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Developing an inventory to Assess Parental concerns and Enable child dental Registration (DAPER)

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Developing an inventory to Assess Parental concerns and Enable child dental Registration (DAPER)

Year I Report: A Qualitative Exploration

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Executive Summary

Introduction

Childsmile is the national oral health programme for children in Scotland. Childsmile Core is a universal programme offering free toothpaste and toothbrushes to all families of children 0-5 years, and offers supervised toothbrushing in nursery schools. Childsmile Practice offers support to families of children at the greatest risk of dental caries. This support aims to help families with children aged 0-2 years to register with a local dental practice, and provides advice on healthy foods and drinks for children. Childsmile has contributed to significant improvements in Scottish children's oral health; nevertheless major disparities remain. Children living in Scotland's most deprived communities continue to suffer from much higher levels of dental decay than children living in more affluent communities. In addition, families engaged in Childsmile Practice do not always attend their appointments at the dental practice, with a failure to attend rate of 32%. Families failing to attend appointments have been more concentrated in the areas of greatest deprivation. It is with this background that the Oral Health and Health Research Programme, Dental Health Services & Research Unit, at the University of Dundee, was commissioned to carry out the DAPER study.

Aim and Objectives

The aim of the DAPER study is to develop an inventory to assess parental concerns and enable child dental registration and attendance for preventive dental care. The main objective of the research contained in this report was to conduct a qualitative exploration to identify the main concerns of parents.

Method

Using a grounded theory approach, 47 mothers with young children were interviewed from across Scotland in 2009. Mothers were recruited with the help of Childsmile staff, health visitors and local voluntary organisations working with young families. Interviews were audio-recorded and transcribed. Transcripts were analysed using grounded theoretical analysis: this involved the use of open, axial and selective coding to identify a core category

in the data. The core category identifies the process through which participants' main concern is resolved, and explains the greatest variance within the data.

Results

A main concern of 'Mothering when it's not for me' was identified amongst mothers. The women described mothering that was far from ideal, and not how they wished it to be. Mothers experienced this concern in response to a variety of pressures. Many women had difficult pregnancies and deliveries; they were unable to breastfeed; their children were difficult and often misbehaved; they experienced depression, and both physical and social isolation. Mothers attempted to resolve these difficulties by engaging in a process of 'getting on with it'. 'Getting on with it' emerged as the core category and can be viewed on a continuum from mothers fully engaged with 'getting on with it', to mothers who were 'unable to get on with it'. Mothers strategies for resolving their main concern included not dwelling on a difficult pregnancy, bottle feeding their baby, compromising with their children, receiving good social support, missing appointments when necessary, staying at home and not help seeking when they were depressed.

Summary

The results of the study indicated that mothers' main concern was 'Mothering when it's not for me'. Mothers were not always able to engage in the type of mothering that they had hoped to. Mothers were depressed, exhausted, low in self-esteem, and unable to control their children.

It is proposed that these issues are likely to impact on a mother's decision to keep a dental appointment for her child. Issues that may have a more direct impact on whether mothers kept appointments included transportation, practical social support, the relationships mothers had with health professionals and interactions with society in general. A 'whole persons' approach is thus required to address the issue of vulnerable families not attending

dental appointments for their children. All the issues outlined above must be taken into consideration to enable mothers residing in poverty to access dental care for their families.

Next Steps

For the next phase of the DAPER study, a Parental Dental Concerns Questionnaire (PDCQ) has been designed using the information gained during the qualitative interviews. The PDCQ will be tested for reliability and validity on a sample of 800 mothers from across Scotland. When the validity and reliability of the measure is established, it will be used with the aim of identifying those families most vulnerable to missing appointments at an early stage, and tailoring the Childsmile Practice programme to offer them greater levels of support.

Introduction

Oral health in Scottish children

Children in Scotland have traditionally had high levels of poor oral health. With this in mind, the Scottish Executive set a target of 60% of 5 year olds to show no signs of obvious dental decay by 2010 (Scottish Executive, 2005). To enable this, an additional target was set of 80% of 3-5 year olds to be registered with an NHS dentist by 2008 (*Ibid*).

In recent years there has been significant progress towards reaching both targets. The 2008 National Dental Inspection Programme identified 57.7% of 5 year olds with no signs of obvious dental decay, following previous year on year improvements (Merrett, *et al.*, 2008). By June 2009, the target of 80% of Scottish children aged 3-5 registered with an NHS dentist was reached and exceeded (ISD Scotland, 2009).

The Childsmile Programme

Improvements in children's oral health in Scotland can, in part, be attributed to the introduction of the Childsmile programme (Merrett *et al.*, 2008). Childsmile is Scotland's national oral health programme for children. Childsmile aims to improve the oral, and general, health of all Scottish children, but is particularly committed to reducing inequalities and oral health disparities. The programme is both universal and targeted in its approach, offering preventive dental care and enabling child dental registration. Every child will have access to Childsmile, but support will be tailored to the needs of individual children and their families.

The implementation of Childsmile has evolved through three main work streams: 1) a core toothbrushing programme; 2) Childsmile Nursery and School; and 3) Childsmile Practice.

1) The Core Childsmile Programme

As part of the core toothbrushing programme, families are provided with free oral health packs up until aged 5. Private and local authority nurseries are invited to take part in daily

supervised toothbrushing, as well as Primary 1 and 2 classes from schools in the 20% most deprived areas.

2) Childsmile Nursery and School

Childsmile Nursery offers children residing in the 20% most deprived areas 6 monthly fluoride varnish application in nursery. Similarly, Childsmile School offers 6 monthly fluoride varnish application to children residing in the 20% most deprived areas in the school setting from Primary 1 onwards.

3) Childsmile Practice

Childsmile Practice is directed at children 0-2 years, and helps to link families to Primary Care Dental Services by age six months. All children are invited to take part in the Practice Programme. Families are risk assessed via their health visitor to determine whether the child is at risk of developing tooth decay. Children identified as at risk are referred to a Dental Health Support Worker (DHSW).

The role of the DHSW is to provide families with oral health information and advice in their homes, to help families to register with a local dentist, and arrange visits to the dental practice. At these visits, parents meet trained dental nurses and are given advice on toothbrushing techniques and information on diet and health. When the child is around 18 months they will be seen by a practice dentist. It is envisaged that in the future older children will be provided with fluoride varnish application and fissure sealants when attending the dental practice.

Existing challenges

Although great progress has been made in improving the oral health of children in Scotland, major areas of concern remain. This is particularly true of children living in Scotland's most deprived communities. Whilst only 26.9% of children in the least deprived areas show signs of obvious dental decay by age 5, 57.8% of children in the most deprived areas are affected by the same age (Merrett, *et al.*, 2008). In addition, only 39.1% of 0-2 year olds are currently registered with an NHS dentist, far short of the 55% target set by the Scottish Executive (ISD, 2009; Scottish Executive, 2005).

These issues highlight that Childsmile Practice has a critical task ahead, particularly in ensuring younger children are registered, and that families in deprived communities are engaged in preventive dental care. This is particularly difficult given that of those families who originally signed up to Childsmile Practice between 2006-2008, 32% failed to attend their dental appointment (Deas *et al.*, 2010). Furthermore, those who were most noncompliant lived in areas of greatest deprivation (*Ibid*).

It is in this context that the Oral Health and Health Research Programme, Dental Health Services & Research Unit, at the University of Dundee was commissioned to undertake the DAPER project (Developing an inventory to Assess Parental concerns and Enable child dental Registration). The project is focused on understanding the barriers to dental attendance in order that families may be identified and supported to access dental health care. The project consists of three parts: a qualitative exploration of parental concerns; the design and validation of a quantitative measure of parental concerns; and a field trial of the measure to identify families requiring additional support. This report will focus on the results from the first part of the DAPER project.

Aim

The aim of the DAPER study is to develop an inventory to assess parental concerns and enable child dental registration and attendance for preventive dental care. The project has three main objectives, which are to:

1. Conduct a qualitative exploration to identify the main concerns of parents.
2. Assess the psychometric properties of the new questionnaire to assess parental concerns regarding registration and access for preventive dental care for their child.
3. Conduct a field trial of the parental dental concerns questionnaire (PDCQ) to identify parents with dental concerns and assess if additional assistance can enable these parents to access preventive dental care for their child.

This report will focus on the work undertaken in investigating the first objective. The first part of the study was conducted between November 2008 and October 2009. The results of the qualitative exploration will inform the design of the second and third study objectives, by identifying parental main concerns associated with accessing dental care and life in areas of high social deprivation.

Method

Sampling and recruitment

Participants were recruited using purposive sampling techniques, that is, participants were recruited based on characteristics most relevant to the study. This included living in areas of high deprivation, or a rural/remote area, in health boards where Childsmile Practice was running, and areas where it has not yet been rolled out.

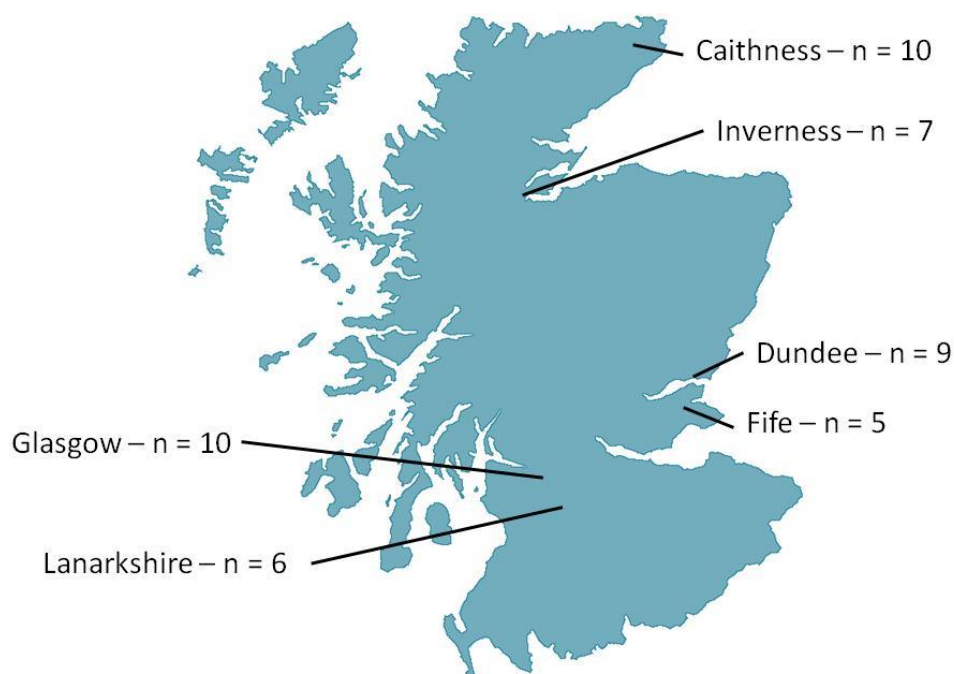
Initially, participants were recruited through health visitors and Childsmile staff, who asked families if they would be willing to take part in an in-depth interview with the researcher (SC). Health visitors and Childsmile staff reported difficulties in contacting families, and recruiting them to take part. Local community groups working with families living in deprived areas were then contacted as a second recruitment method. All groups contacted were willing to help recruit families and introduced the study to those interested in taking part, which proved a more straightforward recruitment method. Nonetheless a drawback of this sampling technique was that we did not know in advance whether mothers being interviewed were taking part in Childsmile. Sampling continued until theoretical saturation of categories had occurred.

The research context

Research participants were recruited from across Scotland, and were living in the following areas: Glasgow, Lanarkshire, Inverness, Caithness, Dundee and Fife. Recruitment in Glasgow, Inverness, Dundee and Fife was in urban areas, and recruitment in Lanarkshire and Caithness in more rural or remote areas. Figure 1 shows a geographical representation of the areas from which recruitment took place.

Childsmile Practice has been running in the west of Scotland (Greater Glasgow & Clyde and Ayrshire & Arran health boards) since 2006. The programme was rolled out in Lanarkshire in 2007 and Highland (including Inverness & Caithness) in 2008. At the time of the study, it had not yet been rolled in Tayside (Dundee) and Fife.

Figure 1 – Interview areas



Ethical considerations

Ethical approval was obtained for the study from the University of Dundee's Research Ethics Committee (Approval number 8129) (See Appendix 1). Advice was sought as to whether ethical approval was required from an NHS research ethics committee. The National Research Ethics Service (NRES) advised that the project was Service Evaluation; therefore, Clinical Governance was consulted in relation to making contact with mothers in each area, rather than ethical approval being submitted (Appendix 2).

In NHS Highland, SC attended the Dental Clinical Governance Group and presented an overview of the study. The group then gave permission for the project to go ahead within Highland, and the project was registered with Clinical Governance. In NHS Lanarkshire there were no formal arrangements for Service Evaluation projects; instead permission was given for the project through Albert Yeung, Consultant in Dental Public Health (Appendix 2).

Nevertheless, there were difficulties in accessing mothers in Lanarkshire as key personnel objected to following up mothers who had been noncompliant with Childsmile without NHS ethical approval. Clarification was sought from Judith Godden, manager of the West of Scotland Research Ethics Service, who deemed that the project could go ahead with the Service Evaluation ruling (Appendix 2).

In Ayrshire & Arran, the Local Research Ethics Committee also judged the project Service Evaluation, and it was registered with Clinical Governance (Appendix 2); however, on the ground, health visitors were not willing to recruit mothers without NHS ethical approval.

Finally, in Glasgow there were difficulties in locating the correct person to approve the project. Andrea Torrie, Senior/Lead Administrator from the West of Scotland Research Ethics Committee Service, also ruled that the project should not undergo ethical review and we were advised to contact Isobel Brown, as Information Governance Manager to register the project (Appendix 2).

Information sheets outlining the purpose of the study, and what was required of each participant, together with written consent forms, were provided to each mother. Informed consent was sought and qualitative data anonymised (Appendix 1).

In-depth interviews

During each interview mothers were encouraged to discuss any topic that was important to them, and assured that no topic would be probed further if they felt uncomfortable. Questions were focused on three main areas – accessing dental care for children, accessing health care in general, and everyday family life with young children. Mothers were encouraged to expand on each of these areas, for example, *‘You said it was his first proper appointment, had he been there before, when you were going?’* Interesting and important points were followed up, and mothers were encouraged to describe their experiences in greater depth. For example, *‘You said that your aunt helped you. Who else was there for you during that*

time? Interesting points were thread into interviews from previous interviews to develop existing codes, and to determine whether new codes could be identified. Each interview finished with the mother being given the opportunity to comment on anything that had not been covered that they felt was important. Mothers were also given the opportunity to ask questions about the interview, or the study more generally.

Interviews lasted between 25 and 70 minutes, taking place either in mothers' homes or at the premises of local community organisations. Thirty-nine interviews in total were carried out: 34 one on one interviews, along with five small group interviews of two or three mothers. Group interviews were not initially included in the research design, but some mothers preferred to be interviewed at the same time as friends or family and this was accommodated. Thirty-five interviews were audio-recorded and transcribed: in two interviews mothers preferred not to be recorded, and in a further two interviews the environment was not conducive to recording. Data saturation occurred after these 39 interviews.

Grounded theory

Grounded theory was used to guide research design, and to collect and analyse data. Grounded theory is a qualitative approach that aims to identify an emerging theory from the phenomena being investigated. When approaching a study using grounded theory techniques, an extensive literature review does not take place before data collection begins. This allows the researcher to approach the topic without preconceptions that could influence the direction of data collection. A theory should emerge from the data, rather than through the use of previously defined categories (Glaser and Strauss, 1967).

Grounded theory aims to move beyond merely describing phenomena, and instead 'develops a theory that accounts for much of the relevant behavior' (Glaser and Strauss, 1967: 30). This is achieved through the identification of processes in the data relating to the particular phenomena. Central to grounded theory is a constant comparative method: data

collection and analysis take place simultaneously, with categories and instances compared throughout the investigative process. From this, a main concern, or problem, relating to the phenomena should emerge, along with the basic social process or behaviours used to resolve this concern.

Data analysis

Data was analysed following a grounded theory approach. Initially, data was coded using open coding techniques. During the open coding phase, the researcher attempts to stay close to their data by examining it line by line. In doing so, the researcher has the opportunity to ask questions of the data, such as ‘what does this mean?’ and ‘what is going on here?’ When possible, participants’ own words are used to create appropriate codes. Codes try to reflect processes; this can be achieved by gerunding nouns by adding ‘-ing’ suffixes to them. For example, when mothers spoke about either having an everyday routine, or not having one, information was coded as ‘routining’ (Charmaz, 2006). Using codes in this way helps to reflect participants’ actions. Codes were constantly compared with one and other, and codes from early interviews followed up in subsequent interviews to aid refinement of categories. Emerging ideas relating to codes were recorded using memos, allowing them to be developed into higher level categories. This process of abstraction was the result of axial coding, that is, investigating the connection between codes and the processes represented, and typing the behaviours represented by these codes (Strauss & Corbin, 1998). Finally, selective coding was used to confirm the core category – the way in which mothers resolved their main concern. Selective coding allowed for the refinement of categories, as all the data and memos were scanned and recoded with the core category in mind. The core category explained the greatest variance in behaviour, and highlighted the ways in which mothers tried to resolve their main concern.

Results

The results will begin with a description of the mothers and their families, followed by a discussion of mothers' main concern and their attempts to resolve this concern (the core category). The behaviour they engaged in to resolve this concern was the core category that emerged from the data. Mothers spoke of the disappointments everyday life with their young children had brought, and talked about their experiences of 'mothering when it's not for me'. Mothers described the ways in which their lives with their children were far removed from an idealised image of motherhood and not how they wished it to be. Mothers attempted to resolve their main concern by 'getting on with it': their behaviour can be viewed as a continuum from being fully engaged and 'getting on with it' to being disengaged and 'unable to get on with it' (See Figure 2 for a diagrammatic presentation of this emerging theory).

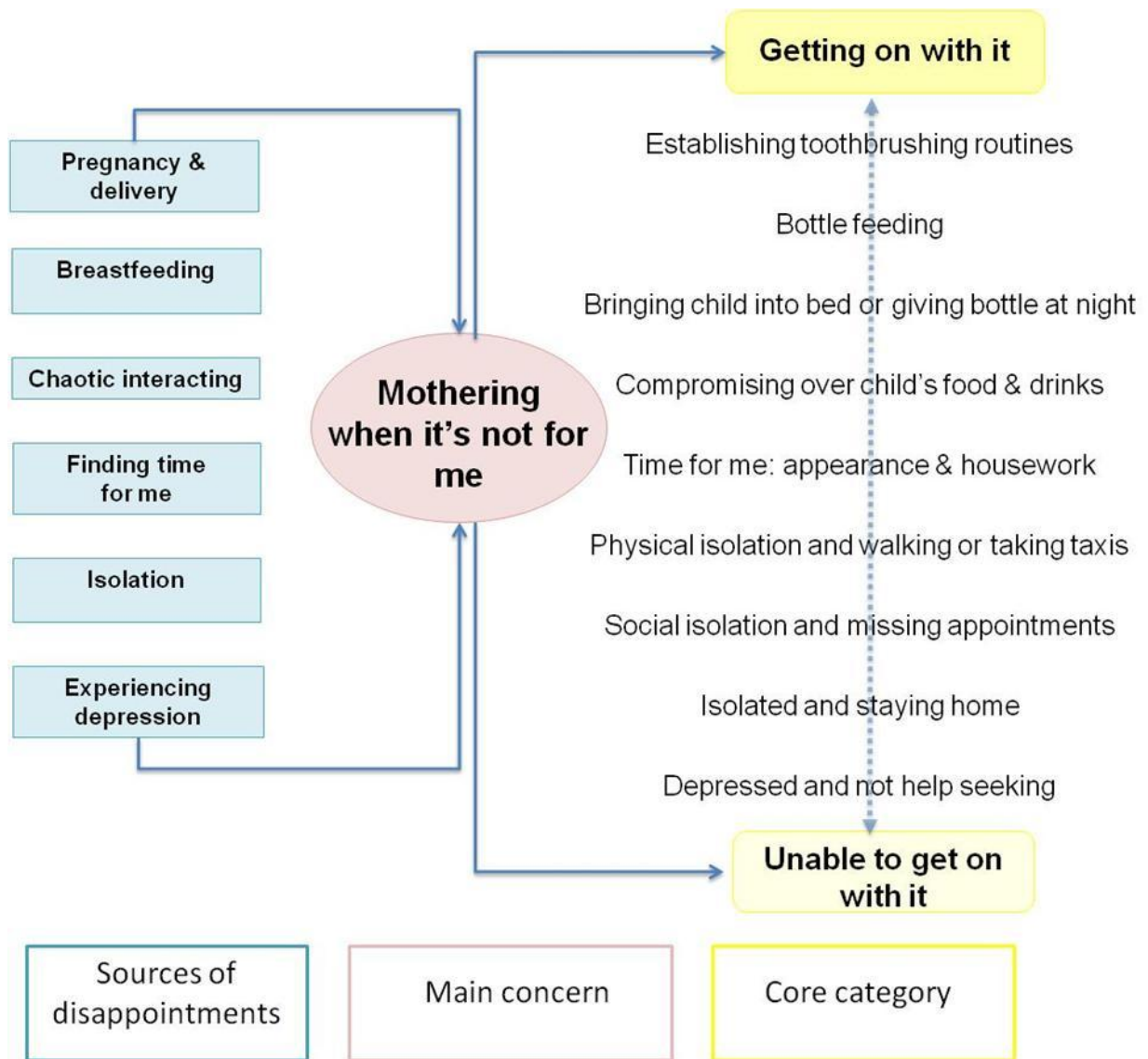
Description of the mothers

From the 39 interviews, a total of 47 mothers took part. Fourteen mothers lived in remote or rural areas and 33 lived in urban areas, with 19 out of this 33 located in major urban centres. All but one mother were of white ethnic background. The number of children within each family ranged from 1 to 10, with a median of one child per mother. Mothers' youngest children ranged in age from five weeks up to four years old. Three mothers disclosed that they were pregnant at the time of the interview.

Main concern: 'Mothering when it's not for me'

Throughout the interviews, mothers discussed the realities of everyday motherhood. These realities were in stark contrast to idealised visions of being a mother. Within Western societies, motherhood is defined prescriptively: mothers *should* be selfless, loving, and happy (Featherstone, 1999; Marshall, 1991). Rubin (1984) describes a 'fantasy' stage during pregnancy in which women actively imagine their baby and life with their baby. The interviews highlighted that the reality of mothering was far removed from this 'fantasy': indeed, mothers described many aspects of traditional motherhood as 'not for me'. 'Not for me' was initially used in relation to breastfeeding, and this phrase was provided as an

Figure 2 – Emerging Theory of Parental Concerns



explanation by many mothers for choosing not to breastfeed. Over time it emerged that ‘not for me’ applied to many aspects of mothers’ lives with their children, and could be extended to incorporate mothers’ perception that others were ‘not there for me’. This applied when mothers felt that they were not given the support they desperately needed, and included lack of support from a partner or family, but also lack of support from health services that were not designed and implemented with their lives in mind. These experiences and difficulties acted as sources of disappointment building into the main concern and fear that despite their children, mothering in the emotional and physical environment in which they found themselves was ‘not for me’.

Pregnancy and Delivery

The first of their disappointments occurred in pregnancy. For these mothers, the deconstruction of the 'fantasy', or idealised image, of motherhood took place long before their child was born through a difficult pregnancy. This contrasted starkly with the image of the ideal 'glowing' mother who patiently awaits her baby's arrival. Instead mothers spoke of being incapacitated, confined to crutches, and unable to care fully for older children. Having to give up work before they had planned to left mothers feeling socially isolated.

'I was in a lot of pain with that. I had like crutches and a support belt because of the bump. We had that from about 21 weeks until I gave birth...I was getting a lot of pain, so obviously I went to the doctor and they sent me to hospital and "That's it, you're not working until you have the baby".'

(Mother 30)

'It's just that my pregnancy was a bit too much. Because he was quite a big baby, so carrying a big baby was pretty stressful because I could hardly walk very far.'

(Mother 4)

In these situations mothers spoke of their frustration, isolation and disappointment,

'I was a bit disappointed with that because I kind of wish I got better care when I was pregnant.' (Mother 16)

The fear that mothering was 'not for me' also resulted from complications during delivery. Mothers unsurprisingly hoped for a straightforward, natural delivery of their baby; however, many had experienced premature births, long labour, the use of forceps or suction cups, retained placenta, and caesarean section. As the majority of caesarean sections were emergencies, mothers spoke of the trauma experienced when delivery could no longer proceed naturally. They also spoke of their immense disappointment at not delivering in the way they had hoped to, missing out on holding the baby as soon as it was born.

'I was a bit disappointed because I was another section and I kind of felt really disappointed when she was born that I didn't do it myself.' (Mother 2)

Often the lack of information given to mothers at this time created tension between her and health care professionals – mothers felt they had been let down, that their care was ‘not for them.’

‘I couldn’t get round my head how all this happened, how after having been in theatre could you have retained product and all this sort of stuff. It really messed my head up quite a bit...in hospital they didn’t really explain anything of what had happened.’ (Mother 5)

Breastfeeding

Health care professionals throughout Scotland are committed to the promotion of breastfeeding; however, only two out of the 47 mothers were successful in breastfeeding their children until the recommended 6 months. There were mothers who managed to breastfeed for only a matter of days before it was clear that the baby would not ‘latch on’. Other mothers tried for weeks, eventually giving up when it became too painful, or their child did not gain weight. Mothers described their disappointment at being unable to feed their baby: they expressed, sadly, that breastfeeding was ‘not for them’, and that they had ‘failed’.

‘I got quite upset and teary about that because I’m so disappointed because I was wanting to give birth properly and I didn’t. I was wanting to breastfeed and that wasn’t working, so I got quite upset with myself.’ (Mother 22)

Other mothers chose from the outset not to breastfeed. They felt that it would be an additional burden on them at a difficult time. One mother said,

‘[The baby] wouldnae be able to stay [with other people]...and I’d be dead embarrassed [breastfeeding], even although they say no to be if you’re outside. Oh no, I’d be too embarrassed doing that.’ (Mother 8)

Finding time for me

Breastfeeding was described as a time-consuming activity, when mothers were increasingly short on time. The women described the difficulty in finding a moment for themselves since their children had been born. Mothers spoke of how the new child took over all aspects of their life and surroundings. They no longer had time to spend on themselves which negatively impacted on their self-esteem. Simple tasks, such as showering, doing their hair, putting on makeup and dressing up to go out, could no longer be taken for granted.

'Self-image is another thing that I lost as well. Before, I would usually do my hair every day, and you know, but once the stretch marks came in, I just, "No." Trying to lose the weight was just horrendous.' (Mother 15)

'I've not really been my usual self...you don't really have time to do your hair the way you like and your make-up and stuff.' (Mother 18)

Lack of time was further compounded when mothers felt that they must also live up to the role of ideal 'housewife' as well as mother. One woman described her uneasiness over the condition of her home during her post-natal depression.

'My washing was piling up and everything was just piling up, and just - I just never really thought it was going to be that hard to be honest with you.' (Mother 4)

Experiencing Depression

The feeling that motherhood was not 'going to be that hard' was felt by many mothers, and 11 of the 47 mothers disclosed that they had suffered from post natal depression, or depression more generally. Many felt unable to care for the baby, some did not want to care for their infant, while others feared they were ignoring an older child.

'At the time it was horrible. Horrible, horrible feeling. It was like a big dark cloud on me every minute of the day. You didnae want to dae anything, go anywhere.'
(Mother 35)

'I just kept thinking "oh it will go away". I just every day kept - and the days turn into weeks, turn into months, and it's not till you look back, you went, "Oh that wasn't right that."' (Mother 7)

Once again, mothers were left feeling that their fantasy of what motherhood would be had not been realised, and the reality was that they were 'mothering when it's not for me'.

Chaotic interacting

Mothers spoke about their interactions with their children and many described their inability to get their children into a sleeping, eating and toothbrushing routine. They struggled with their children's behaviour, and were left feeling that interaction with their children was 'not for me': not how they wished it to be.

Often children woke up late in the morning after a restless night's sleep. These infants did not go down for afternoon naps during the day. Unsurprisingly, this left mothers feeling exhausted. Nights were interrupted with seeing to a crying child, giving them a night feed, or bringing the baby or child into the mother's bed. For these mothers, night-time was stress-filled, and gave them no opportunity to recharge for the next day with their baby.

'The first four months she wouldn't go to sleep until 11/half past 11, and then was up at 5, so that's like six hours but in between that she'd be up for bottles and all. One time I counted, I came down here, and I counted that she'd been up 27 times in the space of 11 o'clock to 5 o'clock. I was exhausted – bags down to here. Honestly – that was a nightmare.'

Feeding was another fraught time characterised by chaotic interacting. Mothers spoke of their children being 'difficult eaters', rarely eating vegetables or cooked food. As their children got older they became more demanding, refusing certain foods. One mother commented that all her son would eat was 'turkey dinos', which she believed had

contributed to him being underweight for his age. Meal times, therefore, were described as a 'battle' between mother and child.

'I have a battle with him every mealtime. And you ask him what he'll want for his dinner and he'll say 'Pasta'. Sometimes he'll say sausages but other than that. And as for chocolates and stuff...' (Mother 6)

Mothers, therefore, battled their children's behaviour. Children's behaviour could be disruptive both inside and outside of the home. Within the home, this could be connected to difficulties controlling the child's demands for food.

'He's wild. I said to him the other day, "You're no getting a drink of milk" and he went in the fridge and got the jug of milk and says, "Well neither are you" and flung the jug of milk.' (Mother 40)

Children's chaotic behaviour outside the home, however, was most problematic and embarrassing for mothers. Children's disruptive behaviours could happen at nursery, school, on the bus, in shops and in waiting areas for dental appointments. Mothers were 'stressed out' when other people looked or commented as their child misbehaved. The following is illustrative:

'The youngest one, she's climbing o'er seats and aw that, and I dae, I get really stressed out. My man will go like that, 'Leave her alone, she's only a wean, let her play and that', and I'm like, 'No', because I can see people looking as if, 'Get a control of her', do you know what I mean?' (Mother 35)

Mothers spoke of children's behaviour deteriorating after the arrival of the new baby. The child's sibling rivalry was apparent as the older child acted out to attract their mothers' attention from the new baby. Behaviour included acting aggressively towards their mother and destroying things. A small number of mothers discussed their children's diagnosed behavioural problems and the negative impact that these had on their family life.

'He lashes out quite a lot...I think it's just because I'm ready to have this baby.'
(Mother 9)

Isolation

Isolation further contributed to mothers' main concern of 'mothering when it's not for me'. Isolation could be both physical and social in character.

Physical Isolation

Mothers were physically isolated in their struggle to simply get out the door with their young children. They described their best intentions to make it to appointments on time, but said that with young children they could not easily plan ahead.

'I've had nightmare times trying to get out the house and you're running late, and you've got everything - coats on – everything, and she has a dirty nappy and everything has to come back off again.' (Mother 1)

When mothers managed to make it out of the house with their children, they then faced the difficulty of using public transport. Those who could drive, had access to their own car, or could walk to local amenities, faced fewer problems in attending appointments; however, mothers that relied on buses or taxis struggled when going out with their children. In remote areas, a local doctor was usually available to families; however, attending the dentist often meant travelling on public transport. For a mother with young children this involved greater time, money and hassle. Mothers had to ensure they made the bus that they set out for, as the waiting time for the next bus was too long. They spoke of the fear of the pram space already being occupied on the bus; this would mean either waiting for the next bus, or folding their buggy.

'It's awkward with the buses, with the wee ones trying to get them on the bus. You've gotta go [10 miles] to get the weans to the dentist or health centre. That bus that we have, if you miss the first bus, then you're hanging about for an hour.'
(Mother 13)

Mothers described the lack of assistance offered by others when they tried to get onto buses, particularly from bus drivers, who harangued them for taking too long to board. To avoid this, many mothers spoke of taking taxis which none of them could not afford.

Physical isolation was also manifest through mothers' experiences of social housing. Many mothers had not lived in the same home since their family were born, or anticipated that they would be moving soon. For younger mothers this happened when they became pregnant and moved into a new home. Then as circumstances changed, or family size increased, mothers had to move again. House moves were perceived as difficult as mothers ended up living in areas where they did not know other people. One mother spoke of her daughter wetting the bed due the stress associated with moving home. When the mothers spoke of moving, they gave an impression of being unsettled, and unsure of where they would end up next.

'We were in homeless [accommodation] for a few years before we got this place and it was absolutely horrible. I hated every minute of it, like. I just kept getting shifted, shifted further away from where we wanted to be.' (Mother 31)

Young mothers who had moved multiple times said that this may explain why they rarely interacted with professionals such as health visitors or dentists: the practices were unaware that the family had moved. At times mothers had to move into an area further from the services they had previously used. Getting out the door and travelling to these appointments, therefore, became more difficult.

Social Isolation

Social isolation was also important in fostering the concern of 'mothering when it's not for me'. In these situations, 'not for me' was extended to incorporate the feeling that others were 'not there for me'. Some mothers said they were not close to their family, or spoke of having family members close by that no longer offered to take care of children, particularly as the children got older. This created a source of tension within extended families.

'Well I don't have a mum and dad near me. Well my real dad he passed away, and my mum I didn't really know her at all. I find it very hard having to rely on [my partner's] parents too.' (Mother 4)

'I can't get a babysitter like most people. They can get a babysitter and go out with their pals and stuff: I can't do that.' (Mother 12)

These feelings were exacerbated when mothers did not have a supportive partner to help them to bring up their children. Some mothers spoke of having to take full responsibility for caring for their children, whilst their partners refused to change nappies or feed their children.

'I do live with a partner, but he's not the most helpful. Like he's not very good at waking up in the middle of the night. I can't leave him alone [with the children] and sleeping. I'm the one who deals with the children. He's not very - he's not very confident at looking after [them].' (Mother 46)

Further social isolation was experienced from wider society. When mothers made the attempt to get out the door with their children they were vulnerable to verbal attack from others. Young mothers appeared particularly vulnerable as people looked disapprovingly at them, or voiced objections when their children misbehaved. One mother spoke of experiencing negative comments when she went out because she was a young mum.

'I was walking, just up the escalator, I just had my pram and this woman started shouting, "You're disgusting. You're just a child having a child...you just have babies to get money off of society and get a house."' (Mother 24)

Isolation from health services

The feeling that others were 'not there for them' extended to health services. One of the most frequently discussed interactions was with health visitors. For some mothers this was a positive relationship, where they viewed their health visitor as someone who 'believed' in them, someone they could connect with. There was similar praise for health professionals, particularly dentists, who recognised that children had to be approached differently to

adults. Dentists with family friendly surgeries, that were patient with children, and who adapted their techniques, were valued by mothers and encouraged their attendance.

‘[The dentist has] got one wall that’s like a big picture on it. He can change it for different people into like different things. It’s like an overhead projector thing and he put clowns on it for [my son]. That’s what I think made him lie in the seat to watch. But he’s really good with kids.’ (Mother 47)

Other mothers, however, talked of their disconnection from health services. They felt that health services and professionals were ‘not there for them’, and were not suited to their family. First, mothers reported negative experiences when accessing services for themselves and their children. Particularly negative was a lack of continuity with health care professionals. Midwives or health visitors could change due to transfers or sick leave. Discontinuity of health professionals left mothers feeling that they had not received the correct level of care. Also, they did not always know that their health visitor had changed, and were surprised when they were contacted by someone they did not know.

‘I don’t think my health visitor knows me properly, you know, because they only see us once a week for so many weeks. There’s not really the time to know anyone.’
(Mother 2)

Mothers with older children spoke of how in the past they always had the same health visitor who visited often and was approachable. This was contrasted with the need to attend clinics at the local health centre, or phoning the health visitor if there was a problem. One mother spoke of the clinics as ‘a production line’.

‘It’s just nappy off, on the weigh, “Right, that’s it, that’s his weight”’.
(Mother 11)

There were particularly negative comments made about accessing dental care, although this was in relation to the mothers’ own experiences rather than with their children. Mothers spoke of their fear and anxiety when attending the dentist, which was derived from negative past experiences.

‘When I was younger...getting a check up and then instead they gave me a filling. And they wouldn’t give me a jag to numb my mouth and he’d cut the bit at the top of my mouth and it kept bleeding. And I think because I was myself I was totally terrified.’ (Mother 32)

In certain areas, attending the dentist was particularly difficult as there were few dental practices willing to take on new NHS patients. For those mothers who could not afford private dental care, attending the dentist was generally the result of an emergency appointment. It seemed that this experience encouraged mothers to take part in Childsmile, as their children were being provided with the free dental care that they did not have access to.

It was evident from across the interviews that mothers’ main concern was consistently ‘mothering when it’s not for me’; that is, the women were attempting to mother in circumstances that were far from ideal. When outlining these experiences, mothers were also keen to talk about how they coped with these difficulties and disappointments.

Core category: ‘Getting on with it’

Mothers resolved their disappointment of ‘mothering when it’s not for me’, by ‘getting on with it’. ‘Getting on with it’ emerged as the core category within the data: the basic social process through which mothers resolved their main concern. ‘Getting on with it’ explained the greatest variance in behaviour from the data, and was viewed on a continuum ranging from mothers who were fully engaged with ‘getting on with it’, to mothers who were disengaged and ‘unable to get on with it’. ‘Getting on with it’ highlighted the lack of choice that was open to these women, many of whom were living in poverty. Although they wished for more positive experiences, they could see few ways to change their circumstances. One mother spoke of the negative changes in family life since her father had died. She said,

‘We just need to get on with it, don’t we, because there’s nothing else for it. There’s nae point sitting moping about, is there? You just need to get on with your life and take every day as it comes as they say.’ (Mother 9)

Mothers who, therefore, were able to cope with their disappointments and the difficulties encountered with their mothering experiences, seemed able to resolve their conflicts by reassessing their life problems and ‘getting on with it’. For instance mothers who had experienced traumatic and frightening deliveries of their children reassessed the experience to look upon it in a more philosophical way. In essence they acknowledged their disappointments, accepted their current life difficulties, but unlike mothers who were ‘unable to get on with it’ focused on the positives – that their child had been delivered safely.

‘As long as the baby’s there, you’re safe, that really is the main thing.’ (Mother 19)

Getting on with it was thus conceptualised as a construct, composed of the mothers’ ability to reassess difficult past live experiences and accept current life circumstances. The following description of the various sources of ‘mothering when it’s not for me’ are presented and re-worked as if by a mother who is ‘getting on with it’.

Breastfeeding

It was previously illustrated that mothers who tried unsuccessfully to breastfeed their babies felt immense disappointment. In giving their child a bottle, however, by ‘getting on with it’, they were freed from their disappointment, as all spoke of how their baby developed from this point on, either through gaining weight, or sleeping through the night. One mother spoke of her relief at giving up breastfeeding as it allowed her to regain her independence.

‘I just really got to the stage where, “I want my body back.” Yeah, you just want it back.’ (Mother 17)

Even those mothers who were able to breastfeed successfully reported their experiences negatively. One mother spoke of taking the decision to 'suffer' in order to breastfeed her son, and the strong will needed to breastfeed in public when people looked disapprovingly at her.

'As far as breastfeeding is concerned, wherever I went I didn't really give a monkeys. I was breastfeeding, you know. I'd have the odd idiot looking at me and giving dirty looks and that's, you know, you've got to expect that. You get a lot of very close-minded people.' (Mother 29)

For this mother, 'getting on with it' meant enduring pain and judgement in order to do what she felt was best for her son.

Those mothers that decided breastfeeding was 'not for them' as soon as their baby was born, were also 'getting on with it', and were trying to gain a degree of control in their interactions with their babies. Breastfeeding was seen as demanding, isolating, embarrassing and painful. These mothers said that they were better able to choose when to feed the baby, and they were physically able to be separated from the baby. One mother described the negative looks she received from others because she looked so young, and said that breastfeeding in public would only give them another reason to look at her. For her, the best way to 'get on with it' was to give her daughter a bottle.

Chaotic Interacting

Rejecting official advice on breastfeeding provided mothers with a means to 'get on with it': this strategy could also be seen in other areas relevant to Childsmile Practice, such as children's eating, sleeping and toothbrushing routines. Where children resisted healthier food, mothers 'got on with it' by compensating; any food as long as the child ate. Mothers provided milk or yogurt, despite knowing that snacking was a reason why their children were not hungry enough to eat other foods. Some mothers commented that their children would only drink juice or milk:

'The only fruit she'll eat is a banana. The only veg she'll eat - does she eat any veg? No, she'll no eat any veg. She doesn't drink water, she doesn't drink milk, she'll only drink juice.' (Mother 24)

Mothers knew that water would be the best drink for their children, but for many, this was not an option available to them: their child decided on what they would drink, not them. In an effort to 'get on with it', mothers would compromise with their child and 'diluted' juice was provided.

'The only thing I have in the house is diluting juice, you know, just the Robinson's, a wee spot and that's it.' (Mother 41)

When children would not go down to sleep, or sleep through the night, mothers also had to 'get on with it'. They did this by giving the child a bottle at night, taking them into their own bed, or allowing the child to stay awake until they fell asleep in the living room.

'I'm trying to get him off the bottles. It's like musical beds sometimes. He's in the cot, oot the cot, in wi' us, oot wi' us, back in the cot...I don't care what the books and aw says - but whatever gets you through the night.' (Mother 41)

Mothers knew this was far from ideal, and not what they wanted, but they needed to 'get through the night'.

Where toothbrushing was not a routine event, it was described as a battle. Mothers spoke of having to physically restrain the child in order to brush their teeth, and in doing so, they acknowledged they were 'getting on with it', rather than ensuring it was done properly.

'Sometimes he's alright with his teeth and other times you've to hold him - physically hold him - doon. Cruel, intit? Sometimes when you hold them down like that and they're screaming and screaming, but you need to dae it.' (Mother 11)

Some mothers also allowed young children to brush their teeth themselves, and only took over if they felt that they had not done it properly. One mother spoke of her daughter never allowing her to brush her teeth which resulted in the child having teeth removed.

Another method of 'getting on with it' was to get children into a routine. Routine was a clear way of mothers staying in control: they decided when the baby ate and slept, and made sure that they brushed their teeth. Children who were in a routine tended to eat well and went to sleep early in the evening, or at specific nap times.

'Total routine. We get up in the morning, breakfast, go to school, then it's lunchtime and the others go to school and then they come home and it's tea time. Then it's suppertime and bed. It is a pure routine.' (Mother 21)

This helped to ensure that the mother stayed in control. Toothbrushing that had been established at an early age, and was part of a morning and evening routine for parent and child, often done as a joint activity with the mother or older siblings, appeared to be a straightforward and stress free time together.

Finding time for me

Mothers in their attempt to get on with it struggled to find time for themselves as their time was taken up caring for their children and looking after the home. There were two main ways that mothers coped with this. First, there were those who still hoped for the ideal and strived for perfection. One mother described the improvement in her mood as she managed to finish her housework,

'I'm getting there because they're getting older. I've caught up with most of my housework and things like that...it's getting better.' (Mother 4)

Secondly, other mothers, however, did not focus on their home and instead enjoyed time spent playing with their children.

'I feel guilty sometimes if I've no been oot wi' D because you're too busy daeing housework and the sun's scorching. Go 'Aw right, we'll just leave that. Come on we'll go oot and play.' (Mother 41)

Similarly there were mothers who no longer worried about how they looked. In their reassessment of their current life they were more concerned with 'getting on with' and taking care of their children.

'I lost [my self-image] a long time ago. You've no got time to get up and dae your hair and dae your makeup and get all ready before you go out. I just get up and brush it and then that's me' (Mother 31)

In this scenario the mothers had shifted their attention from themselves (as 'yummy mummy') to a mother whose life was concentrated on the needs of her child. A difficulty, however, to this approach was the mother who found herself isolated from her partner, family and society.

Isolation

Physical Isolation

Mothers tried to deal with physical and social isolation in a number of different ways. Some were more successful than others in overcoming isolation. In trying to get out the door with their children, mothers spoke about getting up early, planning the night before or simply refusing to make morning appointments.

'I don't do morning appointments now. I phone up the doctors to make an appointment, say, "9 o'clock". "No. Afternoon?" And it's just I don't do mornings at all. I prefer if the appointment was later on in the afternoon or even lunchtime.' (Mother 47)

'The [dental] appointment was for 9 in the morning, and I was a bit like, "I've got to get up at 5 just to get me and him ready for 9". Which is not really – because trying to explain to him the night before and all, "Go to your bed to go to sleep because we've gotta get up early" just doesn't work because they don't understand.' (Mother 45).

In order to avoid an unpleasant journey on public transport, some mothers decided to walk to appointments or shops: even walking in winter was viewed as a preferable option to taking the bus.

'It was the case of a big jacket and cover on the pram, and just go, get on with it.'
(Mother 32)

One mother spoke of being so embarrassed by others' reactions when her child cried on the bus that 'getting on with it' involved walking four miles each way to visit her mother in hospital.

'I could never go on a bus wi' him. I had to walk everywhere because he kept greetin' all the time and I was too embarrassed to go on a bus.' (Mother 40)

Other mothers decided to pay for taxi journeys that they could not afford.

'I'll get a taxi with her. I cannae go on the bus. And that costs a lot of money as well. It's a fiver over and a fiver back. So that's £10 on a Thursday and £10 on a Friday to get to nursery. It's a lot of money.' (Mother 9)

Although both courses of action were inconvenient, they allowed mothers to 'get on with it', to be where they needed to be. The difficulty was, however, that these strategies created additional burdens, such as being a strain on time or financial resources. Their choices were therefore limited by the circumstances in which they were living.

Further complications were evident when mothers arrived at dental surgeries that were not located on ground level. Once again, mothers were faced with the fact that a service was 'not for there for them': they either had to bump the pram up the stairs, or, in order to 'get on with it', they simply did not show up to their appointment.

Social Isolation

Mothers who felt socially connected were better able to 'get on with it' through the help of family, friends or a supportive partner. In addition, when they needed advice, they could easily call upon the support of a relevant health professional.

Having family or friends to call upon was viewed as vital for 'getting on with it', with babysitting one of the major functions provided. This allowed mothers to 'get out the door' alone, or with just one or two of their children. Family or friends could also provide transport to appointments for families. Additionally, family and friends served an essential social function by giving mothers someone to talk to. Lack of adult company during the day left mothers feeling isolated; therefore, having someone they could rely upon to speak with helped ease these feelings.

'It's nice that people still come down and see you and everything and you've got adult conversation and that. I think if you didn't have that, I don't know how you would cope.' (Mother 32)

Partners who shared childrearing with a mother were also important, as this was often the key way that mothers were able to 'get on with it'. Some mothers described themselves and their partner as a 'team', sharing childcare responsibilities '50/50'. There were a small number of mothers who were bringing up their children alone: these mothers were also 'getting on with it'. They spoke of how life was better now that they had left their partners and were bringing up their children on their own.

'I was with her dad at the time, but he's about as much use as somebody that couldn't move, honestly. He did nothing, no night feeds, nothing.'
(Mother 24)

'It's like having a third child there, that's why I'm glad he's gone because it's like you had to ask him to change their bums, ask him to make the dinner...I do everything from the decorating, laying flooring, the garden and looking after the boys.'
(Mother 6)

Mothers who were in a relationship with their children's father, but received little help, had the greatest difficulty. They spoke of their frustration, exhaustion, and the lack of understanding shown to them. Additionally, younger mothers described both physical and emotional abuse that they had suffered from their partners or ex-partners.

'I suppose I'm here I do everything, I get on with it. But he just sits there and just watches. It's really annoying when he does that, it's like "Well it is your children as well."' (Mother 4)

Although this mother spoke of 'getting on with it', she also talked about suffering from post natal depression, her difficulties in looking after the children and struggling to balance part time working and childcare. It appeared that she was disengaged and 'unable to get on with it'.

In dealing with other people's negative reactions mothers also responded in different ways. Some mothers stood up to those that put them down or judged them. The young mother who was told she was 'disgusting' for having a child when she was only a 'child' herself responded by saying,

"Excuse me" – I was 18 at the time – "I'm 18" – not very old but – and she's going, "Yeah you just have babies to get money off of society and get house and everything." "Excuse me, I've worked since near enough the day I had her, and I'm working again now so...." She probably had too much drink that day, she looked like an alchy.' (Mother 24)

This mother refused to accept the criticism levelled at her, and reflected that it was the other woman who had the problem, and not her. Not all mothers, however, were able to respond in such a way – to 'get on with it'. A mother spoke about moving to a new city and neighbours complaining when she would hang her baby's clothes on the balcony to dry. The mother became so afraid of confrontation that she could not leave the house on her own.

'I became agoraphobic...because we had trouble with the neighbours, and then it got to the point where I didn't want to leave the house by myself.' (Mother 45)

This mother endured a year of being unable to leave the house, and was only finally able to 'get on with it' when she moved back to her home town.

Getting on with health professionals

When mothers felt isolated from health services their strategy for 'getting on with it' was withdrawing. Withdrawal meant they no longer had to deal with dental anxiety, health visitors they did not get along with, or appointment times that were unsuitable for their families.

'If I can't make an appointment, I can't make an appointment and that's it. It shouldnae be any questions, or "Why not?", or going into detail. Sometimes they say if you miss another appointment, "Well we can't keep you on our books or whatever", you know what I mean?' (Mother 9)

One mother spoke of her difficulty in getting her baby to sleep through the night. When she attended the clinic to meet with a health visitor for advice, she felt let down by the way she was treated. She said,

'I was really quite disappointed in how that was, in how it was run. So I put in a complaint. I don't think it was right that I was treated like that...I wouldn't go back. I would not go back to one of those clinics.' (Mother 2)

Mothers experiences of being let down by health professionals, of feeling that they were 'not there for me', meant mothers were less likely to engage with services. They felt they were better able to 'get on with it' if they tried to cope in their own way. Withdrawal from services also meant mothers had more time to concentrate on the other difficulties that they faced. Attending appointments that they viewed as non essential could wait whilst they addressed more urgent matters. One mother said,

'Sometimes I don't have money to go out up the street [to the dentists], do you know what I mean? Most of the time - well I havenae been well and sometimes I just cannae get up, or I've got other things to do - I've got a house to run. I've got a wee boy at school who's getting bullied. (Mother 9)

Depression

Although withdrawal from health services appeared to benefit mothers in their quest to 'get on with it', the same strategy was not successful for those mothers who were suffering from post natal depression. Young women who had previously experienced post natal depression spoke of a period when they did not leave their home after their children arrived. One mother said that she would position her baby in front of the television each morning whilst she went back to bed until lunchtime. On those occasions when she did go out, she feared that others would chastise her in some way. Other mothers spoke of not seeking help at the time of their depression, which led to a crisis point where they sought help from others - they wanted to 'get on with it' once again.

'I did hide it. "Aye, she's great" I would tell [the health visitor], because you don't want people to think you're no daeing it, that you cannae dae it, be a mammy. Do you know what I mean? And eventually one day I just broke doon in tears and it was with my family, and I was like "I cannae dae this anymair."' (Mother 35)

A mother reflected on her post natal depression with her first child who had been born two months prematurely. She described trying to withdraw from her son whilst he was still in hospital.

'I remember visiting the nurse and I remember I was feeding him and I remember saying to the nurse 'Oh can you finish feeding him because I've got somewhere' - basically meeting my friend. I remember the nurse looking at me and going like, "You know we're not a babysitting service. Your baby's in intensive baby monitoring." But that was just kind of my - I couldn't deal with it I suppose. Or it could be how I felt, so you sort of runaway from everything. Including yourself!' (Mother 7)

It was only when mothers opened up to others, a family member, doctor or health visitor, and received help, that they felt they were able to once again 'get on with' taking care of their children. Attending support groups and medication appeared the most successful means for mothers to recover from their depression.

Summary

Summary

With the roll out of the Childsmile Practice programme across Scotland, a greater understanding was sought of the facilitators and barriers to families attending preventive dental appointments. Failure to attend rates for Childsmile Practice visits have been highest in those areas of greatest deprivation. Using a grounded theory approach, mothers living in these, and rural and remote areas throughout Scotland were interviewed. A main concern of 'mothering when it's not for me' was identified from the interviews. Mothers' everyday experiences of mothering were far removed from idealised images of motherhood, and they struggled with many difficulties that resulted from a life with few choices. Mothers attempted to resolve their main concern by 'getting on with it'. 'Getting on with it' was the core category identified from the interviews, and explained the greatest variance in the data.

Mothers articulated a feeling that motherhood, as they experienced it, was 'not for me'; however, mothers had little choice other than to 'get on with it.' They engaged in 'getting on with it' rather than an idealised version of mothering. 'Getting on with it' was already experienced by some mothers before their children were born through a difficult pregnancy, or a complicated delivery. These mothers experienced feelings of disappointment, as did those who had wanted to breastfeed but were unable to. Ironically, it was those mothers who shunned official advice on breastfeeding who seemed best able to 'get on with it'. They were able to be separated from their baby, allowing them to have greater freedom. Mothers who encountered difficulties such as these found that they were not always fully supported by health care professionals during this time: they were left to 'get on with it'. This may explain why they reject a programme such as Childsmile: their experience has led them to believe that they will cope better on their own.

'Getting on with it' was evident in relation to mothers' everyday interactions with their children, which in these situations, could be described as chaotic. Often routines were not established, and mothers struggled to get children to sleep, to eat healthily and to brush their teeth. In addition, mothers spoke of having to 'battle' their children's behaviour, and of their embarrassment when children acted out in public. Mothers, therefore, found it

difficult to follow the advice offered by Childsmile concerning food and drinks, and toothbrushing. They were also unable to control their children in public, and feared the reactions of others in the dental practice to their children's disruptive behaviour.

Mothers spoke of 'getting on with it' when dealing with the changes that a new baby brought. The mothers struggled in relation to low self-esteem and finding time. They had to devote almost all their attention to a new baby, which left little time for themselves. They could no longer spend time on their personal appearance, with their partner, or on relaxation. Many mothers felt that when they did have some time, they should be 'getting on' with housework. This might help explain why some mothers fail to attend appointments. Looking after their child and running a home already consumes much of their time; Childsmile Practice may be an additional 'burden' that would negatively affect mothers' ability to 'get on with it'.

The seemingly simple act of 'getting out the door' with children was often impossible for mothers, and they became both socially and physically isolated. In an attempt to 'get on with it', mothers withdrew. Mothers without transport had a particularly difficult time taking small children and babies on buses: this made attending appointments at the dental practice more complicated. Many of the mothers taking part in the study had the additional strain of unstable living conditions. The arrival of a new baby often meant moving into new social housing, further from the health centre or dental practice where they used to attend.

Withdrawal could also be experienced through social isolation when mothers did not have close family, friends or a partner to share childrearing with. Mothers not only lacked practical support, but also emotional support. When there was no one else to help look after children, the whole family would have to be taken along to any appointments. Mothers also reported isolation from wider society in terms of the negativity they had experienced from others in relation to their children. This appeared to be most frequently encountered on public transport: another reason to avoid making unnecessary journeys. Finally, mothers could feel isolated from health services. They reported feeling alienated from health

professionals, unhappy with a lack of continuity, dental anxiety, and expressed a wish for more family-orientated services.

The concerns outlined above highlight that mothers are often engaged in a process of 'getting on with it'. They are unable to be an 'ideal' mother, and when they face adverse circumstances, they do not have the internal or the external resources to change their circumstances and, therefore, try to 'get on with it'. Mothers try to 'get on with it' as best they can; however, some are still left feeling depressed, isolated and with low self esteem. These feelings can be exacerbated as mothers try to function in society with their children. Getting out the door can be stressful, expensive, and, at times, threatening. In these circumstances, mothers retreat and find that one way to resolve these issues is by staying at home.

These issues should not be viewed as unidirectional. Mothers and families are often isolated from services; however, services in turn are isolated from mothers and their families' needs. Too often barriers to access focus on the individual's failure to engage with services, ignoring the fact that dental services are often not responsive to the needs of those individuals (Freeman, 2002). In addition, mothers expressed the view that society in general was negative towards those with young children; such a culture must be recognised and addressed.

Previous research

These issues are also not experienced separately; they interact to contribute to the overall feeling that mothers' lives do not function in the ways they wish them to, and that they are engaged in a constant process of 'getting on with it'. Previous studies investigating nonattendance for preventive health visits have not always fully articulated these issues, focusing instead on the demographic characteristics of parents who failed to attend dental appointments for their children (Barker & Horton, 2008). Indeed, there has been little in-depth research into why parents fail to attend preventive dental appointments for their children.

Those studies that have looked more closely at this issue have identified long waiting times for appointments, and waiting times once families get to the dental surgery, as a major barrier to accessing preventive and restorative dental care (Mofidi *et al.*, 2002; Siegal *et al.*, 2005). This was also highlighted by mothers in this study; however, the mothers linked waiting times to an overall poor standard of care by dental practitioners. This was further illustrated in the isolation of families from health care professionals. Previous studies have highlighted poor interpersonal communication between dentists, and other staff within the practice, and families when they do attend, as a barrier to accessing care (Barker & Horton, 2008; Broder *et al.*, 2002; Kelly *et al.*, 2005; Mofidi *et al.*, 2002). One way that communication can be improved is through continuity of care; this was identified by mothers in Barker and Horton's study (2008) as a facilitator to attendance. Mothers in this study were particularly appreciative of dentists who were 'family friendly', as this is one way that dental anxiety amongst children could be reduced (Broder *et al.*, 2002; Milgrom *et al.*, 1998). Further barriers identified that were also discussed by the mothers in the current study were lack of transportation (Broder *et al.*, 2002; Kelly *et al.*, 2005; Mofidi *et al.*, 2002), mental illness, and lack of social support (Broder *et al.*, 2002).

The identification of mental illness and lack of social support as barriers to attendance are a recognition that additional factors in families' lives impact on whether they make it to the dental surgery or not. There is a need for a 'whole persons' approach by all involved in the promotion of preventive dental care (Barker & Horton, 2008, p12; Weintraub, 2007). This approach was taken in a grounded theory study amongst Swedish parents which identified a core category of 'being overloaded in everyday life' to explain why parents did not take their children to the dentist (Hallberg *et al.*, 2008). Related categories were 'lack of dental healthcare traditions', 'lack of trust in the dental healthcare system' and 'lack of parental confidence'. These categories correspond to those identified in the current study. Both core categories stress that indirect issues impact on parental decisions to attend for preventive dental care. Those mothers in this study who were 'getting on with it' were all experiencing 'overload' in their everyday life. Additionally, subcategories in Hallberg *et al.*'s study correspond to social isolation from services, finding time and chaotic interacting, as identified within this study. It is these issues that lead families to feel that they are 'overloaded' and eventually cause them to withdraw.

Dental studies have not tended to recognise mental health issues, such as depression, amongst parents as a barrier to accessing preventive health care. Symptoms associated with depression were found to predict noncompliance with 'well-child' visits in the US (Jhanjee *et al.*, 2004). This study highlighted that depression was reported by some mothers as an additional burden on family life, and prevented them from 'getting on with it'. Once again issues such as mental illness cannot be ignored if vulnerable families are to receive the support that they require most.

Limitations

One of the most significant limitations to this research study was in accessing families living in areas of greatest deprivation. Initial invitations to take part by health visitors and Childsmile staff were not widely taken up. Similar problems were experienced by Hallberg *et al.* (2008) in their study of noncompliance. The intention was to reduce participant burden by offering to carry out interviews at mothers' homes; nevertheless, it was difficult to access those mothers who had been noncompliant with Childsmile.

Recruiting through local community organisations in areas of high deprivation proved a more successful approach. Families had good links with these organisations and were happy to carry out interviews on these organisations' premises. A drawback of this method was that there was no prior information as to whether the family had been attending the dental practice for their Childsmile appointments. In addition, these families were already engaging with support groups and attending courses to enhance their skills, suggesting that these were not necessarily the most difficult to reach mothers and children. In addition only one mother in the study had emigrated to the UK; it is possible that mothers with different cultural backgrounds experience additional barriers in accessing dental care for their families.

Next Steps

Introduction

In the first stage of the DAPER study, the objective was to understand the main concerns of parents in accessing preventive dental care for their children. The analysis of the data collected in the first year has informed the design of a Parental Dental Concerns Questionnaire (PDCQ).

In this second phase, the objective is to assess the psychometric properties of the PDCQ to assess parental concerns regarding registration and access for preventive dental care for their children. Based on the findings from this report, the PDCQ will investigate attitudes towards attending the dentist, transport to the dental surgery, dental anxiety, social support, depression, daily routine, relationship with health care professionals, and demographic information.

Method

Sample

Eight hundred mothers will be invited to take part in phase two of the DAPER study. Mothers will be provided with an information sheet and written consent forms before participation. Mothers will be accessed through Childsmile staff and, where possible, community groups. Mothers will be contacted, and at a convenient time, the questionnaires will be administered to them.

Reliability study

Four hundred parents without experience of the Childsmile Practice programme will be asked to participate in the reliability study. An exploratory factor analysis will be undertaken to assess the internal reliability of the parental dental concerns questionnaire (PDCQ). To determine the test-retest reliability of the PDCQ, parents will be invited to complete the PDCQ at two different time points. Parents will be given the questionnaires and an arrangement made to re-administer the PDCQ in 8 weeks time.

Criterion validity study

To investigate criterion validity of the PDCQ the same sample of 400 parents will be invited to complete the 5 item Modified Dental Anxiety Scale (MDAS) (Humphris *et al.*, 2000; Humphris *et al.*, 1995).

Construct validity

To evaluate whether the PDCQ can differentiate between compliant parents and noncompliant parents, a second group of parents will be invited to complete the PDCQ. With assistance from Childsmile staff, mothers who have (n=200) and have not complied (n=200) with the Childsmile Practice programme will be contacted and asked to complete the PDCQ at a convenient time.

Statistical analysis

The data will be coded and entered onto an SPSS data sheet. The data will be subjected to intraclass correlations, correlation analysis and *t*-tests. The data will also be subject to an exploratory factor analysis (EFA) and reliability analysis (cronbach alpha) to assess the internal consistency of the scales.

The second step will test the predictive ability of the model. Confirmatory Factor Analysis (CFA) and structural equation modelling will be used to test the model.

References and Acknowledgements

References

- Barker, JC, Horton, SB. (2008). An ethnographic study of Latino preschool children's oral health in rural California: Intersections among family, community, provider and regulatory sectors. *BMC Oral Health* **8**, 8.
- Broder, HL, Russell, S, Catapano, P, Reisine, S. (2002). Perceived barriers and facilitators to dental treatment among female caregivers of children with and without HIV and their health care providers. *Pediatr Dent* **24**, 301-308.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage.
- Featherstone, B. (1999). Taking mothering seriously: the implications for child protection. *Child and Family Social Work*, **4**, 43-53.
- Freeman, R. (2002). Social exclusion, barriers and accessing dental care: Thoughts on planning responsive dental services. *Braz J Oral Sci* **1**, 34-39.
- Glaser, BG, Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company.
- Hallberg U, Camling, E, Zickert, I, Robertson, A, Berggren, U. (2008). Dental appointment no-shows: Why do some parents fail to take their children to the dentist? *Int J Paediatr Dent* **18**, 27-34.
- Humphris, G, Freeman, R, Simpson, K, Gibson, B, Whelton, H. (2005). Oral health-related quality of life 8-10 year old children: An assessment of a new measure. *Community Dent Oral Epidemiol* **33**, 326-332.
- Humphris, G, Freeman, R, Campbell, J, Tuutti, H, D'Souza, V. (2000). Further evidence for the reliability and validity of the Modified Dental Anxiety Scale. *Int Dent J* **50**, 367-370.

Humphris, G, Morrison, T, Lindsay, SJ. (1995). The Modified Dental Anxiety Scale: validation and United Kingdom norms. *Community Dent Health* **12**, 143-150.

Information Services Division, Scotland National Statistics. (2009). Registrations with the NHS General Dental Service (GDS). <http://www.isdscotland.org/isd/4680.html>.

Jhanjee, I, Saxeena, D, Arora, J, Gjerdingen, DK. (2004). Parents' health and demographic characteristics noncompliance with Well-Child visits. *J Am Board Fam Pract* **17**, 324-330.

Kelly, SE, Binkley, CJ, Neace, WP, Glae, BS. (2005). Barriers to care-seeking for children's oral health among low-income caregivers. *Am J of Public Health* **95**, 1345-1351.

Marshall, H. (1991). The social construction of motherhood: An analysis of childcare and parenting manuals. In Phoenix, A., Woollett, A. & Lloyd, E. (Eds.) *Motherhood: Meanings, Practices and Ideologies*. Thousand Oaks, Sage Publications, 66-85.

Merrett, MCW, Goold, S, Jones, CM, McCall, DR, Macpherson, LMD, Nugent, ZJ, Topping, GVA. (2008). *National Dental Inspection Programme Scotland*. Scottish Dental Epidemiological Co-ordinating Committee.

Deas, L, Kidd, J, Brewster, L. (2010). *Childsmile Practice Primary Care Dental Services Monitoring Report for the Period 2006-2008*.

Milgrom, P, Mancl, L, King, B, Weinstein, P, Wells, N, Jeffcott, E. (2008). An explanatory model of the dental care utilization of low-income children. *Med Care* **36**, 554-66.

Mofidi, M, Rozier, RG, King, RS. (2002). Problems with access to dental care for Medicaid-insured children: What caregivers think. *Am J of Public Health* **92**, 53-58

Poulton, R, Caspi, A, Milne, BJ, Thomson, WM, Taylor, A, Sears M.R, et al. (2004). Association between children's experience of socioeconomic disadvantage and adult health: a life-course study. *Lancet* **360**, 1640-1645.

Rubin, R. (1984). *Maternal Identity and the Maternal Experience*. New York: Springer.

Scottish Executive (2005). *An Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland*. Edinburgh, Scottish Executive.

Siegal, MD, Marx, ML, Cole, SL. (2005). Parent or caregiver, staff, and dentist perspectives on access to dental care issues for Head Start children in Ohio. *Am J of Public Health* **95**, 548-558.

Strauss, A, Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. London: Sage.

Weintraub, JA. (2007). Family matters: Influence of biology and behavior on oral health. *NY State Dent J.* **73(2)**, 14-9.

Acknowledgements

We would like to acknowledge the Childsmile Programme (award number: 121.804490) who funded this study.

This phase of the DAPER project would not have been possible without the cooperation of all the families that took part in the study. We are indebted to them for the time they spent speaking with us.

We would also like to thank those individuals and organisations who helped with recruitment: Childsmile staff and health visitors and the following voluntary organisations: the St Andrews Project Dundee, Homestart North East Fife, Homestart Glenrothes, Stepping Stones for Families, Greater Easterhouse Family Forum.

We would like to thank Sheela Tripathee for her assistance in formatting and preparation of this report.

Appendices

- Appendix 1: Ethical Approval Documents
- Appendix 2: NHS Project Approval Documents
- Appendix 3: In-depth Interview Topic Guide
- Appendix 4: Overview of Interview Locations
- Appendix 5: Financial Information
- Appendix 6: Meetings of the East of Scotland Childsmile Group
- Appendix 7: Presentation Slides

Appendix 1 – Ethical Approval Documents

- Parental information sheet
- Parental consent form
- UREC letter

PARTICIPANT INFORMATION SHEET

IMPROVING ACCESS TO DENTAL HEALTH CARE IN MOTHERS AND CHILDREN

This is a project that is being carried out by University of Dundee, and funded by the Scottish Government. Before you decide whether you would like to take part, please read this information very carefully. It tells you all about the study and what's involved if you wish to take part.

WHAT IS THE PURPOSE OF THE STUDY?

This study is hoping to improve access to health care in mothers and children. We are trying to find out more about the concerns of mothers throughout Scotland, particularly in accessing health care. We would like to ask you to help us with the study.

WHO WILL BE TAKING PART

Mothers of babies that will be, or have been, invited to take part in Childsmile, a programme to improve the dental health of children across Scotland.

WHAT WILL HAPPEN DURING THE STUDY?

If you agree to take part, we will ask you to consent to take part in the study. We will invite you to speak freely about your baby, how your baby is developing, and your family life. The interview will last around 30-45 minutes and will be in complete confidence. This will take place in your home or in a place agreeable to you. You will receive an oral health pack as a thank you for taking part.

WHY SHOULD I TAKE PART IN THIS STUDY?

By taking part in this study you will be providing us with vital information about your concerns for your baby and accessing health care for you and your baby. Your help will help us to improve health programmes in the future.

DO I HAVE TO TAKE PART IN THIS STUDY?

No, taking part is completely up to you.

CAN I WITHDRAW FROM THE STUDY?

Yes, you can withdraw from the study at any time without any penalty. You do not need to give a reason but it would be nice if you could let us know if it has anything to do with the study. If you do withdraw, you will still receive your oral health pack.

WHAT ABOUT CONFIDENTIALITY?

Everything said and discussed will be confidential. The interview will be recorded, and notes will be written up from the recordings. These recordings and notes will be kept for five years and then destroyed. When the results are written up, your name will be changed to protect your and your family's identities. No one will be able to link any information to you or your family. All information will be stored in a safe place that can only be accessed by the University researchers working on this study.

ARE THERE ANY RISKS FOR ME IF I DECIDE TO TAKE PART IN THIS STUDY?

There is unlikely to be any risk to you if you wish to take part in the study. However, if you feel uncomfortable talking about any of the topics then you should feel free to say, and this will not be followed up any further. If any problems are raised, and you feel you need more support, then with your permission, we would be happy to contact your health visitor to follow this up with you.

YOUR RIGHTS

If during, or after the interview, you have any questions you should contact Stephanie Chambers on 01382 420068 or on her mobile phone 07794752740. If you wish to receive a copy of the results from the study then please get in touch with Stephanie on the numbers given above.

If you are unsure of any point of this document then please ask the researcher to explain it to your satisfaction.

Thank you for considering taking part in this study. If you decide to take part, you can be sure that your help will make dental health care easier for new mums to access in the future.

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

INFORMED CONSENT FORM

IMPROVING ACCESS TO DENTAL HEALTH CARE IN MOTHERS AND CHILDREN

PLEASE SIGN YOUR NAME BELOW TO CERTIFY THAT:

1. The researcher has explained fully the nature and procedures involved in the study.
2. You have read and understood the information sheet given to you.
3. You understand that you are free to withdraw from the study at anytime and for any reason without affecting your future care.
4. You agree for the interview to be recorded and later written up, and the information kept for a period of 5 years.
5. You have had the opportunity to ask questions about the study.
6. You have agreed to take part in the study.

Signature of participant: _____ Date _____

Please note that participants must date their own signature

Name of participant: _____

Signature of researcher: _____ Date _____

Name of researcher: _____

Stephanie Chambers

From: Peter Willatts [p.willatts@dundee.ac.uk]
Sent: 13 March 2009 09:27
To: Stephanie Chambers
Cc: Elizabeth Evans
Subject: Ethics application UREC 8129, Improving access to health care in mothers and children

Dear Stephanie,

Thank you for answer my questions and making the requested changes. Your application has been approved and you may begin work on the study.

Good luck with your research.

Peter Willatts
Chair, University Research Ethics Committee

Dr Peter Willatts
School of Psychology, University of Dundee, Nethergate, Dundee, DD1 4HN, UK.
Email: p.willatts@dundee.ac.uk
Tel: +44 (0)1382 384618; 384623
Fax: +44 (0)1382 229993
The University of Dundee is a registered Scottish charity, No: SC015096

The University of Dundee is a registered Scottish charity, No: SC015096

Appendix 2 - NHS Project Approval Documents

- National Research Ethics Service Ruling (email)
- Permission to work in NHS Lanarkshire (email)
- Clarification on Service Evaluation, Judith Godden, manager of the West of Scotland Research Ethics Service (email)
- NHS Ayrshire & Arran Local Research Ethics Committee Service Evaluation ruling (letter)
- NHS Greater Glasgow and Clyde, West of Scotland Research Ethics Committee Service, Service Evaluation ruling (email)

National Research Ethics Service Ruling (email)

Stephanie Chambers

From: NRES Queries Line [queries@nres.npsa.nhs.uk]
Sent: 12 November 2008 10:29
To: Stephanie Chambers
Subject: RE: Query regarding research/service evaluation

Your query was reviewed by our Queries Line Advisers.

Our leaflet "Defining Research", which explains how we differentiate research from other activities, is published at:

<http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit>

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee.

I'd deem this service evaluation.

If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.

Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.

This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

Regards

Streamline your research application process with IRAS (Integrated Research Application System). To view IRAS and for further information visit www.myresearchproject.org.uk

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Steet
London
W1T 5HD

Website: www.nres.npsa.nhs.uk
Email: queries@nres.npsa.nhs.uk

Permission to work in NHS Lanarkshire (email)

Stephanie Chambers

From: Yeung, Albert - Consultant, Dental Public Health [Albert.Yeung@lanarkshire.scot.nhs.uk]
Sent: 28 January 2009 15:23
To: Stephanie Chambers
Cc: Frew, Susan - Childsmile Co-ordinator
Subject: Childsmile evaluation in Lanarkshire

Dear Stephanie

I have looked at your project proposal that was forwarded to me by Janie Reid.

From our point of view, there is no problem for you to carry out interviews in our areas. Please liaise with Susan Frew regarding the logistics of identifying your participants.

It happens that I will be attending a meeting at the DHSRU @ 11.00 am on Thursday 29 January 2009. Perhaps I can have a chat with you if you are around.

Best wishes
Albert

C. Albert Yeung
Consultant in Dental Public Health
Lanarkshire NHS Board
14 Beckford Street
Hamilton
ML3 0TA

Tel: 01698 206341
Fax: 01698 283654
Email: albert.yeung@lanarkshire.scot.nhs.uk

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<http://www.nhslanarkshire.org.uk/>

Clarification on Service Evaluation, Judith Godden, manager
of the West of Scotland Research Ethics Service (email)

Stephanie Chambers

From: Godden, Judith [Judith.Godden@ggc.scot.nhs.uk]
Sent: 24 March 2009 12:49
To: Stephanie Chambers
Cc: Pauline.Conway@lanarkshire.scot.nhs.uk; Hamill, Raymond (MK) Head of Clinical Effectiveness
Subject: FW: Childsmile evaluation in Lanarkshire
Attachments: 1_NRESqueryform.doc; RE: Query regarding research/service evaluation; Childsmile evaluation in Lanarkshire; Ethics application UREC 8129, Improving access to health care in mothers and children; Ethics application UREC 8129, Improving access to health care in mothers and children; 6_PARTICIPANT INFORMATION SHEET.doc; 7_INFORMED CONSENT FORM.doc

Dear Stephanie

Thank you very much for sending me through the details of your study. I have read through the information and have no reason to take a different view from the one you originally received from the NRES Queries Line. The study based on the information supplied would not be considered to be research therefore an ethical review from a NHS REC is not required.

I have copied in Pauline Conway from Lanarkshire who is the current Co-ordinator for the Lanarkshire Ethics Committee and also Raymond Hamill who has responsibility for NHS Management Approval within Lanarkshire for their views.

I hope that this will help enable you to continue with your study in Lanarkshire.

Kind regards

Judith

Dr Judith Godden
Manager/Scientific Officer
West of Scotland Research Ethics Service
Tennent Institute
Western Infirmary
Glasgow G11 6NT

Tel: 0141 211 2126
e-mail: judith.godden@ggc.scot.nhs.uk

From: Stephanie Chambers [mailto:S.Chambers@cpse.dundee.ac.uk]
Sent: 23 March 2009 16:27
To: Godden, Judith
Cc: Frew, Susan - Childsmile Co-ordinator
Subject: FW: Childsmile evaluation in Lanarkshire

Dear Judith

RE our earlier telephone conversation, I have attached the relevant documents for the study. I have numbered the attached documents and an explanation of each is provided below:

- 1) An overview of the project, and the information sent to NRES.
- 2) Email with NRES reply
- 3) Email from Albert Yeung, consultant in dental public health giving the go ahead for the project.
- 4) Email from myself answering University ethics committee queries.
- 5) Email from chair of University ethics committee giving the go ahead for the project.
- 6) Participant Information Sheet
- 7) Participant consent form

NHS Ayrshire & Arran Local Research Ethics Committee
Service Evaluation ruling (letter)

Research and Development
58 Lister Street
Crosshouse Hospital
Kilmarnock
KA2 0BB



Stephanie Chambers
Research Assistant
Dental Health Services Research Unit
University of Dundee
The Mackenzie Building
Kirsty Semple Way
Dundee
DD2 4BF

Tel: (01563) 825856
Fax: (01563) 825806

Date: 26 February 2009
Your Ref:
Our Ref: KB/NM

Enquiries to: Karen Bell
Extension: 25960
Direct Line: 01583825850
Email: Karen.bell@aaaahf.scot.nhs.uk

Dear Stephanie

Evaluation of Childsmile Practice

We have received confirmation from NHS Ayrshire and Arran Local Research Ethics Committee stating that ethical review is not required for the above project. I can confirm that R&D Management Approval will not be required either.

If however you do make changes to the protocol for this project, please resubmit the paperwork to Research and Development for review, as this might change the status of the project.

May I take this opportunity to advise you that this project should be registered with the Clinical Governance Department in NHS Ayrshire and Arran. The Clinical Governance Department can be contacted at 56 Lister Street, Crosshouse Hospital or on 01563 825860.

Good luck with your project and if you require any assistance in the future please don't hesitate to contact us.

Yours sincerely

A handwritten signature in blue ink that reads 'Karen L Bell'.

Dr Karen L Bell
Research & Development Manager

c.c. Mrs Jacky Williams, Clinical Governance Manager, Crosshouse Hospital

NHS Greater Glasgow and Clyde, West of Scotland Research
Ethics Committee Service, Service Evaluation ruling (email)

Stephanie Chambers

From: McGinley, Paula [Paula.McGinley@ggc.scot.nhs.uk]
Sent: 22 July 2009 09:33
To: Stephanie Chambers
Subject: Evaluation of Childsmile Practice: Service Development Proposal

Stephanie

I apologise for the delay in responding to your request. I have written to Andrea Torrie (Senior/Lead Administrator from West of Scotland REC Service) asking her to advise me whether your project required ethical review.

I am pleased to report that your project will not require ethical review by an NHS Ethics Research Committee.

Please inform me when you are going to run the project within this Board so that I can inform Isobel Brown, the Board's Information Governance Manager. I would also be grateful if you could advise where it needs to be registered within the Data Protection Office or Caldicott Guardian.

Finally can I wish you every success with the project. Please do not hesitate to contact me if I can be of further assistance.

Regards

Paula McGinley for Ray McAndrew

PA to Kevin Hill & Ray McAndrew
Oral Health Directorate
Townhead Health Centre
Tel: 0141 531 8958
Fax: 0141 531 8957

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Appendix 3 – In-depth Interview Topic Guide

Interview Guide

Initial open ended questions

[For those areas where Childsmile has been running

Who told you about the Childsmile programme? What did you think? Why did you want your child to take part?

What has been your experience of the Childsmile programme? What happened when you met the Childsmile team? How has the information been helpful? (New information?)

Do you attend a dentist yourself? What has been your own experience of going to the dentist? Were you encouraged to brush your teeth when you were growing up?

Could you tell me about a typical day for you since you've had (*baby's name*)?

What have been the biggest changes in (*baby's name*) since they were born?

Can you tell me how you felt when you found out you were expecting (*baby's name*)?

What was going on in your life then?

How did you view being a mum before then?

What has been the most difficult challenge for you since becoming a mum?/ What negative changes have occurred in your life since (*baby's name*) was born? (Ask about weaning/teething/getting out the door/out and about with baby)

How do you manage this?

What positive changes have occurred in your life since (*baby's name*) was born?

What will you worry most over the next few months?

Who has been the most helpful to you during this time? How has he/she been helpful?

Has any organisation been helpful? What did it help you with? How has it been helpful?

How did you find your care before and after your pregnancy?

How are you able to get around? (Own car? Access to public transport? Cost of public transport).

Ending questions

Is there anything else you might not have thought about before that occurred to you during this interview?

Is there anything else you think I should know to understand better?

Is there anything else you would like to ask me?

Appendix 4 – Overview of Interview Locations

The table below provides an overview of the order of interview locations

Number of interviews	Location
7 interviews	Inverness
6 interviews	Lanarkshire
10 interviews	Caithness
3 interviews	Dundee
1 interview	Dundee
2 interviews	Glenrothes
6 interviews	Glasgow
1 interview	Dundee
3 interviews	St Andrews

Appendix 5 – Financial Information

K

Research Finance Office

Childsmile Dental Public Health Unit Glasgow Dental Hospital & School 378 Sauchiehall Street Glasgow, G2 3JZ		EXPENDITURE 1/11/08-31/10/09	
Staff		35,906.98	
Indirect costs		47499.78	
Consumables		518.10	
Travel		988.51	
Other Expenditure		50.00	
Equipment		0.00	
Estates Overhead		12502.75	
PI Time Overhead		0.00	
Total	0	97,466.12	0
Expenditure to date: 31/10/2009			

Payments received to date	£245,009.00
---------------------------	--------------------

Developing an inventory to assess parental concerns and Enable child dental registration (DAPER study)
University Ref: 121.804490
Award Holder: Professor Ruth Freeman

Appendix 6 – East of Scotland Childsmile Meetings

Meetings held throughout phase one of the DAPER project as part of the East of Scotland Childsmile Group:

1. 3 March, MacKenzie Building, University of Dundee
2. 7 April, Bute Medical School, University of St Andrews
3. 17 June, MacKenzie Building, University of Dundee (with Childsmile East researchers)
4. 9 September, Bute Medical School, University of St Andrews
5. 10 November, Inverness

Appendix 7 – Presentation Slides

The slides in this appendix were used in either full or shortened form in the following presentations:

1. BSDR Glasgow, 2nd September 2009
2. SDPBRN symposium, 22rd October 2009
3. Division of Clinical and Population Sciences and Education Seminar, University of Dundee, 28th October 2009
4. Childsmile Regional Coordinators group meeting, Inverness, 10th November 2009

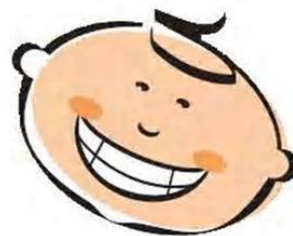
Reducing barriers to Childsmile Practice: understanding the main concerns of mothers

Stephanie Chambers
Oral Health and Health Research Programme
Dental Health Services Research Unit
University of Dundee



Background

Childsmile Practice



The DAPER study



**Developing an inventory to
Assess Parental concerns and
Enable child dental Registration**



DAPER aim & objectives

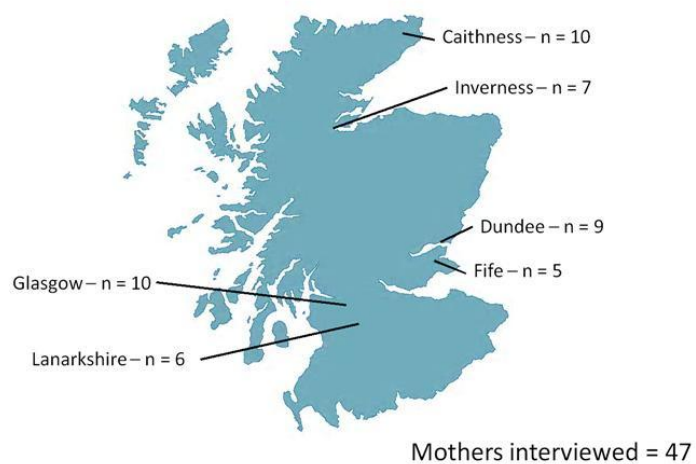
Develop an inventory to assess parental concerns and enable child dental registration & attendance

1. Identify the main concerns of parents,
2. Assess psychometric properties of a questionnaire to assess parental concerns regarding registration & access for preventive dental care for their child,
3. Conduct a field trial of the parental dental concerns questionnaire, and assess if additional DSW assistance can enable parents to access preventive dental care for their child.

A grounded theory approach

- Theory 'grounded' in research context
- Purposive sampling
- Constant comparative method
- Follow up key points from previous interviews
- Identifying main concern through 'core' category

Recruiting mothers



Interviewing mothers

- In home or at negotiated location e.g. nursery/playgroup
- Youngest child ranged: 5 weeks to 4 years
- Lasted 25-70 minutes
- 34 one-on-one interviews
- 5 small group interviews
- 35 interviews were recorded using a digital voice recorder

Interviewing mothers



Interviewing mothers

- Introduction & questions
- Experiences of Childsmile Practice* & accessing dental care.
- Accessing health care generally.
- Everyday life with their child/children.
- Oral health pack given as a small thank you

* If Childsmile Practice was running in their area

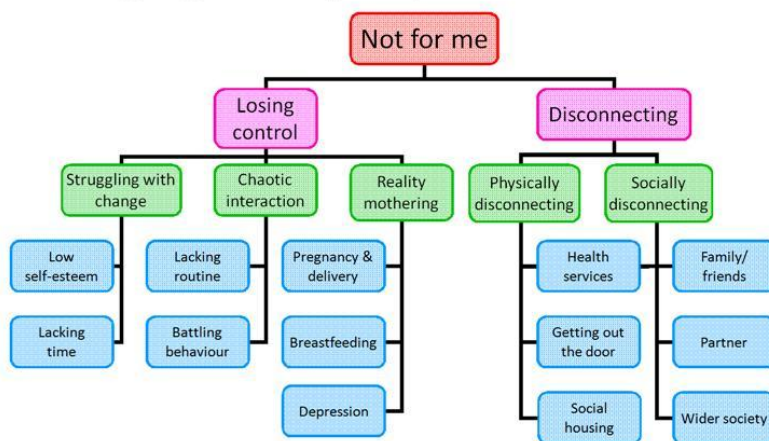
Data analysis

- Data collection & analysis simultaneous
- NVivo software
- Data was coded sentence by sentence
- Memos
- Higher level categories created
- A single core category identified from the data

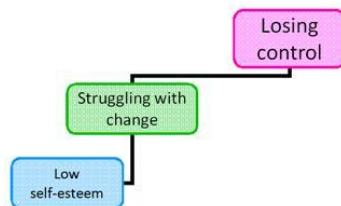
Motherhood



Emerging theory of parental concerns



Losing control: struggling with change

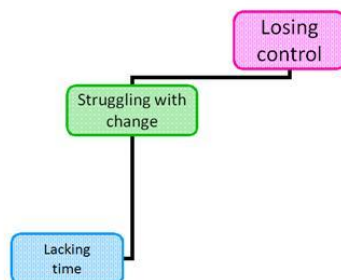


Low self-esteem

'Self-image is another thing that I lost as well. Before I would usually do my hair every day and you know, but once the stretch marks came in, I just, "No." Trying to lose the weight was just horrendous.'

'I've not really been my usual self...you don't really have time to do your hair the way you like and your make-up and stuff.'

Losing control: struggling with change



Lacking time

'Me and my husband never get any time to ourselves...and I think that's one of our big problems because we never get to go even to the pictures for a couple of hours.'

'I think the reason I feel like this is because I don't feel I have time to myself. If I can find that time I can be more myself.'

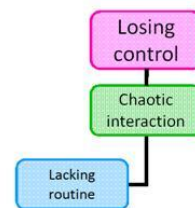
'Housework. Housework, everyday it's housework: washing, dishes.'

Losing control: chaotic interaction

Lacking routine

'I'm trying to get him off the bottles. It's like musical beds sometimes. He's in the cot, oot the cot, in wi us, oot wi us, back in the cot...I don't care what the books and aw says - but whatever gets you through the night.'

'Sometimes he's alright with his teeth and other times you've to hold him - physically hold him doon...Cruel, intit? Sometimes when you hold them down like that and they're screaming and screaming but you need to dae it.'



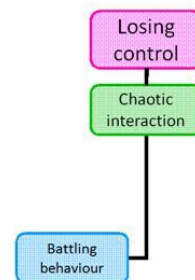
Losing control: chaotic interaction

Battling behaviour

'He's wild. I said to him the other day "You're no getting a drink of milk" and he went in the fridge and got the jug of milk and says "Well neither are you" and flung the jug of milk.'

'The youngest one, she's climbing o'er seats and aw that [in waiting rooms], and I dae, I get really stressed out.'

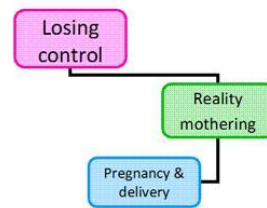
'He lashes out quite a lot...I think it's just because I'm ready to have this baby.'



Losing control: reality mothering

Illness during pregnancy

'It's just that my pregnancy was a bit too much. Because he was quite a big baby. So carrying a big baby was pretty stressful because I could hardly walk very far.'



Complications with delivery

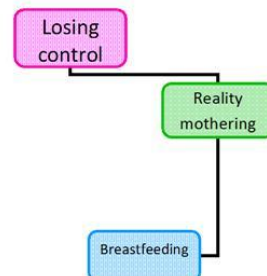
'It really freaked me out when my husband was all dressed in the surgeon's outfit and I thought "Oh no this is not what I wanted - a nice natural birth."'

'It just sort of detached you from the actual moment that was supposed to be so special about it all.'

Losing control: reality mothering

Breastfeeding rejected

'He wouldnae be able to stay [over]...and I'd be dead embarrassed, even although they say no to be if you're outside. Oh no, I'd be too embarrassed doing that.'



Breastfeeding unsuccessful

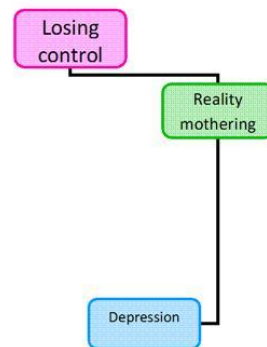
'I got quite upset and teary about that because I'm so disappointed because I was wanting to give birth properly and I didn't. I was wanting to breastfeed and that wasn't working, so I got quite upset with myself.'

Losing control: reality mothering

Experiencing depression

'It was just that the walls were all coming in on me. I couldnae just get oot and do my ain thing anymore. I had this wee life to look after, and to take wi me.'

'I just kept thinking "oh it will go away". I just every day kept - and the days turn into weeks, turn into months, and it's not till you look back you went "oh that wasn't right that."

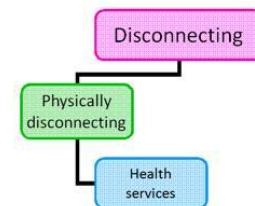


Disconnecting: physically

Health services

'Sometimes when I'm standing at that bus station I'm thinking..."See if there's a buggy on this bus, I'm going to have to just leave it and get the next one in half an hour" because there's no way I could decollapse a buggy with a baby.'

'It's awkward with the buses, with the wee ones trying to get them on the bus. You've gotta go [10 miles] to get the weans to the dentist or health centre. That bus that we have, if you miss the first bus then you're hanging about for an hour.'



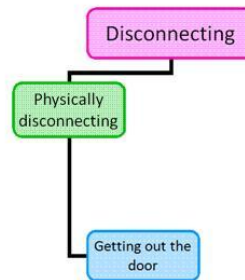
'Most of the time actually we were getting taxis...it was costing me a fortune.'

Disconnecting: physically

Getting out the door

'I've had nightmare times trying to get out the house and you're running late, and you've got everything - coats on - everything, and she has a dirty nappy and everything has to come back off again.'

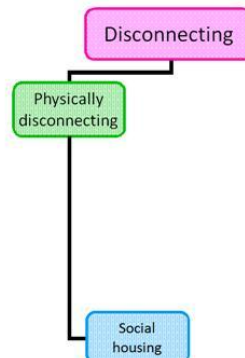
'I usually get up half an hour before I leave, now I have to get up 2 hours [before]. Because I forget that I've got to get me ready, and her. Feeding, changing.'



Disconnecting: physically

Social housing

'We were in homeless [accommodation] for a few years before we got this place and it was absolutely horrible. I hated every minute of it, like. I just kept getting shifted, shifted further away from where we wanted to be.'



Disconnecting: socially

Health services

'[My health visitor] believed in me and she was honest with me and backed me up whereas everybody else would just leave me to dae it myself but she was there 110%.'

'I don't think my health visitor knows me properly, you know because they only see us once a week for so many weeks. There's not really the time to know anyone.'



Disconnecting: socially

Health services (dental)

'When I was younger...getting a check up and then instead they gave me a filling. And they wouldn't give me a jag to numb my mouth and he'd cut the bit at the top of my mouth and it kept bleeding. And I think because I was myself I was totally terrified.'

'[The dental nurse] was a bit kind of, I don't know, kind of stand offish, you know? So I didnae feel that she was kind of confident in what she was doing.'



Disconnecting: socially

Family/friends

'Well I don't have a mum and dad near me. Well my real dad he passed away, and my mum I didn't really know her at all. I find it very hard having to rely on [my partner's] parents too.'

'I can't get a babysitter like most people, they can get a babysitter and go out with their pals and stuff, I can't do that.'

'It's nice that people still come down and see you and everything and you've got adult conversation and that. I think if you didn't have that, I don't know how you would cope.'

Disconnecting

Socially disconnecting

Family/friends

Disconnecting: socially

Partner

'I was with her dad at the time, but he's about as much use as somebody that couldn't move, honestly. He did nothing, no night feeds, nothing.'

'It's like having a third child there, that's why I'm glad he's gone because it's like you had to ask him to change their bums, ask him to make the dinner...I do everything from the decorating, laying flooring, the garden and looking after the boys.'

Disconnecting

Socially disconnecting

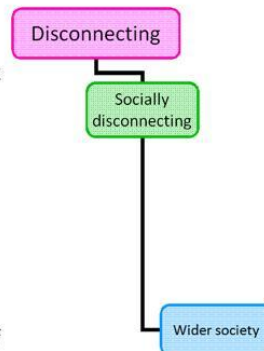
Partner

Disconnecting: socially

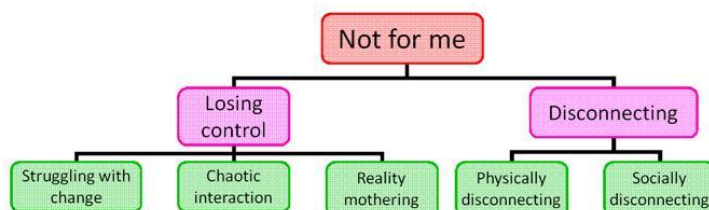
Wider society

'I could never go on a bus wi him. I had to walk everywhere because he kept greetin' all the time and I was too embarrassed to go on a bus.'

'I was walking, just up the escalator, I just had my pram and this woman started shouting, "You're disgusting. You're just a child having a child...you just have babies to get money off of society and get a house."'



Emerging theory of parental concerns



The DAPER study



1. Identify the main concerns of parents,
2. Assess psychometric properties of a questionnaire to assess parental concerns regarding registration & access for preventive dental care for their child,

The DAPER study



Possible measures to be tested:

- Self-esteem
- Routine
- Behaviour of child/older children
- Complications (pregnancy and delivery)
- Depression
- Mode of transport
- Dental anxiety
- Experiences of health care
- Social support

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