An Investigation of the Views of Parents in Otago on Dental Care for Primary School-Aged Children by the Community Oral Health Service Prior to the Introduction of the Hub-Based Clinic System

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Abstract

Background and Objectives: Prior to the introduction of the Southern District Health Board’s reconfigured Community Oral Health Service in Otago, a project was undertaken with parents to investigate their knowledge, understanding and views of the historical School Dental Service and of the Community Oral Health Service that was being introduced.

Methods: Focus groups were run during 2011 in ten selected schools (parents with children in years 1-8) across two areas in Otago to represent urban and rural settings and to represent parents who were already travelling to dental services.

Results: Parents valued the traditional School Dental Service in Otago highly, generally agreeing that the service based in schools was accessible and convenient for parents and children. Rural parents who had always taken their children to dental appointments viewed it as a normal process, accepting that there could not be a service located in every school. Parents were aware that facilities were out-of-date. They highlighted the challenges of locating therapists since they started moving from school to school in the later 1990s and felt it was difficult for children seeing different therapists at each recall. There were diverse views on the proposed new system. Some parents felt that school-aged children should go to dental clinics on their own or with peers, while other parents welcomed the opportunity to attend when their child was having health care.

Conclusion: It appears that the Community Oral Health Services should have an ongoing process to seek the views of parents and children about the service.

Introduction

The New Zealand School Dental Service was developed in the early 1920s with the first graduates beginning practice in 1923. The provision of care to preschool and primary school-aged children has continued until the present time. Over time, marked changes have occurred in the service with the move from a restorative to a preventive model of care; the introduction of fluoride; improvement in equipment and materials and notably the move in training to university programmes. One aspect that had not changed was the emphasis on providing the care in clinics on school sites where possible. It was clear by the end of the 1990s that many of the clinics were out-dated and were no longer appropriate facilities for the delivery of health care.

In the early 2000s, reviews of child oral health, including identifying where the disparities were and what services were being provided, took place. A report to the Minister of Health by the Public Health Advisory Committee in 2003 noted that the school dental services played a key role, but there were disparities in access for Maori, Pacific, rural, transient and socioeconomically deprived children. The report also noted that re-orientation of services was needed to improve access for children from early childhood onwards. The continuing need to provide access to care remains and is evidenced by the 2009 National Oral Health Survey Report that recorded that 79.7% of 2-4-year-olds were caries-free and 14.9% had untreated decay; 51.0% of 5-11-year-olds were caries-free in their primary teeth and 22.5% already had caries in their permanent teeth; only 44.7% of 12-17-year-olds were caries free. The report clearly indicates that there are disparities in oral health status for Maori and Pacific children and adolescents.

In 2006, the Ministry of Health’s report: “Good Oral Health for All, for Life”, noted a future approach was to develop community-based dental services for children, with the potential to expand to adolescents and low-income adults. Furthermore, it noted a mix of service providers would be involved in the future, including DHBs, PHOs, Maori, Pacific and non-governmental organizations (NGOs). It was envisaged that a team of oral health providers would work together–dentists, dental therapists and dental assistants. The report also stated that services would be provided in a range of facilities, including stand-alone community-based clinics or community-based clinics co-located with a school, community health centres, other multi-purpose community-based centres, or mobile units in outreach locations. Following the report, a major shift in the delivery of services was developed throughout New Zealand. The Southern District Health Board planned to introduce a combination of fixed ‘hub’
clinics and mobile clinics in Otago to serve its rural and urban child population.

In 2011, planning was underway for the introduction of the updated Southern District Health Board Community Oral Health Service in Otago. The previous service was delivered in school-based clinics in the main, with the use of some mobile clinics in later years. Parents did not generally attend appointments with their school-aged children except in rural areas and most communication took place with information forms and consent forms that were sent home with the children or by telephone. The care to be delivered by the Community Oral Health Service was based on central hub clinics, including mobile hub clinics, which could be taken to schools to act as a clinic for a greater area. It was expected that parents would be responsible for taking their children to the new clinics in most instances. In some areas, either the Community Oral Health Service or some schools were looking at developing transport options for children and even parents who would be unable to take their children because of financial or transport issues.

Reviewing the literature did not reveal any specific published information on the opinions of consumers (parents and caregivers) of the previous service other than a few brief newspaper reports of public consultation meetings that were taking place prior to the development of the new service. Therefore, the aim of this study was to capture parents’ views on the School Dental Service as it had existed and to seek their thoughts on the new system that was being introduced. This would allow information to inform later surveys once the new Community Oral Health Service had been in place for several years.

Methods

Ethical approval was obtained from the University of Otago Ethics Committee (Approval No 10/180 Date: 20.09.10).

Participants

Focus groups were run during 2011 in ten selected schools (parents have children who are in years 1-8) across two areas in Otago to represent urban and small town/rural settings. Focus groups are not meant to be representative, but a range of schools were sought to add potential diversity to the types of opinions, beliefs and values expressed (Davidson, 2003). The schools also represented settings where parents had already been taking their children to a clinic away from their school. The number of focus groups chosen was based on the resources available to undertake the work. A quota sampling approach was used to identify schools from across various strata of size, decile and geography. The seven schools chosen in the urban setting represented 9 percent of the local schools and in the small town/rural setting the three schools represented 13 percent of those within the territorial local authority. Other than a rural/urban mix, schools were also selected on the basis of whether they were already familiar with transporting children to receive dental services and those that had clinics operating on site. A year 7-13 high school, an intermediate school and a full primary school were approached in order to access parents of year 7 and 8 students (11-12 year olds). Full details of schools are not shown so as to maintain their anonymity, which was part of the agreement to participate (Table 1). Upon agreement with each school principal to participate, the liaison researcher (3rd author) then negotiated with the principal as to the best way to recruit parents to undertake the focus groups and where. This was done in some schools by meeting with a preformed group, such as the Parent Teacher Association (PTA) or Board of Trustees. This was carried out in other schools by placing an invitation in the school newsletter inviting people to contact the researcher or asking if they would like to join in an interview with a preformed group. The latter approach was more successful.

Procedure

The last two authors of this article conducted focus groups during Terms 2 and 3 of the school year. They were held at the school at a time that suited participants, usually at the beginning or end of when preformed groups would meet. All focus group

### Table 1: Detail of Schools involved in Focus Groups

<table>
<thead>
<tr>
<th>School</th>
<th>Usual Delivery of Oral Health Care in 2011</th>
<th>School roll size</th>
<th>(2011) decile group</th>
<th>Pakeha (%)</th>
<th>type</th>
<th>Size of group</th>
</tr>
</thead>
<tbody>
<tr>
<td>One school Urban</td>
<td>Parents take children to a clinic 2 minutes away at another school</td>
<td>100+</td>
<td>8-10</td>
<td>60+</td>
<td>Yr 1-6</td>
<td>3</td>
</tr>
<tr>
<td>Four schools Urban</td>
<td>Dental Clinic on site</td>
<td>150+</td>
<td>4/5</td>
<td>80+</td>
<td>Yr 1-8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100+</td>
<td>1-3</td>
<td>50+</td>
<td>Yr 1-6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100+</td>
<td>6/7</td>
<td>70+</td>
<td>Yr 1-6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>200+</td>
<td>6/7</td>
<td>60+</td>
<td>Yr 7-8</td>
<td>5</td>
</tr>
<tr>
<td>Two schools Urban</td>
<td>Transport by taxi van to Training Clinic at School of Dentistry</td>
<td>150+</td>
<td>4/5</td>
<td>70+</td>
<td>Yr 1-6</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>850+</td>
<td>8-10</td>
<td>70+</td>
<td>Yr 7-13</td>
<td>4</td>
</tr>
<tr>
<td>One school rural</td>
<td>Mobile dental clinic comes to school</td>
<td>200+</td>
<td>1-3</td>
<td>60+</td>
<td>Yr 1-6</td>
<td>6</td>
</tr>
<tr>
<td>Two school rural</td>
<td>Onsite clinic</td>
<td>200+</td>
<td>6/7</td>
<td>80+</td>
<td>Yr 1-8</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>250+</td>
<td>6/7</td>
<td>70+</td>
<td>Yr 1-6</td>
<td>9</td>
</tr>
</tbody>
</table>

Type: Yr 1-8 = Full Primary, Yr 1-6 = Contributing, Yr 7-8 = Intermediate, Yr7-13 = secondary
participants were given an information sheet and asked to sign a consent form prior to beginning the interviews.

Focus groups discussions are usually qualitative in nature and consist of participants who share a common characteristic (Waldegrave, 2003). In this case participants were parents of children receiving care from the Otago District Health Board School Dental Service. The questions used to initiate and structure the focus group interviews are shown in Table 2.

Some rules of engagement are provided at the beginning of each interview. People are advised to only share what they are comfortable in doing so and that participants respect what is shared and not pass information and views to others (Smith, 1995).

Analysis
Interviews were recorded and then transcribed by the last author of the paper. These transcripts were then manually coded by following an inductive thematic analysis (Braun & Clarke, 2006) common to descriptive qualitative research (Vaismoradi, Jones, Turunen & Snelgrove, 2016). This approach uses the following phases: familiarizing yourself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and lastly writing.

The last author began the initial analysis and the second author joined in at the point of reviewing themes, having read transcripts. Manual coding was judged sufficient for 10 transcripts where both authors had facilitated discussion. The themes have been used to structure the findings presented in the next section.

Results
The information collated from across the focus groups has been summarized into three sections. The first is the parents’ experiences and views on the system, as they understood it. The second section examined where they got information and support about children’s oral health. The last section focuses on understanding how the parents saw their involvement and responsibility for their children’s oral health care and the impact the new service might have on parents’ ability to meet this responsibility.

Parents’ Comments on the School Dental Service
We wanted to hear what parents thought about the School Dental Service as they knew it. For the majority (7 of the 10 schools) this was based on their experience of on-site clinics. One of the on-site clinics was a visiting bus clinic and the rest were older purpose built clinics on school property. For the other three schools not using clinics on site, they already had arrangements to visit clinics elsewhere.

Parental experiences and preferences
In general, most parents expressed a preference to keep the on-site services. The benefits cited by parents with regard to the current system were its accessibility and convenience for both parents and children.

Parent: I think it works really well, I mean, you always have through the school notices and things, you always know when the dental nurse is here, and I also like the fact that, before any work is done on your child’s teeth, you get a consent form home to say exactly what it is that is that they are planning on and if you’ve got any problems you can go in a talk to them. (urban on-site 1)

Parent: It is the convenience of having a health service at school, which does not require much on the part of parents. You know that they are getting their teeth seen without too much difficulty. (urban on-site 2)

The belief that children could go to the dental therapist without parental involvement also applied to schools where children were provided transport to a clinic.

Parent 1: It saves us having to drag kids to the dentist.

Parent 2: Because there are people working. (urban off-site 1)

The parents did not seem to notice the contradiction that prior to children starting school they had accepted the responsibility of taking their children to see the dental therapist. The confidence in the system was supported by the relationship with therapists, which began before the children started school.

Parent: Even before my two girls started here [at school], you know as pre-schoolers, we’d get to use the dental service as well, and I’ve always found them really good. (urban off-site 1)

Parent 1: I’ve got a friend who has a child enrolled at [early childhood centre] and they give [toothbrushes] out.

Parent 2: Yeah, cause I think the first check-up is when they are twelve months old isn’t it? (rural mobile 1)

Many parents mentioned that there were things about the on-site clinics that help children. This included the fact that children could go to the clinic with a friend or classmate and that they would cooperate better without their parents there.

Parent 1: And they go in groups of kids too, so they can bounce off each other.

Parent 2: Yeah, because you’re tough when you’re with your mates. (rural mobile 1)

Another advantage mentioned was that a school staff member could take the child directly to the clinic if the child had toothache. Parents from schools with on-site clinics saw therapists as part of the school environment and school life, so talking to the therapist was normal.

A number of parents expressed the idea that dental therapists belong in school. Overall, parents supported the school-based system because it was viewed as child friendly and it showed a level of flexibility and responsiveness that parents appreciated.

Parent: I don’t think I have ever had either of my girls complain that they have to go to the dentist – it hasn’t been an issue. It’s like part of everyday – there’s no fear of going to the dentist, so I don’t know why we used to be [scared], you know maybe it’s the whole being plucked out of class in front of everybody and then over to the other side of the school or something. (urban on-site 1)

There were some parents, especially those that were already taking their children, who were clear that they did wish to attend the clinic with their children.

Parent: The big difference is that I was actually there, and I quite like that because when it was done at school he would just come home with a thing [note] that he had been seen. (urban off-site 2)
Table 2: Focus Group Questions

**Introductions**
When the tape is running ask for first name of the parent, which year their children are in and approximate time of the last visit to a school dental therapist.

**Current system**
Please tell us about what you think works well with the current school dental service? What sort of things don’t work so well? What information do you get about your children’s oral health when they see the therapist? How is this information given to you? (e.g., pamphlet with tick boxes, in person with the therapist, by phone.) Is there other information you think you should be given? Tell us about how you consent to your child being seen or having treatment? Do you go to the clinic with your child when they are having a check-up or treatment? Follow up by asking why depending on the answer.

Home discussion around whether parents/guardians should be present when children are receiving medical care as opposed to dental care.

**Parental understanding**
There was some variation in parental knowledge about how the current system worked, especially the frequency of check-ups. They were unclear of how often the children were seen – once or twice per year. They did however appear to understand that there would be a form to sign if the children needed treatment.

**Parent 1:** They were checked in class, and then sent home with – ‘no work to be done’ – until you’ve consented to the next work to be done and at that stage you can question anything.

**Parent 2:** I have no problems with the way they managed it. (rural on-site 1)

Some parents who did not currently go with their children expressed concern that they received little feedback on their children’s oral health. This seemed to vary somewhat between the groups with some happy just to know they had had a check-up and others wanting reassurance that everything had been looked at and the teeth were healthy. In some groups the parents said they were able to call the therapists if they wanted information and were happy with that. Some parents did acknowledge that if they did start taking their children to the therapist they would probably be better informed.

It appeared that the levels of communication varied between schools or different locations and it was not clear if this was related to the therapists themselves or to how the service was run in the different areas. There were some issues raised with the system. A number of parents referred to the challenge of changing appointments, especially when the therapist was no longer based at the school. Not all parents had mobile phones and there were difficulties expressed about finding the number to call. There was frustration with phoning to actually talk with a therapist and make an appointment. They were not comfortable with the rotation of therapists to different clinics, finding it difficult to locate a therapist if they had moved and were concerned about finding an unfamiliar clinic. They also expressed concern about seeking care out of school hours or during holidays.

**Parent 1:** If you are new to the area – you look in the phonebook and it’s not listed under school dental services, or dental nurse. You have to know the name of a school, to look under their dental clinic to actually find it…

**Parent 2:** I had major issues trying to track them down, because I would phone, but if they were busy, because they can’t always answer the phone, you know, because
they are dealing with a child – so you leave messages and they try and phone you back and leave a message because I’m busy, and it took us about four or five days to literally make contact.

Parent 3: I wonder how many people don’t ring up because it’s a cell phone? – because it annoys me when it’s a cell phone, personally, I don’t mind texting.

Parent 4: It’s still time out, it isn’t just that trip – it’s time off work – to get to school – to get there, wait there.

Parent 2: But at the end of the day, if your child is in pain you’re going to do anything to go and help her. (rural on-site 1)

Support for parents to take their children to the dental therapist

Some schools were already transporting their students elsewhere to get dental treatment and this was something that the parents felt their children enjoyed. For one group, the bus acted as a shuttle with children taking about 60-90 minutes between leaving school and returning. Those parents thought having children go to a hub clinic would work as long as transportation was provided. Another school had a mobile bus visiting. It retained the convenience and accessibility, as well as providing a sense of adventure for the children. Parents were generally happy with that.

Parent 1: Well you don’t have to worry about taking them.

Parent 2: But also, it was also the convenience, because when do you have the time? As I mentioned, I’ve got five children – and they get two children out of class, like my son, who last year had something and he brought the thing home and he was really nervous about it, really nervous about it, so I came and knocked on the door and went and seen them, and said look, he’s really quite nervous about it, so they knew when they got him they would be prepared… so they explained it to him before he actually went through it, and he was also able to take one of his friends from class to go with him. (rural mobile 1)

In one school, parents took their children to the dental therapist based at another school. The focus group parents were happy with the arrangement, but commented that they were perhaps not representative of most parents in the school, as they were not working and had the time to attend appointments without having to juggle work and other commitments (the focus group for this school was held during school time). In this school there was an additional challenge expressed by the principal, that parents would sometimes just arrive to collect their children to go off to the dental therapist without prior warning so children might miss out on scheduled achievement testing or other activities.

When the principal approached the therapist about this the therapist said it would to be too difficult to inform the school of scheduled appointments.

Some of the parents recognized that the clinics had not been maintained and that therapists were working in unsatisfactory settings, as well as being on their own.

The clinics have not been maintained and therapists are working in unsatisfactory settings. There has been inconsistency in therapists. They might be working alone rather than in pairs. They get rotated but it would be better if children got to know the same person.

They need to develop a relationship with the person given that they are going to be sticking things in their mouths, drills and needles. (urban on-site 2)

Sources of information about child oral health

Discussion about where parents obtained information about looking after their children’s oral health revealed a range of sources. Plunket, school and the School Dental Service were identified as main sources of consistent information during their child’s early years.

Interviewer: And where do you get your information from, about oral health in general?

Parent 1: The Plunket nurse, generally that’s where it starts. (rural mobile 1)

They described some information being sent home in the school newsletters and oral health being linked in with other health lessons taught at school. Information available after the transition to school was more sporadic – and came from sources such as school health programmes, magazines, television, contact with on-site dental therapists (in class visits to provide education), general knowledge/shared information with other parents, and product suppliers (of toothbrushes and toothpaste). Not all schools appeared to be involved in oral health activities. Some parents made the point of saying that their experiences varied across their children in terms of the oral health concerns they might have. They expressed uncertainty about their knowledge and in their children’s knowledge of oral health. It was clear there was confusion about the ‘appropriate’ toothpaste to use, the method of brushing, fluoride use and other prevention. Everybody would have liked more information from the therapist about these. Contact with dental therapists during visits was identified as an excellent way of gaining knowledge specific to their own child’s needs and in relation to oral health and tooth development generally. Parents shared their experiences of incidents with their children that made them rethink about own knowledge and confidence in relation to oral health care.

Parent: I took all three of them to my own dentist. It was just for re-assurance that they were okay, because I did have this slight lingering doubt about, because they always had these clean bills of health from the school dentist, I just wanted re-assurance that everything was okay, that was the reason for that really. (urban off-site 1)

Parental involvement/responsibility for their children’s oral health care

In the focus groups, parents were asked about their views on having the responsibility to take their children for dental care. In part, their comments appeared to be determined by the level of confidence that they had in the service. Parents expressed a high level of trust in the service to monitor their children’s oral health and in the therapist’s capacity to work with children in an appropriate manner and also to inform them if there were issues that required on-going intervention. Most recalled their own negative childhood experiences of the dental clinic referring to it as the ‘murder house’. However, it was clear that this term was almost non-existent for their children and they felt the system was much improved.
Parents’ opinions were divided with regard to the issue of parental involvement for their children attending appointments. Several parents considered the change to be a positive one, and felt that parents should take on this responsibility. Other parents commented that they felt the dental experience was sometimes less stressful for their children if they were not present. They cited the camaraderie with their peers and independence as positive factors, but viewed their own ‘fears’ about the dentist and the bond with their child as potential hindrances. Some were adamant that it was their responsibility, but they did comment that the system needed to be flexible around appointment times.

**Parent 1:** I think it’s the parents’ responsibility to make sure their children’s teeth are all right, I mean personally— you take them to the doctor – you take them to the dentist. (urban off-site 1)

**Parent 2:** Many parents are working at the maximum to provide the necessities without the difficulty of this new responsibility. At the same time parents need to make sure their children’s teeth are all right, I mean personally— you take them to the doctor – you take them to the dentist. (urban off-site 2)

There were parents who commented that it was totally different from going to the doctor, which happened when ill-health occurred, whereas regular visits to the dentist for a “check-up” was a preventative role that made children more aware of their teeth and should mean less treatment was required later. For children with high treatment needs, some parents commented there could be a problem having several treatment visits and perhaps being “knocked out” on the “surgical bus” was easier. Parents talked about how some parents might not prioritise dental appointments if they did not think there was a problem, suggesting that they may not see the value in routine check-ups and therefore they would not make time to take their children. They felt the traditional system meant parents didn’t have to think about oral health check-ups as they would happen as a matter of routine. The primary concern raised by parents was the belief that some children would miss out if it were left entirely to parents, particularly with the routine assessment checks.

**Parent:** At least this way it’s almost like you don’t have to worry. (urban off-site 1)

### Anticipated challenges

In each focus group, people commented there would be parents who could not access transport for financial or other reasons or who would have no one to take their children if they were working. There were many references to the challenges parents would face in ensuring that their children received access to care.

**Parent:** Scheduling around work arrangements will present challenges depending on work place flexibility. I had to take a late lunch to be at this meeting today. So will all work need to be done in the hub? For example, can screening be set up within school and without parents if most children’s teeth are okay.

There are people in all sorts of arrangements that will create exceptions to the idea of children visiting with parents, for example, the home-based carer who has four other children through the week. There are the shift workers and those who travel out of town. (urban on-site 4)

Transport, costs and parking were concerns raised, with transport being an issue in both urban and provincial settings. They described catching a bus with several children, managing buggies, waiting in poor weather and trying to schedule appointments that would match the bus timetable. Some parents felt that they should insist that the service provide transport. Taking time off work, loss of income and shift work were other barriers parents expressed concern about. So although the service itself was provided, they perceived the new system was now going to be an extra cost for families and that some would not be able or willing to support the new system. There was a feeling in all the groups that there was a lack of information about how the new system would work. This lack of information when combined with a sense of confidence in the traditional system made parents feel that the negatives would dominate. So while they did recognize the value of turning up to visits and getting information from therapists, the increased possibility that some children would not get the care they received previously, dominated discussion. Many thought it would be very busy and there may be less time to ask questions. In general, the issues were around the delivery of the care and not the care itself.

**Parent:** Well, they are the trained professionals – for me it’s always been an issue of accessing the service, but the actual care that the children have got is great. (urban on-site 1)

There was also a concern that having children go off site would mean they are missing out on class time:

**Parent:** I mean, just because of the issues of parents having to pick them up and take them down there, it just means they are going to be out of the classroom for longer – and that is more disruptive for the classes as well – and, um, the child’s lost the opportunity for learning for that session. You know, at least here, if it was here – they just pop over and then they are back in the classroom – what, five, ten minutes. (rural on-site 1)

Given the changes that were about to be implemented, parents wanted their comments to be heard and expressed a wish to be consulted again once the new system was in place. Some parents would like to know how many children were not receiving care, so that they could help find a way to help those children in their school. The question was asked if other parents or school personnel would be in a position to take children to appointments, if they had the approval of the parents concerned.

### Discussion

An important finding from the focus group discussions was the overall high level of trust and belief in the value of the School Dental Service as it had been. There were individual experiences recorded that had been negative, but this was in contrast to the vast majority of parents saying that the school dental therapists have been friendly, responsive and provided a level of care that seems appropriate for
their children. This was recorded across all the groups and included parents who already had been responsible for taking their children to the therapist away from their child's school. No previous information indicating this in New Zealand could be found and other studies had been conducted overseas. Sundram and Kingston (1981) reported parents had a high level of satisfaction with the South Australian School Dental Service. Othman and Abdul Razak (2014) surveyed adolescents who had received care from a mobile school dental service in Malaysia. Overall 62% were satisfied with the care provided. While general satisfaction was expressed about the personnel, concern was expressed about not having things explained and students' loss of school time waiting to be seen because there were no out of school-hours appointments. This was discussed in the present study also.

Another interesting finding was the contrast in the views of parents comparing visits to medical practitioners or a dental therapist. Parents clearly indicated that children generally only went to the doctor when they were ill or had a problem, whereas oral health was preventative and they expressed the value of having regular check-ups to find problems before they became a concern. Several parents noted that if you waited for the child to have toothache the damage was already done. They generally believed that regular check-ups provided prevention, although this aspect was not investigated further and whether parents understood that an examination alone would not add any preventive aspect to the child's oral health is not known. Of concern were the numbers of parents who appeared to disconnect oral health with general health based on the comments that having dental care should be part of school life and many parents believed they did not need to be involved. This is interesting to consider as most other areas of health would expect parents to be present when children to receive health care apart from health screening. This is an issue for dentistry and indicates that efforts need to be made to connect oral health with general health at many levels, including linking oral health records to general health records and linking oral health problems such as early childhood caries to children's general health, noting that dental problems do not occur in isolation from general health. An example of this is the growing understanding of the links between early childhood caries and overweight and obesity in adolescence (Alm et al, 2008; dos Santos Junior et al 2014).

The discussion that occurred around the new responsibility for many parents to take their children to the dental therapist provided contrasting views. For some parents this was seen as a considerable burden because of the impact on families, work, arranging transport, and finances. For parents who had already been doing this, there was less of an issue and perhaps when the new service is reviewed in several years, parents will not have the expectation that someone else is responsible for getting their children to a dental clinic. The concerns as raised, are important to consider to ensure those who cannot access clinics can be supported. The issues included transport – not having access to a car, or a bus route or the money to pay for getting there. Another issue was parents getting away from work commitments so they could accompany their children. Several parents noted that workers might not be able to afford to lose a half-day to bring a child and they wonder whether they will be able to bring all their children in one visit. It would be interesting to know if parents, who seriously consider that their children should be seen at school, had actually enrolled their children and taken them to the clinic when they were pre-schoolers. If the new service has flexibility including some extended hours this may address some of the issues raised.

In almost all groups, parents noted that there were children in their schools who would miss out, as parents would not have the belief that regular dental check-ups were important. This is something that should be monitored after a few years to identify if this has indeed occurred. The issue of parents not taking their children because of their own past experiences or fears of dentistry was not raised in any of the groups, although many parents did describe unpleasant past incidents when they attended the School Dental Service as children. Parental anxiety has been identified as a barrier to their children receiving timely care in several studies, including that of Smith and Freeman (2009). It might be expected that this could occur in the new system. On the positive side it was encouraging to hear that several of the groups were willing to identify ways of making the new system work if the District Health Board was willing to consider the issues and potential solutions.

The question of where parents seek or find information about child oral health was answered similarly to other studies in New Zealand (Rothnie et al, 2012). In all instances, the Royal New Zealand Plunket Society was seen as a key provider of oral health information, alongside the School Dental Service and print and other media. Parents who took part in the focus groups indicated they did want more information about their children's oral health to avoid anxiety when problems occurred, and many admitted that they would probably be better informed if they attended with their children.

The outcomes of the discussions need to be taken in context as parents who make an effort to turn up to focus groups on topics like oral health know that there are other parents where this interest or the opportunity to participate is less important. The strength of this study was that it accessed a broad range of issues held across parents. However, it does not provide a quantitative description of the scale of these concerns nor assess if such concerns were equally held in different parts of the country. The issues raised in this study would support the development of more comprehensive surveys that could be conducted nation-wide and post the implementation of the Community Oral Health Service.

There is a possibility that children may not access care as successfully in the new system. As the parents demonstrated, personal experience determines their views, as do the views of others. They recognize that the "murder house" was a feature of their life growing up, but that it is not their children's experience. If parents think
that their children are getting good treatment and that the service remains flexible, responsive and friendly then that should see their views continue. If accessing the service is too difficult, even for those who want to, there is a risk that the traditional support for the service may decrease. It seems that it is in the interest of the new DHB Community Dental Service to continue to seek the views of parents of children in the future.

References


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