Perceptions of access to oral care at a community dental hygiene clinic for women involved with the criminal justice system

Kathleen M Herlick*, MSc; **Ruth Elwood Martin**[§], MD, FCFP, MPH; **Mario A Brondani**[†], DDS, MSc, MPH, PhD; **Leeann R Donnelly***, BDSc, MSc, PhD

PRACTICAL IMPLICATIONS OF THIS RESEARCH

- Dental hygiene students who participate in community-based learning engage with a wide range of populations and learn about the socioeconomic factors that affect access to oral care.
- Understanding how to provide appropriate oral care to women involved with the criminal justice system may improve dental hygiene services and access for this marginalized and vulnerable population.

ABSTRACT

Background: Women involved with the criminal justice system are often marginalized or vulnerable and may face oral health inequities. Through a community-engaged program at a Canadian university, dental hygiene students provided preventive care at an organization supporting this population. This study explored the impact of these oral care services from client and organization staff perspectives. **Methods:** One focus group with 6 clients, 2-person interviews with 4 clients, individual interviews with 3 clients, and one focus group with 4 organization staff members were conducted. Discussions were audio recorded, transcribed verbatim, and analysed thematically. The concept of access, proposed by Penchansky and Thomas (1981) and Saurman (2015), was used as the conceptual framework to organize the themes. **Results:** Nine themes were identified from the focus group and interview discussions: limited options, convenience, realistic expectations, respect and attention, no judgement, physical environment, communication, clients' unique needs, and appropriate messaging. **Discussion:** The clinic's close proximity and services, for which women did not need to pay out-of-pocket, facilitated access to preventive care. The person-centred and trauma-informed care further facilitated access. However, access to comprehensive care through referrals was limited by cost and likely issues of stigmatization from other dental care providers. Clinic aesthetics, advertising, and communication between the students and women receiving care also hindered access. **Conclusion:** Preventive oral care services provided at this clinic for marginalized and vulnerable women who have been involved with the criminal justice system were valued by clients and staff. Findings will help inform future community-based dental hygiene clinics for this population.

RÉSUMÉ

Contexte : Les femmes qui font face au système de justice pénale sont souvent marginalisées ou vulnérables et peuvent être confrontées à des inégalités en matière de santé buccodentaire. Dans le cadre d'un programme engagé sur le plan communautaire, mis en place dans une université canadienne, des étudiants en hygiène dentaire ont prodigué des soins préventifs dans une organisation qui soutient cette population. La présente étude a exploré les répercussions de ces services de soins buccodentaires du point de vue des clients et du personnel de l'organisation. **Méthodologie :** Un groupe de discussion comprenant 6 clients, des entrevues à 2 personnes avec 4 clients, des entrevues individuelles avec 3 clients et un groupe de discussion avec 4 membres du personnel de l'organisation ont été menées. Les discussions ont fait l'objet d'un enregistrement sonore, puis ont été transcrites textuellement et analysées par thèmes. Le concept d'accès, proposé par Penchansky et Thomas (1981) et Saurman (2015), a été utilisé à titre de cadre conceptuel pour organiser les thèmes. **Résultats :** Le groupe de discussion et les entrevues ont permis de définir 9 thèmes : choix limités, commodité, attentes réalistes, respect et attention, absence de jugement, environnement physique, communication, besoins uniques des clients, et messages appropriés. **Discussion :** La proximité et les services de la clinique, pour lesquels les femmes n'avaient pas à payer de leur poche, ont facilité l'accès aux soins préventifs. Les soins axés sur la personne et les soins adaptés au traumatisme ont davantage facilité l'accès. Cependant, l'accès à des soins complets par l'intermédiaire de renvois a été limité par le coût et les enjeux de stigmatisation probables de la part d'autres fournisseurs de soins dentaires. L'esthétique de la clinique, la publicité et la communication entre les étudiants et les femmes recevant les soins ont également entravé l'accès. **Conclusion :** Les clients et le personnel ont attribué une valeur aux soins buccodentaires préventifs fournis à cette clinique réservée aux femmes marginalisées et vulnérables qui ont été impliquées dans le système de justice pénale. Les résultats permettront d'orienter les cliniques communautaires futures d'hygiène dentaire destinées à cette population.

Keywords: community dentistry; community–institutional relations; criminal justice system; dental clinics; dental health services; health services accessibility; oral health; oral hygiene; vulnerable populations; women
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*Department of Oral Biological and Medical Sciences, Faculty of Dentistry, The University of British Columbia, Vancouver, BC, Canada
[§]School of Population and Public Health, Faculty of Medicine, The University of British Columbia, Vancouver, BC, Canada
[†]Department Oral Health Sciences, Faculty of Dentistry, The University of British Columbia, Vancouver, BC, Canada

Correspondence: Kathleen M Herlick; katie.herlick@alumni.ubc.ca
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INTRODUCTION

Women who are involved with the criminal justice system (CJS) are a subset of women in our society who are often marginalized or vulnerable. These women have been touched in some way by the CJS: they may have experienced incarceration themselves, may be at-risk for incarceration due to poverty, homelessness or substance use, or they may have a parent, child, other family member or partner who has been incarcerated. Women who are marginalized or vulnerable because of homelessness,[1,2] substance use[3] or incarceration[4,5] have often had disadvantaged and traumatic backgrounds and experience inequities in oral health and access to oral care. Individuals experiencing homelessness in Toronto, Canada, have poor oral health and limited access to dental care.[2] Individuals in England who use drugs also have greater difficulty accessing dental services and a significantly higher level of oral health problems compared to those who are gender and age-matched who do not use drugs.[3]

Oral health status and access to oral care for women incarcerated in Canada is not well documented. However, a 2017 study highlighted that access to dental care is important to help keep women out of prison.[6] Lack of access to dental care in the community was associated with self-reported reengagement in criminal activity for women released from provincial incarceration in British Columbia.[6] Women incarcerated in London, England, are more likely to have poor oral hygiene, an increased incidence of caries, higher sugar intake, and to smoke and use drugs compared to those who are not incarcerated.[5]

Women in transition from incarceration to living in the community face unique barriers to oral health care in Canada. In 2017, 14% of adults admitted to provincial and territorial correctional institutions and 8% admitted to federal institutions in Canada were female,[7] with an overrepresentation of Indigenous women.[8] Women in correctional institutions in Canada often serve short sentences[9] and face many transitional challenges after incarceration, including obtaining employment, securing housing, and accessing health care.[10,11] Women leaving prison have expressed the desire to improve or maintain their oral health during the transition period,[12–14] yet the financial burden of dental services in Canada[15,16] and the stigma of incarceration,[17] lack of housing or poor oral health[18] can hinder access to health care. In a study exploring access to dental care for previously incarcerated individuals in New Brunswick, 33% of formerly incarcerated individuals said their access to dental care had improved compared to access in prison, 23% said it had decreased, and 44% said it remained the same after release from prison.[14] The privately administered and delivered model of oral health services in Canada may be insufficient to meet the needs of women who are marginalized or vulnerable, and an alternative method to provide accessible oral care is needed.

Given the privately delivered model of oral health services in Canada and the complex issues around access to oral care, community-engaged learning within dental hygiene programs may offer the opportunity to address oral health inequities through advocacy, health promotion, and the provision of preventive care and oral health education. It also allows those involved to learn directly from each other.

One of these community-engaged learning initiatives was established in 2013 by the University of British Columbia's dental hygiene degree program and the Elizabeth Fry Society of Greater Vancouver (EFry), located in New Westminster, Canada. EFry is a non-profit organization that was originally established to support women preparing to leave prison, but now also supports women and their families who are marginalized or vulnerable due to a variety of experiences with the CJS including incarceration, homelessness, substance use, and having a family member or partner who has been incarcerated. EFry offers programs and services that emphasize gender-specific support and aims to address issues of poverty, homelessness, addiction, and mental health problems specific to women. In this community-engaged learning program, fourth-year dental hygiene students provide preventive oral care with no out-of-pocket costs, oral health education, health promotion, and referrals for dental care for women and their children who are clients of EFry. The clinic is located within a women's drop-in centre, which offers a safe space for women who are marginalized or vulnerable and/or who have experienced trauma from men—a frequent occurrence among justice-involved women[19]—to seek shelter, wash clothes, eat, socialize, and collect donated clothing.

EFry is currently planning for a new dental clinic to provide comprehensive oral health services to its clients. Identifying how clients and staff at EFry perceive the current dental hygiene clinic will help to inform the development of this new clinical space. This study aimed to explore clients' and EFry staff's perceptions of how the clinic has influenced access to oral health care, and addressed the following question: "How has the current community-based dental hygiene clinic influenced access to oral care for women impacted by the criminal justice system?"

METHODS

Ethical approval was received from UBC's Behavioural Research Ethics Board (H14-01925). Focus groups, 2-person interviews, and individual interviews were conducted with clients and EFry staff to explore perceptions of the clinic and how it has influenced access to oral care. Previous client satisfaction surveys were also reviewed.

Review of client satisfaction surveys

Data from 62 satisfaction surveys, which clients were encouraged to complete after receiving preventive services, were analysed quantitatively and qualitatively to identify access-related aspects of the clinic that clients perceived

as satisfactory and less satisfactory. Such aspects helped to inform the interview guide.

Focus groups and interviews

Qualitative methods were used to explore how the clinic influenced access to oral care from the perspective of clients and EFry staff. The concept of access to health care, proposed by Penchansky and Thomas[20] and Saurman[21], was used as the conceptual framework for this study and the reporting of its findings. In this framework, access to health care is a concept with 6 interrelated dimensions: affordability, accessibility, availability, acceptability, accommodation, and awareness.[20,21] Affordability describes the relationship between service costs and clients' ability to pay.[20] Accessibility describes the relationship between the location of the service and clients and focuses on transportation, distance, and cost to reach the service.[20] Availability describes whether the amount and type of service meet clients' needs.[20] Acceptability refers to clients' attitudes towards the service or provider and the provider's attitude towards clients.[20] Accommodation refers to the interaction between how a service is organized to accept clients, including appointment scheduling and operating hours, and clients' perceptions of these factors.[20] Finally, awareness refers to the clients' awareness that the service exists and their ability to access the service.[21]

The study used purposive sampling to recruit EFry staff members to participate in a focus group. Two EFry staff members helped identify 8 staff members in different roles and programs who have close contact and engagement with clients who access services at the dental hygiene clinic or who might have unique perspectives on how the clinic has influenced access to oral care for this subset of clients. Among the 8 individuals identified, 4 staff participated. These staff members worked in the building in which the dental hygiene clinic was located, in various roles and programs, including a women's drop-in centre, a transition house, housing services, and organization administration. Three of them directly engaged with clients in their daily work. Convenience sampling was used to recruit clients to participate in focus groups; clients were recruited through posted flyers around the EFry building. Client participants had to be 18 years of age or older, English-speaking, and a past or present client of the dental hygiene clinic. Clients of the clinic and clients who participated in our study were not asked specifically about their experiences with the CJS, including incarceration, to create a low-barrier clinic and to avoid potentially stigmatizing the women. Six clients participated in a first focus group (conducted by author LRD). Because of difficulties in recruiting participants for additional focus groups, author KMH conducted 2-person interviews with 4 clients, one of whom had also participated in the first focus group, which was later discovered. Continuing difficulties in recruiting clients to meet in-person for a focus group prompted author KMH to conduct individual phone interviews with 3 other client participants.

A semi-structured interview guide was developed for the focus group with EFry staff and for the focus group and interviews with clients based on the concept of access[20,21] and the review of satisfaction surveys. This guide allowed participants to discuss aspects of the clinic important to them while also emphasizing access-related issues. Examples of interview questions are, "What are some reasons why you decided to come to the dental hygiene clinic here, as opposed to going to a different clinic?" and "What do you think about the appointment system here at the clinic?" Clients received a $25 grocery store gift card for their time. Staff did not receive an honorarium as they were being compensated through their employment while participating in the study. Qualitative data collection and analysis were conducted concurrently so data analysis from previous focus groups and interviews could inform the remaining focus groups and interviews. Data from the focus groups, interviews, and client satisfaction surveys were also compared to ensure credibility of the findings by identifying common factors related to access.

Qualitative data analysis

Focus groups and interviews were audio recorded and transcribed verbatim, and transcripts were managed in NVivo 12™ (QSR International). Data from the focus groups and interviews were analysed thematically, as described by Braun and Clarke.[22] Transcripts were each reviewed once and compared to the audio recording to ensure accuracy and familiarity with the data.[22] The study used an inductive approach to thematic analysis to analyse the focus group and interview data; data were analysed on their own, and codes and themes were identified apart from the conceptual framework used.[22] Data that related to the research question were coded line-by-line; extracts of data from the transcripts, rather than individual data items, were coded to ensure that context of the discussions was retained.[22] Codes were then organized into themes, which were identified based on their prevalence across focus groups and interviews; a theme was defined as salient if it was voiced by more than one participant.[22] Thematic analysis was iterative by which codes were revisited to ensure their consistent application within and across transcripts. Themes were then arranged within the 6 dimensions of the concept of access mentioned earlier.[20,21] Collection of focus group and interview data was conducted concurrently with thematic analysis until no new or "surprising" codes and themes were identified.[23]

To ensure trustworthiness of the analysis, 2 authors (KMH and LRD) made preliminary codes for the first focus group separately and met to discuss the coding until reaching consensus. KMH then carried out the remainder of the thematic analysis, meeting with the other authors frequently. To ensure validity of the initial thematic analyses, 7 client participants were contacted by phone and given an opportunity to provide feedback about their input and the analysis as a member checking exercise.[24]

Four client participants chose to listen to a short summary analysis over the phone; 2 chose to review the entire transcript sent by email as requested; and 1 participant chose to review both and was given a hard copy of the transcript in person. All 7 participants were satisfied with the initial analyses and 5 provided additional information and clarification to their initial statements. One participant who reviewed the entire transcript also changed the wording and grammar of a phrase she had initially said in the focus group to better reflect what she wanted to convey.

RESULTS

Review of client satisfaction surveys

Survey respondents were satisfied with their care and grateful for the service. Some aspects of the dental hygiene clinic were perceived as less satisfactory, including whether the oral care providers had the necessary supplies to provide care, clients' comfort level in receiving care, the perceived impact on clients' oral health knowledge, whether the care providers explained the time needed for treatment, and whether clients received a referral for additional care (Table 1). Respondents made suggestions to improve the clinic atmosphere, including music for distraction purposes, more comfortable dental chairs, and brighter lighting (Table 2). To improve care, suggestions included providing explanations about the nature of and time needed for care, having specialized oral self-care supplies for clients, and providing written oral self-care resources (Table 2).

Access to oral health care

Based on the focus groups and interviews with clients and organization staff, 9 themes were identified in relation to access to oral health care. For the purposes of reporting and in the interview transcripts, all participants were assigned a pseudonym.

1. Limited options—Affordability

Not needing to pay out-of-pocket for the services provided was a major reason for attendance at the clinic. As Melanie and many other participants told us, "[You're] the only ones that do free cleaning...everywhere [else] you either need coverage, insurance coverage or work coverage." Clara also described how limited options for affordable oral health care can exacerbate oral health problems, and how the clinic's affordability allowed her to access care and become aware of such problems:

> *If [the clinic] wasn't for free, honestly, I wouldn't have [come] and I wouldn't know what was going on so I would have neglected [my mouth], it would have got worse, I would have been in pain, I wouldn't have been able to eat properly. So to be aware of what's going on was awesome.*

Participants whose coverage would have been limited to diagnostic or emergency treatment, or maximized if they had to use it for restorative care, were able to receive preventive services without using their current dental coverage, as Carrie described:

> *I receive government disability benefits so there's only a limited amount of funds for a two-year period of time, and I find that the government benefits are not adequate... I wanted to try it to see what this clinic was like, and not to exhaust my government benefits too quickly.*

Some participants related affordability to the convenient location of the clinic, which mitigated transportation costs had it been located elsewhere. As Sabrina told us, "It's free! So I like to come to here. Otherwise I have to take a bus, two-zone fare, to pay the fare, then pay the cleaning fee."

2. Convenience—Accessibility

The clinic was accessible because it is conveniently located in the same building where clients attend for other services, as well as being close to public transit and participants' place of residence or employment: "It's convenient. It's

Table 1. Participant responses to each satisfaction factor

Satisfaction factor	Agree/Partly agree (%)	Neutral (%)	Partly disagree/ Disagree (%)
Student was able to provide a referral for additional care (n = 54)	72.2	22.2	5.6
Clear explanations about time to complete care (n = 62)	80.6	8.1	11.3
This clinic improved oral health knowledge (n = 56)	89.3	7.1	3.6
Felt comfortable receiving care at this clinic (n = 56)	94.6	1.8	3.6
Student had the equipment and supplies to complete my care (n = 55)	98.2	0	1.8
Clear explanations about details of care (n = 62)	100.0	0	0
Information is kept private and confidential (n = 56)	100.0	0	0
Respectful treatment (n = 62)	100.0	0	0

Table 2. Examples of survey respondents' suggestions to improve the clinic and care

Satisfaction factor	Comments
Clinic location	A location closer to Vancouver
Clinic environment	I'm comfortable with student and instructor, however, the light and supplies is [sic] not enough
	Needs better ceiling lighting
	Better arm rest supports
	Music is a healthy distraction
Student–client communication	Why we are checked for cancer? The feeling of face or throat (student professional) can feel uncomfortable. Also if every tooth gum must be poked-checked. My student was respectful, professional my question was about the reason for the procedure itself as we all have different life experiences.
	Time estimate would be useful
	It would be nice to have a phone # to contact you throughout the week
Having specialized oral self-care supplies	Have some equipment needed by patient—did not have the reach brush for back teeth
Providing written oral self-care resources	A sheet from the student dentist about how to take care of my teeth maintaining oral health

free and I'm always here at the drop-in, why not [attend the clinic]" (Rachel). For other participants, the location of the clinic was seen as inconvenient because of the cost of travel, as voiced by Melanie:

> *I didn't bring my children because normally everything that they need is covered by assistance. So I can go somewhere closer to where we live for them... To take the SkyTrain it costs me ten dollars for a bus pass each day that I went, which took two days to fully clean my whole mouth. And, if I had to cart two children...that would be more difficult. Plus extra [money] for [transit] passes.*

3. Realistic expectations—Availability

Preventive services including oral health assessments, periodontal therapy, fluoride varnish, oral health education, sealants, temporary restorations, and referrals were available to meet clients' needs, but not other dental services, as Rachel commented:

> *I wish there's the same service you're getting for the hygiene thing if we could have like, free dentist...even if it's gonna take a long time, if it's gonna be...in a school setting, it's okay as long as [my mouth problems] can be taken care of.*

Participants discussed that the cost of referred care precluded them from having their dental needs met, and that they would only access the referred care when in pain. While participants were seeking services beyond what the dental hygiene clinic provided, including orthodontic services, extractions, restorations, and crowns, they had realistic expectations, as voiced by Lauren:

> *There's only so much free stuff that they can do for you, right? I mean if you wanna get like surgery, or fillings, or root canals you can't because, that's not what you guys do, right?*

4. Respect and attention—Acceptability

Participants valued their interactions with the dental hygiene students and clinic instructor and perceived them to be respectful and attentive. Participants felt respected in terms of how they were greeted: "Last time I was there [she] remembered me...she's like 'Oh yeah, I know you from before', and yeah, I really like her" (Lauren). Participants valued being called by their names, while attention during appointments was also valued, as Jamie explained: "They didn't leave me sitting in the chair to go and do anything else. The attention was constant." Melanie further described how attentive the students were, frequently checking in to ensure her comfort: "[The student] constantly asked me if I was okay, how I was doing, like she really did try and be gentle. She wasn't just like zoning in and working away at it like it was a sculpture...She knew there was a person behind those teeth." Respectfulness was further demonstrated through the provision of clear explanations of the time needed to complete care and the oral procedures to be performed. Carrie described why she values such explanations:

> *I care about my body. I want to know what goes on, everything... Every part of my body, my mouth is very important, my teeth are important, an important part of my physique. In my opinion, in general, if a person is performing this type of invasive procedure in someone else's body, explanations should be given, except for urgent or emergency situations.*

5. No judgment—Acceptability

Participants also valued that they were not judged or looked down upon because of who they are. Allie, for example, did not feel judged due to her gender: "When they know I'm transgender they don't [make me] feel [like] I'm [a] different person to any person here... They wanna make sure I'm okay." Melanie was relieved she was not judged by the condition of her dentition or income level:

> *They didn't look grossed out when they saw how unclean my teeth were...you always worry about how they're gonna react, when they look in your mouth and see the neglect... They didn't treat me as if I was any lower than they were. ...I didn't feel judged.*

However, Melanie later described an experience at the clinic in which she felt subtly judged because she felt she was perceived as not being able to afford further dental care:

> *[The student] said we could talk about [a referral] after and then we just didn't. ...I think I even felt discouraged before even knowing anything...she said it would cost still like at least a hundred dollars a month, probably on some payment plan. So I don't know, she just figured I couldn't afford that or, I'm not really sure why.*

While clients viewed the dental hygiene students as non-judgmental, staff also described how the clinic's location at EFry created a low-barrier and less judgmental environment compared to typical dental clinics, as Daniela discussed:

> *...I've heard from some of my clients that had to go access a dentist and call, and even just to make that phone call there's that barrier there, there's that judgement that they hear on the other end of the phone. So, to actually come here and know that...it's a safe environment, you know, it's part of the EFry program.*

Serena, another EFry staff member, similarly noted how clients may have difficulties attending referrals at other dental clinics due to acceptability considerations:

> *...I think the fact [the clinic is] in our building...makes a big difference... Part of the issue with when you guys make referrals, and then clients don't go to the referrals, it's that they don't want to or that they can't take that extra step to get themselves in that other location.*

6. The physical environment—Acceptability

The environment of the clinic within the women's drop-in centre was perceived differently by clients. Most participants accepted the environment: "[The clinic feels] at home...this is my second home... I used to be here every single day" (Rachel), while others did not:

> *I was expecting...sort of a good set up, and I saw what they had to work with. I did feel a little bit more uncomfortable. Just because I was thinking "is this actually sanitary enough?" ...Like their tools look shiny and they got a tray, but the floor looks...well used... But you get past that and you realize what they're doing for the greater cause. (Melanie).*

Participants described the clinic as dimly lit and small in size but accepted that, as Lauren said, because "you have to make do with what you have." Participants perceived the small size to be mostly problematic for the dental hygiene students as they needed to navigate a small space, and some perceived such navigation problems as affecting the length of the appointments.

7. Communication—Accommodation

The clinic is organized to accept clients over the phone or in person, and clients perceived the availability of walk-in appointments as accommodating. Both clients and staff discussed difficulties in communicating over the phone, as noted by Serena: "There's sometimes...a disconnect in clients trying to connect with the students and get appointments made or things sorted out, or information clearly conveyed between the two sides." Clara discussed how the availability of walk-in appointments was accommodating for her in spite of such communication difficulties:

> *I think we had a little bit of difficulty with [making an appointment]. My support worker was trying to call...she left a message, and no reply back. So I kind of just showed up. And I guess there was an available spot where someone didn't show up. So I was lucky to get in.*

The clinic's limited operating hours made it difficult for dental hygiene students to contact clients in a timely manner, and staff discussed how this could be perceived as unaccommodating given the clients' often transient lifestyles. Serena explained, "The client might not even remember making that phone call...or be around anymore!" Clients also reported difficulties in communicating over the phone but did not perceive these difficulties as problematic, although one participant was frustrated because they ended up communicating through voicemails.

Staff also discussed how their clients may have difficulty expressing their needs when contacting referral appointments, as Rachelle, an EFry staff member, highlighted, "If [the referral] was for a specific cause in the

mouth, they might not know the words to use to say that." Serena further discussed how to accommodate clients through the referral process:

> *What I think could make a difference…is that we don't do it for them but that we support them in doing it… We might write some notes about what they would say on the phone if they're nervous about that—"I don't know how to talk to this person," "What do you say?"*

8. Clients' unique needs—Accommodation

Participants appreciated that the dental hygiene students accommodated their unique needs. Melanie described how the students considered her children during appointments: "They watched [my children] for me outside of the working room… I don't think any other dentistry place would have been able to do that." Sabrina also described how the clinical instructor (the dental hygiene student faculty mentor) accommodated her care needs because she performed maintenance care during the summer when the students were unavailable.

9. Appropriate messaging—Awareness

Participants became aware of the clinic through volunteering at EFry, hearing about it from support workers, from word-of-mouth at a women's shelter nearby, and from posted flyers. However, overall awareness of the clinic seemed to be poor. Participants noted that other EFry clients were unaware of the clinic, and some others might have assumed that preventive services could not meet their oral health needs. Staff discussed how some clients with low English literacy might not understand information on clinic flyers, as explained by Serena: "We put up all these posters everywhere but a lot of our clients aren't reading those posters. Or they just see, you know, certain words like 'UBC' or 'students' and so they don't take in that information." Clients and staff discussed methods to better inform other clients, including having dental hygiene students facilitate face-to-face information sessions for clients and staff. Serena also noted the power of peer influence: "If [clients] can talk to other clients who have gone [to the clinic] you can see a shift in their attitude."

DISCUSSION

This study explored how a community-based dental hygiene clinic influenced access to oral health care for women involved with the CJS in New Westminster, Canada. The clinic's affordability and convenience and the respectful, attentive, and non-judgmental quality of the care provided facilitated access, while alternate communication approaches and clinic promotion strategies should be considered to further facilitate access.

Affordability, accessibility, and availability

Clients discussed how the cost of oral care and transportation, as well as the availability and affordability of comprehensive services affected their ability to access oral care. Clients discussed the limited availability of oral health services in the community that do not require out-of-pocket fees, suggesting that this clinic presented a unique opportunity for women to receive preventive care, which would otherwise be unaffordable. The cost of oral health care is a major barrier for Canadians, as 17.3% of those in the general population avoid visiting the dentist due to cost.[25] Clients who received public dental benefits said their benefits are limited and do not financially support all of their oral care needs. They also discussed how their fixed income precludes their ability to afford transportation to and from oral care services. This finding is unsurprising since the majority of those involved with the Canadian CJS live at or below the poverty line,[26] and transportation and treatment costs are the main reasons people avoid the dentist.[16] The cost of care and transportation are also barriers to oral care specifically for people who experience homelessness,[1] an important consideration since women involved with the CJS may experience homelessness. While transportation was identified as a general access barrier, clients were willing to cover transportation costs to this clinic, suggesting that other factors besides affordability influenced access. In regard to access to comprehensive care, while students provided referrals to trusted, low-barrier, reduced-cost clinics located in the clients' own neighbourhoods, women expressed that even these services would be difficult to accommodate financially.

Although not discussed by participants in this study, availability of services may also affect access to care, particularly for individuals receiving social assistance whose perceptions of oral health may lead them to opt for dental services that improve their appearance.[27] Other women may have thus not attended the current clinic due to the unavailability of onsite dental services that women perceived as having the potential to improve their appearance. Overall, the realistic expectations that women held about the services offered suggest that women were happy to receive any type of oral care, as long as there were no out-of-pocket costs.

Acceptability

Clients valued the personable care they received at this clinic, particularly being respectfully greeted by name and receiving close attention. For those who are marginalized, approachable and friendly dental care providers can help facilitate access to oral care.[28] Women involved with the CJS often experience fragmented health care and transient relationships with health care providers,[29] so being greeted by name could have relayed to women that they are truly valued as clients of this clinic. Women also appreciated

that they received continued preventive oral care while the community-engaged learning program was out-of-session, which may have conveyed a genuine concern for their well-being. Women expressed that being closely attended to during appointments relayed thorough care. For women involved with the CJS, particularly women who are transitioning from incarceration to the community, the slower care at this clinic could have allowed women to feel like they were being taken care of by the oral care providers. Women leaving incarceration are often overloaded with competing demands, including managing health, mental health, and past trauma, securing education, employment, and safe and affordable housing, and reuniting with and caring for children.[30] These competing demands likely limit the time and energy that women have for self-care.

Clients also valued the respectful context in which care was provided, noting specifically the explanations given about the oral care procedures. Respect is a crucial aspect of person-centred care (PCC), as it relays to individuals that they are competent to make decisions about their care and have the right to do so[31]; individuals can feel neglected and powerless if dental care providers do not adequately communicate the details of their care.[32] One survey respondent further indicated the importance of students providing explanations about oral care procedures since women at this clinic may have experienced past trauma (Table 2). Considering that women involved with the CJS have often experienced abuse or other trauma,[19,33] it is imperative for oral care providers to practise trauma-informed care (TIC).[34] For example, oral care providers must be aware that a touch to the body may trigger trauma memories for some.[34] For women who have experienced abuse, touching their mouth, head or neck and performing treatment without warning may provoke fear.[35] Informing individuals of the procedures being performed is an important aspect of communication within a TIC approach.[34] It can help those who have experienced trauma feel a sense of control over their body.[36] Being informed of the length of appointments is also an important part of communication in an oral health care setting.[37] Women perceived the explanations they were given regarding the time needed to complete care as acceptable, although some survey respondents were less satisfied. This discrepancy could be due to participant sampling, as women who had negative experiences at the clinic may have been less willing to participate in the interviews.

The students' non-judgmental approach to the women's oral status, income level, gender or other factors facilitated access to care. This finding is not surprising considering that those from marginalized populations, including those who are lesbian, gay, bisexual, and transgender[38] and women who have experienced homelessness or incarceration,[39] often face barriers including stigmatization and discrimination when accessing health care. They value service providers who are non-judgmental and sensitive to their needs.

Poor client–student communication resulted in one client feeling judged for having low income, indicating that those providing care for this population must be sensitive to both the overt and subtle ways in which judgments may be relayed. PCC, particularly open communication and including women in the decision-making aspects of their care, may help mitigate such perceived feelings of judgment.[32] EFry staff also discussed that perceived stigma from other providers may have impeded access to referred dental care. Individuals who are marginalized or vulnerable may avoid accessing health care due to stigma; those who experience homelessness may be fearful of attending the dentist and feel disrespected and stigmatized because of their lack of housing and poor oral health,[18] and individuals who have experienced incarceration may forego disclosing their incarceration history for fear of being stereotyped or treated differently by health care providers.[17] The EFry clinic mitigated the need for women to disclose such experiences. However, it is possible that fear of stigmatization due to marginalizing factors, including income status, housing situation or incarceration history, precluded access to comprehensive oral care.

Accommodation

Accommodating this population's unique care needs facilitated access. Clients valued that their children were accommodated during appointments, an important consideration since women involved with the CJS often have children; over 70% of women who are federally sentenced in Canada have children younger than 18 years of age.[40] EFry staff discussed that women might have difficulties navigating the referral process, specifically communicating with other dental care providers, and noted the value of having students guide women through this process. Further ways in which this population may be accommodated include providing written oral self-care education and written instructions about how to contact referrals.

Miscommunication between students and clients impeded access. Women struggled to contact students about appointments and information throughout the week while the students were not at the clinic. It is possible that women inquiring about the clinic experienced similar difficulties, thus precluding them from initiating contact. The availability of walk-in appointments seemed to mitigate these communication challenges, as the clinic was flexible in terms of accommodating women's schedules. Attendance at a community-based dental clinic in England for individuals experiencing homelessness was similarly influenced by the clinic's ability to accommodate these clients, whose lives can often be chaotic, by not penalizing them for missing appointments and by accepting walk-in appointments.[28] To encourage more timely communication in light of the clinic's limited operating hours, EFry

staff could be involved in scheduling appointments for clients while students are not at the clinic. Improved communication between students and clients could also help facilitate wrap-around care.

Some physical aspects of the clinic environment may also have impeded access, as women preferred clinic environments that were larger, appeared cleaner, and were aesthetically appealing in terms of brighter lighting and more comfortable dental chairs. Women's preference for a larger space could relate to past experiences of trauma, as those who have experienced trauma may be triggered by enclosed spaces.[36] Other women may not have attended appointments at this clinic because of similar concerns or because they did not feel comfortable seeking care at a more casual health care site. Findings suggest that women from this population may be more comfortable accessing care at a clinic that is community-based and approachable in terms of location and provider characteristics but also reminiscent of a typical health care clinic in certain physical aspects such as clinic size, lighting, and aesthetics.

Awareness

Finally, clinic promotional efforts seemed to hinder access. Other clients were not aware of the scope of services offered, and clinic information flyers could be unclear for women who are unfamiliar with the EFry building, ineffective for those who have low English literacy or intimidating for women who are uncomfortable with a university-affiliated clinic. Women might have been uncomfortable seeking care from an academic institution due to negative perceptions about research institutions or they may have been wary of receiving care from students rather than registered dental hygienists. Compared to clinic flyers that lack appropriate messaging, face-to-face information sessions with clients and staff may be more effective to relay information. Clinic promotion strategies should also be modified to shift the emphasis from the clinic's affiliation with the university to its affiliation with EFry.

Limitations

The generalizability of our findings is limited since women attending this clinic are not asked to disclose information about their experiences with the CJS, including incarceration history, and this study also did not ask participants to disclose these experiences. Thus, the study participants' specific involvement with the CJS remains unknown. Findings from the review of satisfaction surveys may also be skewed since clients may have completed more than one satisfaction survey as they are anonymous. Moreover, some women who completed a satisfaction survey were less satisfied with the provision of referrals, perhaps due to the required out-of-pocket costs of care or because there was no option on the survey to indicate that the client received no referral. Our collation of data from focus groups and phone interviews may have also limited our data obtained, as phone interviews may elicit more sensitive information compared to in-person interviews.[41]

The small convenience sample also limits the generalizability of our findings. We expected greater participation because of the honorarium and food provided to participants, and previous ease with participant recruitment. The unstable living conditions of this clientele could have affected their ability to follow through with participation, which was evident when some clients who initially confirmed their participation were unable to attend a focus group at the last moment. Some clients might have also been fearful of losing access to the clinic or to other EFry services if they disclosed negative information about the clinic, and so they decided to not participate. Those who did participate might have chosen to present a more positive view of the dental hygiene services offered. Moreover, no Indigenous women participated in our study, which was not surprising given our previous experiences working with this population and their reluctance to participate in traditional approaches to research. Future research on access to oral health care for this population would benefit from including Indigenous perspectives.

Given the difficulties that we experienced in conducting focus groups, individual interviews may be more appropriate for similar populations. Extra patience should be exercised when recruiting research participants from this population. Participant attendance should be confirmed if possible and researchers should anticipate no-shows by recruiting more participants than necessary and allowing adequate time for recruitment if using focus groups as the method of qualitative data collection. It would also be beneficial to ask women at the time of recruitment whether they would prefer to participate in a focus group or an individual interview, either in person or by phone. Accommodating their preferences may help women feel more comfortable participating in research and encourage their follow-through with participation.

CONCLUSIONS

Women who are involved with the CJS are an underserved population in terms of oral health care. They face multiple barriers when trying to comfortably access services. Our findings highlight the need for dental hygienists to be aware of this population's personal history and previous encounters with the health and dental care system, as well as the competing priorities in their lives. This study found that access to care for this population can be improved by creating a community-based, safe, low-barrier, and convenient location for the delivery of affordable services. Services offered in a respectful, attentive, and non-judgmental manner are valued. Ensuring timely and effective communication, wrap-around care, and appropriate clinic promotion materials will further facilitate access for this population. Introducing dental hygiene students to this population through community-engaged learning may help to improve access to comprehensive dental care for this population in the future.

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CONFLICTS OF INTEREST

The authors have declared no conflicts of interest.

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