, they tried home remedies, over-the-counter available medicines, visited physicians for antibiotic prescriptions or visited hospital emergency departments for oral problems. The participants put it:
“If I have a toothache or something I take oral-gel or some product from drug store.” [Participant Y]

“If I have any kind of abscess or infection, couple of times I went to doctor and got antibiotics.” [Participant S]

“If I have real bad pain or even abscess, I don’t go to dentist. I just brushed my teeth, take Ibuprofen for couple of days, then pain goes away.” [Participant F]

“If I have to go in emergency, I will go to hospital.” [Participant C]

d. Perspectives on visiting dentists regularly: Most of the participants reported that they did not like visiting dentists mostly due to fear from past bad experiences. One respondent described,

“I have been delaying visiting a dentist because I don’t relish the thought of them pulling my teeth and put dentures in it.” [Participant S]

Another participant was anxious from her past bad experiences with the dental visits,

“I don’t go to dentists. I am scared. They have scared me.” [Participant N]

A participant described why he did not want regular dental visits,

“No, I don’t like to go to dentists. Because when I was really young, I remembered when I went to dentist and it really hurt when they put the needle in, so I ran away and then my mom finally caught me and brought me to dentist, and he called me ‘chicken’. He said, “Oh! You are just like a chicken”, the dentist, that’s why I never like dentists.” [Participant P]

Another participant suffering from a chronic disease explained how she kept on delaying her dental visits because of her uncomfortable experiences in the past,

“They [dentist] told me what I have to get done, but I kind of delayed, in the course I delayed, you know what I mean? I mean it’s something stuck in my head that I will have to get it out, but my childhood fear!!” When asked about her fear, she replied, “It is the way they are, the quickness and roughness they had, you know? Basically it is the equipment they have now, the equipment now a days is lot better. It is more advanced. Like you have wheel chair in which you
can relax, you know what I mean, it doesn’t bother the dentist you go to. They are lot gentler now than they were. They don’t force you put in a solid chair.” [Participant R]

**e. Perspectives on accessing dentists versus accessing physicians:** A majority of the participants thought that it was harder to see a dentist as compared to seeing a physician.

One young adult participant explained,

“It’s harder with dentist. Physicians are all over the place. There are walk-in clinics everywhere, right? Dentists are not like that. It is harder for dentists, more expensive, more specialized field, right?” [Participant V]

A woman respondent’s viewpoint was,

“Doctors are easy to find. Like people here found a doctor for me. But I think I haven’t tried to find a dentist. My guess is it would be way harder because they are super busier than the clinics are. We have walk-in clinics here but I don’t know if there are walk-in dentists here. I don’t know if I want to go to walk-in dentist. I don’t know, may be in emergency. I think it will be harder to find a dentist for sure.” [Participant X]

**Theme 4. Suggestions for preventing oral health problems and enhancing access to oral health care**

This theme and related sub-themes includes the suggestions provided by the participants to prevent oral health problems among them and to improve access to oral health care.

**a. Diet:** Many homeless respondents felt that there should not be any distribution of sweets at the shelters or other food centers for homeless people. According to one of the participants,

“What has to happen here is that they got to stop giving them sweets. That’s all they do down here. They give out sweets. Lots of people don’t take their time, they don’t have the initiative to brush their teeth because they have bad life,” [Participant B]

Another homeless respondent stated,
“There are lots of programs for food, but no milk, no calcium. Lots of carbs, but vitamins are missing, lots of people have vitamin deficiencies, calcium deficiencies, and without potassium bones suffer.” [Participant E]

b. Oral health care outreach programs: Homeless participants thought that there should be dental outreach programs through which homeless people could be contacted and provided enough information about oral health care and resources available for them. A homeless participant was concerned,

“Lot of people have rotten teeth down here and most of them don’t care, because nobody ever said, “Hey, you should get this done.” Nobody comes down. Lot of people need to be taken by their hands and led. Most of them when they are asked, they say, “no, no, no”, they shy away. Because, I don’t know, may be some bad experience in their past and so they automatically say no, and they just shut right down, because they don’t want to live through that again.”

[Participant B]

Another participant suggested,

“What public health center needs to do, personally go in, take a look at their teeth. What we can do in dental outreach is actually people talk to people about oral health. Because people, down here, don’t know anything. Once they don’t know, they are vulnerable. You ask them, “Hey! You know this, you know that”. You get their attention and you can stop lot of dental problems.”

[Participant E]

There was another suggestion,

“I think there should be people like you to come and say, “Hi! Why aren’t you seeing your dental hygiene,” you know? May be it is better for your mental wellbeing, right? That would help people.” [Participant U]

c. Communication with dentists: Participants felt that dentists should consider spending some time with their patients before actually starting work on their mouths. They felt knowing the history of a patient is necessary so that dentists can have a holistic picture of the oral health problems. The
participants emphasized a preference for having a conversation with the dentist about the treatment plan before commencing the actual treatment. The descriptions were as follows:

“I want to feel secure with the person first, before I start let them working on my mouth. I would like them talking about it for first 2 or 3 sessions, then start doing something little by little, step by step until the final progress is done. Because that way, you get to know your dentist instead of just being a number.” [Participant C]

“Better communication. Before even you get teeth cleaned they should talk to you, what they are going to do, how they are going to do. What procedure they are going to use, the results of the procedure and also the price.” [Participant F]

d. More generous public oral health insurance: Most of the participants felt that if they were provided more dental coverage, they would have experienced easier access to oral health care services. As some participants put it:

“We need more avenues, like if there were free dental clinics or coming to just your teeth looked at then it would be better, you know?” [Participant Y]

“People like you should tell the powers like the dental association of BC and the provincial government that we don’t need $500, nothing can be get done, just x-rays and couple of cleanings. We need at least $1000 for whole mouth. We need $1000 a year that way we can look after our teeth better.” [Participant F]

e. Community dental clinics (CDCs): Participants were asked to comment on reduced cost dental services or community dental clinics. From the responses it was clear they did not know about such clinics. Had they been provided information about such services, they could or would consider visiting such clinics for oral health problems. A young man said,

“Well, the thing is, I am glad you mentioned that, if you call 211, they won’t give you that information. Go to the shelter, they won’t have that posted on the wall. Go to emergency rooms and they won’t have that printout. Go to anywhere, the information is not just distributed. It takes
a lot effort. You can provide the service, but you are gonna need a team of marketing it. If there is enough you need to market it where we can hear wherever we go, not like TV or radio, people don’t have money, you know? Where ever we go and in shelters, it is not there. If they keep posting, keep posting and then yes, I would consider, I would consider, but there is none, there is none. Like I said I was surprised you are the first one that I hear.” [Participant N]

Another participant reported,

“I don’t know about community dental clinics….I don’t know. I know nothing about it.” [Participant X]

Another participant suggested,

“No, I haven’t heard about them. They, may be, should advertise more. I have no clue.” [Participant Y]

5.3 Summary

The four main themes and several sub-themes that emerged from the transcripts include: i) experiences in using oral health services; ii) the barriers they perceive to access oral health care services; iii) their perspectives in oral health and oral health care as originating from their past experiences with the access to and use of the oral health care; and iv) their thoughts on how to improve their oral health in general. The next chapter intends to discuss and scrutinize the findings in detail from the perspective of existing literature on oral health and homelessness.
6. Discussion

This chapter discusses the findings in light of the existing literature and addresses the weaknesses in the study design and measurements and how the findings support or refute the current literature. Finally, it introduces the implications to homeless peoples’ oral health based on my analysis.

6.1 What the study did and what it discovered

The research inquiry for this study included: 1) What are the self-reported perspectives on oral health and oral health care providers among the homeless adults in Vancouver?; 2) What were the experiences by homeless adults in Vancouver in using oral health care services?; and 3) What are the perceived barriers (if any) to access oral health care among the homeless adults in Vancouver? This study is an attempt to address these questions using a qualitative research design. Participants to be involved in the research interviews was a purposefully invitation directed to a sector in society—Vancouver’s homeless persons; twenty-five (25) people agreed to be a part of the study. Participant interviews were audiotaped, transcribed and analyzed. The analysis determined four theme clusters. These themes were: 1) Experiences With the Oral Health Service Utilization, 2) Perspectives on Oral Health and Oral Health Care, 3) Perceived Barriers to Access Oral Health Services, and 4) Suggestions for Preventing Oral Health Problems and Enhancing Oral Health Care. These themes were divided into sub-themes that further describe the research findings.

The study results showed that majority of the participants perceived and/or encountered negative experiences with the oral health care services. The remaining participants did not recall any disappointing dental visits and indicated dentists are considered professionals and more knowledgeable about the services they render to their patients. Participants reporting negative oral health service experiences with dentists cited them as being cruel, dishonest, discriminatory, disrespectful, greedy, and incompetent. The service providers at the hospital emergency departments were also considered not any better than the dentists they had experienced in professional offices.
The study results showed that participants did not consider dental students to be competent. Moreover, they perceive that the dentists who provide proper treatments worked only in richer communities in Vancouver.

Multiple perceived barriers to access to oral health care services were seen as contributing to the deterioration in their quality of oral health. Expensive oral health care and lack of coverage were described as the main barriers to access oral health care services. It was further perceived that the scope in the current public oral health services is much less and results in unmet needs for homeless people. Given this scenario where homeless participants did not have any coverage or enough coverage to cover the dental care expenses, and that dentists are non-caring, homeless participants felt at a loss as to where to go during the times they needed oral health care services. Participants reported they did not have any information about the reduced rate dental clinics or community dental clinics, where they would have considered visiting for dental problems. Some participants did not exhibit any interest in accessing oral health care services. Even when they lost their front teeth, they just did not care, and in some cases, they did not consider there was a need to visit dentists and improve their oral health.

Restrictions in accessing oral health-care include the lack of contact information by both the participants and service providers. For some, it is their disability (physical and/or mental) that restricts them in accessing oral health care services. Substance abuse (drugs and/or alcohol) were also reported in responses as reasons for missed appointments.

In general, participants perceived their oral health to be poor. They had a multitude of oral health problems and symptoms including pain, cavities, broken or chipped teeth, infections, and missing teeth. These conditions in poor oral health greatly impacted their self-perceived quality daily life and functioning through pain, chewing problems, speaking, and smiling. Many of the participants indicated they would put greater importance into taking care of their oral health after they realized that they had lost much of their oral health. They also stated it was hard for them to improve the current status of their oral health because of the barriers to access oral health care. The participants did not favour visiting
dentists due to their past disappointing dental visits. The main concern reported by the homeless participants was having their teeth pulled; the prevalent perception was that the dentists would extract their teeth because this is the only treatment they can access through the public oral health services. They also perceived and understood that dentists prefer to extract all their teeth so they can make dentures afterwards and make more money. Rather than visiting dentists, the homeless participants prefer to try home remedies, over-the-counter medicines, going to physicians for antibiotics, and visiting emergency departments for oral problems.

The participants also believed that oral health problems such as dental caries and gum infections could be prevented if sweets were not distributed in the shelters. In addition, the study results suggests homeless adults wished to have better communication with dentists. They urged the dentists to spend some time with them informing them about their dental problem and its treatment possibilities before starting the actual procedures. For public oral health authorities, homeless adults suggest they should consider enhancing public oral health programs specific for them—their needs and challenges. The participants realized that oral health care outreach programs would be beneficial for people who lack knowledge about the available resources and have in-built fears about dentistry. They had concerns that health professionals and social-service providers tend not to talk about oral health.

6.2 The limitations of the study

It is important to acknowledge the limitations associated with the study design. Most notably, the recruitment of study participants was initiated and confined to a sample of homeless adults. As such, there could be a participant bias with those who consented to participate. While the monetary incentives might compromise the ethical concept of free informed consent i.e., the participants should not feel coerced to participate (75) but I believe the payment of $30 commensurate with the difficulty of homeless adults’ participation, both emotionally and physically. Providing remuneration to participants could lead them to provide responses what they believed to be favorable to me rather than providing an authentic description of their perspectives and experiences with oral health-care (76). The similar
concept of the social desirability bias i.e. “systematic error in self-reported measures resulting from the desire of the respondents to avoid embarrassment and project favorable image to others” (77), could have affected the study results too. Another important issue to be considered is the recall bias in experiences reported by participants, particularly after an extended period of time since those experiences. It is also noteworthy that the respondents might not be able to provide the level of detail that the researcher is interested in or may require. Answering probe questions may lead some participants to cues to answer in a certain way to please the researcher. Another consideration is related to the possibility of approaching the data with an informed bias, more likely to find evidence, or a deductive approach, in support of the theory. It cannot also be negated that the cross sectional nature of the study design might have overemphasized or underestimated emotional reactions. In addition to the above, the study in homeless adults’ oral health is limited to one city only and one specific community in the city. Differences in patterns in oral health care delivery across other Canadian provinces imply that the results cannot be generalized to homeless adults in Canada, e.g., As of 2015, the recipients of income assistance in Quebec were eligible to receive more generous public oral health services such as amalgam filings for the posterior teeth, esthetic fillings for anterior teeth, prefabricated crowns, x-rays, local or general anesthesia, root canal procedures, scaling of teeth and extractions etc. (78). These services are not covered under the public oral health system in BC. The more equitable access to oral health-care services in the province of Quebec might produce different results than those produced by this study.

As a professional, my experiences with homeless patients led to my own concerns and opinions about oral health of homeless adults and what this research project discovered might be bound up with these opinions. During interview process and data analysis, I was in the dilemma of my role as a supporter for both the homeless adults and service providers. As a dental professional, I might not be an objective data gathering tool and that was a concern for me about my role in this research as the main instrument of data collection. These feelings might have influenced my focus on selecting the data for analysis and the
interpretation of that data. But as the study participants were not known to me before the commencement of the study, I could engage with the interview process confidently.

This is a small window of exploration in oral health care system for homeless adults; future studies may involve broader communities of homeless adults from provinces and territories across Canada. Future research is also necessary to understand the ethnicity and gender related differences in the oral health care experiences among homeless communities in order to refine the factors affecting oral health care utilization among this vulnerable population. Considering the unique needs of this population, studies are crucial for designing sustainable programs and policies to mitigate the burden of oral diseases among homeless adults.

6.3 How the findings support or refute the current literature

The participants having positive experiences with the use of dental services demonstrate their trust in the dentists by indicating that dentists are professionals and more knowledgeable than them. Prior studies suggest that trust is an important component of positive patient-doctor relationship and determines patients’ satisfaction with the health care they receive (79). The participants describing their negative experiences demonstrated a lack of trust in dentists. This is consistent with the finding of Bedos's (6) and Wallace’s (8) studies in which welfare recipients and low income people respectively reported that dentists are dishonest. In both of these studies the lack of trust was defined in terms of dentists’ being greedy and interested in performing un-warranted treatments just to make more money. My study also indicated that even service providers at hospital emergency departments behave non-empathetically with homeless adults when they approach them for oral problems. Another Canadian study has shown that only symptomatic treatment or no treatment at all is offered at the emergency departments of hospitals (80), but those studies have not shown any attitudinal issues associated with services providers.

The reported experiences of erroneous treatments and negligence by dentists were related to the perception that only student dentists or incompetent dentists practice in the DTES of Vancouver—the
more experienced dentists prefer to work in richer or more affluent communities but there is no prior evidence where homeless people have reported experiences regarding dental students.

The experience of discrimination was described from two aspects. First, members of First Nations perceived that dentists were mean and discriminatory to them at the point of care and exhibited demoralizing behaviour towards them. There is no reported discrimination by dentists against Aboriginal peoples in Canada. Racial discrimination has been reported in another study which examined the racialism and egalitarian discourses among Aboriginal people in the Canadian health care system (81). The dental health care sector may not be free of prejudice but the perceived experiences of racism may be related to the social and ideological contexts in which the oral health care was provided. The second form of discrimination faced by the homeless adults in this study was related to their disabilities and health conditions such as AIDS and cancer. Similar findings were found in studies where welfare participants reported a lack in the availability of dentists who would accept them for dental care (6). Other studies examined the dentists’ perspective who view these type of patients as not lucrative because the government payment rates are very low and do not match the fee guide suggested by the dental association (56).

The coping strategies of home/self remedies, over-the-counter medicines, visiting hospital emergency departments and visiting physicians for antibiotics described by the study participants are consistent with other studies (6,43).

The greater proportion of homeless participants in this study reporting poor oral health is not surprising given the existing literature (82). The findings in the impact from poor oral health on comfort, eating, smiling, and communicating is consistent with other studies (32,83). However, different from the Bedos study (49) in which people on social assistance cared more about aesthetics than the biomedical impacts and opted to have their remaining teeth extracted to receive aesthetically pleasing dentures, participants in my study favoured keeping their remaining teeth for as long as possible.
Regarding regular dental visits, the homeless participants have negative attitudes due to their past “bad” experiences (e.g., discomfort, discrimination, dismissal, and so on) and their understanding that they would not get the appropriate treatment. Similarly, other studies have shown a negative attitude by welfare recipients towards visiting dentists, but those were attributed to a general fear towards pain associated with certain dental procedures (48).

This study found that homeless people perceive dentists to be less approachable than physicians because of lack of availability of dentists and cost of care. It is easy to conceptualize this finding based on the fact that Canada’s system of health insurance does not include dental services (84). Furthermore, according to the study results, there is a lack in awareness of programs and information about available dental services among homeless communities.

Participant comments on the availability and distribution of sweets at shelters and other food programs for homeless people is noteworthy. Given there are studies on sweet consumption and homelessness (85), individuals with potentially poor oral hygiene habits (by choice or circumstances) along with inadequate dental services (as this study shows) should be a concern in dietary considerations provided by homeless shelters and care facilities. However, this discussion also leads to another question and point for inquiry—are the comments by participants an attempt to place blame elsewhere (i.e., if there were no sweets to rot my teeth I wouldn’t have a problem), or a legitimate concern (i.e., the foods being provided have a high sugar content replacing foods with high nutritional value?) It is surmised there could be a number of reasons such as unawareness, costs, friendly/hospitality gesture etc.

Dentistry is a regulated profession upholding its membership to ethical practices and high standards of care in Canada. Oral health care professionals are bound to provide, and be cognizant of, work-related ethics and professional regulations. Prior research in the health care sector has advised health care professionals to know how their attitudes and assumptions influence the way they deal with patients (86) and oral health professionals are not exempted. People, who are treated like they do not matter, will feel like they do not matter. Modified behavior for vulnerable patients as seen among dentists (53) plays an
important role in maintaining a patient's dignity. Personalized care demands small acts of kindness and respect and yet takes little time to perform such act (87). Dentists may need to be reminded, and counseled, that they should be able to identify patients’ situations, feelings, and motives, and acknowledge the patient as a person, not just clinically fixing their oral health problems. The practice of dentistry requires the exchange of information elemental to fostering a sense of trust, honesty and openness. In addition, a gentle look or reassuring touch is an important if not vital gesture to patients, particularly vulnerable persons, in reassuring the care and procedure is both professional and in their best interest.
7. Conclusions and Implications

This chapter concludes the study and presents the possible implications with emphasis on potential strategic directions for research, policy and practice.

7.1 Conclusions

I found that majority of the participants ranked oral health as very important as they recognized its impact on their quality of life in terms of eating, smiling, talking, and general health. Most of them perceived poor status in their current oral health mostly in terms of broken fillings, spaces due to extracted teeth, and dentures related problems. Even then they did not like visiting dentists and associated their non-willingness to dental visits with the fear arising from their past bad experiences of dental service utilization. They would rather try home remedies and other on-the-counter available medicines to treat their dental problem or even went to emergency departments for oral health problems. Visiting a physician was considered far easier than visiting a dentist because the participants thought that the dentistry was a specialized field and there were less availability of dentists.

The participants’ perspectives on oral health-care providers were constructed out of their past experiences with the oral health service utilization. These experiences included both positive and negative engagements with dentists. The participants who thought that the dentists were professionals and it was not appropriate to question their work did not report any bad experience with oral health service utilization. The majority of the bad experiences at the time of accessing and utilizing oral health services included dentists being cruel, dishonest, discriminatory, greedy, and incompetent.

Different participants perceived different kinds of barriers to access oral health-care services, however, the cost or affordability in dental care was the factor reported by the majority of the participants. Other reported barriers included lack of knowledge about the available oral health-care services, lack of
availability of dentists, lack of motivation towards seeking oral health-care, alcohol abuse, disabilities, and lack of having a contact information.

7.2 Implications

The purpose of this section is to convey the ‘So What’ message to my findings. The ‘Findings’ Section reported the descriptions, experiences and perceptions in oral health-care by the homeless adults involved in this study. The findings in the analysis include: areas for further research, implications in oral-health care practice, and the possible implications for dental policy along with potential strategic directions for dentistry.

7.2.1 Implications for research, practice, and policy

Gelberg-Andersen’s BMVP suggests three broad factors (predisposing, enabling, and need) among vulnerable populations in determining health-care behavior and health outcomes. The study findings support the BMVP model and present that the factors such as homelessness, substance abuse, and mental illness may predispose the adults to perceive specific attitudes towards oral health-care. Health services resources and social services resources were among many other enabling factors affecting behavior towards health-care in the BMVP. Taken together, the study findings also demonstrated the need for enabling factors (Figure 3) that could possibly bring positive change in the behavior towards self-oral health-care and utilization of professional oral health-care services among homeless adults. Figure 3 proposes multiple pathways, some of them interconnected with each other, affecting the oral health-care related behavior of homeless adults. The intent of this figure is also to show that presence of all the enabling factors together would be more affective rather than any single factor.

Interventions against homelessness intended to improve the overall quality of life of homeless people including their oral health (88). Currently there is a lack of emphasis on the oral health of homeless adults by such social support interventions. The promotion of certain oral health strategies such as, distributing information about oral health and available oral health resources for homeless adults;
distributing basic oral health-care supplies (e.g., tooth brushes and tooth pastes); and promoting habits of healthy eating and curbing foods with high sugar contents (e.g., sweets) could bring major changes in the oral health-care related behaviour among homeless adults who come in contact with such services (89).

Figure 3: Pathways relating enabling factors, self-oral health-care, behaviour towards seeking oral health-care, and oral health outcomes.

Outreach oral health programs as strategic efforts by professionals and oral health administrators could also have a positive effect on the oral health behavior of homeless adults through enhanced knowledge about the available oral health-care resources among homeless adults and more visibility between
service providers and homeless adults. The emergence of community dental clinics was an effort by not-for-profit community organizations to ease the access to oral health-care among the vulnerable people in BC. Unawareness about such resources adds to the divide between homeless adults and oral health services. As suggested by the study participants, the outreach in oral health programs could potentially be more informative and motivate homeless adults towards positive oral health behaviours.

The lack of oral health-care coverage has been a major factor described by the study participants affecting negatively to their accessibility to oral health-care. The current focus in public oral health programs is reaching specific populations such as children and people with disabilities. The current study suggests that more generous public oral health services for homeless adults could ease their access to oral health-care and have a positive bearing on the behavior towards oral health service utilization among homeless adults. There is an evidence that the oral health-care utilization increases in association with expanding dental benefits to medicaid enrolled individuals (90). For example, there was seen a 7.2% point increase in oral health-care utilization in 2007-2008, and a 11.0% point increase in oral health-care utilization in 2009-2010 after initiating an expanded dental benefit program for poor people between the age groups of 19-64 years in Massachusetts in 2006 (91). However, it is important to remember that increasing the oral health-care benefits alone in the absence of other enabling factors would be less affective to impact positively on behavior towards oral health-care utilization (92).

My study participants’ reported negative experiences in oral health procedures from student dentists. The study participants perceived dental students as being inexperienced professionals. These findings does not connote that there should not have been such initiatives where dental students were provided opportunities to learn treating vulnerable people within community based dental programs.

Recommendations for including more community oriented curricula continued after the publication of Dental Education at the Crossroads: Challenges and Change, by the Institute of Medicine in 1995 (93). In 2002, dental educators at international levels emphasized the importance of including dental public health in dental education (94). The US National Academy of Science also recommended including
patient centered care with emphasis on public health as a competency requirement in health professions education (95). As a result of such recommendations, there is a continued growth in community based dental education. These educational components aim to develop communication skills, ethical and social responsibilities, and shape future career orientations among dental students (96), and to enhance access to oral health-care in underserved communities (97). There is evidence that dental students who performed clinical duties within community based programs experienced more restorative procedures and felt more clinically prepared than those who performed similar clinical duties in dental school (97). However, in another study dental students felt that they were still in the learning phase of their education and faced confusion with treatment planning and treatment procedures while working on vulnerable people especially medically complex or mentally ill patients (98). In short, these evidences indicate that such community based dental programs have win-win situation for both the providers (in terms of clinical competence outcomes) and the receivers (in terms of gaining access to oral health-care). But the focus has been mostly on the impact of programs on students’ competence and attitudes towards treating vulnerable people (97). The experiences of homeless people of using services through such student led community programs are under-investigated. However, there is an evidence that the reduced fee and ease of obtaining appointment at student teaching clinics affect patient’s cooperation and understanding for dental students (99). Also the environmental factors and student abilities e.g., supervision, and attitudes, skills and knowledge impact patient’s acceptance of dental student clinical practice (99). Given the fact that the student led clinical performances (both in the educational institute and in the community dental programs) in Vancouver are based on the reduced fee structure (100), my study participants’ non-acceptance of students’ performances alludes to considerations on the environmental factors and student abilities mentioned earlier. These considerations may enhance dentist-homeless patient relationship and ultimately patient’s satisfaction level (99).
7.3 Summary

The study participants perceived oral health to be very important for them. They felt their current oral health is poor and needing oral health-care services but they were reluctant to seek oral health-care services due to past bad experiences with service utilization. Participants reported experiencing dentist cruelty, dishonesty, discriminatory attitudes, greediness, and incompetence. They perceived the cost of care as a major barrier to access oral health-care among the many other barriers, such as, the unavailability of dentists, lack of motivation to seek oral health-care, lack of information about the available oral health-care resources, the absence in having permanent means or methods in contact information, alcohol abuse, and disabilities.
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Appendices

A. Study poster

THE UNIVERSITY OF BRITISH COLUMBIA

Do you want to earn $30
In one hour?

What Experiences Do You Have For
Dental/Oral Problems?

We Need Your Help for a study of dental/oral health services for people who are homeless

The Study:

We are looking at how people who are homeless use dental/oral health services, and what types of services they use. We are interested in experiences that homeless persons have, and the treatment(s) they receive when they visit hospital/dental office for dental/oral problems. We hope that the results will be used to improve dental/oral health care for homeless people.

Who Are We Looking For?

People who are homeless and can do short face-to-face interview (30-60 minutes).

The study is being done for MSc thesis purpose in the School of Population and Public health at the University of British Columbia.

Thank You.
B. Consent form

Participant Consent Form

Oral Health Care among Homeless People in Vancouver

1. Who is conducting the study?

Principal Investigator: …

Co-investigator(s): ……..

This research is done for graduate degree and is part of a thesis. The information collected during the interviews will be used to analyze the experiences of patients who go to emergency department for dental problems. This analysis will help documenting the status of ease of use of dental services among homeless people. This documentation will be part of a thesis, which can be publicly accessed.

2. Why should you take part in this study?

You are being invited to take part in this research study because you have recently visited emergency department for dental problem. We are doing this study to learn more about the ease of use of dental services among homeless people.

3. What happens to you in the study?

If you say “yes, I want to be in the study”, you will have one face to face interview with a study person for 20-30 minutes at a place decided through your and the interviewer’s mutual agreement. You will be asked questions related to your experiences with the services provided to you for dental problems at the emergency department.

We want the interview to be audio-recorded in order to augment the study notes. The audio recording will be kept confidential. Only the principal investigator and the co-investigator will have access to the audio recording. The audio recording will be destroyed after the documentation of the information collected during the interview is completed.
Please circle one of the options below to indicate your choice for the interview being audio-recorded:

Agree (yes)
Agree (no)

4. **How will the study results be disseminated?**
The results of this study will be reported in a graduate thesis and may also be published in academic journal articles and books.

5. **Is there any way being in this study could be bad for you?**
We do not think there is anything in this study that could be bad for you. Some of the questions we ask might upset you. Please let the study person know if you have any concerns. You do not have to answer any question if you do not want to.

6. **What are the benefits of participating?**
We do not think taking part in this study will help you. However, in the future, others may benefit from what we learn in this study.

7. **How will your identity be protected?**
All identifiable information is strictly confidential; there will be no identification of you personally on any records or in the final report. Confidentiality will be achieved by the researchers using a code number on any printed or computer documents, and by storing this information in a locked filing cabinet, or under password if kept on a computer hard drive.

8. **Will you be paid for taking part in this research study?**
A remuneration of $30 for your participation will be provided to you at the end of your interview.

9. **Who can you contact if you have questions about the study?**
If you have any questions or concerns what we are asking of you, please contact the principal investigator or co-investigator. The names and telephone numbers are listed at the top of the first page of this form.

10. **Who can you contact if you have complaints or concerns about the study?**
If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at …… or if long distance e-mail …….. or call toll free ……..

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your access to further services from the emergency department.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

____________________________________________________
Participant Signature                                   Date

___________________________________________________
Printed Name of the Participant signing above
C. Interview guide for the first interview

1. What is the first thing that comes to your mind when you hear about dental/oral health?

   Probe question: Could you describe a little bit more?

2. How would you describe your oral/dental health at present?

3. How important to you is taking care of your dental/oral health?

4. Please tell me about your visit to dental/oral health service that went well for you.

   Probe question: could you please describe?

5. Could you please tell me about a dental visit that didn’t go well?

   Probe question: could you please describe?

6. What do you think about courtesy and respect at the place where you go for dental care?

7. How do you think about your communication or talk with your dentist?

8. How do you think how clear were the instructions about symptoms to watch for and when to seek further treatment or care?

9. When you received care for your dental problem, were you given any referral to some place for further treatment?

10. Where did you often go for dental care (private dental office, community dental clinic or emergency department)?

11. How do you think about the ease of use of or access to oral health-care in Vancouver?

12. Have you ever visited emergency department for dental problem?

13. Is there anything that you would like to ask me or you think I should know?

14. Demographic information:

   Age?
   Gender?
   Native status?
   Where are you staying?