



## Challenges identified in a pilot outreach dental service for Traveller children in Hackney, East London

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**Impetus for action:** Inequity of dental health and dental service use for Travellers in the UK. National guidance on improving community oral health, stresses an imperative to involve and engage with “those whose economic, social and environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services”. **Solution:** Oral health promotion and simple treatments were provided on two Traveller sites from a mobile dental unit (MDU) over a 5-day period and patients with extensive oral disease were referred to a fixed-site clinic for continued care. **Outcomes:** Most children, 60%, reportedly brushed once daily or less, only 40% brushed twice daily. Obvious visual caries were evident in 23 out of the 35 children (66%). A moderate to high risk of developing future caries was identified in 92% of Traveller children based on their existing diet, oral hygiene practices and caries experience. **Future:** Oral care was successfully provided on an MDU, but this is an expensive resource and should not be considered a permanent solution. Oral health promotion messages delivered in the families’ homes or local community settings through their established health services, such as health visitors or community nurses, may help to reinforce good oral hygiene and diet practices and needs robust evaluation.

**Key words:** travellers, access, mobile dental unit, children, oral health, England

### Initial impetus for action

In the London district of Hackney, UK, there live around 600–800 Gypsies and Travellers; with 115 adults and children living on five local authority sites (HCHWB, 2014). Gypsy, Roma and Travellers share cultural values such as nomadism, viewing “nomadism is not purely about moving from place to place but a way of looking at life and the world.” However they remain distinct ethnic groups, each group with their own culture and traditions and are legally recognised as such and are protected from discrimination under the Equality Act 2010 (Francis, 2010). The “health inequality between the Gypsy Traveller population in England and their non-Gypsy counterparts is striking, even when compared with other socially deprived or excluded groups and with other ethnic minorities” (Parry *et al.*, 2007). Parry and colleagues discussed the widespread communication difficulties between health workers and Gypsy Travellers, with defensive expectation of racism and prejudice. Barriers to health care access are outlined, with several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and healthcare professionals, and attitudinal barriers. They reported that educational disadvantage, the role played by environmental hardship, social exclusion and cultural attitudes were consistent with the finding there is a health impact of being a Gypsy Traveller over and above other socio-demographic variables. Similarly, there was a reported inequity of dental health and dental service use for Travellers in Hertfordshire, UK (Edwards and Watt, 1997). Parry (2007) recommended

that methods are needed to improve access and cultural safety of health services for Gypsy Travellers, emphasising the need to work in partnership with communities in the delivery of health care.

National guidance for local authorities on improving community oral health, stresses an imperative to involve and engage with “those whose economic, social and environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services.” The document highlights, as a specific example, mobile communities such as Travellers (NICE, 2014). Recommendations include: creating tailored interventions that may involve the use of outreach services in delivering evidenced-based advice, demonstrating toothbrushing, free oral hygiene materials and provision of dental services through local care pathways. The Community Dental Service (CDS) of Bart’s Health NHS Trust currently has a responsibility to ensure access for vulnerable groups and provision of dental care for patients who have difficulties accessing ordinary “high street” dentistry (NHS, 2010). The community nurse working with the Travellers in Hackney contacted the CDS with concerns of oral problems within the Traveller child population.

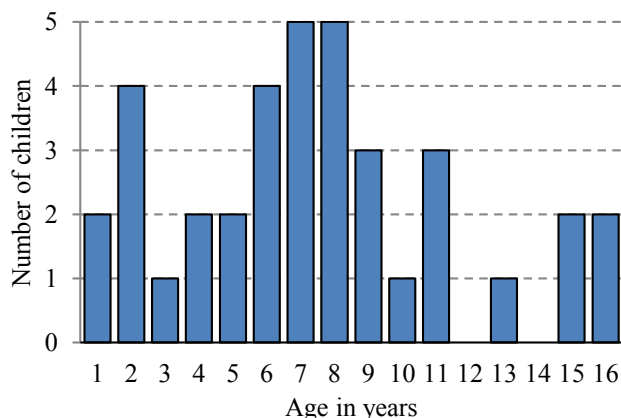
### Solution suggested

The aim of this pilot was to work collaboratively with the community nurse responsible for the Traveller community based within Hackney council: to ensure that the Traveller children had access to dental prevention and oral care; to assess the extent of any oral problems, to engage with the

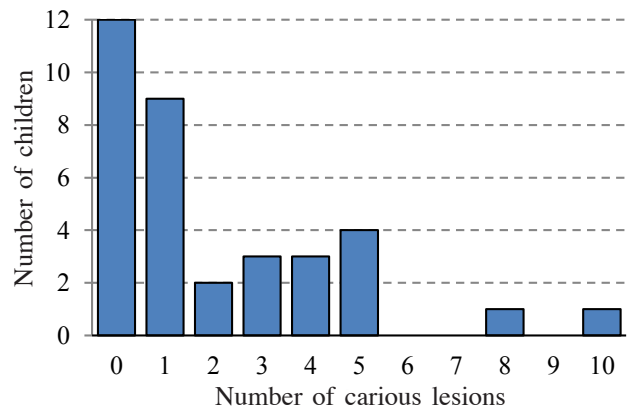
Traveller families on site and to evaluate the outcomes of a pilot outreach dental service. A team consisting of the community nurse, dentist and dental nurse attended two Hackney Traveller sites over a period of five days with an additional day of home visits for the harder to reach families based in nearby homes. Oral health assessments were offered to all children, with consent obtained from the parent of the child. Diet cariogenicity was recorded and a caries risk assessment undertaken (AAPD, 2014; SIGN, 2014) with appropriate prevention, oral hygiene and diet advice being given to each child and accompanying adult in accordance with national guidance (PHE, 2014). Simple treatments were provided on the Traveller site from a mobile dental unit (MDU). Those children with extensive oral disease were referred, via a local care pathway, to a fixed-site dental clinic within the CDS. The referred appointments, where possible, were made with the examining dentist to preserve continuity and develop a trusting relationship between the service and the Traveller community. The collected information was anonymised and entered into a password protected spreadsheet. The results were audited to assess the value of the pilot service.

### Actual outcomes to date

Examinations were performed for 37 children with ages ranging 1-16 years, mean 7 (Figure 1). Some 60% of the children reportedly brushed once daily or less, only 40% brushed twice daily. All children whose frequency of brushing was once daily or less were performing their oral hygiene regimen in the morning, rather than at night. Of those children aged seven years and under, 53% were supervised by a parent when brushing. A moderate to highly cariogenic diet was consumed by 95% of Traveller children seen. A moderate to high risk of developing future caries was identified in 92% of Traveller children based on their existing diet, oral hygiene practices and caries experience. Obvious visual caries were evident in 23 out of the 35 children (66%), excluding two children who were unable to be examined fully (Figure 2). Most children (85%) had seen a dentist within the last two years for routine examination and three requested to attend their own dentists for dental treatment.



**Figure 1.** Age distribution of the children involved in the Hackney project (n=37)



**Figure 2.** Distribution of the number of carious lesions present in the examined child population by age (n=35)

The treatments provided on the MDU for the remaining 32 children were: 32 applications of fluoride varnish, 21 children had radiographs, 27 restorations (for 16 children), and 22 fissure sealants (for seven children). Twenty-six children had their treatment completed. Comparison of the level of efficiency using units of dental activity (NHS, 2005) showed that much less was achieved in those terms than would be the case in general dental practice working under NHS contract (54 units of dental activity over 6 days, 12 in the lowest band and 14 in the second band).

### Challenges Identified

Challenges encountered during the project included difficulties in obtaining informed consent when children attended with adults other than their biological parents. Many of the families had the same surname, this created difficulty when attempting to identify male relatives as fathers who had parental responsibility as opposed to uncles and other family members. There was also the issue of Traveller mistrust toward medical practitioners. This project made use of home visits for hard to reach families to provide reassurance and develop trusting relationships between patient and practitioner in a familiar environment. Collaborating with a familiar community nurse also helped to allay some of the Travellers' reservations and uncertainties associated with attending the MDU. However, this time-consuming collaboration reduced the time available for treatment. These factors need to be considered when using such an expensive resource as an MDU.

The cost of an MDU can be prohibitive when considering whether or not to implement an outreach programme; both the initial start-up and ongoing costs can be high (Douglass, 2005). Simons *et al.* (2013) suggested that costs include staffing, petrol, permits, cleaning, consumables, decontamination and transportation. They suggested that the high cost was only feasible where programmes are short term. The signposting of patients to a fixed-site clinic may overcome some of the cost implications associated with the MDU.

Verbal feedback from families, after engagement with the MDU and SCD team was positive and encouraging.

Research has identified that many children, especially those from lower socio-economic families, have limited access to dental care, increased oral disease experience, transportation problems and poor appointment attendance (Croucher and Sohanpal, 2006; French *et al.*, 1984; Jones *et al.*, 1997). MDUs have been successfully employed in many communities to address these issues; school-based MDUs (Clarke *et al.*, 1992; Mulligan *et al.*, 2010; Simons *et al.*, 2015) demonstrated improved access to dental care for vulnerable children and the MDU has been used to significantly increase the uptake of dental care for homeless people (Simons *et al.*, 2012). There is recognition that implementation and management of MDU programmes is complicated (Douglass, 2005). However, they provide an innovative solution to bringing dental care to underserved communities, are well accepted and can reduce missed appointments (Douglass, 2005; Simons *et al.*, 2015). The MDU may be valuable in overcoming disparities in access to dental care for Travellers and may be the most appropriate first step on to a local care-pathway for this cohort of children, despite the high costs involved and lower levels of treatment activity than that likely to be achieved in a fixed dental clinic.

The practitioner on the unit was experienced in providing outreach dentistry to vulnerable and marginalised patient groups. A continued care pathway made use of the presence of the same dental practitioner when referring between fixed and mobile sites for further care – this may also have helped develop more trusting relationships between Travellers and the CDS. However follow-up treatment courses were poorly attended, four children were referred to the local CDS clinic, only one attended once and their treatments were still incomplete after 3 months. Intensive engagement is required to complete courses of dental treatment for ADD traveller children, for example:

*“One family referred to the fixed site, has a child with “special needs” and a younger sibling. Both had extensive untreated dental decay, requiring a dental general anaesthetic (DGA) for completion of treatment due to the age of the children and cooperation issues. The mother has refused the option of DGA, thought to be partly due to her own “dental fear” and mis-information about the risks of DGA and general distrust. She has specifically said “she doesn’t want to be persuaded to consent for her child to have a DGA”. There exists complex social problems, the children have a safeguarding protection plan and there is a history of domestic violence with the father having a restraining order. They have missed six dental appointments out of eight made at the fixed site and a further home visit has been conducted by a dentist accompanied by the traveller community nurse to explain the risks and benefits of a DGA. The “team around the family” had postulated that the mother’s concerns were justified and in line with her beliefs and they wanted advice as to whether “significant harm” would be a consequence of not having a DGA. The CDS safeguarding lead is working closely with the social worker, the children’s doctor, a clinician experienced in paediatric dentistry and the school nurse to address the situation.” Community Dental Officer, CDS*

The poor attendance at the local clinic may explain why although the majority of children claimed to have seen a dentist in the last two years, there was minimal evidence that preventive behaviours had been adopted and the majority of children had active caries. It suggests that increasing the provision of culturally appropriate oral health promotional activities is needed to help to change attitudes toward health-care, and enable Travellers to understand that poor oral health can be reduced by adopting good self-care practices. It is important to provide self-care advice sensitively (Condon and Salmon, 2015). This type of intervention, combined with a fluoride varnish and tooth brushing programme could be provided more cost-effectively by oral-health promoters, working collaboratively with other health/social services/schools, and with other local community groups trusted by Travellers, e.g. religious organisations and voluntary groups. The MDU could then be provided on a six-monthly rotation within this programme to provide dental treatment if required.

### **Future implications and learning points**

The majority of children seen in this small pilot had visible evidence of caries, moderate to highly cariogenic diets, and were assessed as moderate to high risk of developing future caries. Comparison with local and national dental epidemiological surveys was not possible as radiographs were used, the children had mixed dentitions, were a wide age range, and this was not a calibrated examination. The data collected from these particular authorised Traveller sites may also not be representative of Travelling communities and other communities may have very different traditions and experience of oral disease. Qualitative research within the Traveller community on oral health related quality-of-life and acceptability of the MDU and dental treatment would be beneficial to supplement the quantitative data.

The Traveller community in Hackney is small in number but this pilot showed they had significant oral problems and require intensive input to enable children to complete courses of dental treatment. Oral care was successfully provided on an MDU, but this is an expensive resource and should not be considered a permanent solution. Furthermore, the use of an MDU within this Traveller community could contribute to their social exclusion.

A more effective oral care pathway, working closely with health/social services/schools/local community groups and local dentists, enabling children to attend general dental practices needs to be established if a reduction in the high level of active decay is to be achieved. Recent clinical commissioning guidance from NHS England stresses the importance of “challenging primary care providers to deliver care to those who need it most” (NHS England, 2015). The majority of Traveller children might be treated in general dental practice without requiring specialist services, directing these patients toward primary care will help to reserve access to specialist care for those who need it most, for example the children described above. These children required intensive input and it was only by working closely with social services, community nursing, health visitors and the safeguarding team that their issues could begin to be addressed. The dental care was a small part of a much larger social situation for the family and resolution of the issues is still on going to address the dental needs of the children.

Oral health promotion messages delivered in the families' homes or local community settings through their established health services, such as health visitors or community nurses, may help to reinforce good brushing and diet practices.

## References

- American Association of Paediatric Dentistry, AAPD (2014): *Guidelines on caries-risk assessment and management for infants, children and adolescents*. Illinois: American Association of Paediatric Dentistry. [www.aapd.org/media/policies\\_guidelines/g\\_cariesriskassessment.pdf](http://www.aapd.org/media/policies_guidelines/g_cariesriskassessment.pdf)
- Clarke, J.R., Bradnock, G. and Hamburger, R. (1992): The uptake and completion of dental treatment using a mobile clinic in central Birmingham, UK. *Community Dental Health* **9**, 181-185.
- Condon, L.J. and Salmon, D. (2015): "You likes your way, we got our own way": Gypsies and Travellers' views on infant feeding and health professional support. *Health Expectations* **18**, 784-795.
- Croucher, R. and Sohanpal, R. (2006): Improving access to dental care in East London's ethnic minority groups: community based qualitative study. *Community Dental Health*, **23**, 95-100.
- Douglass, J.M. (2005): Mobile dental vans: planning considerations and productivity. *Journal of Public Health Dentistry* **65**, 110-103.
- Edwards, D.M. and Watt, R.G., (1997): Oral health care in the lives of Gypsy Travellers in east Hertfordshire. *British Dental Journal* **183**, 252-257
- Francis, G. (2010): *Traveller Voices*. London: NHS City and Hackney. [www.hackney.gov.uk/assets/documents/traveller-voices.pdf](http://www.hackney.gov.uk/assets/documents/traveller-voices.pdf)
- French, A.D., Carmichael, C.L., Furness, J.A. and Rugg-Gunn A.J. (1984): The relationship between social class and dental health in 5-year-old children in the North and South of England. *British Dental Journal*, **156**, 83-86.
- Hackney and City Health and Wellbeing Boards, HCHWB (2014): *City and Hackney Health and Wellbeing Profile JSNA data update*. [www.hackney.gov.uk/assets/documents/city-and-hackney-health-and-wellbeing-2014.pdf](http://www.hackney.gov.uk/assets/documents/city-and-hackney-health-and-wellbeing-2014.pdf)
- Jones, C.M., Woods, K. and Taylor, G.O. (1997): Social deprivation and tooth decay in Scottish schoolchildren. *Health Bulletin*, **55**, 11-15.
- Mulligan, R., Seirawan, H., Faust, S. and Habibian, M.J. (2010): Mobile dental clinic: an oral health care delivery model for underserved migrant children. *California Dental Association* **38**, 115-122.
- National Institute for Healthcare Research and Excellence, NICE (2014): *Oral health: approaches for local authorities and their partners to improve the oral health of their communities*
- NHS (2005): *The National Health Service (General Dental Services Contracts) Regulations 2005*. London: The Stationery Office.
- NHS (2010): *Salaried Primary Dental Care Services; Toolkit for Commissioners*. London: NHS
- NHS England (2015): *Guide for commissioning dental specialities – special care dentistry*. London: NHS England.
- Parry, G., Van Cleemput, P., Peters, J., Moore, J., Walters, S., Thomas, K. and Cooper, C. (2007): The Health Status of Gypsies & Travellers in England. *Journal of Epidemiology and Community Health* **61**, 198-204.
- Public Health England, PHE (2014): *Delivering better oral health: an evidence-based toolkit for prevention* 3<sup>rd</sup> edn. London: PHE.
- Scottish Intercollegiate Guidelines Network, SIGN (2014): *Preventing dental caries in children at high caries risk. Section 3: Primary prevention of dental caries*. Edinburgh: SIGN.
- Simons, D., Pearson, N. and Evans, P. (2013): A pilot of a school-based dental treatment programme for vulnerable children with possible dental neglect: the Back2School programme. *British Dental Journal*, **215**, E15.
- Simons, D., Pearson, N. and Movasaghi, Z. (2012): Developing dental services for homeless people in East London. *British Dental Journal* **213**, E11.
- Simons, D., Pearson, N., Evans, P., Wallace, T., Eke, M. and Wright, D. (2015): Improving access to dental care for vulnerable children; further development of the Back2School programme in 2013 *Community Dental Health* **32**, 68-71.