parent’s views on children’s oral health
The SCC assesses the consumer perspective in any situation by analysing the position of consumers against a set of consumer principles.

These are:

ACCESS
Can consumers actually get the goods or services they need or want?

CHOICE
Can consumers affect the way the goods and services are provided through their own choice?

INFORMATION
Do consumers have the information they need, presented in the way they want, to make informed choices?

REDRESS
If something goes wrong, can it be put right?

SAFETY
Are standards as high as they can reasonably be?

FAIRNESS
Are consumers subject to arbitrary discrimination for reasons unconnected with their characteristics as consumers?

REPRESENTATION
If consumers cannot affect what is provided through their own choices, are there other effective means for their views to be represented?

About the Scottish Consumer Council

The Scottish Consumer Council (SCC) was set up by government in 1975. Our purpose is to promote the interests of consumers in Scotland, with particular regard to those people who experience disadvantage in society. While producers of goods and services are usually well-organised and articulate when protecting their own interests, individual consumers very often are not. The people whose interests we represent are consumers of all kinds: they may be patients, tenants, parents, solicitors’ clients, public transport users, or simply shoppers in a supermarket.

Consumers benefit from efficient and effective services in the public and private sectors. Service-providers benefit from discriminating consumers. A balanced partnership between the two is essential and the SCC seeks to develop this partnership by:

• carrying out research into consumer issues and concerns;
• informing key policy and decision-makers about consumer concerns and issues;
• influencing key policy and decision-making processes;
• informing and raising awareness among consumers.

The SCC is part of the National Consumer Council (NCC) and is sponsored by the Department of Trade and Industry. The SCC’s Chairman and Council members are appointed by the Secretary of State for Scotland. Future appointments will be in consultation with the First Minister. Martyn Evans, the SCC’s Director, leads the staff team.

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There is no doubt that the state of children’s oral health in Scotland leaves a lot to be desired. There are particular problems in deprived areas, and there is considerable inequality in oral health between different groups in our society. The Scottish Consumer Council is pleased that the Scottish Executive is taking these problems seriously, and consulting on ways in which children’s oral health can be improved.

To contribute to this consultation, the Scottish Consumer Council decided to try to find out more about what parents of young children affected by some kind of disadvantage thought about their children’s oral health. What we found was that these parents support an approach that addresses the root causes of oral health problems, including poverty and diet, rather than attempting to deal with the consequences of these underlying problems.

The parents we spoke to expressed concerns about the Scottish diet and about the standards of school meals. They were aware of the importance of a healthy diet and they were in favour of anything which would make it easier for them to access healthy food. Equally, they understood the importance of oral hygiene and regular toothbrushing, although some of them spoke of the cost of toothbrushes and toothpaste. Many of those we spoke to had difficulty in finding a dentist who would take on NHS patients.

We also explored these parents’ knowledge of and attitude to the use of fluoride in improving oral health. What we found was considerable concern about the consequences of adding fluoride to our public water supply, and a concern that they simply did not know enough about the effects of fluoride, both the advantages and the possible disadvantages. They felt that they would need to know a lot more about what levels of fluoride were safe, and about how to make sure that their children were not getting more fluoride than was good for them. In general, they wanted to be able to make their own choices about whether to use fluoride or give it to their children. They wanted sufficient information to be able to make that choice for themselves and they wanted to be able to work out how fluoride from different sources will ‘add up’ to the amount their own children need.
I believe that this research provides interesting evidence of the views and attitudes of parents in Scotland. It shows a relatively high level of awareness of what helps oral health, and a degree of caution about how fluoride should be used. The parents expressed a strong preference for preserving people’s right to choose, and for good information and advice about how much fluoride was safe.

Graeme Millar

Chairman
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In response to the Scottish Executive consultation Towards Better Oral Health in Children the SCC has undertaken research to examine parents’ views on how best to tackle children’s oral health. This study places special emphasis on parents’ views on the use of fluoride as a preventative measure.

The SCC has a specific remit to promote the interests of disadvantaged consumers. This study focuses on those parents who might have experienced some disadvantage due to being on a low income, coming from an ethnic minority background, being a single parent or living in a part of Scotland that is geographically remote.

Six focus groups were undertaken where we asked parents about their views relating to oral health and oral health care; on the use of fluoride and experiences of caring for their and their children’s teeth.

The report looks at the factors which parents believe contribute to children’s oral health, namely, diet, oral hygiene and dentistry. It examines current levels of knowledge and awareness of fluoride and details parents’ reactions to the various proposed initiatives which use fluoride in alternative ways.

Diet was considered the single most important factor relating to children’s oral health. The Scottish diet, with its high consumption of sweets and fizzy drinks was criticised but there was a good awareness of what a healthy diet should be. Cost and availability were the biggest barriers to a healthy diet and parents found food labels confusing. Parents believe they can control the diet of their young children but older children are more likely to have a poor diet as their parents have less influence.

Food in schools was an issue for many parents. Excessive choice, unhealthy options in school dinners and vending machines selling sweets and fizzy drinks were criticised. Parents wanted schools to be places where healthy eating could be encouraged, and where healthy choices and free drinking water were available.
Children’s oral hygiene habits tend to reflect those of their parents with toothbrushing being the main means of achieving good oral health. Those on low incomes find the cost of toothbrushes and toothpaste can be a barrier to good oral hygiene. The provision of free toothpaste and toothbrushes was suggested as one solution. Schools and nurseries may have a role to play in improving children’s oral health through toothbrushing initiatives.

Most parents want their children to attend the dentist yet children’s attendance habits reflect those of their parents. Many parents do not attend the dentist regularly largely due to fear and cost. A lack of availability of NHS dentists was the single greatest barrier for those living in Dumfries. Any effort to encourage children to attend the dentist should target parents and address the barriers identified.

Knowledge about fluoride was very limited in all of the groups. This may be due, in part, to reluctance by dentists to give advice about fluoride. Use of fluoride was mainly limited to toothpaste.

When parents were asked about fluoride being added to the public drinking water supply or to their diet they expressed a number of concerns. They were worried about a chemical being added to their diet; the potential risks to long term health associated with fluoride; the potential effects of swallowing it; fluorosis and fluoride supplements being viewed as an alternative to good oral hygiene; and a healthy diet. They also believed that those who are allergic to fluoride would face problems where initiatives were introduced and that the correct dosage of fluoride would be extremely difficult to calculate.

Respondents rejected the idea of adding fluoride to water because people could not choose whether or not they received fluoride. They were sceptical about whether everyone would benefit from fluoride and those living in poverty might consume less water than others and subsequently would benefit least.
Alternative methods of delivering fluoride received a more positive response. Fluoridated milk in nurseries was felt to be a reasonably acceptable idea although children who do not drink milk would not receive any potential advantages. Adding fluoride to salt, which is considered unhealthy, would seem contradictory and confusing. Parents were unhappy with the notion of children accepting fluoride tablets from a teacher: this was felt to be a parental role and introducing a culture of tablet taking did not receive favour.

The groups wanted information about fluoride. Specifically they wanted to know about dosage, who stood to benefit from fluoride, and potential risks to long-term health.

Fluoride was viewed as a sticking plaster solution and parents thought the best way to improve children’s oral health was to address the cause which they believed to be diet and poverty.
Chapter 1 Introduction

The Scottish Consumer Council (SCC) has a specific remit to promote the interests of disadvantaged consumers. In response to the Scottish Executive consultation Towards Better Oral Health in Children the SCC has undertaken research to examine parents’ views on how best to tackle children’s oral health. This study places special emphasis on parents’ views on the use of fluoride as a preventative measure.

1.1 Aims of the study

The study aimed to focus on those parents who might have experienced some disadvantage due to factors such as being on a low income, coming from an ethnic minority background, being a single parent or living in a part of Scotland that is geographically remote.

The aims of the research were:

- to access and provide qualitative information about targeted groups of parents’ views on oral health and oral health care
- to gain an insight into the barriers to good oral health faced by these parents
- to provide qualitative information on parents’ views on the use of fluoride, and in particular, the alternatives outlined in the consultation document
- to access information on how children’s oral health might be improved.

1.2 Methodology

Six focus groups were undertaken in the following places:

- Craigmillar, Edinburgh
- Glasgow (two groups)
- Port Glasgow
- Oakley, Fife
- Dumfries
The recruitment of the focus groups was undertaken by the Scottish Consumer Council, and the Scottish Community Diet Project provided contacts with existing community groups. The focus group discussion typically took place at the group’s normal meeting times. As a result of this approach the group composition was heavily biased towards women with only two men participating across all six groups. In total, 53 people participated in the focus groups.

A control group of parents from social groups ABC1 was recruited by the Scottish Consumer Council and this discussion took place in the SCC offices in Glasgow. This group was recruited to establish whether there were any issues particular to those experiencing disadvantage.

The five projects with which the study worked were:

- Greengables Nursery School, Craigmillar, Edinburgh
- Meridian Black and Ethnic Minority Women's Information and Resource Centre, Glasgow
- The Rainbow Family Centre, Port Glasgow
- Oakley Healthy Options, Oakley, Fife
- Gingerbread, Dumfries

By focusing on those who experience disadvantage we were able to explore the factors which contribute to poor oral health, and its links with deprivation.

The focus group discussions took place between the 12th and 22nd of November, 2002. A topic guide was prepared and this provided the basis for the discussion. However, groups were free to discuss other matters which they felt were relevant to children’s oral health.

All the group discussions were recorded and transcripts made. This report has been prepared using the transcripts from the discussions. Discussions lasted roughly one and a half hours.
1.3 Structure of this report

Chapter 2 looks at the factors which parents believe contribute to children’s oral health, namely oral hygiene, diet and dentistry. Within each of these factors, levels of knowledge, current behaviour and barriers are examined.

Chapter 3 examines current levels of knowledge and awareness of fluoride and where that information has come from. It details parents’ reactions to the various proposed initiatives which use fluoride in alternative ways including adding fluoride to the public drinking water supplies, the use of fluoridated milk or salt in various settings, and fluoride tablet/drop regimes in nurseries and primary schools.

Chapter 4 summarises the findings of the study, and draws conclusions, highlighting the main issues raised by parents.

As a qualitative study this work seeks to represent a range of views which arose in the course of discussions. It does not claim to be a representative study, rather it highlights themes and issues. However, there was consensus in many areas, and we believe that this study provides robust evidence on parents’ thoughts on how best to approach the problem of the poor oral health of Scottish children. It cannot give a quantitative measure of the strength of conviction or the number of people holding any view. However, where possible, some indication is given of where the balance of opinion lies.

The quotes throughout the report are attributed to the groups which made them. Where the quote is from the control group of ABC1 parents, this is attributed to ‘control’.
Parents were asked what they felt contributed to healthy teeth and gums. They typically cited good oral hygiene regimes in the home, a healthy diet and regular visits to the dentist as the main factors. There was also recognition that parents and other adults play a crucial role in educating their children and setting examples (for better or worse).

There was also some recognition of genetic factors predetermining the health of teeth and gums. This was not discussed at length as parents tended to focus on factors over which they had or could have influence.

2.1 Diet

- diet was considered the single most important factor relating to children’s oral health
- parents do not find it easy to know when diet is healthy for teeth
- parents believe they can control the diet of their young children
- older children are more likely to have a poor diet as their parents have less influence
- parents had concern about their children’s diet when other people looked after them.

All the groups mentioned diet before any other factor. There was a very high awareness that a healthy diet is an important factor in building healthy teeth and gums. A diet containing fruit and vegetables was viewed as healthy while poor diets were described as those containing fizzy and sugary drinks, and sugary foods, particularly sweets. At this level there was generally good knowledge as to what constituted a healthy diet.

However ‘healthy’ products were not necessarily good for children’s teeth. Some parents thought they were providing their children with healthy drinks when they gave them fruit juice and later found out that fruit juices were acidic and could damage teeth.

Even the parents in the control group found this hard. They talked about assimilating a wealth of sometimes contradictory messages, and how they had come up with a diet they believed would cause minimum damage to teeth and health in general.
‘We’ve moved on to red grape juice because it’s got the colour, diluting it and trying not to give them as much.’

Control

Participants felt under pressure to balance other health benefits while taking care of teeth.

‘But they’re getting vitamins from fruit juice. My oldest will not eat fruit and veg so I think at least she’s getting vitamin C. But then she’s had to get two of her milk teeth out… I found it really traumatic. Is that because I’m giving her lots of fruit juice? And you think you can’t do anything right.’

Control

The diet of pregnant mothers was specifically mentioned by a couple of groups as having an effect on building children’s teeth and gums. One mother said that her doctor had told her prescription drugs she had taken while pregnant had caused her daughter’s discoloured teeth.

A couple of the groups mentioned sugar in medicine as a cause of dental decay for children. In both groups there was some awareness that sugar-free alternatives were available but said they had not been offered this option by their doctors.

Calpol is very sweet. My children always say “Mummy I’m not well. Give me Calpol”.’

Meridian, Glasgow

Parents of younger children felt they had a lot of control over what their children ate. However, they did not have control when their children were being looked after by other people. Grandparents, in particular, were blamed for giving children unhealthy food and drinks. Sweets were used to pacify children and these tended to be sweets which are sucked on and would ‘keep children quiet’ for a while.

‘They (grandparents) want to keep him happy. They give him everything.’

Meridian, Glasgow
Those who had older children felt they had less control over their children’s diet as their older children spent less time with them, had their own pocket money and became more assertive.

‘They start going uptown and spending all their money on chips and rubbish.’

Dumfries

‘I can’t tell my boy not to drink Irn Bru. He’d look at me like I’m stupid.’

Port Glasgow

Diet at school

- excessive choice and unhealthy options in school dinners were criticised
- vending machines selling sweets and fizzy drinks were felt to be inappropriate
- parents wanted to see free water in schools and the return of free milk.

Parents were not confident that they knew what their children ate and drank while at school. The school lunch system was heavily criticised by a few of the groups. Excessive choice and unhealthy food were the main criticisms. One parent described a system where children pick up a tray and choose from a variety of options, many of which are unhealthy. This posed particular problems for very young children. One parent of a five-year-old boy described him choosing a bar of chocolate, sweets and a cake for his lunch. Parents thought that such a level of choice was unmanageable by very young children. Many parents thought their own experiences of school dinners was preferable to the systems their children experience. They felt that two choices, both healthy, had been a better idea.

It was felt that schools were inappropriate places for children to be able to buy sweets. Tuck shops were criticised because many did not sell any healthy alternatives to sweets and crisps, and parents were particularly unhappy about vending machines containing sweets and fizzy drinks being in schools and being available at any time of the day.

A number of parents also raised the issue of access to healthier drinks for their children. Many lamented the loss of free school milk and others were very keen to see free water readily available to children in schools.
Schools and nurseries came under fire for giving children the wrong messages about healthy eating. One parent in the control group spoke about chewy sweets being given regularly as rewards in school and another mentioned a nursery school teacher who would shake a sweet tin to get the children to be quiet before giving them all a sweet.

One parent said her child had been ridiculed by his friends for bringing fruit to school. Peer pressure from other children to eat unhealthy food was mentioned in most of the groups.

‘When he goes to school he watches other people, other children. You can’t control in school. In school they eat whatever they want. I’m not there. They eat chips. They eat ice cream.’

Meridian, Glasgow

The Scottish diet

• the Scottish diet, with its high consumption of sweets and fizzy drinks was criticised
• there was a good awareness of what a healthy diet should be.

The Scottish diet was criticised by parents in the control group. Those who had lived elsewhere previously talked about a very noticeable difference in diet in Scotland. This was characterised by the amount of sweets consumed by children and the popularity of fizzy drinks. One parent felt the diet in Glasgow to be especially bad.

‘Glasgow is atrocious for sweets. We lived in London and we lived in Edinburgh and the difference is just shocking. It’s just everywhere from such an early age. The nursery that my son went to in London, you never got a biscuit, you got fruit and juice. And here it’s biscuits. A tray of biscuits is brought out. And it’s juice never water.’

Control
Recognition of the unhealthy nature of the typical Scottish diet was echoed by the group of ethnic minority women who all believed the Scottish diet was very unhealthy compared to the diet of their country of origin. They found the cost of the foods they would have cooked with in their country of origin to be prohibitive. Fruit and vegetables were felt to be especially expensive.

‘That is what the problem is. All the sugary food. They are so cheap. And when you see something that is less money you feel so tempted to buy it.’

Meridian, Glasgow

‘In our country we have sweets only for special occasions. Not every day. Every day we have fresh fruit. Better than here.’

Meridian, Glasgow

Although the control group and the group of ethnic minority women were most critical of the Scottish diet, parents in all of the groups were aware that a typical Scottish diet is unhealthy. In all of the groups parents spoke of efforts they made to provide their children with a balanced diet. Parents made efforts to limit their children’s intake of sweets in order to minimise damage to teeth. Some limited eating sweets to meal times and some tried to avoid sweets which stay in the mouth for a long time, such as chewy sweets and lollipops, favouring chocolate instead.

Parents were trying to find a balance in taking care of health and not depriving their children of sweets entirely.

‘If you deny them (sweets) they’re just going to gorge them all the more when they do get them, when they’re older and they’ve got their own money.’

Oakley

‘They get sweets, but not over the score.’

Port Glasgow

‘Chocolate and crisps are better for your teeth than boiled sweeties.’

Dumfries
Barriers to a healthy diet

- cost and availability were the biggest barriers to a healthy diet
- food labels can be confusing.

The main barriers to a healthy diet were cost and availability of good quality produce. Cost appeared to pose a greater problem than availability. Many of the parents were living on low incomes and the main deciding factor employed when shopping for food was price. Parents described how the cheapest were often more unhealthy containing higher levels of sugar and salt yet when shopping on a budget they were forced to select the cheapest option. A healthy diet was therefore perceived by some as an expensive option and not accessible by all even if the motivation were there to eat more healthily.

‘Personally I find it really hard to afford healthy food.’

Port Glasgow

Respondents described how small local shops did not stock fresh fruit and vegetables and, without a car, they were unable to get to a supermarket to buy fresh produce.

Ideas for combating the effect of poverty on oral health included subsidising healthy food or providing fruit tokens to families on low incomes. The idea of taxing ‘junk’ food was also proposed.

Although all the groups were very clear about the importance of a healthy diet in building healthy teeth and gums, they felt it was sometimes difficult to know what was healthy and what was unhealthy. Product labelling confused parents with many not knowing whether ‘sugar-free’ drinks were harmful to teeth.

‘I find that Sunny Delight and Ribena “Toothkind” confusing cos I’ve heard they’re actually bad for teeth.’

Dumfries

‘I used to think sugar free fizzy juice was ok, but it’s still acidic.’

Port Glasgow
2.2 Oral Hygiene

- good oral hygiene is believed to be achieved primarily through toothbrushing
- parents’ oral hygiene habits are mimicked by their children
- the cost of toothbrushes and toothpaste can be a barrier to good oral hygiene.

Toothbrushing was viewed as the main means of achieving good oral hygiene. Parents’ control over and input into their children’s oral hygiene habits was mixed. Some claimed to brush their children’s teeth while others trusted their children to brush their teeth themselves. Children aged seven or eight and older were generally trusted to brush their own teeth but some parents trusted children as young as age three or four to brush their own teeth.

Some parents reported that their children were not happy to brush their teeth. Reasons for not wishing to brush teeth included a dislike of toothpaste, particularly the taste of toothpaste, and toothbrushes.

‘I still can’t get mine to do them. They just won’t put a toothbrush in the mouth. I’ve bought toothbrushes, toothpaste, the lot. They don’t like the feel of the toothbrush and one of them doesn’t like the taste of toothpaste’

Craigmillar

Setting an example to their children was perceived as an important factor in establishing good oral hygiene habits. There was recognition that children were likely to mimic their parents’ habits. Parents who admitted to not brushing their own teeth regularly had problems getting their children to brush their teeth. Others said they brushed their own teeth at the same time as their children brushed theirs. They spoke of good habits being established early and carried through to adulthood as a matter of course.

‘When you brush your teeth, let them see you brush your teeth. Then they copy you.’

Meridian, Glasgow
While some adults mentioned flossing and using mouthwash as part of their own oral health regimes they felt this to be inappropriate for children.

Novel approaches of informing children about oral health care were suggested, for example, delivering information in child friendly formats such as cartoons. Health education was suggested in all the groups. Having dentists or dental hygienists visit schools to speak to children about taking care of their teeth was another suggestion.

‘I think kids should have a dental talk, maybe annually.’

Dumfries

The provision of free toothbrushes and toothpaste to those on low incomes was suggested. Another suggestion, made in a few groups, was to continue toothbrushing schemes, run in nurseries, through to schools.

‘Carrying on what they do in nursery. After a snack they brush their teeth. Carrying that on through the schools.’

Oakley

‘Even if they brushed their teeth once a day in school. That’s something.’

Port Glasgow

2.3 Dentists

- the main barriers to attending the dentist are fear and cost
- a lack of availability of NHS dentists was the single greatest barrier for those living in Dumfries
- most parents want their children to attend the dentist
- children’s attendance habits reflect those of their parents.
The attitudes of parents to dentists, and then practice in terms of attending for regular treatment are important in relation to children’s oral health. Children’s experience of dentists will be coloured by their parents’ attitudes and practices. The majority of adults attending the group discussions were registered with dentists, although not all attended regularly. The main reasons for selecting a dentist were close proximity to the home or a personal recommendation. One woman chose her dentist because, due to her fear of dentists, she felt she could only attend one who would offer an anaesthetic.

The main barriers to adults regularly visiting a dentist were:

- fear
- cost
- accessibility to NHS dentists.

Those who were not registered with dentists were not keen to visit the dentist and this was due, in most instances, to fear and cost. One woman was not registered with a dentist because she felt her teeth were very healthy and she saw no need to attend.

A significant minority (typically two or three per group) of those from disadvantaged areas reported some kind of fear of going to the dentist. This was not evident in the control group or the ethnic minority group. This fear was often described as starting in childhood due to some unpleasant experience. This emphasises the need for modern dentistry to adopt a more relaxed and pain-free approach.

‘Probably because when I was a kid I never went to the dentist. I only went to the dental hospital. Butchers. Cos they’re all students.’

*Craigmillar*

Cost was mentioned in all the groups as a deterring factor. It seemed to be of greatest significance where families were working but still on a low income. As such they were not entitled to free NHS dentistry yet felt they did not have enough money to pay for check-ups and treatment. These people were most likely to attend only when in pain.
‘I went regular when I had my maternity exempt card whereas before I didn’t go. It’s too expensive.’

*Craigmillar*

‘I went when it was free. Got them polished and everything.’

*Oakley*

The single greatest barrier in obtaining dental care for the Dumfries group was the lack of dentists taking NHS patients. The groups believed there was no availability of NHS dentists in the town. Those in the group who were not already registered with an NHS dentist believed they had the option of travelling long distances to see a dentist or not attending at all. As single parents with young children, the Dumfries group felt it was almost impossible to see a dentist and were greatly frustrated by this.

‘I hear all the time of people having to travel to Lockerbie, Annan, 15, 20 miles around. And when you’re working that’s really hard.’

*Dumfries*

‘The dentist I’m with now will not take on any more because they’ve got so many NHS patients. They’ve stopped their waiting list at 150. Not one dentist in Dumfries is registering one more NHS patient.’

*Dumfries*

There appeared to be an even division between adults who attended regularly, usually every six months, and those who attended only when they were in pain or knew they needed treatment.

‘Some people just go like they go to the doctors. Just go when there’s something wrong.’

*Craigmillar*

Some were cynical about the need to attend the dentist every six months.

‘A lot more people now are saying don’t go unless there’s something wrong. That this every 6 months is a nonsense, it’s to make dentists money. That you should hold back and go when something’s wrong.’

*Control*
Given that there were significant barriers to the adults going to the dentist many made great efforts to ensure that their children did go. Many parents were very happy with their current dentists and very impressed with their dentist’s relaxed attitudes towards their children. A few negative experiences of taking children to the dentist were reported. Negative experiences appeared to be more common where there was a shortage of NHS dentists. Good dentists were described as those with patience and those prepared to take time to explain treatments to children. It was felt that if all dentists demonstrated these attributes then take-up of dental care might be improved.

‘I’ve got a super one now who, with the girls, she spends a lot of time, they come in and just play with the toothbrush, and she’s got the telly and she’s got toys. Just building up trust.’

Control

Visiting the dentist was perceived by the parents as a much more positive experience for children now than it was when they were children. Dentists are felt to be more understanding now, particularly with children and nervous patients.

‘They enjoy the waiting room. They’ve got some toys, and they can play and see other children. They enjoy.’

Meridian, Glasgow

‘They think it’s great: the chair and all these things round about it.’

Oakley

Children’s attendance habits tend to mirror those of their parents. The exception to this was where children received check ups in school. Some parents from a few of the groups talked about their children having check-ups in school but the majority of parents thought their children had not seen a dentist in school. Taking dentists into schools was proposed as a way of ensuring children received regular check-ups.
Parents believed that by attending themselves they were setting a good example for their children. This was related to the notion of establishing good habits early which would be carried through to adulthood.

‘I go. We all go as a family. I always take them. If you dinnae get in the habit of going then they won’t go.’

*Craigmillar*

‘My youngest, she’s 18 months, she just screamed. But it’s the experience of actually going, sitting on my knee, I don’t even know if he got a look.’

*Control*

There were, however, some instances where parents did not want to visit the dentist but did take their children or encourage their children to go. One parent who didn’t regularly visit the dentist herself nevertheless recognised the importance of setting a good example and aimed to give the impression that she did go.

‘I dinnae mind taking the kids but I won’t go myself. I tell them I go. They think I go. There’s no reason for them to find out you have a fear. When they’re at school we could be doing anything.’

*Craigmillar*
3.1 Knowledge of fluoride

- knowledge about fluoride was very limited in all of the groups
- dentists were reluctant to give advice about fluoride.

Participants in all the groups had very limited knowledge regarding fluoride. Most knew of it only as an ingredient in toothpaste and, less often, in mouthwash.

Those who were slightly better informed had heard of it when attending health promotion talks organised within their communities. Some parents had also received information from health visitors and dentists. A few parents from the control group had discussed, with their friends, whether or not to provide fluoride supplements to their children. There was some confusion about whether or not it was in public drinking water supplies in Scotland. There was a low level of awareness of the debate in the media regarding adding fluoride to public drinking water supplies.

Parents who had tried to find out about fluoride admitted to still being very confused. Those who had tried to find out about fluoride were doing so in order to find out whether or not they should be supplementing their child’s diet with fluoride. For the most part they tried to get this information from their dentists but found that their dentists were reluctant to give clear advice one way or the other. One parent from the control group described the response she had got from her dentist as woolly. She had bought fluoride tablets but never used them because she was unconvinced of the need for them and worried about potential drawbacks. Another parent had been told by her dentist that fluoride really only benefited children whose teeth were forming i.e. babies under a year old and those losing their milk teeth.

For the majority of parents awareness of the benefits of fluoride did not extend beyond some notions that it strengthened teeth. At the outset of each group participants were asked what they thought contributed to building healthy teeth and gums. There was a low level of awareness of fluoride as a major contributor to oral health. Fluoride was only mentioned in the control group and in this instance it was in the context of an ingredient in toothpaste. None of the other groups mentioned fluoride.
3.2 Use of fluoride

- use of fluoride was mainly limited to toothpaste.

When asked if they or their children received fluoride in any form, participants generally responded that they received it only in toothpaste. A few participants had used fluoride drops or tablets for their children, some had been given these by their dentists and some had bought them. No one had consistently provided their children with fluoride drops or tablets.

Although there was an awareness that fluoride is contained in toothpaste, very few parents saw the fluoride content of toothpaste as a reason to purchase a particular brand. When buying toothpaste, parents cited price, taste and branding as factors which influence them.

‘They’re (toothpaste) too expensive. Some of them are £2.50, £3. Whereas I go into Asda and get the ‘smartprice’ one about 19 pence. I don’t care what kind it is, it’s toothpaste.’

Oakley

3.3 Concerns about fluoride

Parents are concerned about:

- a chemical being added to their diet
- potential risks to long term health associated with fluoride
- potential effects of swallowing it
- fluorosis
- fluoride supplements being viewed as an alternative to good oral hygiene and a healthy diet.

Despite the lack of knowledge about fluoride, there were significant concerns expressed about adding it in any way to the diet. Much of this concern was about additives generally and possible harmful health consequences.
There was an awareness that too much fluoride could have negative effects but participants were unclear as to what the negative effects were and how they were caused. Concerns which were articulated included the risks to long-term health including osteoporosis, Alzheimer’s, and cancer.

‘Safety is the main worry.’
*Craigmillar*

‘I’m worried about too much fluoride, cancer, this sort of thing.’
*Control*

There was a higher awareness of the risk of mottled teeth (fluorosis) with some parents having been told that their or their children’s discoloured teeth were a result of too much fluoride. Those whose children had mottled teeth spoke of the psychological difficulties this posed for their children. Children with aesthetically unattractive teeth suffered a lack of confidence as a result.

‘That’s the reason I’ve got discoloured teeth. Cos of the fluoride.’
*Oakley*

Concerns were expressed over fluoride being ingested. As the majority had only ever received fluoride topically, that is, in toothpaste and mouthwash, they were keen to know of any potential health repercussions that could be a result of swallowing it. Children are supposed to use only a pea-sized amount of toothpaste and spit it out due to concerns of getting too much fluoride. This was seen as contradictory to the notion of adding fluoride to the diet.

‘I worry about the children swallowing it. It just says in anything I’ve read about kids’ toothbrushing that they’re not to swallow it.’
*Oakley*

‘I always make sure they spit the toothpaste out.’
*Port Glasgow*
Some considered that adding fluoride to people’s diet could be detrimental to oral health as it might be seen as a substitute for a good diet and good oral hygiene.

‘If they gave them drops then most parents would think, well what’s the point of brushing their teeth then?’

Oakley

‘I think it just gives parents another chance to be lazy with brushing their children’s teeth. They aren’t going to brush their weans’ teeth.’

Dumfries

3.4 Attitudes to fluoride

• fluoride was viewed as a sticking plaster solution
• diet and poverty were believed to be the main contributors to poor dental health
• those who are allergic to fluoride would face problems where initiatives were introduced
• the correct dosage of fluoride would be extremely difficult to calculate.

The focus group facilitator provided the groups with a brief description of fluoride and its potential benefits. No evidence was provided by the facilitators as to some of the reported negative effects of fluoride other than fluorosis which is mentioned in the consultation paper. The various options set out in the consultation document were put to the groups and they were asked for their opinions on each one.

There was a very strong belief in all the groups that using fluoride more extensively was not the best way to deal with Scotland’s poor dental health record. It was felt that adding fluoride dealt only with the symptoms and not with the cause of the problem: adding fluoride was viewed as a sticking plaster solution. The groups were very clear that the primary reason for poor dental health was diet, and that poor diet was closely associated with poverty. Participants were keen to see Scotland’s poor diet and poverty addressed.
‘Fluoride isn’t going to tackle the cause of the problem. It wouldn’t change habits.’

Port Glasgow

A few of the groups were very concerned about the effect of all these initiatives on people who were allergic to fluoride. Adding fluoride to water was thought to pose the greatest problems for those suffering from allergies but all of the alternative methods discussed were felt to pose significant problems.

When talking about proposed fluoride initiatives as well as current intake of fluoride, concerns about dosage were expressed. Since people drink and eat differing amounts of water, milk and salt and it is possible to have too much fluoride, the groups struggled to understand how they could ensure their children did not receive too much.

‘I’d have to limit the amount of water he drank to stop his teeth getting damaged.’

Dumfries

The groups were asked if fluoride was to be delivered to people as part of their diet how this might be done. The question elicited a number of responses including adding it to the public drinking water supplies and a variety of food and drinks. Another response which came up in a few groups was to add fluoride to sweets and fizzy drinks. The rationale behind this suggestion is simply that it targets those most likely to benefit from fluoride.

‘Or sweeties. The wrong thing to say. Put it in the sweeties. Every kid likes and gets sweeties. So it’s a fast sure way of getting fluoride. I know it’s not good but you’re allowed so many sweeties anyway.’

Craigmillar
3.5 Adding fluoride to the public drinking water supplies

Respondents rejected the idea of adding fluoride to water because:

- people could not choose whether or not they received fluoride
- they were sceptical about whether everyone would benefit from fluoride
- those living in poverty might consume less water than others and subsequently would benefit least.

The great majority of parents rejected the suggestion of adding fluoride to the public drinking water supplies. While they could see that adding fluoride to the public drinking water supply would have the advantage of reaching the majority of the population this was also felt to be a disadvantage. Adding fluoride to the water was seen to deny people the right to choose whether or not they received fluoride.

‘When it comes to water you can’t have a choice because water is for everyone.’

*Meridian, Glasgow*

The groups were sceptical about whether everyone would benefit from fluoride and unhappy about those who didn’t stand to benefit from receiving it. They were also unhappy that people who currently took care of their children’s teeth would not have access to drinking water that didn’t contain unnecessary chemicals.

‘Is fluoride good for everybody? Because everybody is different.’

*Port Glasgow*

‘I think it’s a case of you want water to be as pure as possible. So why are we starting to put things in it just in case it is going to help your teeth?’

*Oakley*
There was a feeling that children living in poverty would be the least likely to benefit from adding fluoride to public drinking water supplies as they were less likely to drink water. This was considered a major drawback since it is children living in poverty who have the greatest need for improved dental health. The bad diet which contributes to unhealthy teeth is largely characterised by a high intake of fizzy drinks. Therefore it was considered that children living in poverty might drink very little drinking water as a result.

It is worth noting that a few of the groups were unclear about whether or not Scotland already had fluoridated drinking water supplies yet once they knew that the drinking water supplies were not fluoridated they were adamant they stayed that way.

3.6 Alternative methods of delivering fluoride

Alternative methods of delivering fluoride received a more positive response.

Alternative methods of delivering fluoride would offer people the choice of whether or not to supplement their diet with fluoride. However, parents feel they are bombarded with information regarding diet, particularly their children’s diet. Having fluoridated and non-fluoridated versions of products on the market was viewed as yet another difficulty for parents in determining what constitutes a healthy diet for their children.

‘There’s so much pressure on parents to try and give their kids the right diet.’

Choice was regarded as an essential factor by all the groups. Therefore the alternative suggestions of adding fluoride to milk and salt were better received than the suggestion of adding fluoride to water. However, participants felt that those struggling on low incomes might not prioritise buying goods supplemented with fluoride and therefore have little effect on the very groups currently more likely to suffer dental decay.

‘It would only be bought by parents that are terribly aware.’
3.7 Fluoridated milk

- fluoridated milk in nurseries was felt to be a reasonably acceptable idea
- children who do not drink milk would not receive any potential advantages
- there was an assumption that fluoridated milk would cost more than non-fluoridated milk
- some thought that fluoridated milk sold at a cheaper price would successfully target those living in poverty.

Some thought that children would be more likely to drink milk than water and might stand to benefit more than adults if fluoride was delivered in milk. The main advantage of adding fluoride to milk was felt to be the choice this option offered.

‘The choice can be there if you want. If you want fluoride in the milk then you can go and buy it.’

*Craigmillar*

However adding fluoride to milk would mean that children who did not drink milk would not receive any potential benefits. Many parents had children who disliked milk or for whom it was not part of their diet.

‘My daughter is allergic to dairy products so she would miss out.’

*Oakley*

‘You would need an alternative for the kids that don’t drink milk.’

*Port Glasgow*

There was scepticism expressed over whether or not fluoride could be added to milk without changing its flavour.

Some assumed that fluoridated milk would involve an extra cost. However, a few groups suggested that if take-up was to be maximised then fluoridated milk should be sold at a reduced price.

‘If it was cheaper or the same price and fluoride did not affect the taste then I think parents might support that.’

*Oakley*
Parents thought that offering fluoridated milk in nurseries and schools would successfully target children but wondered about children younger than nursery age not receiving the potential benefits of fluoridated milk. They also mentioned that school holidays were quite significant and wondered if that would have any implications. Several parents had concerns about the cost of fluoridated milk in schools.

‘Not every parent can afford to pay every single week. If you’re on a low income and you’ve got three or four kids.’

*Dumfries*

### 3.8 Fluoridated salt

- adding fluoride to salt, which is considered unhealthy, would seem contradictory and confusing
- adults would benefit more than children.

The idea of adding fluoride to salt was poorly received overall. Participants felt that contradictory messages would be given. On the one hand people are being told to reduce salt intake for health reasons. On the other hand fluoridated salt may seem to consumers to be a healthy choice.

‘Do you not think more people would be inclined to use salt if they thought it had fluoride in it.’

*Craigmillar*

‘They’ve been telling us to cut down on salt for years.’

*Port Glasgow*

If salt was to be used in catering establishments the groups were keen that non-fluoridated salt versions should be on offer too. If people did not want to receive fluoride then the use of fluoridated salt in catering establishments would limit the choice of where to eat for those people. Once again, there were concerns about the lack of choice provided by this option.
Although there was a high awareness of health advice to cut salt intake there was general acceptance that salt intake in Scotland is high and that adding fluoride to salt would reach a high proportion of the population. It was felt that fluoridated salt would target adults as their salt intake was believed to be higher than children’s.

3.9 Fluoride tablet/drop regimes in nurseries and schools
- parents were unhappy with the notion of children accepting tablets from a teacher: this was felt to be a parental role
- introducing a culture of tablet-taking did not receive favour.

As with the proposed schemes offering fluoridated milk in nurseries and schools, concerns were expressed about pre-nursery children not receiving fluoride. Additionally many of the parents felt that giving children tablets or drops was a strictly parental role. They were not happy with the notion of children accepting something orally from a teacher. Some parents believed that all necessary nutrients should be included in a well-balanced diet and that a culture of supplements was not desirable.

They were also unhappy with the notion of introducing a culture of taking tablets or drops. It was felt that children might then be more likely to think it was acceptable to take a tablet themselves.

‘I don’t suggest you take tablets. Children don’t know which tablet is good and which tablet is not.’

Meridian, Glasgow

3.10 Information
The groups wanted information about fluoride. Specifically:

- they wanted to know about dosage
- who stood to benefit from fluoride
- potential risks to long-term health.
The groups had a lot of questions regarding fluoride and were very keen that objective information should be given to enable them to decide whether or not to supplement their or their children’s diet with fluoride.

The groups wanted to know about dosage and how dosage could be calculated. They wanted to know exactly who stood to benefit from fluoride. They were particularly concerned about long-term safety and risks to health.

‘We want to know about these things before we start to use it (fluoride). Just more information.’

Meridian, Glasgow

The groups were asked who they would most like to receive information about fluoride from. Dentists, doctors and the government were the most common responses. Dentists were described by some as being independent and as such a reliable source of information. Participants also mentioned the media as a source of information, and others said they would want to look into the matter themselves and discuss it with friends.

Participants had mixed opinions about receiving information from the government with some believing them to be trustworthy and others sceptical about the motivation for adding fluoride to people’s diet. The scepticism was born from a worry that fluoride might allow some short-term dental health targets to be met at the expense of longer-term health problems.
This chapter summarises the main findings of the study. Overall, the groups were very keen to see the dental health of Scottish children improved.

‘Scotland really could do with a better load of teeth.’

Dumfries

Diet

Diet was considered the single most important factor relating to children’s oral health. Most of the parents we spoke to were keen to improve their children’s diet, but described some of the factors which made this hard. These included the cost and availability of a healthy diet, the difficulty of understanding product labelling, poor school meals, the ready availability of fizzy drinks in schools and a culture which rewarded children with sweets. While most parents were confident that they could control their children’s diets when they were young, they had concerns about what happened when someone else was looking after their children, and what happened as they got older and made their own choices about what to eat.

As a result of these concerns, most of the parents would like to see more emphasis on encouraging healthy eating, including making a healthy diet more affordable and accessible. Because labels could often send misleading messages, they would like information on labels which enabled them to make informed choices when they bought and prepared food.

The parents we spoke to believed that schools had an important role to play in encouraging and promoting healthy eating. They were concerned about what they saw as contradictory messages from schools which taught healthy eating but did not provide it in canteens and vending machines. They would like more to be done to make use of schools as places where healthy eating could be supported, and where healthy choices were available. They wanted good quality drinking water to be available in all schools.
Oral hygiene

The parents in the study were generally aware of the importance of toothbrushing and of establishing good habits in relation to oral hygiene. Some of them admitted that they either did not set their children a good example themselves, or that they left it to their children whether or not they brushed their teeth. Some commented on the cost of toothbrushes and toothpaste, particularly those on low incomes and with large families. The provision of free toothpaste and toothbrushes was suggested as one solution.

This suggests that there may be more which could be done to encourage toothbrushing through initiatives in nurseries and schools, where there is evidence that such schemes can be effective ways of improving oral health.

Dentists

There was wide recognition of the importance of going to the dentist to maintain children’s oral health. In general, parents were keen that their children attend the dentist even if they did not like going themselves. There were, however, significant barriers to this, relating to the availability of NHS dentists, fears about cost, and the ability of dentists to create a child-friendly environment which encouraged children to attend. When a parent is reluctant to attend a dentist, this may make it more difficult for a child to establish a regular pattern of attendance.

Our findings suggest that it is important for the Scottish Executive to consider how it improves access to dental services, particularly for those in areas where NHS dental services are scarce, and also for those on a low income, but who are still liable to pay charges. The parents in our study were particularly keen that dentists should provide check-ups for children in school.
Fluoride

The message which came over from all the groups of parents was that they considered the most important thing was to address the underlying causes of poor oral health, in particular poverty and poor diet, and that the use of fluoride should not be considered to be the main way to tackle children’s oral health. There was a feeling that, if fluoride was added to the public drinking water supply, people might view this as an alternative to good oral hygiene and that children’s teeth would suffer as a result.

There was a low level of knowledge about fluoride, both about its possible public health benefits and about possible adverse effects. The use of fluoride was in general limited to toothpaste, apart from a few parents who had used drops or tablets with their children.

The parents we spoke to had real concerns about fluoride being added to the public water supply, and although they did not have any evidence of adverse health effects apart from fluorosis, they were unhappy about adding something to the water which would remove their choice. They were concerned about people who might be allergic to fluoride, and about people who did not need any additional fluoride and who might suffer adverse health effects as a result. They were not sure that those who most needed help with their oral health would benefit from adding fluoride to water, as they might not drink much water.

Overall, they wanted very much more evidence and objective information about the benefits and disadvantages of fluoride. They wanted more information about the levels of fluoride which a child could receive without being put at risk of fluorosis, and they wanted advice about how the amounts of fluoride in toothpaste, drops and other potential sources of fluoride would add up to a safe dose. Some of the parents described the reluctance of dentists to give them advice on dosage levels. They wanted to know more about the difference between swallowing fluoride, and using it in toothpaste or mouthwashes, when it was used topically, particularly when there seemed to be advice not to allow children to swallow toothpaste, to avoid fluorosis.
There was a range of concerns expressed about adding fluoride to the diet in other ways, and these are described above. Overall, there was less resistance to fluoride where there was a choice about whether to use the product. Parents were not averse to the idea of fluoride being added to milk, for use in schools and nurseries or for use at home, provided there was clear information on the product, and provided people retained the choice about not having fluoridated milk if they did not want it. They had more concerns about fluoride being added to salt, which was itself something which should only be used in moderation in a healthy diet. They were not keen on the idea of nurseries or schools giving children fluoride drops or tablets, as this was seen as something which should only be done by parents.

In all the possible scenarios in which fluoride might be used, the parents were concerned that they should always be able to calculate what was a safe dosage for their child. As a result they wanted much better information and advice than they believed was currently available.