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Dental professionals participating in a home visiting programme for first-time parents

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Background: A home visiting programme was offered to first-time parents in the south of Sweden to reduce health inequalities among young children and support parents. The programme involved a collaboration between child healthcare nurses and midwives, social workers, and dental hygienists/dental nurses. It is unusual for dental professionals to participate in such programmes. ***Objective:*** To describe the experiences of collaboration between child healthcare nurses and dental professionals and their views on the programme from a dental perspective. ***Basic Research Design:*** Qualitative semi-structured interview study with content analysis. ***Participants:*** Four child healthcare nurses, three dental hygienists, and two dental nurses. ***Results:*** Analysis identified five themes: contribution of knowledge, reinforced oral health advice, family-based oral health advice, financial considerations, and future role of the dental care. ***Conclusions:*** Participants stressed the importance of dental professionals' knowledge, the need for child healthcare nurses and dental professional to conduct home visits together to deliver family-based and reinforced dental advice. They suggested a follow-up visit and the participation of the public dental service before a private dental care provider since most children will visit a public dentist later. The programme was perceived as worth the costs, but for the best utility, the resources should primarily be for non-native parents. Further research should focus on the effect of the home visiting programme on the children's oral health.

Keywords*: collaboration, young children, oral health promotion, home visit, interprofessional teams, qualitative research*

Introduction

Early prevention and support for families with young children is important as early childhood adversity is associated with poor health and social problems throughout life. To meet the needs of young children and their parents, many countries implement preventive home-visiting programmes involving collaboration between professionals from different disciplines (Finello *et al.,* 2016). This paper concerns a home visiting programme for first-time parents in southern Sweden that aimed to achieve more equal health. The programme was funded by the Swedish government and supported by politicians at the regional level. Child healthcare nurses conducted home visits together with midwives, social workers, and dental hygienists or dental nurses during the child's first 15 months. Dental professionals do not commonly conduct home visits to families with children. Therefore, this paper focuses on the programme from a dental perspective.

Dental caries is a major health problem in most industrialized countries and the most common chronic childhood disease (Pitts *et al.,* 2017). In Sweden, about 4% of children of the age of three had caries in 2021, which is in line with previous years (National Board of Health and Welfare, 2022). However, there are disparities between children depending on their background. Risk for caries is more common among children of parents born outside Sweden (Julihn *et al.,* 2021) and of low socioeconomic status, such as low educational level, low income, and unemployment (Kramer *et al.,* 2019). Furthermore, parents' oral health habits and attitudes to oral health during their children's infancy and early childhood have consequences for children's oral health. Therefore, oral health education, with focus on parents' lifestyle and oral health habits, is recommended (de Castilho *et al.,* 2013; Isaksson *et al.,* 2019).

It is difficult to conclude what kind of oral health education is most effective in preventing childhood dental caries (Mosdøl *et al*., 2015). However, research indicates that home visits conducted by dental professionals providing oral health education are effective (Babar *et al.,* 2022; Koh *et al.,* 2015; Kowash *et al*., 2006; Plonka *et al.,* 2013). Home visiting programmes might also be cost-effective (Koh *et al.,* 2015).

In the region in southern Sweden with the home visiting programme, children are examined by a dental nurse or a dental hygienist at the age of one. The first dental visit is at the age of three, but might be earlier if a risk for caries has been identified. Collaboration between dental professionals and other professionals can contribute to preventing childhood caries (Heilbrunn-Lang *et al.,* 2020). In Sweden, dental care guidelines recommend collaboration with child healthcare as it reaches almost all Swedish children (National guidelines for dental care, 2022). Within the standard child healthcare programme, all parents with a new-born child are offered two home visits by a child healthcare nurse (one to two weeks and eight months after birth) and then regular visits at child health centres up to the age of five. Child healthcare nurses tell the parents about tooth brushing and healthy dietary habits, but according to the guidelines for dental care, the information could be more effective through collaboration between child healthcare and dental care professionals.

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The home visiting programme was running as a project between September 2019 and December 2022. The number of home visits was extended from two to six. The visits were conducted by a child healthcare nurse accompanied by a midwife (1–2 weeks after birth), a social worker (2–3 weeks; 4, 10, and 15 months after birth), and a dental hygienist or a dental nurse (8 months after birth). The programme was voluntary for parents and cost-free. It was not targeted towards special types of families, such as those of particular ethnicities or socioeconomic background. Guidelines structured the theme for each home visit, but the health professionals could adapt the information and support to individual family needs. The programme started with four inter-professional teams; thereafter, twenty four teams joined, but two of these dropped out. In total, three dental hygienists and three dental nurses participated. One hygienist and one dental nurse were from the public dental service (PDS), with the others from a private dental care provider. The dental professionals could be part of more than one team. However, the dental hygienist and the dental nurse from the PDS were each part of one team.

In a previous paper, the health professionals' managers stressed that the programme required more resources but that it probably would be cost-effective in the long run due to improved health among children, causing fewer to seek healthcare and dental care. Furthermore, the programme could be a good opportunity to demonstrate the important role of dental care in such interventions (Franzén and Nilsson, 2021). This paper aims to describe child healthcare nurses' and dental professionals' experiences of working together in the home visiting programme and their views on the programme from a dental perspective.

Method

This paper draws on a larger research project with the managers and the health professionals of the four initial programme teams. The professionals conducting the home visits had not previously worked together in these teams. A total of 12 health professionals were interviewed during November 2020 and May 2021: four child healthcare nurses, two midwives, three dental hygienists, and three social workers. It was not possible for two midwives and one social worker to participate in this study. There were only three dental hygienists because one worked in two teams. The data in this paper are based on interviews with the four child healthcare nurses and the three dental hygienists from these four teams. Additionally, two of the three dental nurses who participated in other teams were interviewed in November and December 2021. One was from the PDS and one from the private dental care provider. The third dental nurse was not available for the interviews. The interviews with the midwives and the social workers are not included here as they did not conduct home visits with the dental professionals.

The interviews were conducted by three researchers, including the author. The health professionals were interviewed individually and digitally because of the COVID-19 pandemic. The interviews lasted from 45 minutes to about one hour and were recorded and transcribed by the author and another researcher. The interviews were semi-structured, using an interview guide but with room for the participants to talk about issues that they considered important (Hinton and Ryan, 2020). Consequently, participants could talk from their perspectives as health professionals. The guide concerned the health professionals' experiences of conducting home visits and collaborating in inter-professional teams, and their views on the home visiting programme itself (not targeted towards special types of families, the number of visits, suggested improvements). The questions were based on the researchers' theoretical knowledge of inter-professional collaboration, preventive work for improved health and wellbeing, and political support for equal health.

Participants gave written informed consent before the interviews. The project was reviewed by the Swedish Ethical Review Authority (dnr. 2020-03435).

Analysis focused on the collaboration between the child healthcare nurses and the dental professionals and on the home visiting programme from a dental perspective. The interviews were analysed using qualitative content analysis (Elo and Kyngäs, 2008) by the author, who has experience in working as a dentist and of qualitative research. The transcripts were first read thoroughly several times to get an overview of the whole and to identify data relevant to the aim. Relevant sections of data were then coded and grouped into categories that were compared for similarities and differences. These categories were then grouped into overarching themes. The derived categories and themes are presented in the following section. Quotes are used to illustrate the themes. The interviewed professionals are labelled with letters – child healthcare nurse (CHN) and dental professional (DP) – and numbers. The quotes are edited slightly to improve readability.

Results

Five themes emerged from the analysis: The first *Contribution of knowledge,* influenced the next two themes *Reinforced oral health advice* and *Family-based oral health advice.* The last two themes, *Financial considerations* and *Future role of the dental care,* concerned organizational aspects of the home visiting programme. Overall, both the child healthcare nurses and the dental professionals expressed positive views on working in teams and on the participation of dental professionals at the home visits. However, their views differed slightly between and within the professions.

Contribution of knowledge

This theme contains the professionals' view of how they contributed knowledge and learned from each other with relevance to children's oral health and general well-being.

Child healthcare nurses understand and assess children's development and health, and support parents. They usually inform parents with young children about the importance of fluoride toothpaste brushing and healthy dietary habits. However, although they have some dental knowledge, they appreciated the participation of the dental hygienists and dental nurses and their expertise. One child healthcare nurse related that the dental hygienist contributed valuable advice about tooth brushing and the importance of avoiding sugary foods as food had been introduced into a child's diet at the time of the home visit.

It is not only about how to take care of the teeth, but the food. Because when she participates, the child has already begun to eat. We can talk about good food; she can talk about hidden sugar. (CHN4)

Dental professionals' knowledge comprised healthy tooth brushing and dietary habits as well as the condition of the mouth. The child healthcare nurses, and dental professionals might have similar knowledge about healthy habits, but the dental professionals knew more about oral health, as a dental hygienist stressed:

It will be new products, baby food, and we can help each other a lot. Can you eat this? How much sugar does it contain? And usually, it contains a lot of sugar. The gingiva could be little red and then the child healthcare nurse does not have so much knowledge about why that is. (DP3)

The dental nurses' and dental hygienists' knowledge could also be useful in identifying a child who at risk of harm. According to one dental hygienist, an indication of harm could be when a child has multiple decayed teeth. Consequently, dental professionals contributed knowledge that could be important for both children's oral health and general well-being.

Learning from each other

The health professionals not only contributed knowledge but could also learn from each other. One child healthcare nurse pointed out that she had originally thought she had enough dental knowledge, but that she had learned a lot. The new knowledge became useful when she met other parents later.

I thought I was pretty good at that, but I have learned a lot that will be of benefit for all [parents] who do not participate in this home visit programme. (CHN2)

Similarly, a dental nurse related that child healthcare nurses had told her that they had developed and then applied their dental knowledge in meetings with other parents. However, dental professionals also learned from the nurses, and the professionals could support each other when talking to the parents.

I have learned a lot from them and can remind them about what is dangerous, if the child is lying on the sofa and they forget to pick things up. And they also remind me and can say 'just a little toothpaste on the toothbrush'. (DP3)

Reinforced oral health advice

Working in teams helped to reinforce professional information, with advantages informing in parents together, with the means to reach professional agreement.

The child healthcare nurses and the dental professionals strived for the best support for the parents. A benefit of inter-professional home visits was that it allowed the professionals to help each other and together stress advice relevant to oral health, for example the importance of good diet and tooth brushing habits.

I have experienced many times that it has become very important for the families that you emphasize the same things . . . the food and the tooth brushing, how important it really is. (DP2)

Another benefit was that the dental professionals could talk about traumatic dental injuries when the child healthcare nurses talked about safety at home, and hence strengthen the importance of safety.

To deliver similar information, the professionals should not argue in front of the parents. To reach an agreement on what to say and how to answer parents', a child healthcare nurse related that she and the other professionals discussed possible conflicts before they met the parents. One possible conflict between the child healthcare nurses and the dental professionals concerned night-time breast-feeding when a child had got teeth.

Me and the dental hygienist talked a lot about night-time breastfeeding and about waking a child up if you have been giving them a bottle at night and brush the teeth or not. So, this was what we knew we could have a different view on. (CHN2)

A dental nurse also talked about different views between the professions on night-time breastfeeding and described how they could reach agreement:

I discuss breastfeeding [with the mother], that when a child has more teeth, at the age of one and a half years, it is good to stop night-time breastfeeding. I asked [the child healthcare nurse] 'What do you think?' The mother is breastfeeding the whole time. The nurse says, 'At this age it might be more breastfeeding'. And then together with the parents we agreed that when the child is little older no night-time breastfeeding and tooth brushing after the last meal. (DP4)

Family-based oral health advice

The third theme concerns the opportunity for the health professionals to together deliver oral health advice adapted to the needs of the families and in a comfortable environment.

Both child healthcare nurses and dental professionals felt the extended home visiting program allowed them to better adapt their advice to the needs of the families compared to when they met families at their workplaces. From an oral health perspective, the home visits allowed the professionals to see what parents gave their children to eat and drink, and whether sugary food and drinks were available, for example, a bowl of candy on a table. Although the child healthcare nurses could tell parents about healthy diet and oral hygiene habits, it was primarily done by dental professionals at the home visits. The dental professionals based their information on what they observed during the visit.

When we visit them at home, we can see a little of what they have on the table and what the child has in their hand, and then we can for example [ask] 'does he eat this often?', so we build on to that in that way. (DP1)

Further, at a home visit that the parents showed the food or drinks they had bought and asked whether such products were good from an oral health perspective. A dental hygienist who visited a family could see when a child was drinking juice in a baby bottle and informed the parents why they should avoid that.

The advice to the parents was also adapted to the number of a child's erupted teeth and on the questions from the parents about what and how often a child should eat, as a dental nurse stated.

Meeting the families in their own homes was also preferable as it was a more comfortable environment. The dental professionals could deliver information in a relaxed way, and the parents did not have to be nervous, which they might be at a dental clinic. This was beneficial, especially in vulnerable environments:

It is incredibly good in some vulnerable environments that we talk about this early in that simple and relaxed way that we do. That we are not at a clinic in white clothes and pointers, and they are scared and nervous when they show up, but that we are there as their friend or support. (DP2)

Financial considerations

This theme concerned reflections about the dental professionals' participations at the home visits in relation to the use of resources and whether those resources should primarily be used for non-native parents.

The dental professionals pointed out that meeting families at their own homes took more time than at a dental clinic. However, most of them still believed that the home visiting programme was a good strategy to prevent caries in young children and therapeutic dental care, making it cost-effective in the long run for society and the dental care services. One dental hygienist explained the goal of the home visiting programme:

The goal is improved oral health. In the long run, it will be cheaper for society. It is obvious for me that it is always more cost-effective with prevention. Dental care for children with cavities in every tooth is incredibly expensive, for both society and the single dental clinic. (DP2)

However, dental professionals' participation in the programme was also questioned as it was time consuming. Therefore, a dental professional suggested that families should be given preventive advice at dental clinics and to more than one family at time would be more cost-effective:

Instead of conducting home visits, dental care providers can do it at a clinic and invite all [families with] eight-month-old children in a forenoon or afternoon or for a whole day. (DP5)

Knowledge about good eating and oral hygiene habits differed between parents. The professionals emphasized that while every family needed some basic information, parents from other countries usually had less knowledge and worse oral habits and therefore needed more support. Consequently, the home visiting programme could primarily focus on non-native parent:

Parents from other countries have jobs, know the [Swedish] language, but follow their own traditions. It is better if the resources go to families with a foreign background. (DP4)

Future role of the dental care

The last theme reflected on the number of home visits by dental professionals and whether the PDS or a private dental care provider should participate.

Dental professionals participated at the home visit when a child was eight months old. This timing was appropriate to the eruption of a child' first tooth, but some dental professionals argued for two home visits. A second visit, when more teeth had erupted, would make it possible to see whether the parents followed the advice and, if needed, give them more support.

It would be valuable to follow up a little later through another meeting, maybe at the end of this project [to see] how it is going with the teeth, because then more teeth have erupted. (DP3)

A follow-up home visit need not be offered for all families, but be based on family needs, established during the first visit. However, it was also recognised that one home visit might be sufficient and would the resources most efficiently. As child healthcare nurses also have knowledge on good oral health habits, they could do the follow ups:

It is a little wasteful of recourses, because everything is about the economy. The child healthcare nurses also talk a lot about food and tooth brushing, so I think they could manage to do the follow up. (DP2)

Dental hygienists and dental nurses from the private dental care provider formed part of all but two teams in the programme. The dental professionals stressed that it would be better for the children's continuity of care if only the PDS participated, because most children would be examined by a dentist from the PDS at the age of three.

The majority of the children will be called to the public dental service, so it would have been more self-evident if the public dental service had accepted because they will follow up the children. (DP3)

It would also be preferable from a child healthcare perspective if the PDS participated, because it would be possible to continue the collaboration between child healthcare nurses and dental professionals. One of the private dental professionals stated:

A child healthcare nurse said that if I had worked at the public dental service, we could have continued to have a relationship. Now I will disappear to my previous job. So, if this [home visiting programme] happens again it would be better if the public dental service participates. (DP2)

Discussion

Home visiting programmes for parents with young children utilize inter-professional teams to meet the needs of the families (Finello *et al.,* 2016). This paper

described child healthcare nurses' and dental professionals' experiences of working together in a home visiting programme for first-time parents (aimed to reduce health inequalities) and their views on the programme from a dental perspective.

Both child healthcare nurses and dental professionals emphasized that the dental professionals contributed expert dental knowledge. The professionals also learned from each other, which indicates that they together could play an important role for both children's oral health and general health and wellbeing. Further, the participation of dental professionals resulted in oral preventive advice being stressed by both groups, which was believed to be more effective than when the professionals worked individually. Nonetheless, child healthcare nurses and dental professionals had different views on night-time breastfeeding. In Sweden, the recommendation is that mothers should exclusively breastfeed for the child's first six months and then use it as a complement up to the age of 12 months or more (Swedish Food Agency, 2022). Dental professionals should encourage mothers to breastfeed for optimal development and health for their child (UK guidance, 2019). However, as night-time breastfeeding beyond the age of 12 months can increase the risk of tooth decay, the importance of good oral hygiene is stressed in Swedish guidelines (Swedish Association of Local Authorities and Regions, 2022). To avoid conflicting advice in the programme, professionals discussed breast-feeding both before and during a home visit. As the participation of the dental professionals is an opportunity to encourage breastfeeding and give oral hygiene advice, a professional agreement is valuable.

Another argument for the participation of dental professionals was that their oral health advice could be tailored to the needs of the individual family. At the parents' own homes, dental professional could *see* what the children had to eat and drink. The parents could also be more comfortable than at a dental clinic and feel safe to ask questions. Adapting oral health advice to the individual family needs and questions is in line with a person-centred approach, which is recommended for improving health outcomes and encouraging individuals to follow advice (Robinson *et al.,* 2008). Early oral health education with focus on parents' lifestyle and oral health habits is recommended because parents' knowledge is significant for children's oral health (de Castilho *et al.,* 2013; Isaksson *et al.,* 2019).

Home visits by oral health therapists is one way of working that can be effective in preventing childhood dental caries (Plonka *et al.,* 2012; Koh *et al.,* 2015). The dental professionals who participated in the home visits were dental hygienists and dental nurses. The use of these professionals is important in preventive dental care aimed at reducing oral health inequality among children (Ramos-Gomez, Kinsler and Askaryar, 2020). Early oral health promotion by non-dental professionals can also be important in caries prevention among families with young children (Brännemo *et al.,* 2020; Heilbrunn-Lang *et al.,* 2020). Receiving help from non-dental professionals might be useful if dental professionals are not available. However, healthcare nurses appreciated the dental professionals' expertise. This is in line with health visitors in United Kingdom, a profession similar to child healthcare nurses in Sweden, who visited parents with a new-born child. Most health visitors felt confident discussing oral health with parents, but their knowledge on fluoride effectiveness and toothpaste use varied (Oge *et al*., 2018). Therefore, dental professionals should not be neglected in preventive oral health interventions. However, it is difficult to conclude which kind of health education and support for parents that is most effective in preventing childhood dental caries (Mosdøl, Forsetlund and Straumann, 2015).

Despite benefits of the home visiting programme, suggestions for improvements were made from a dental perspective. The dental professionals wished to conduct a follow-up home visit, but felt that child healthcare nurses could perform the follow ups. Further, they argued for a targeted approach towards non-native parents, who often needed more oral health advice and support. More caries has been observed among children of parents born outside Sweden (Julihn *et al.,* 2021), which suggests a need for targeted interventions towards this group. However, the effects of targeted home visiting programmes are not self-evident (Sandner *et al.,* 2018).

The participation of the dental professionals at the home visits used more resources. Most of the dental professionals believed it to be worth the costs as it could improve oral health among children, creating savings in the long run. The financial considerations should be related to the free dental care for children and young adults up to 23 years of age in Sweden, financed by taxes in a capitation system. This system might lead to dental care providers not being remunerated for all treatment costs, which means that oral healthy patients are desirable.

The professionals stressed that the PDS should participate instead of professionals from private dental care, as most children will visit a PDS clinic from the age of three years. About 80% of children in Sweden visited the PDS in 2016 (Swedish government official report, 2021). If dental hygienists or dental nurses from the PDS conducted the home visits, their relationship with the child healthcare nurses would not be broken. In turn, the professionals could together care for the child during early childhood. Additionally, a continuity in the relationship between dental professionals and parents is valuable for establishing trust. Bad experiences or dental fear among parents might cause them not to bring their child to a dentist. Perhaps trust in a dental hygienist or a dental nurse can be helpful in such circumstances.

One limitation of this paper is the number of participants. The number is small because the larger research project that this paper is based on focuses on the initial four inter-professional teams in the home visiting programme; further, the dental professionals could be part of more than one team. Another limitation is that study was conducted in Sweden and therefore the findings cannot be generalized to other contexts. Nonetheless, this paper contributes knowledge that would be of interest for politicians and policymakers in discussions about introducing similar programmes. Further research is needed about the effect of the home visiting programme on children's oral health as the effectiveness of oral health interventions is not self-evident.

This paper's focus was on both child healthcare nurses' and dental professionals' views on the home visiting programme from a dental perspective, to get a

deeper understanding compared to that resulting from focusing on only one of the professions. The data were interpreted by the author, who has a professional background as a dentist. Researchers' pre-understanding can be used positively to evaluate their research, but it can also constrain the development of new knowledge (Alvesson and Sandberg, 2022). The description of the analysis and the presented quotes from the interviews will make it possible for readers to assess the validity of the interpretation (Elo and Kyngäs, 2008).

Conclusions

Child healthcare nurses, dental hygienists and dental nurses who collaborated in the home visiting programme stressed the importance of the dental professionals' knowledge and the benefits of conducting home visits together. Moreover, the dental professionals suggested a follow-up visit and preferred the participation of the PDS instead of a private dental care provider. The programme was perceived as worth the costs, but the resources should primarily be for parents born outside Sweden for the best utility. Further research should focus on the effect of the programme on children's oral health.

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