Building oral health capacity in a women’s health service

Angela Durey, Susan Kaye Lee, Bola Adebayo and Linda Slack-Smith

Abstract. Adult women in Australia are more likely than men to have no teeth, more missing teeth or have a dental hospital admission. Experiences of war, family and domestic violence, mental health or alcohol and other drug use problems may also negatively affect women’s oral health. Yet, oral health is often excluded from primary healthcare. Little is known about what helps or inhibits primary healthcare service workers to promote oral health to women in need. Identifying the perceptions and experiences of such workers is a step towards a strategy to develop resources to support them in raising oral health issues with disadvantaged clients. This paper presents findings from a qualitative study conducted at a community-based women’s health service, which used focus groups to investigate workers’ perceptions of promoting oral health and accessing services for their clients. Findings indicated how structural issues informed oral healthcare, where workers generally did not consider oral health their responsibility, were reluctant to raise the issue with clients and had limited oral health knowledge and resources. To overcome these barriers, workers identified the need for oral health resources and better linkages to the dental system to help support their clients.

Introduction

Poor oral health is a major cause of morbidity across the lifespan, involving pain, eating problems, hospital admissions and general anaesthetics, sometimes resulting in significant expense (Mouradian et al. 2000; Selwitz et al. 2007). Good oral health is integral to general health and wellbeing in the context of appearance, eating, speaking and socialising (Women’s Health Victoria 2016). Financial and other barriers can delay dental treatment, affecting both individuals and the wider community. Barriers result in dental morbidity and more costly dental care and indirect costs associated with missed employment, education and care responsibilities (Productivity Commission 2016). Dental conditions were the second highest cause of acute, yet potentially preventable hospitalisations in 2013–14 (Australian Institute of Health and Welfare, AIHW: Chrisopoulos et al. 2016). Such hospitalisations could be avoided with the provision of timely and adequate dental care in the community (Productivity Commission 2016).

Investigation of the influences of sex and gender on oral health has been limited, and many data are presented without adjustment or stratification for age (Doyal and Naidoo 2010). Recent Australian data indicate that adult women are more likely than men to have no teeth (edentate), more missing teeth or have a dental hospital admission. (AIHW: Chrisopoulos and Harford 2013). Although sex and gender influences on oral health are not well understood, saliva composition and flow, hormones and timing of tooth eruption may play a role (Russell 2013). Untreated dental caries and periodontal disease can lead to chronic pain and exacerbate comorbidities (Mouradian et al. 2000; Selwitz et al. 2007), particularly in disadvantaged population groups such as women with experiences of domestic violence, mental health and alcohol and other drug use problems and those from war-torn areas (AIHW 2017; Slack-Smith et al. 2017). Many women facing these issues have experienced physical and psychological trauma that can affect their overall health status, including oral health. For example, many women suffer head, neck and facial injuries from family and domestic violence (FDV) (Muelleran et al. 1996). The head and neck is the area most often injured in hospitalised cases of assault of women and girls of all ages (59% of cases). This was also true when the perpetrator was a spouse or domestic partner (61%) (AIHW 2017). However, the negative effects of FDV on women’s oral health have received less attention compared with their general health (Women’s Health Victoria 2016). One Portuguese study reported oral trauma to be present in 13% of injuries from FDV, including injury to teeth, gums, palate, jaw bones and tongue (Caldas et al. 2012).

Identifying information and resources that health workers require to raise and discuss oral health issues with their female clients is important in assisting community-based services to

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What is known about the topic?

- Oral health is often excluded from primary healthcare. Health professionals, who are not dental professionals, often have limited, if any training in oral health.

What does this paper add?

- This paper identifies the importance of including oral health in primary healthcare, and provides qualitative evidence regarding how to support non-oral health professionals to promote oral health to women who experience disadvantage.

promote oral health in disadvantaged population groups. This paper presents findings from a qualitative study investigating health and social service workers’ perceptions of their client group’s oral health and the oral health resources they need to support them in their roles.

Methods

Setting and recruitment

Given that there are limited studies of oral healthcare of women from disadvantaged and traumatised backgrounds in Australian primary healthcare settings, we adopted an inductive approach guided by grounded theory (Strauss and Corbin 1998) to identify key themes from the perspectives of care workers. The study was conducted at a not-for-profit community-based health service in the Perth metropolitan area. The organisation provides health services for women and their families, including those from Aboriginal or Torres Strait Islander and culturally and linguistically diverse (CALD) and refugee backgrounds; and those experiencing mental health issues, FDV, alcohol and other drug problems or eating disorders. Study participants included paid and unpaid workers at the health service.

Ethics approval (RA/4/1/8290) to conduct the research was obtained from the Human Research Ethics Committee at the University of Western Australia.

Data collection

Focus groups were conducted at locations convenient for participants, primarily in the workplace. Participants were given information sheets and invited to sign consent forms before discussions were audio-recorded. Questions guiding discussions elucidated barriers and enablers to workers promoting oral health to clients and perceived accessibility of dental services for their clients, and included:

- intention to discuss oral health with clients;
- knowledge of barriers and enablers to oral health;
- knowledge of referral pathways and dental services;
- current, as well as needed resources to assist workers in promoting oral health and access to dental services; and
- challenges workers faced in discussing oral health issues.

Data analysis

Audio-recordings were transcribed and imported into NVivo (ver. 11, QSR International Pty Ltd, Melbourne, Vic., Australia, see http://www.qsrinternational.com/products_nvivo.aspx) for organising and managing qualitative data. Guided by grounded theory, researchers independently conducted a line-by-line analysis of focus group transcripts that were open-coded and sorted into categories (barriers and enablers), and then more selectively coded for key themes emerging from the data relating to the research questions (Strauss and Corbin 1998; Huberman 1994). Findings were then discussed and reviewed, and key themes were agreed and summarised, noting any similarities and differences between the groups.

Results

Five focus groups were conducted with thirty-two female health and social service professionals, workers and volunteers. Most participants were born outside Australia (Table 1) and ages ranged from 23 to 75 years (median age 51 years). In total, 38% held post-graduate qualifications. Apart from two volunteers, all were paid employees of the service.

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Barriers

Many participants considered that, although a client’s oral health ‘is important, it is not in our role’ to raise it as an issue. While openly discussing other issues such as sexual health with clients, several participants considered raising oral health an ‘invasion of their privacy’ and:

- It is very intimate – yet I can talk about discharges from the vagina to a group of women and not feel I am being offensive . . . I tell them where they can go and get help [Focus Group 4].

Although one participant explained that telling a client they have an oral health issue, such as bad breath, could result in ‘any self-esteem [being] destroyed’, another reflected that some clients might appreciate being told, and it was the worker’s own discomfort that prevented her:

- Even though it is an important issue for them, I can avoid it to protect my own awkwardness [Focus Group 4].

Some participants were uncertain about bringing up oral health with women from culturally and linguistically diverse backgrounds:  

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I don’t know about how you would go with multicultural women. I just think there would be some shame around that if it is not our area [Focus Group 1].

Another suggested they would ‘wait for them’ to bring up oral health as an issue.

The lack of information about oral health and requirements to access dental services was another key barrier:

So you are an Australian resident. ‘Yes, you can access into the school dental system’. ‘No, you are too young’. I don’t know what you do. So that is tricky, because you are trying to keep it all in your head and it is quite hard [Focus Group 3].

Confusion prevailed about who could access which service:

‘If you are a Veteran Affairs client, you can access into this service. If you are a child, you can access into the school dental program. If you are Aboriginal, you can access into this program.’ But it is like this knowledge is in the universe, but it is never written down anywhere [Focus Group 3].

Participants acknowledged problems navigating the current dental system where ‘our at risk’ clients would find it very difficult’. This led to uncertainty about appropriate referral pathways, available dental services for their clients and visa requirements to access services:

...for some of the women who are here on different visas it is really hard to find services for them because, you know, if they are on this visa, they can access into this, whereas if they are on that visa, they can’t [Focus Group 3].

According to one participant, newly arrived migrants, including those on student visas:

...just have no idea of how the dental health system works and no idea how to access it [Focus Group 3].

In addition, lack of knowledge about the cost of services was also a significant barrier in assisting clients to access care:

So, actually understanding how the system works and how you can actually get in there, how to work the system is the actual thing. And then what do you do if you can’t pay the money upfront? Can you do a payment plan? [Focus Group 3].

Asylum seekers sometimes could face similar problems:

...none of them had any Medicare or anything like that so they had to rely on the free [services] [Focus Group 1].

One participant considered it ‘almost cruel to say ‘by the way you need your teeth attending to’ when they can’t do anything about it’. There was consensus between the groups that oral health was not a priority when their clients were in crisis, even though overall it was considered an important aspect of general health. One participant mentioned that some mental health clients:

...will oftentimes opt for dental care as being, you know, above seeing a psychiatrist or therapist or any of that. You know, it is a priority for them, as a sort of key health issue [Focus Group 3].

Enablers

Some participants acknowledged that avoiding the discussion of oral health with their clients could constitute a potential risk factor to overall health and mentioned strategies on how to begin such a discussion:

I think oral health will often come up with a client when you are talking about nutrition, because when you are starting to get down to, ‘Well, do you have high sugar content in your diet?’ and how that may affect their behaviour, their moods; for example, then you would probably move into the conversation more around oral health [Focus Group 3].

Another participant suggested workers also needed more awareness of the relationship between oral health and general health:

I think just information around what poor oral health can cause for health professionals would be very valuable, because, as you said, there would be incidents where people would have a complication but think it is something else, and if the health professional can see some sort of link back to oral health, then they are likely to at least ask the question [Focus Group 3].

Participants also welcomed information on minimising harm to oral health for clients with eating disorders, alcohol and drug problems or those on medication. The importance of care providers increasing their knowledge about oral health, particularly when a client might require emergency treatment, was also discussed. Participants agreed that a plan of simple tips on managing common risk factors for oral health (such as sugar and certain medications) and knowing when to direct their clients to a health service would be useful:

When would you send a patient or a client to their GP? When would you send them to the hospital?... Like, the usual one is something like they have been bashed and they have got broken teeth and bits of teeth and ‘Oh, they will just have to wait to Monday’. I am thinking, ‘No, they don’t have to wait for Monday. They can actually go and get pain relief and stuff from the hospital’ because, you know, they actually have teeth that are just hanging on, so they are in danger of breathing them in... [Focus Group 3].

Some participants suggested dental professionals and their staff needed to understand the importance of building good relationships with women who have been marginalised or who may have experienced trauma or violence. It was important that these women felt comfortable attending the service, noting that at one local clinic:

The receptionists are always friendly. And they describe everything that they are going to do. They sit you down first and then put you in the chair, ‘This is what we are going to do. This is what it is going to cost.’ And it does make a huge difference to having that trust in someone [Focus Group 3].
Building trust is particularly important when English is not well understood, raising questions at an organisational level:

If that patient doesn’t have good English, then are there interpreters available able to relay those messages? But that gaining confidence and communication is vital isn’t it? [Focus Group 3].

Sensitivity to context was particularly relevant when dental professionals treat women with experiences of domestic violence and other types of physical or psychological trauma, reiterating the need for professional development in this area:

In terms of some form of trauma informed practice where they learn the basics around, you know, like, what is trauma informed practice? If you have somebody who has been quite severely traumatised, it is really, really important to ask permission for practically everything you do [Focus Group 3].

Without this sensitivity, women can enter:

...this sort of whole cycle of they won’t go back because they are too terrified of the way it feels ... we do actually see a lot of women who have been sexually assaulted and abused, so having ... a man, like, leaning over them just gives huge flashbacks and all sorts of problems with that [Focus Group 3].

Some suggested that promoting oral health should be introduced into the newly arrived migrants’ settlement program, whereas most participants suggested more information was needed on understanding the dental system:

It is almost like there is a perception that Medicare and emergencies cover all our general health, and then there is dental and oral health, but that is different [Focus Group 3].

Key barriers to workers discussing oral health with their clients included perceptions that oral health was not their responsibility, leading to reluctance to bring up the issue; uncertainty about their clients’ cultural views about oral health; limited knowledge and resources related to oral health; and referral pathways and visa requirements to access public dental services. To overcome these barriers, participants recommended workshops on oral health as part of their professional development. These workshops would include basic information about oral health, including risk factors such as high sugar intake as well as appropriately referring clients to dental professionals or a hospital. Workers indicated that learning about harm minimisation strategies would also be useful when working with clients with eating disorders, alcohol and drug problems or for clients on medication. They also suggested developing resources to help them raise oral health issues with their clients, including information on the cost of services, location, whether services were child-friendly and availability of female dentists including those from CALD backgrounds. Participants also highlighted the need for resource materials to reflect the cultural diversity of their clients.

Findings from the focus groups are being used to develop resources to support workers raise risk and protective factors related to oral health and access to care with their clients.

Discussion and conclusion

Oral health is important to general health and wellbeing. Despite the rhetoric that dental disease is preventable, few studies have sought to understand how various community support groups perceive oral health and dental care, and which factors enable some groups to engage in preventive dental care and others to avoid it. Understanding how people conceptualise oral health is important; do they consider dental caries a preventable disease? Can they identify what prevents good oral health outcomes? A recent synthesis of existing literature identified that, despite advances in how oral health is conceptualised, it is often still referred to in dental research as the absence of disease with a focus on individual dysfunction and disability (Brondani and MacEntee 2014). Research and practice often centre on encouraging individuals in our society who are most burdened to do better to improve oral health. Such approaches can be counter-productive, implicitly blaming and shaming individuals for poor oral health (Durey et al. 2017).

Our findings suggest difficulty and confusion accessing dental services, lack of information about cost and referral pathways and oral health not generally being included in primary healthcare. This suggests the need to shift the focus to a more upstream approach that offers a broader perspective on oral healthcare by taking into account the relationship between structure and social practice. Structure is defined as social, political and economic factors beyond the control of individuals that affect social practice (White 2002); in this case, oral healthcare in a general or primary healthcare setting. In Australia, dental professionals often work in isolation and are not well linked with primary health workers, with each group missing opportunities for inter-professional collaboration that can improve practice and health outcomes (Tippin et al. 2016). Structural factors that can improve oral healthcare include better education for dental professionals about prevention and providing opportunities for dental and other primary healthcare workers to collaborate and share their knowledge and skills in ways that change their practice in primary healthcare settings and benefit women from disadvantaged and often traumatised backgrounds to improve their oral health outcomes (Crocombe et al. 2014; Keeling and Fisher 2015). Evidence suggests women are seldom asked by dental professionals about FDV, but would like to be (Nelms et al. 2009), raising the question of where the problem lies.

Community support workers can play an essential role in this process by promoting oral health to those in need. Yet, at a structural level, they are often under-resourced in terms of education and training in appropriate knowledge and skills about oral health and linkages with the dental profession (Frenkel et al. 2002; Catteau et al. 2016; Adebayo et al. 2017). Findings from our study suggest that providing information (including referral pathways) and resources for health and social service workers in a community-based women’s health centre and fostering collaboration with dental professionals can improve practice by increasing awareness about the importance of oral health and its associated behaviours. This approach can be a useful strategy to promote the overall health and wellbeing of women who have experienced disadvantage and trauma.
Limitations
Given the small sample size and specific setting, findings cannot be generalised across other settings. However, although the study focused on one not-for-profit women’s health service in the Perth metropolitan region, we would cautiously anticipate that findings would be similar across other jurisdictions and in regional and rural areas, given the lack of standardised oral health education and training for non-dental health professionals (Crocombe et al. 2014).

Conflicts of interest
The authors declare that they have no conflicts of interest.

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References