Fluoride And Caring for Children's Teeth

Parent Survey

A joint UCC/Health Services research project to inform national policy and planning of dental services

Second Class

HRB Health Research Board

UCC Coláiste na hOllscoile Corcaigh, Éire University College Cork, Ireland

Thank you for agreeing to participate in this study.

This Survey Booklet has 6 parts. The information you are providing is very important to us; please complete all questions, right to the end of the booklet.

We ask questions about different factors that could affect your child's teeth e.g. going to the dentist, your child's toothpaste, and what they eat and drink. We also ask some questions about how you feel about your child's teeth, your child's physical activity and the family. Finally we ask questions about how your child's oral and dental health affects their wellbeing and everyday life, and how it affects the family.

Instructions

- Most questions can be answered simply by putting a tick ✓ in the box next to the answer that applies to you/your child.
- Please complete all 6 parts of the survey, right to the end of the booklet.
- When you have finished answering all of the questions, please put this booklet, the completed and signed medical history form, the completed residential history questionnaire and the signed consent form, along with the filled water bottle in the Ziplock bag, into the envelope provided and have your child return the sealed envelope to his/her teacher without delay.

Part 1

➢ Please answer the following questions about your child's attendance at the dentist

1. My child had his/her <u>first visit</u> to a dentist (including HSE/school dentist)

at the age of _____ *(Enter age in years)*

OR

My child has never been to a dentist ☐0 Go to **Q10**

2. What was the reason for this first visit? (Tick one box only)

Check up	☐1
I felt treatment was needed but my child had no pain	☐2
My child was in pain	☐3
I was sent an appointment by the HSE/school dentist	☐4
Other e.g. trauma to teeth *(please describe)*:	☐5

_____

3. My child <u>last</u> went to the dentist

at the age of _____ *(Enter age in years)*

OR

My child is currently undergoing treatment ☐0

4. When your child does go to the dentist (excluding orthodontic/braces), why does he/she normally go? (Tick one box only)

For a check-up every 6 months or at least once a year	☐1
For a check-up at least every two years	☐2
When I or my child feels he/she needs treatment	☐3
When my child is in pain or has a problem	☐4
When sent an appointment by the HSE/school dentist	☐5

5. **When your child goes to the dentist (excluding orthodontic/braces), what type of dental service does your child usually attend?** (Tick one box only)

HSE/school dentist	☐1
Private dentist (Republic of Ireland)	☐2
Private dentist (Northern Ireland)	☐3
Dental Hospital	☐4
Other *(please describe):*	☐5

_____

6. **Has your child ever received treatment (examination or other treatment) from the HSE/school dental service?**

Yes	☐1
No	☐2 Go to **Q10**

7. **When your child used the HSE/school dental service was it for** (Tick one box only)

Emergency treatment (relief of pain, trauma)	☐1
Routine treatment (e.g. exam, fissure sealants, fillings)	☐2
Both – emergency and routine treatment	☐3

8. **Were you satisfied with the service your child received from the HSE/school dental service?** (Tick one box only)

Very satisfied	☐1
Satisfied	☐2
No opinion/doesn't concern me	☐3
Dissatisfied	☐4
Very dissatisfied	☐5

9. **In the last 6 months, have you (or your partner) ever had to take time off work or away from other responsibilities to bring your child to a dentist because he/she had a toothache?** (Tick one box only)

Yes	☐1
No	☐2

10. **In the last 6 months, have you ever had a sleepless night because your child was awake with toothache (excluding teething/cutting teeth)?**

Yes	☐1
No	☐2

11. **In the last 6 months, has your child ever missed school because of toothache?**

Yes	☐1
No	☐2

12. At what age do you think a child should have his/her <u>first visit</u> to a dentist (HSE/school dentist or private) (Tick one box only)

Before his/her first baby (milk) tooth appears	☐1
When his/her first baby (milk) tooth appears	☐2
When he/she starts preschool	☐3
When he/she starts primary school	☐4
When he/she is sent an appointment by the HSE/school dentist	☐5
When he/she is in pain or has a problem	☐6

Part 2

- Kindly continue and answer the following questions on how you feel about your child's teeth

13. If your child had a painful <u>baby tooth</u> would you prefer if it was (Tick one box only)

Filled	☐1
Taken out	☐2
Don't know/No opinion	☐3

14. If your child had a painful <u>back</u> tooth and it was not a baby (milk) tooth but a permanent (adult) tooth would you prefer if it was (Tick one box only)

Filled	☐1
Taken out	☐2
Don't know/No opinion	☐3

15. If your child had a painful <u>front</u> tooth and it was not a baby (milk) tooth but a permanent (adult) tooth would you prefer if it was (Tick one box only)

Filled	☐1
Taken out	☐2
Don't know/No opinion	☐3

16. Are you happy with the <u>colour</u> of your child's permanent (adult) front teeth? (Tick one box only)

Yes	☐1
No	☐2
Don't know	☐3

17. Have you noticed any brown, creamy or white marks on your child's permanent (adult) front teeth that don't rub off? (Tick one box only)

Yes	☐1
No	☐2
Don't know	☐3

18. How do you feel about the position/alignment/straightness of your child's permanent (adult) front teeth? (Tick one box only)

Very satisfied	☐1
Satisfied	☐2
No opinion/indifferent	☐3
Dissatisfied	☐4
Very dissatisfied	☐5

19. We would like to know what parents value most about their child's teeth. There are no right or wrong answers to this question.

*Please rank the following options from 1 to 4 in the order that you believe is **most important** for your child. Use only **one number** for each box and **do not repeat any numbers.***

1=most important; 2=second most important; 3=third most important; 4=least important

Having white teeth	☐
Having healthy permanent teeth with no fillings	☐
Having healthy baby (milk) teeth with no fillings	☐
Having straight teeth	☐

Part 3

- We would like to know about your child's toothbrushing, and use of toothpaste and mouthwash

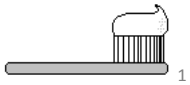
20. How often does your child use toothpaste when brushing his/her teeth? (Tick one box only)

Never	☐1
Most days but not every day	☐2
Once a day	☐3
Twice a day	☐4
More than twice a day	☐5
My child does not usually brush his/her teeth	☐6

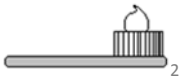
21. What type of toothpaste does your child use? (Tick one box only)

Toothpaste with fluoride	☐1
Toothpaste without fluoride	☐2
None	☐3
I don't know	☐4

22. How much toothpaste does your child use on his/her toothbrush? (Please circle the image that matches your answer)


1

(Full Brush)


2

(Pea-sized)


3

(Very small amount)


4

(None)

23. Fluoride is added to toothpaste to help prevent tooth decay. Which of the following do you think might be the recommended fluoride content for toothpaste for children in Ireland? (ppm = parts per million)

500 – 750 ppm ☐1
1,000 – 1,500 ppm ☐2
2,000 ppm or more ☐3
I don't know ☐4

24. These pictures show children rinsing their teeth after brushing. Which picture shows what your child usually does?

My child's teeth are not usually brushed ☐1

Picture 1
Using the toothbrush to rinse ☐2

Picture 2
Rinsing directly from the tap ☐3

Picture 3
Cupping hands to rinse ☐4

Picture 4
Using a glass to rinse ☐5

My child does not rinse ☐6

Other *(please specify)*: ☐7

_____

25. Does your child usually use mouthwash (Tick one box only)

Never	☐1	if **'Never'** Go to **Q28**
Infrequently	☐2	
Once a week	☐3	
A few times a week	☐4	
Every day	☐5	

26. When your child uses mouthwash, is it usually

Immediately or shortly after brushing	☐1
At a different time to brushing	☐2

27. Does your child's mouthwash contain fluoride? (Tick one box only)

Yes ☐1 No ☐2 Don't know ☐3

28. Has your child ever taken a course of fluoride tablets or drops? (Tick one box only)

Yes ☐1 No ☐2 Don't know ☐3

Thank you for your help so far!

Part 4

- We would now like to ask you about what your child normally eats and drinks and about their physical activity.

29. How many times does your child have sweet food or sweet drinks between meals? (for example, sweets, biscuits, cakes, juice, squash (diluted), fizzy drinks, fruit drinks etc.) (Tick one box only for each option below)

On a typical weekday (Monday, Tuesday, Wednesday, Thursday or Friday)		**On a typical day at the weekend (Saturday, or Sunday)**	
Never	☐1	Never	☐1
Once	☐2	Once	☐2
Twice	☐3	Twice	☐3
Three times	☐4	Three times	☐4
Four times	☐5	Four times	☐5
Five times	☐6	Five times	☐6
Six times or more	☐7	Six times or more	☐7
Don't know	☐8	Don't know	☐8

30. What type of water does your child usually drink? (Tick one box only)

Tap water mostly	☐1
Bottled water mostly	☐2
Both tap and bottled	☐3
My child does not drink water	☐4

31. If your child drinks tap water, is it (Tick one box only)

Unfiltered	☐1
Filtered using a cartridge filter in a water jug	☐2
Filtered under the sink (reverse osmosis)	☐3
Other *(please describe)*:	☐4

_____

32. Does your child ever have a drink by the bedside in case he/she gets thirsty during the night?

Yes ☐1 No ☐2

If you answered 'Yes' what type of drink does he/she usually take?

Tap water	☐1
Bottled water	☐2
Squash (diluted)/fruit drink	☐3
Milk	☐4
Other *(please describe)*:	☐5

_____

33. What type of water do you usually use for preparing and cooking food? (Tick one box only)

Tap water mostly	☐1
Bottled water mostly	☐2
Both tap and bottled	☐3

34. How many times in the <u>past 7 days</u> has your child done <u>at least 20 minutes of hard exercise</u>, hard enough to make him/her breathe heavily and make his/her heart beat faster? (Hard exercise includes, for example, playing football, jogging, or fast cycling.) Include time in physical education (PE) class.

None	☐1
1 to 2 days	☐2
3 to 5 days	☐3
6 to 7 days	☐4

35. How many times in the <u>past 7 days</u> has your child done <u>at least 20 minutes of light exercise</u>, that was <u>not</u> hard enough to make him/her breathe heavily and make his/her heart beat faster? (Light exercise includes, for example, walking or slow cycling.) Include time in physical education (PE) class.

None	☐1
1 to 2 days	☐2
3 to 5 days	☐3
6 to 7 days	☐4

Thank you for that information – nearly there!

Part 5

- Please tell us a little about your family

36. Are you the child's

Mother ☐1
Father ☐2
Other *(please specify)*: ☐3
_____

37. Who is the child's primary caregiver?

Mother ☐1
Father ☐2
Other *(please specify)*: ☐3
_____

38. What type of healthcare cover do you have? *Please tick ALL that apply*

Full medical card ☐1
GP visit card ☐2
Private health insurance e.g. VHI/Aviva ☐3
PRSI ☐4
No healthcare cover ☐5
Other *(please describe)*: ☐6
_____

39. In general, how would you describe your child's health in the past year?

Very healthy, no problems ☐1
Healthy, but with a few minor problems ☐2
Sometimes quite ill ☐3
Almost always unwell ☐4

40. What is the highest level of education both Parents/Caregivers have completed to date?

	Mother/Female caregiver	Father/Male caregiver
Primary or less	☐1	☐1
Intermediate/Junior/ Group Certificate or equivalent	☐2	☐2
Leaving Certificate or equivalent	☐3	☐3
Diploma/Certificate	☐4	☐4
Primary degree	☐5	☐5
Postgraduate/Higher degree	☐6	☐6

41. Food choices vary between different cultures and this can have an effect on dental health. We would be grateful if you could tell us if your ethnic or cultural background is

Irish ☐1 Other ☐2 *(Please specify)*:_____

Thank you. Just one more part to complete.

Part 6

- This part asks about the effects of oral conditions on your child's wellbeing and everyday life: we are interested in any condition that involves teeth, lips, mouth or jaws

Please **do not discuss the questions with your child,** in this part of the survey we are interested in the parents' perspective.

42. How would you rate the health of your child's teeth, lips, jaws and mouth?

Excellent ☐1 Very Good ☐2 Good ☐3 Fair ☐4 Poor ☐5

43. How much is your child's overall well-being affected by the condition of his/her teeth, lips, jaw or mouth?

Not at all ☐1 Very little ☐2 Some ☐3 A lot ☐4 Very much ☐5

44. How much is the daily life of your family affected by the condition of his/her teeth, lips, jaw or mouth?

Not at all ☐1 Very little ☐2 Some ☐3 A lot ☐4 Very much ☐5

In this section, each question is followed by the same set of options. Please give the response that **best describes your child's experience**. If the question does not apply to your child, please answer with "Never".

45. During the last 3 months, how often has your child had:

a. Pain in the teeth, lips, jaws or mouth?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Food caught in or between the teeth?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Food stuck in the roof of the mouth?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Bad breath?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

46. During the last 3 months, how often has your child:

a. Had difficulty biting or chewing firm foods such as fresh apple, corn on the cob or firm meat because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Had difficulty drinking or eating hot or cold foods?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Taken longer than others to eat a meal because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Had trouble sleeping because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

47. In the last 3 months, has your child:

a. Been upset because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Been irritable or frustrated because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Been anxious or fearful because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Acted shy or embarrassed because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

48. In the last 3 months, has your child:

a. Missed school because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Not wanted to talk to other children because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Had a hard time paying attention in school because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Avoided smiling or laughing when around other children because of his/her teeth, lips, mouth or jaws?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

Thank you for taking the time to complete this survey and support this important study!

CHECKLIST

Please check you have done all of the following:

Completed all parts of this Parent Survey	☐
Completed and signed the Medical History Form	☐
Completed the Residential History Questionnaire	☐
Signed the Consent Form	☐
Asked your child to sign the Assent Form	☐
Taken a sample of tap water and securely fastened its bottle cap	☐

Now, please put this booklet, the completed and signed Medical History Form, the completed Residential History Questionnaire, the signed Consent Form, along with the filled water bottle in the Ziploc bag, into the envelope provided and have your child return the sealed envelope to his/her teacher without delay.

Thank you.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