FEATURE

CHILDREN'S DENTAL HEALTH – A MOTHER'S PERSPECTIVE

On what seems like a frequent basis, new statistics are being presented highlighting how poor children's dental health is. What many of us often overlook is the significant strides made in the last 30 years. Take the number of children admitted to hospital for dental treatment in 2013-14. Yes the number of children reported on is worryingly large – around 26,000 – but on the whole oral health is improving, with fewer children experiencing dental decay according to the 2013 Children's Dental Health Survey, than just ten years ago.

To help identify and understand some of the issue surrounding children's oral health, we speak to two mums from very different backgrounds about their offspring's teeth.

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'As a mum I know how much my kids change in six months, which makes the idea of extending the length of time between appointments crazy.'

Harriet Adamson, working mother

I must admit, when I was a child my oral health was never a priority. And I can sort of understand that. Attitudes towards oral health were entirely different when I was growing up. Smoking advertising was still widely prevalent – and accepted – and health warnings were only just being identified. We didn't have power brushes, and teeth were barely covered at school. If you didn't know how to care for your teeth properly, there was very little opportunity to find out.

Fast forward 30 years to my first born, and I was determined to learn from my own experiences. This is often the case with mums, or at least those in my friendship circle. My boy had some problems with the alignment of his teeth, and after having a couple removed, he opted for braces. For me, this highlights the differing approach so many families have now. My husband and I recognised the importance of good oral health, and took steps to ensure that would be the case. I often wonder how many other parents faced with the same situation would even consider that, but then again that is where the problem lies.

I was fortunate to pick up information from my health visitor early on, who set me on the right path. Their importance is too often overlooked. When you have had your first child your primal instinct as a mother is for their safety and security. You need guidance on how best to establish good health routines, and oral health is no different. I didn't even know I should clean my children's gums, even before their teeth come through. I would hazard a guess I am not alone in this.

I have read a lot in the press surrounding diet and the role of sugar. It is all well and good warning people about the dangers of sugar, but the practicalities are very different. I know children aren't born with a sweet tooth, but I would be very surprised to find anyone – even in the dental profession – who sticks to the advice on sugar. On the one hand we are constantly told about the need to have five portions of fruit and vegetables a day, but on the other we are warned about the potential damage fruit can do to teeth. It is quite a mixed message. I have always given my children fresh and dried fruit. I find fresh fruit and vegetables and a healthy diet more expensive than fast food, so it comes as no surprise to learn that families on low income and in deprived areas of the country have problems with their children's teeth.

So where does this leave me as a mother? When the news broke about the number of children going to hospital to have teeth taken out, I was appalled to read how some experts said it was down to neglect. Some of us just don't know how important it is. Perhaps if these so-called experts spent less time criticising parents and invested more time in educating those in need, maybe we would be hearing about a totally different set of figures.

I firmly believe in the world we live in now more and more families will spend less and less time with their children in the morning and evening due to increased work commitments. Does this mean we spend less time with them during their oral health development? Potentially, yes. Two minutes isn't two minutes when you have to get your child ready for school and encourage them to brush their teeth. It's even worse if you have more than one child. I don't want this to sound like an excuse, but it is a practical problem. I am proud that my children have good oral health. I hope to see my grandchildren have even better oral health than my own children. It's the education that is needed. I'm not an academic or in the dental industry, so family and health visitors are all I had.

Mhari Coxon, dental hygienist

You always want to do the best for your kids. That's a given. The parent generation before us had the bad experiences, had the fillings, had the amalgam, had the bad visits. Those experiences meant those parents always took their kids to the dentist, so their own children didn't have to go through that. There is a gap in the middle class not transferring what they have been taught. To them, good oral health has been taken for granted.

To an extent that ambivalence has been caused by a number of problems. Two parents working long hours and extended care mean your child's eating is pretty much out of your control. For us we had breakfast club, after school club and school dinners to go with that too, so very quickly through no fault of your own you don't know what your child is eating. This leads

to a feeling of guilt for being a working parent, and you just want to spoil your child. Children are great at making bad choices when it comes to treats, and you can't say no when you don't see them for long periods of the day.

If you look at things like Jamie Oliver and his school meals campaign, it reassures dental professionals, like myself, who have to rely on schools providing my children with healthy school meals. Education is a big part of what we do, and I would encourage oral health teams to forge links with schools and go in and educate them on good oral health practices. If you leave schools to plan their own meals without some direct intervention, budget will always take precedence. It is more cost effective to give children lower quality food than fresh produce on a daily basis.

Those who do have expendable income often get it wrong too. I have heard so many stories of smoothies and fruit juices available as a healthy option. With a little bit of education, they would know these drinks are actually packed with sugars and are pretty bad for children's oral health. You may as well give them a toffee and let them chew on it for the day.

For busy mums like me, even with the extensive dental background I have, sometimes the balance between what is good for teeth and what is good for the family does not overlap. I know I have to try and provide my three children with five portions of fresh fruit and vegetables a day, but the increased consumer choices we have mean my kids don't always like the same fruit and vegetables as I do. I don't want to be the mum who forces their child to eat brussel sprouts or broccoli, so I let them make up their own minds. If that means fruit bags, which are packed with sugars, then so be it. We try and find compromises. For instance if they would like orange juice, they can have it through a straw.

When I heard that almost 26,000 children were admitted to hospital every year due to caries, my first thought was one of neglect. It isn't parents who are trying to do the right thing, or that their best isn't up to scratch. It is those who aren't doing anything at all. It can be dealt with through education, but us as dental professionals might not see those particular children until they have their first brown patch on their teeth. It is too late at this stage. Education is great, but it has to come at the right time. The first conversation about good oral health has to come from the midwife, followed up by the health worker and the dental professional at their first visit. It is difficult to implement an oral hygiene routine for someone who has not been brought up with one.

As a dental mum, implementing good routines for my children wasn't as easy as you'd think. It's still a nightmare. You do have to nag. Even though they know you know what you're talking about and aren't just being a nagging mum – especially in the eyes of teenagers – they don't fully understand the value of doing it so they try to cut corners. They have never had that negative experience, so they do not see the value in good oral health. The initial curriculum at primary school was great. My kids come home full of enthusiasm about teeth and why they needed to keep them clean, but somewhere along the line secondary schools need to take greater responsibility and carry on the education. This is all happening at a time when your children are growing into young adults and making decisions for themselves, so it's crucially important we do that.

> 'In general the problem is always diet.'

The dental industry can help to bring about further changes too. As a mum I know how much my kids change in six months, which makes the idea of extending the length of time between appointments crazy. It's not just physical changes, but it can be dietary and habitual changes too. All of these can have a significant effect on teeth, particularly as children are still developing.

My three boys each present their own challenges. My eldest is 17 and has orthodontics. He has been fine under my supervision with a great diet. Of course, given his age he doesn't listen, but the biggest challenge with him is just around the corner. He is about to go to university, and there is always a concern that he might not keep to that regime. University students are quite a high risk group. Many of them visit the dentist when they have just finished university with high caries activity, so I hope he doesn't fit into that bracket by the time he graduates.

My middle one is quite a challenge too. He is autistic, so his attention span is akin to that of a gnat. He often forgets how long he has brushed his teeth for, but he has an electric toothbrush with timer to help.

My youngest is 11 and has a mixed dentition. There are plenty of wobbly ones, which means cleaning is always an issue. In general the problem is always diet. We have a really good one in the house, but not outside. That is where parents need to keep on top of their kids at home as much as possible. It will pay dividends.

FAILURE TO INCLUDE DENTISTRY IN HEALTH DEBATE HURTING PATIENTS AND TAXPAYERS

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The British Dental Association (BDA) has responded to David Cameron's first speech on health.

The Prime Minister called for a new 'approach to public health and preventable diseases', but made no reference to oral health.

With tooth decay the leading cause of hospital admissions among children the BDA has called for joined-up thinking that can reap benefits for patients and the taxpayer.

Mick Armstrong, Chair of the BDA's Principal Executive Committee, said: 'Tooth decay remains the leading cause of hospital admissions among children, and government must recognise that comes with a human and very real financial cost.

'When it comes to other health professions, government is talking sense about lessening bureaucracy, doing away with meaningless targets and keeping patients out of hospital wherever possible. But until decision makers show their intention to make dentistry part of this debate we will still see children admitted to hospital for treatment that could be delivered by a dental practitioner, at less cost to the taxpayer and far less distress to the patient.

'Successive governments have failed to even consider 'oral health' as a part of the 'health' agenda. This government must not make the same mistake. The focus on prevention and public health is the right one, but dentistry cannot and must not be left out of that debate'.

NEW CDO ANNOUNCED

Following the retirement of Barry Cockcroft in February of this year, NHS England has announced that his successor will be Sara Hurley BDS(UBrist) MFGDP(UK) MSc(UCL) MA(KCL). Sara will serve as principal dental adviser and the professional head of dental staff in England. Sara will act as a senior member of the Medical Directorate, and work collaboratively to improve outcomes for patients, and champion the role of dentists and dentistry within the health system.

Sara qualified from the University of Bristol Dental School in 1988. Commissioned into the Royal Army Dental Corps, she has continued to broaden her clinical dentistry portfolio gaining Membership of General Dental Practitioners (UK) in 2003, a Masters in Dental Public Health at University College London 2004, and a King's College MA in Defence Studies 2007. Her career has flexed across the domains of dental public health, wider healthcare policy and healthcare commissioning as well as undertaking operational healthcare management and strategic leadership assignments in a range of UK and overseas locations.

She commented: 'I am delighted and honoured to be taking up this new challenge as an integral member of the Medical Directorate at NHS England. The role of Chief Dental Officer remains a crucial link between decision-makers, patients and the wide range of front line providers that enable dental health. I am determined to use this position to articulate the dental health needs of our patients and, working collaboratively across the breadth of the dental healthcare profession, present directly to Ministers and NHS leaders our fresh ideas; ideas that will contribute to achieving our shared goals of quality health outcomes and better oral health for all.'

Sara will now leave her post with the Royal Centre for Defence Medicine where she worked closely with the NHS in assuring access to, and quality of, healthcare for injured personnel. Concurrently, she also acted as the Chief Dental Officer for the Army and, in recognition of her work, was appointed as a Queen's Honorary Dental Surgeon in September 2014.

BE CLEAR ON COSTS, DENTISTS URGED

Dentists are reminded to ensure treatment options and costs are clearly explained prior to treatment being provided to avoid disagreements with patients.

A recent report from the Parliamentary and Health Service Ombudsman urged dentists to be clearer with patients about what they charge to help avoid confusion.

MDDUS dental advisor Doug Hamilton suggests that, while the vast majority of dentists would never intentionally misinform a patient over treatment options and costs, there seems to be an increasing number of complaints arising from fee-related misunderstandings.

'Many of these disputes can be avoided by the provision of a cost estimate to patients prior to dental treatment being provided. Practitioners have an ethical obligation to ensure patients have clear information on charges, including the need to provide a revised estimate if at any point the proposed treatment plan requires to be amended.

'Failure to comply will not only undermine any attempts to rebut a patient's complaint, but may also lead to investigation by the GDC.'

A DAY IN THE LIFE

12 PEOPLE. EIGHT DAYS. ONE GOAL

'Everybody wants to do good. The real difference makers, in my opinion, are those who want to change the way things are being done for the better. We don't patch things up and move onto the next hero project.'

The words and mantra of Bridge2Aid CEO Mark Topley (45), who after 11 years of involvement and running the charity, remains as dedicated as ever in making a difference.

Bridge2Aid was established by founders Ian and Andie Wilson in 2002. The pair met in Tanzania in the mid-1990s as Ian made short-term dental visits and Andie helped to build an orphanage in the Mwanza region. Ian and Andie were later married in the UK but shared a strong desire to return to Tanzania. After having children the couple returned to Africa and they begin working with Bukumbi Care Centre – a care centre set up by the Tanzanian government during the 1970s for people affected by leprosy and other disabilities. The Wilsons also begin discussions with local and national government and other local agencies concerning the need for dental serives in the region.

Having worked in the field of oral health since 2003, Mark joined Bridge2Aid in 2005 and established Bridge2Aid's Dental Volunteer Programme (DVP) with his wife Jo and B2A co-founder Ian.

In January 2006 Mark and his wife Jo moved to Mwanza, Tanzania to develop Bridge2Aid's work. From small beginnings, the charity, its team and volunteers have now trained over 350 government health workers in emergency dentistry, treating over 31,000 people in the process and making access to treatment available to over 3.5 million people.

So what does a day in the life of a Bridge2Aid volunteer look like? Mark tells us more.

It is a very intensive, one-on-one eight day course. Given the intensity of what we do in Tanzania, it was our goal at the very beginning to spend a week with all of our volunteers to train them to our standards and expectations. Just look at extractions. Everyone will have their own idiosyncrasies when carrying out this procedure.

The purpose of this is to bring everyone onto the same page. It doesn't matter if you have been qualified for 15 days or 15 years, the camaraderie and team ethic begins even before we have left the tarmac.

When we arrive it is often after a long flight with a few changes, so everyone is understandably a little bit weary. On our first full day we are straight in with full-on orientation. This is generally where we run through the dos and don'ts and cultural awareness and sensitivities. For instance it is rude to point in Tanzania, and I fully believe in respecting the culture you are working in. We are not there to impose our ways and cultures on the Tanzanian people. We are there to work and adapt to theirs. When Ian first wanted to make a difference, I always remember him telling me he wanted to integrate whatever we did into normal society for it to become a way of life.

Day two is on to training. We run through a lot of theory with the local health workers, who take on a watching brief while the volunteers run through the practical side. This is extremely detailed and relies heavily upon the expertise of the dentists we take. That is why our screening process in the UK takes several months. We have to find the right people to contribute who can hit the ground running. We don't want to waste a minute, given we only have a maximum of eight days with the health workers.

By the time days three and four arrive, we are in a position where our dentists are supervising local health workers performing tooth extractions. It's a highly rewarding thing to see for the volunteers. Maybe that's why so many people tell me it's a huge buzz and they get hooked instantly.

Now we are 10 years on from our first involvement in Tanzania, and I'm delighted to say we have successfully integrated the scheme to such an extent that we have handed it over to the government. We have recently established a successful pilot in Rwanda, who for historical reasons have an extremely young regime keen on implementing changes. They are excited about what we can offer the healthcare system. The data is there to show how successful we have been.

A health worker trained in emergency dental treatment by Bridge2Aid provides access to 10,000 people and can see over 200 dental patients a year. In addition, 84% of patients visiting a Bridge2Aid trained health worker will receive an extraction and immediate pain relief.

Since there has been access to emergency dental care in the rural areas made available through training local health workers, the district dental facilities have experienced a 34% decrease in the number of dental patients. This is why in other parts of East Africa we are currently engaged in discussion with a number of high-ranking government officials about the programme and the benefits it can offer.

Some people ask me why do we do this, and the answer is quite simple. When you are out there it may be a bit of an emotional rollercoaster, but you come back a better person. In my early days I met what I would describe as a hallmark patient. I remember it vividly. It was towards the end of the programme – the last day in fact – when a father came to us with a fractured jaw from where his dentist had attempted to take six teeth out. He had an almighty swelling and bone fragments imbedded in his jaw. He had been unable to eat and was on the edge of desperation. That is when it hit home just how vital our work was. It is bittersweet to know many years later our service is still required, but I know we have made substantial progress and improved many, many lives.

The same applies to children. It can, and has often, left volunteers in tears seeing the condition of their mouths. For us pain relief is a priority. Educating the health workers and the locals will always be a running theme. So many people risk injury by performing complicated procedures purely because they cannot afford it. That is why Bridge2Aid exists and will need to exist for the foreseeable future.

INTERVIEW BY DAVID WESTGARTH

BDA AND BDIA ANNOUNCE NEW 'STRATEGIC PARTNERSHIP'

The British Dental Association (BDA) and the British Dental Industry Association (BDIA) are delighted to announce that they have agreed a new 'Strategic Partnership' allowing both organisations to work more closely over the coming months and years.

BDA Chief Executive, Peter Ward, commented: 'This exciting new Strategic Partnership will benefit the whole Dental Community and will provide a higher level of engagement, from manufacturers and trade companies, right through to the dentists and their teams'.

The aim of this Partnership will be to:

- Bring both Associations closer together in the eyes of the whole dental sector
- Deliver better value to the sector through a change of culture and a closer working relationship between the BDA and BDIA
- Provide value for members and the wider industry wherever it is possible to do so.

The Partnership recognises the strong identities and individual nature of each association, whilst effectively looking to deliver a comprehensive business solution for the profession and the industry through activities such as both the BDA's British Dental Conference and Exhibition in the spring and BDIA Dental Showcase in the autumn of each year.

Tony Reed, BDIA Executive Director, added: 'By working in partnership we believe than we can create better value for the members of both associations. Our two major dental events can together provide all that practices need to maintain an up to date understanding of developments in materials, equipment and techniques and a solution to their educational requirements in terms of clinical and business needs.'

By working in partnership both associations believe that better value for their members can be achieved.

BDIA LAUNCHES ITS 'CODE OF PRACTICE FOR DENTAL CPD'

The British Dental Industry Association (BDIA) is delighted to announce the launch of its 'Code of Practice for Dental CPD'. The Code has been developed to provide assurance to users of verifiable dental continuing professional development (CPD) that a provider signed up to the BDIA Code is committed to using quality controls in line with the legal requirements set out by the General Dental Council.

BDIA Executive Director, Tony Reed, comments, 'The BDIA is pleased to introduce our new Code of Practice which responds to a significant need in the marketplace for a system that supports access to a diverse range of high quality CPD activities'.

Every member of the dental team should expect outstanding quality when planning their professional development, just as they would when choosing new equipment, and the BDIA Code of Practice for Dental CPD helps to identify providers dedicated to meeting these high standards.

The Code sets out what a user can expect from a verifiable CPD activity offered by a Code signatory and has been designed to be applicable to all types of CPD, including seminars, workshops, publications, online activities, exhibitions, conferences, training and workplace sessions, whether paid for or free of charge.

Providers signing up to the Code commit to take steps to ensure quality at all stages of their CPD products, from the way activities are designed through to the final delivery to users, as well as how feedback is handled as part of an ongoing process of improvement.

BRINGING FIRST SMILES TO CHILDREN

On Friday 19 June, the British Society of Dental Hygiene & Therapy is running First Smiles, a campaign aiming to introduce oral health education to young children in the classroom. Dental hygienist Katrina Britton is a staunch advocate of delivering better oral health for children. As she says in her own words, 'it's all about education'. Having worked with children previously, Katrina knows the value of early intervention before it is too late.

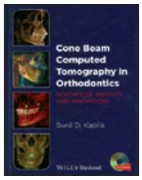
'The aim of dental health promotion in schools is to inform pupils, parents and staff how they may prevent dental disease and encourage the early adoption of oral health practices in young children. Recent evidence shows that school-based tooth brushing campaigns can be effective in reducing dental disease. First Smiles is an excellent opportunity for me to do this. As a dental hygienist I feel that it is our professional duty to impart our knowledge to help improve the community's dental health.

'In my area there are a lot of hygienists. I hope many others will unite and help to bring about reductions in the level of caries we see on a daily basis. I see it regularly. There are little pockets of deprivation in my local area, yet we know it is a bigger problem in some of the larger cities in the UK.

Katrina's top tips for holding an event:

1. **Be prepared.** First Smiles is fantastic because it does give me plenty of incentive to get involved. The free toothbrushes are great. There's even a letter to contact a school if you're doing it for the first time. I often take a puppet, some disclosing tablets and a goody bag. It is important to have as many props with you as possible.
2. **Be creative.** I am visiting two schools. For one I am going into their school, and the other I have invited them to the practice. I'll be transforming Noah's Ark Dental Practice into different stations. One will focus on healthy eating and the others will be a variety of role play sessions designed to make the children feel comfortable in the dental surrounding.
3. **Be welcoming.** It may well be the first visit for many of the children. Establishing a relationship between you and them early is crucial to giving them the platform for good oral health habits. Children aren't born with a sweet tooth, nor are they born afraid of the dentist. The more welcoming the environment, the more chance we have of improving their oral health.

BOOK REVIEW



CONE BEAM COMPUTED TOMOGRAPHY IN ORTHODONTICS: INDICATIONS, INSIGHTS AND INNOVATIONS

S. D. Kapila
Wiley Blackwell
price £116.99; pp 544
ISBN 9781118448489

Imaging methods in dentistry provide essential information needed to plan and treat orthodontic abnormalities as well as diseases of the head and neck. Cone beam computed tomography (CBCT) is a relatively modern imaging method that obtains lots of clinically relevant information. I set about reading this book to increase my understanding of CBCT methodology, dosage to patients, image interpretation and to gain a full understanding of its uses. I found that this book covered these subjects very well and went further than I expected in explaining this type of imaging.

The book itself is split into three sections. The first part is the 'technical' information that explains the science of image formation and encompasses the history of imaging and radiation effects. The second part discusses and emphasises the need for a good evidence base in the use of any relatively new technique, as well as protocols for usage of CBCT in orthodontic practice. The third part describes how to interpret a CBCT scan, as well as covering topics such as temporary anchorage devices, planning treatment in craniofacial anomalies and in orthognathic surgery. These are the chapters with direct clinical relevance that make it more clear how powerful a tool CBCT is and the illustrations are excellent.

Overall this is a very technical book and as such this does give a full understanding of the subject. Every discussion is backed up by relevant research articles when appropriate and it is written well. The images used to illustrate, for example, visualising ectopic canines help the reader understand the true strength of CBCT imaging compared to conventional views. The book does provide a framework for the use of CBCT and emphasises case selection and outlines appropriate cases.

I'd recommend this book to anyone who wants a detailed understanding of CBCT or how to interpret the images as it does both well. As such it would most likely be of most benefit to postgraduate students, radiographers, orthodontic trainees or specialists or those with an interest in clinical imaging. It would suit those who like to appreciate the fine details of the scientific methodology as well as the clinical relevance.

J. MURPHY

MOSBY'S ORTHODONTIC REVIEW

J. English, S. Akyalcin, T. Peltomaki, K. Litschel
Elsevier
price £94.99; pp 352
ISBN 9780323186964

This text is intended for dental students, GDPs, orthodontic trainees and specialist orthodontists. It aims to provide a review of the core knowledge surrounding the practice of orthodontics, whilst providing updates for experienced clinicians with respect to clinical issues and technological advances.

The textbook is laid out in an orderly manner, in a style which is conducive to its use by students: each section within a chapter is headed by a question, a format which lends itself to answering exam-style questions.

On review, the text would not seem entirely appropriate for anyone other than dental students or inquisitive GDPs. The knowledge presented does not provide much beyond a basic explanation of orthodontic considerations and techniques, and thus, the book cannot provide adequate review of knowledge for orthodontic trainees or specialists.

In summary, the authors provide an adequate review of fundamental orthodontic concepts, and the text would be well aimed at dental students and GDPs seeking a better than superficial understanding of this speciality.

H. ALI

DENTINE HYPERSENSITIVITY: DEVELOPING A PERSON-CENTRED APPROACH TO ORAL HEALTH

P. G. Robinson
Academic Press
price £95; pp 336
ISBN 9780128016312

Dentine hypersensitivity: developing a person-centred approach to oral health provides an extremely useful resource for dental practitioners who are interested in gaining an in-depth understanding of dentine hypersensitivity.

The book is organised into four sections and consists of 18 chapters in total. The first section of the book provides an introduction to the main material contained within the volume. It provides a detailed biomedical background to dentine hypersensitivity (DH) in terms of the clinical presentation of the condition. It progresses to discuss some of the physiological issues associated with tooth sensitivity and highlights that the application of a biomedical perspective alone is not sufficient as a means of identifying the best course of action to effectively treat DH (chapter two). Chapter three discusses the epidemiology of DH as a means of exposing the scale of the issue and the inherent dangers of failing to diagnose the condition. Chapter four progresses to discuss the various courses of treatment that are available to clinically manage DH and highlights some of the recent innovations that have been made in the field.

Part two focuses on previous research in the area of DH and examines some of the existing subject expertise that is available. In particular, it focuses on the condition-specific oral health-related quality-of-life measure, which incorporates a dentine hypersensitivity experience questionnaire that aims to help practitioners develop a biopsychosocial understanding of the condition.

In the fourth part of the book, the emphasis switches to understanding what DH actually means and how oral health research is required for practitioners to develop an understanding of the ways in which dental health can have implications beyond the mouth alone.

This book provides an extremely interesting overview of the ways in which social and behavioral science can have profound implications for the treatment of dental conditions and the ways in which practitioners interact with and treat patients. With a retail price of £95, it represents a significant investment; however, it contains valuable insights into a common condition that dental practitioners frequently encounter, and will therefore be a useful read for dentists who are commencing their own practice or who have a specific interest in the DH condition.

H. ÇOLAK