Community Dental Health (2019) **36,** 137–142
Received 29 October 2018; Accepted 3 February 2019

doi:10.1922/CDH_4488Csikar06

Identifying the barriers and facilitators for homeless people to achieve good oral health

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Objective: A qualitative exploration of the barriers and facilitators for people experiencing homelessness achieving good oral health. **Participants:** Adults using two homeless centres in Leeds. **Methods:** Focus group discussions were convened with homeless people using support services. Both an inductive and deductive approach to data analysis was taken. Themes were identified and then a framework applied to analysis using Nvivo software. **Results:** Three focus group discussions with 16 participants were conducted with people experiencing homelessness. The barriers identified were insufficient information on local dental services, negative attitudes of oral health professionals, low priority of dental care, anxiety and cost of dental treatments. Facilitators included single dental appointments, accessible dental locations and being treated with respect. **Conclusions:** Despite the barriers that prevent people experiencing homelessness from maintaining and improving their oral health, the participants were aware that they needed oral healthcare and requested that dental services were made available to them and were accessible in line with their socioeconomic status and needs.

Key words: *Oral Health, Homeless Persons, Qualitative Research*

Introduction

The prevalence of homelessness is increasing in England. Crisis defined homelessness as 'those sleeping rough, living in hostels, shelters and temporary accommodation, statutorily homeless, hidden homeless (squatters, 'sofa-surfers', those involuntarily sharing with other households on a long-term basis, and people sleeping rough in hidden locations) (Fitzpatrick *et al.*, 2018). The challenge around understanding the full extent of how many people are experiencing homelessness is related to how such data is collected, official statistics assess the proportion of people who are 'statutorily homeless'. These figures do not account for the so-called "hidden" homelessness; people sleeping rough on the streets, or in tents, cars, etc. Rough sleeping alone has been estimated to have increased by a 15% since 2016 (Ministry of Housing and Communities and Local Government, 2018). The causes of homelessness are complex and have been suggested to stem from poverty, relationship breakdown, substance abuse, loss of temporary housing, mental health problems (Thomas *et al.*, 2012). The impacts of homelessness on health are stark; life expectancy is 30 years lower than the general population, due in part to exposures to higher health risks (Thomas, 2012).

Poor oral health has been associated with a greater risk for a series of systemic conditions, for example cardiovascular disease, diabetes and kidney diseases (Linden *et al.*, 2013; Chapple, 2014). The beneficial impacts of good oral health on general health are well known. However, improvements in oral health have other effects, such as greater sense of control, confidence, self-esteem and social functioning (Daly *et al.*, 2010). Across the general population oral health is improving (NHS Digital, 2011). This is not the case in those experiencing homelessness, with dental health being the largest unmet health need for this group (Simons *et al.*, 2012). Dental attendance amongst this population is lower than the general population (Coles *et al.*, 2011). Understanding the barriers that this vulnerable group face is essential to ensure that the dental care system can accommodate the service needs of the society it seeks to serve. The cost of dental treatment, dental anxiety, a lack of perceived need for treatment and oral health being a lower priority have been suggested by some authors as potential barriers to accessing services and to maintaining oral health for this group (Freeman, 2002; Gray, 2007; Hill *et al.*, 2011; Coles *et al.*, 2012; Lamb *et al.*, 2014; Groundswell, 2018). Due to such constraints, many people experiencing homelessness delay seeking dental care until they experience acute dental pain, which in turn can lead to treatment in hospital or emergency settings (Conte *et al.*, 2006). This group of people report higher rates of substance use and mental illness, which further put their oral and general health at risk (Coles *et al.*, 2011). Groundswell (2018) found that 90% of homeless service users in London had oral health problems and 30% were currently experiencing dental pain. This was further compounded by poor diet, drug and alcohol misuse, including tobacco use and mental health problems.

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The challenges faced by people experiencing homelessness in the Scottish and London studies are acknowledged by health and social care services in Leeds, West Yorkshire. The Leeds Health and Wellbeing Board (HWB) signed a homeless health charter in 2015, which outlined that the HWB should ensure all commissioning decisions are informed by the experiences of homeless people. The Leeds Health and Wellbeing Strategy (2016-2021) also outlined that vulnerable groups and areas of the city should have fair access to person-centred services, build upon the strengths of individuals and communities to reduce health inequalities (Leeds Health and Wellbeing Board, 2016). This study therefore aimed to understand the barriers and facilitators to achieving and maintaining good oral health by homeless people in Leeds.

Method

Ethical approval was obtained from the University of Leeds Dental Research Ethics Committee (DREC: 191214/KV/154). Three focus groups were undertaken at two homeless support services in Leeds using a pre-piloted interview topic guide. The topic guide was underpinned by research evidence on homeless populations and the challenges they face maintaining their oral health (Christiani *et al.*, 2008; Daly *et al.*, 2010; Coles *et al.*, 2011).

Co-ordinators at the two homeless centres were asked to identify 4-6 homeless people who were current service users to take part in a focus group for up to 1 hour. Potential participants were deemed to have the capacity, were not under the influence of alcohol or other substances and posed no safety risk to the research team. Convenience sampling was the appropriate approach as the coordinators knew their clients and were able to identify those who could interact with this process without distress or inconvenience to themselves. Participants were approached in person at the centres and were given information about the study both verbally and in writing to take away to consider one week before the focus group. Those who attended the focus group session were then given the information sheet and consent form by the research team, which was read to them to ensure a clear understanding of the process. The potential participants were given the opportunity to ask any questions at the time or anytime up to the start of the focus group. The participant information sheet outlined that the focus group would be audio-recorded, that participation was voluntary and that participants were free to withdraw their contribution to the discussion until the point of data analysis.

Three facilitators were present alongside the coordinator at each centre with KVC leading the discussions with input from JC & JMR. The facilitators (a research psychologist, public health researcher and a dentist) were not known to the participants. Following the focus group, participants were given the opportunity to review the data at a follow up workshop to sense check findings and discuss next steps for dissemination.

Analysis

All focus groups were audio recorded, transcribed verbatim and then analysed in conjunction with the written accounts of the facilitators from each group. A theoretical or deductive approach was used to undertake the analysis after themes were developed inductively from the focus group transcripts, driven by the research questions (Boyatzis, 1998; Hayes, 1997). The preliminary coding was undertaken by JMR and discussed with two further members of the research team (KVC, JC). Codes were developed and refined by discussion between the research team and organised into a framework (Ritchie *et al.*, 2013). All codes were reviewed, and redundant codes explored and discounted as appropriate final codes were agreed and an analytical framework produced (Gale *et al.*, 2013). The Andersen Model (Andersen, 1995; Baker, 2009) was then used to understand how the factors that affect dental service utilisation according to oral health need, access to dental care, and self-beliefs or perception of oral health.

Results

Sixteen adult people experiencing homelessness using the services of two homeless centres in Leeds took part (14 males and 2 females). Three codes were identified, 'Patient-related factors', 'oral healthcare professional-related factors' and 'governmental, political and societal factors', which contained sub-categories pertaining to barriers and facilitators to of achieving good oral health for people experiencing homelessness.

Code 1: "patient-related factors" related to the participants' personal context and lifestyle. Three sub-categories emerged: dental anxiety, low priority of dental care and cost of dental treatment. With regards to dental anxiety, most participants recalled feeling some degree of anxiety when attending dental clinics. One participant indicated that his fear stemmed from the noise of the handpiece he heard as a child:

...when I was ... younger ... my family would take me to the dentist. As soon as I'd hear the drill, I'd be off! They'd have to physically restrain me! To... get owt done!"

The participants reported that their levels of anxiety were exacerbated when they knew the dentist they were going to be treated by was newly qualified or if they were a dental student working under the direction of a qualified dentist:

"*And I've avoided going to the Dental Hospital because... people say that, you know, some of the people like they're students and they're not quite properly qualified and that, that unnerves me a bit really!"... "The students make me anxious because I'm... not totally sure if they know exactly what they're supposed to be doing!"*

Participants reported feelings of panic and anxiety even over routine dental check-ups where no formal treatment takes place:

"I'm going into the dentist, just for check (up)...I can't go in because I'm panicking. I try one day, I'm inside and I'm 'oooh', no, thanks a lot."

Having to deal with a myriad different problems and the competing needs experienced on a daily basis was reported to reduce oral health as a priority in everyday life. A participant remarked: *"If you have got loads of other stuff going on in your life, dental hygiene is probably down there until obviously it becomes painful and then it goes up there..."*

Participants also reflected that their prioritisation of oral health may be linked to literacy, which may also impact on their health literacy: *"When you're alone there is no-one there to explain what these letters mean. I've missed appointments because of this. I cannot read and cannot understand what they are writing…."*

This is further compounded by the impact of a chaotic and busy lifestyle:

To be honest in the last sort of 6 months, I haven't really er brushed my teeth on a regular basis like every day. And, do you know what I mean, and ... partly because I'm been homeless part of the time, but em… I know I've got problems because like I started trying to brush them again regularly and I got really bad pain." A participant when asked what could help them go to the dentists for regular check-ups remarked: *"It's having time! He might not look it, but he's busy you know! Being homeless, it's a busy life being homeless! Believe it or not."*

Low priority of dental care and cost of dental treatment was identified as a sub-code under "patient-related factors". One participant outlined that financial constraints have an impact of their ability to pay for dental treatment: *"I am from the benefit yeah so I can't pay with my benefit money because I need to buy food and clothes and, so, just like minimum pay when you have benefit"* Another one added: *"If I want new teeth I've got to go steal them off somebody else and I move!" ... "I'm a poor man yes I am."*

"I'd like doing it, I'd like it because with new teeth it won't hurt anymore, but it's expensive." Dental treatment debt was expressed as a contributing factor to their current financial burden: *"And then I got a letter through saying that I owed seventy-five pound for work that they had done. And I erm, you know, I explained to them and said look I am on benefits this that and the other, and they weren't having any of it and eventually people came knocking on my door to take stuff out of my flat, you know. And that put me off as well"*

Code 2: Oral healthcare professional-related factors. Participants reported feeling stigmatised, disrespected and not treated like every other patient when attending dental consultations. Participants expressed this as one of the main reasons for not seeking regular dental care and did not feel confident in their interactions with oral health teams. This was a recurrent discussion "*Why are all dental receptionists right narky?"..."They don't make you feel welcome at all. They make you feel right nervous and anxious like you don't want to be there."*

Many participants complained that dental care professionals have a paternalistic attitude towards them, which in return had a negative impact on their self-esteem and dignity: *"It seems like maybe it's just me but it feels like every time you go to the dentist you are going up to this like snobby land. You know like where it is full of like middle class erm fifty-year-old women who are all like 'well this is how you are supposed to have done it and why you haven't done it like this before'. Sorry. And it just feels like you are getting a lecture all the way down the line." "Feels like they are punishing you sometimes, like well you haven't looked after your kid as... teeth as a child, or a young adult and you're suffering now so put up and shut up with it. You know what I mean?"* Furthermore, the participants mentioned that oral health professionals tend to rush their interactions with them, and don't seem to have enough patience to listen and understand their concerns: *"when they are just saying this is what is wrong with you I will give you this now, you have got to go cos I have got to see the next patient, it's like well wait a minute I haven't even explained what's wrong with me. You are just fobbing me off and giving me this medicine and then letting me go. It's like how am I supposed to make myself feel better."*

Participants felt that oral health professionals should be less judgemental towards people who are experiencing homelessness in order to make them feel more comfortable when seeking dental care. A general feeling that the dentist focuses on "customer loads" rather than patient care was expressed. Many participants recalled being rushed out of the dental practice.

Code 3 Governmental, political and societal factors. Participants explored the issues relating to access, information and fitness for purpose in accessing NHS dental care services. One of the major barriers outlined by participants in accessing dental care services was the lack of an appropriate point of contact. This reduced their awareness of available high street or community dental services, illustrated by a participant attempting to find a dentist who is accepting NHS patients: *"You phone someone up for help, right, and by the time they have got round to the third or fourth person you might have got about half the information that you need to be able to go and see them kind of thing. But it's like they make it so complicated"*. After securing an appointment, the challenges still remain as to locating the dental practice and getting there at the designated time: *"...And I didn't have a clue where it was. And I'm there running down cos I was about ten minutes to find it and to get there and I'm running down and I am out of breath and I'm like that [breathing hard] Just so you couldn't be late otherwise I wouldn't have got seen, do you know what I mean?"*. These barriers were reported to increase frustrations with the dental system and increasing their mistrust of the dental system, often abandoning further attempts at seeking oral healthcare: *"...and you just think well what is the point? Do you know what I mean? What is the point of trying your best when you just can't get anywhere? You just feel like just giving up. Do you know what I mean?"* These discussions highlighted an oral health need and desire to seek oral health care for people experiencing homelessness, however there is a mismatch between the existing structures and processes and the needs of this group of people, which differ from those of the general population.

Participants proposed possible solutions (facilitators) to help them attend dental services. A single appointment for consultation and treatment could be helpful: *"I would like to go there and get seen straight away and get what you need to get pulled out of your mouth straight away. Instead of having to make another appointment and going back and then making another appointment and going back, do you know I mean? I would just like to go to a dentist explain what happened and get it pulled out and there you're done. You don't have to mess about."* Oral health promotion or oral health education sessions delivered at the facilities where participants usually go for their meals would also be beneficial: *"Somebody that can give you know, (yes) somebody that can actually sit down in that room there where they see you, look in your mouth and*

go yes you might need to get a bit of attention on this. Or you know."…"10 minutes. 5, you know, have a word with dental nurse. You know what's wrong and then it's down to you to make an appointment. Or to then pursue whatever you need to do. Yes."

The participants outlined that dental teams have a crucial role and provided a service which they felt they wanted to access: *"But they're doing a good job, I don't want to stay away from them, you know what I mean, but … I mean they're doing a good job, you know…."…"you know what I mean, so I don't mind walking miles just cos I know it's gonna get done."*

The discussions revealed that oral health maintenance is the lowest priority, whilst dental pain and, to some extent, aesthetic factors were drivers for increasing participants prioritisation of oral health. Dental anxiety and the paternalistic approach of dental care professionals were barriers, which can mitigate or reduce a desire to seek care, whilst the facilitators are mainly focussed on logistical issues that could help and stimulate oral health maintenance. Figure 1 – Barriers and facilitators of achieving good oral health is a visual representation of the barriers and facilitators to achieve good oral for those who are experiencing homelessness.

Discussion

The results presented have shown that people experiencing homelessness face complex challenges accessing oral health care services in Leeds, and this is consistent with other research studies with similar populations at other locations (Collins *et al.*, 2007; Hill *et al.*, 2011). Participants' perceived barriers were thought to be contributing to declines in oral health and where they place oral health on their list of priorities. This population often struggle with alcohol and substance use, negative attitudes and poor general health, which have a cumulative negative effect on their ability to maintain and access oral health care (Caton *et al.*, 2016). Living a transient lifestyle, coupled with social exclusion impacts on their desire and ability to access services and preventative advice.

The Andersen Model (1995) is useful to understand the factors that affect this group of people's dental service utilisation related to their oral health need, their access to dental care, and self-beliefs or perception they have regarding how their oral health is affected.

Access to dental care was outlined as a barrier for the people experiencing homelessness in this research. Participants reported challenges of accessing ongoing dental care and also being able to make and keep dental appointments, especially those scheduled in the future. Caton *et al.* (2016) outlined how participants requested flexible appointments to overcome these challenges. Being able to access care in one appointment (both advice and treatment undertaken) was seen as a facilitator in the present study. Where necessary, assistance from housing and healthcare coordinators was also a facilitator to care. Many participants had visited a dental clinic after a conversation with the homeless service training coordinator, others went with friends who had had treatment there before and some on the recommendation from staff at community centres. Our findings suggest accessible oral healthcare services could have a significant health impact on people experiencing homelessness by addressing dental pain, which in turn could improve oral health and possibly increase self-confidence.

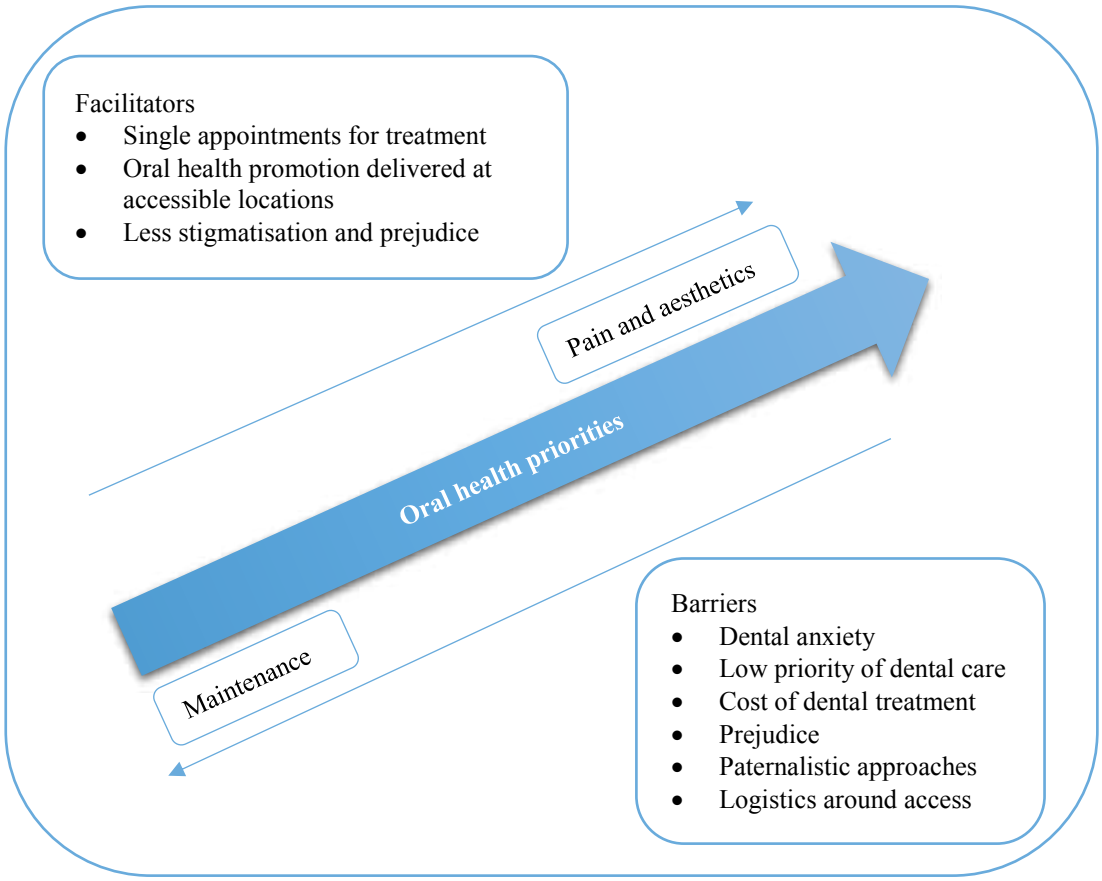

Figure 1 – Barriers and facilitators of achieving good oral health

Participants expressed their reluctance to seek care due to the confusion over the payment structure and the costs of missed appointments. Issues related to finances presented people experiencing homelessness with a potential barrier as they were unaware of the payment structure related to dental care. Many individuals may indeed be able to access free dental care. Lacking a stable address made it very challenging for participants to gain an appointment and often to attend such an appointment (Ciaranello *et al.*, 2006; Daly *et al.*, 2010). The NHS Business Services Authority gives guidance to dental teams regarding patients with 'no fixed abode':

'If the patient is of 'No fixed abode' you can use your dental surgery address. You will need to make a note of doing this on the patients' dental records for reference.' https://contactcentreservices.nhsbsa.nhs.uk/selfnhsukokb/AskUs_Dental/en-gb/9704/fp17-completion/41557/what-address-can-i-put-on-a-fp17-claim-if-the-patient-has-no-fixed-abode.

Ensuring that homeless centres understand what is available to people experiencing homelessness is one step towards removing or reducing this potential barrier to seeking care. Identifying ways in which people experiencing homelessness can be supported to access and navigate services should be prioritised. For example, Christiani (2008) utilised mentors to support navigation of the medical system for 18-24 year olds. Participants outlined in the present study that until their contact with a homeless centres, they lacked motivation to access regular dental care amongst the range of problems they were experiencing.

Levels of (oral) health literacy were identified as a barrier for participants who had difficulty understanding letters sent to them. This in turn impacted on their prioritisation of their oral health. Inadequate oral health literacy can contribute to poor access because individuals may not understand the importance of oral care or their options for accessing it (Coles *et al.*, 2011). Participants expressed reluctance to seek professional care, due to a combination of very urgent and immediate non-dental issues. Dental care therefore slipped down their list of priorities; often only becoming a priority when their problems were acute and requiring urgently attention.

This study aimed to provide an exploratory cross-sectional snapshot of the experiences, values and beliefs of people experiencing homelessness to understand the barriers and facilitators to achieving and maintaining good oral health. Further research could be undertaken with a larger sample of similar people to explore potential solutions proposed within this research. Whilst a convenience sample is not representative of the population at large, it does add more data to the research landscape, supporting our understanding of the health needs of this diverse group. The research team were able to engage with participants through a close working relationship with social care staff at the homeless centres. There is a concern that the sampling process may have increased selection bias as the most vulnerable people may not have been selected to take part due to their physical and emotional capacity. It would be advantageous therefore, to undertake a longitudinal social anthropological study to overcome such limitations, this would allow the researchers to establish a long-term sustained interactions with people who are currently experiencing homelessness rather than through facilitation and to some degree selection of participants by care staff.

As the numbers of people experiencing homelessness grow within the UK, creative solutions are needed to meet the needs of this particular population. One example is Crisis, a charitable organisation that offers emergency dental care service for people experiencing homelessness in London during the Christmas period. The project is called Crisis at Christmas Dental Service (CCDS) and it reports an increasing number of patients attending these services every year (Doughty *et al.*, 2018). Dental care professionals operate this service on a voluntary basis, offering oral health preventive advice and treatment in line with *Delivering Better Oral Health* (Public Health England, 2014). Although these initiatives are invaluable in addressing the immediate clinical need of the people experiencing homelessness, it is important to consider upstream interventions and strategic changes to the system, including early prevention across multi-sectorial stakeholders to address the determinants of homelessness. This research adds additional evidence regarding those who experience homelessness related to their oral health, it also gives the Leeds Health and Wellbeing Board information to make commissioning decisions based on the experiences of homeless people.

The role of civil society is becoming more and more important to provide asset-based, sustainable interventions. These are crucial in tackling oral health inequalities affecting especially the most vulnerable groups.

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