Safeguarding children: **noticing dental neglect**

Following the article in September's *BDJ Team* on identifying child abuse, **Jenny Harris**, Chair of the expert group which produced the Child Protection and the Dental Team guidance, outlines how to identify and respond to dental neglect

We all share a responsibility to safeguard children in our society – the term 'safeguarding' describing a wide range of measures to protect children, to prevent impairment of their health or development, to ensure they are kept safe and helped to reach their potential. It is easy to see that children's dentistry has a role to play in this. Within safeguarding lies 'child protection' – the activity to protect children who are known to have been maltreated or are at risk of harm.

When we talk about child maltreatment (abuse and neglect) a good place to start is to consider children's rights and children's needs. Children themselves learn about their rights. They learn that they have a right to be looked after and not to be hurt by other people. But it goes much further than this: under Article 24 of the *UN Convention on the Rights of the Child*,[1] children have a right to *"enjoyment of the highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health."* Children have a right to have someone to provide for their dental needs and to look after their oral health.

Thinking back over my own caseload in the past 15 years or so, based mainly in a community clinic setting, what is striking is the large number of different presentations of maltreatment I have seen. Sometimes we noticed an injury, sometimes there was a delay seeking treatment or there was something in the explanation for that injury that just didn't add up. On other occasions it was the interaction between the parent and child that alerted us, and once or twice children have come straight out with a disclosure of abuse. But, in my own practice, dental neglect is undoubtedly the commonest safeguarding issue I come across.

In this article I want to consider the contribution that dental professionals can make to child protection by noticing dental neglect, which most commonly manifests as severe untreated dental caries.

Dental neglect is a common problem worldwide. It is a problem that presents both to general dentists and to specialists, it can present early in childhood or at any time through to adolescence, and it is present at some level in both populations that generally enjoy excellent standards of health and wellbeing, and in those that are known to experience high levels of poverty and deprivation.

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Our UK definition of dental neglect, adapted from our statutory definition of neglect, defines dental neglect as *'the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral health or development.'* [2] This definition emphasises persistence and the likelihood of serious impairment of the child's health or development. Note that it makes no reference to parental motivation; whether dental neglect is intentional or entirely unintentional (such as when due to lack of education or resources), the need for action to protect the child is the same.

The scientific literature that directly addresses this subject is fairly limited, but a well-conducted systematic review[3] gives us an evidence base for identifying the features of oral neglect:

- failure to seek or delay seeking dental treatment
- failure to comply with or complete treatment
- failure to provide basic oral care
- impacts such as pain and infection (see box 1).

Box 1. Impacts of dental disease

- toothache
- crying
- stopping playing
- disturbed sleep
- difficulty eating or change in food preferences
- absence from school
- repeated antibiotics
- dental general anaesthesia
- lower body-weight, growth and quality of life
- poor dental appearance
- local infection
- severe infection

Children's own voices help us to build up a picture of how their oral health affects their lived experience.[4] Children themselves report effects on eating, sleep and their school day, as shown in box 2.

I find it useful to consider as a 'rule of thumb' three features that give me particular cause for concern, that meet my threshold for doing more. Firstly, obvious dental disease, especially that which is clearly obvious to a lay person or non-dental health professional. Secondly, an impact on the child - ideally we find this out by asking the child, but parents, carers or others involved with the family, such as nursery school staff, must also be asked. And thirdly, that acceptable care has been offered yet the child is not receiving treatment. This last point indicating our responsibility to facilitate care by providing family-friendly dental services that are convenient and meet the needs of children and families.

This isn't always an easy topic to tackle in the dental surgery. Dental neglect, like general neglect, presents along a spectrum of severity. At one end optimal oral health and, at the other, unacceptable dental neglect. It is a challenge for us to decide at what place along that spectrum do we call it dental neglect. At what point does our team need to do more to support the family? And at what threshold do we need to take action to ensure the child is protected from harm?

It is important to be aware of some particular circumstances in which children may be vulnerable; not to stigmatise them but to ensure they receive the support they need. Children with disabilities are known to be at greater risk of maltreatment of all kinds. A range of family circumstances may lead to chaotic lifestyles that impact on children's welfare: circumstances such as homelessness, parental mental health problems, alcohol or substance abuse. We will of course want to look out for children who are already known to social services and are subject to a child protection plan or are looked after in care, so that we can support them and their families, but we know that they are probably just the tip of the iceberg and there are many more maltreated children that never come to the attention of the authorities.

Of course it is not enough simply for the dental team to notice dental neglect; we must take action too. It is helpful to think in terms of a tiered response using three stages of intervention, depending on your level of concern:

'IN MY OWN PRACTICE, DENTAL NEGLECT IS UNDOUBTEDLY THE COMMONEST SAFEGUARDING ISSUE I COME ACROSS.'

Box 2. What children say about the impact of having dental caries (Gilchrist, Rodd, Deery & Marshman, 2015)

"I had like half an hour's sleep then I kept waking up and it started hurting again" Lily, age 12

"It was like sharp" Liam, age 13

"I couldn't eat apples 'cos that, 'cos skin kept going in" Brodie, age 9

"It did stop me eating on my teeth" Wayne, age 9

"Yeah, I get tired at school" Lily, age 12

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Table 1 Preventive dental team management of dental neglect: a whole team approach (Source: Harris et al, 2006.[5] Used with permission)

Guide for action	Action required	Suggested team member/s responsible
Raise concerns with parents	Explain clinical findings, the possible impact on the child, and why you are concerned	Dentist
Explain what changes are required	Explain treatment needed and expectation of attendance	Dentist
	Give advice on changes needed in diet, fluoride use and oral hygiene	Therapist, hygienist or dental nurse as appropriate
Offer support	Consider giving free fluoride toothpaste and brush	Dental nurse
	Offer the parent or carer a choice of appointment time	Dental receptionist
	Listen for indications of a breakdown in communication, or parental worries about the planned treatment, and offer to discuss again or to arrange a second opinion if this is the case	All team members
Keep accurate records	Keep accurate clinical records	Dentist and/or other team members
	Keep accurate administrative records of appointments and attendance	Dental receptionist
Continue to liaise with parents/carers	Keep up open communication with the parents and repeat advice, so that they know what is expected of them	All team members
Monitor progress	Arrange a recall appointment	Dentist and dental receptionist
If concern that child is suffering harm, involve other agencies or proceed to make a child protection referral	Consult other professionals who have contact with the child (e.g. health visitor, nursery nurse) and see if your concerns are shared	Dentist and/or other team members
	Take further action without delay if indicated	Any member of the team

Stage 1. Preventive dental team management - this involves raising concerns with parents, offering support to meet the child's oral health needs, setting targets, keeping records and monitoring progress. Every single member of the dental team has a role to play (see Table 1). Comprehensive dental treatment must be arranged with an initial focus on relief of pain and provision of preventive care. In order to overcome problems of poor attendance, dental treatment planning must be realistic, achievable and negotiated with the family. If concerns remain, management should progress to the next stage.

Stage 2. Preventive multi-agency management - the dental team then liaises with other professionals, such as the health visitor or school nurse, general medical practitioner or social worker, in order to share information, to ask if concerns are shared and to clarify what further steps are needed. It should be checked whether the child is subject to a child protection plan. A joint plan of action should be agreed and documented, with a date specified for review.

Stage 3. Child protection referral - if the situation is found to be too complex or deteriorating, and there is concern that the child is suffering significant harm, a child protection referral should be made to children's social services according to local procedures.

So what might this look like in practice? I will give an example of how a dental team might notice dental neglect and respond. A 6-year-old boy attended with caries in all four second primary molars, having had dental extractions under general anaesthesia two years previously and then not been brought for follow-up. Alongside explaining concerns to parents, providing intensive preventive advice with a free toothbrush and toothpaste, these carious teeth were restored with preformed metal crowns using the Hall technique (Stage 1 response).

At his next check-up he was doing well but then again was not brought to subsequent follow up appointments. After no response to our letters and phone calls, we made a home visit and found mother not home but four children in the care of a teenage babysitter who talked to us on the doorstep. There were bags of uncollected rubbish in the front garden. I had concerns that he might be at risk of harm due to neglect so I discussed by telephone with his special school (where we already had contact via an established tooth brushing and dental screening programme) and his family doctor. We agreed I would make a child protection referral (escalation to a Stage 3 response).

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Children's social services made contact to assess his needs. He subsequently returned to dental care, when my first priority was to fissure seal his first permanent molars before they too could become carious. Today he continues to attend regularly with younger members of his family. Now aged 16, he maintains good oral hygiene and has not developed any new caries in all that time. The dental input over the course of his childhood has, I think, made an important contribution to improving his health and wellbeing.

We have known for a long time that missed appointments are a big problem in dentistry. In recent years there has been a call to think not of the child who 'Did Not Attend' but instead 'Was Not Brought'. This idea is based on the fundamental right of the child to healthcare. This simple change in terminology encourages us to think of the significance of a missed appointment from the child's perspective, and urges us to document the date so we can build up a chronology. Only when we do this can we begin to understand how much the child is missing out by not receiving the care they need as a result of persistent poor attendance.

In the past decade dentistry has made great progress in relation to safeguarding children. Yet there is still great potential to further enhance how dental teams work together with other health and social care professionals to safeguard children when we have concerns about dental neglect. To do this effectively we will need to strengthen communication pathways, particularly with public health nurses (health visitors and school nurses).

Furthermore we ourselves need support if we are to do this job well. We need good training. We need clear guidance documents. We need to be able to get advice about individual cases and a source of emotional support. In my own team we work closely together: dentist, therapist and dental nurse discussing and making shared decisions, and always seeking external expert help from our local Safeguarding Named Professionals if we need it. I couldn't do this job on my own. Only when we work together and rely on each other can we be sure of making the right response for the child. Studies with social workers have shown that there are strong links between the quality of support an employer provides to the practitioner and what they can provide to the child.

So, in conclusion, we always need to be looking out for the general wellbeing of the children who sit in our dental chairs. Dental neglect is an important concern that we must be able to recognize and respond to. We need to be aware that children who are being neglected are not likely to ask for help. They often don't realise they are being neglected or abused – they don't know what they don't have. So they are not going to spell this out to us (Fig 1). They need us all to be alert, ready to be their voice and to make that cry for help on their behalf.

'DENTAL NEGLECT... PRESENTS ALONG A SPECTRUM OF SEVERITY. AT ONE END OPTIMAL ORAL HEALTH AND, AT THE OTHER, UNACCEPTABLE DENTAL NEGLECT. IT IS A CHALLENGE... TO DECIDE AT WHAT PLACE ALONG THAT SPECTRUM DO WE CALL IT DENTAL NEGLECT.'

Fig. 1

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Jenny Harris is a Consultant in Community Paediatric Dentistry in Sheffield, membership secretary for the British Society of Paediatric Dentistry, project lead for Child Protection and the Dental Team and BSPD representative to the NSPCC Health Liaison Committee.

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