Summary of: A school-based epidemiological study of dental neglect among adolescents in a deprived area of the UK

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FULL PAPER DETAILS

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VERIFIABLE CPD PAPER

Objective To assess the prevalence of two types of dental neglect (DN) for adolescents attending secondary schools in a deprived inner city area: neglect of the prevention of oral disease (DPN) and neglect of dental treatment (DTN). **Design** This study used cross-sectional data from Phase III of the research with East London adolescents community health survey (RELACHS); a longitudinal school-based epidemiological study that followed up a representative random sample of pupils in 29 secondary schools across three boroughs of inner North East London. Participants were clinically examined and answered a supervised questionnaire. DN was assessed in relation to DPN (measured by reference to experience of dental conditions and/or dental pain) and DTN (measured by reference to experience of at least one untreated dental condition and/or dental pain). Dental conditions included dental caries and traumatic dental injuries. **Results** Four in ten adolescents in the study experienced DPN and five in ten experienced DTN. Adolescents with special educational needs without a statement, refugee and those 'looked after' by a local authority experienced a higher proportion of both types of DN. **Conclusions** In an inner city deprived area, the proportion of adolescents with DN (either DPN or DTN) was of significance. Refugee adolescents and looked after children may be more at risk of DN.

EDITOR'S SUMMARY

Dental neglect is a form of medical neglect but what are the implications of recognising this? In this paper the authors looked at both neglect in terms of treatment needs *and* more unusually in terms of prevention of oral disease.

As mentioned by Professor Newton in the Commentary, the question of neglecting prevention is an interesting one. The majority of us are guilty of some prevention neglect of ourselves and our children. The general public is well aware that tobacco is bad for general and oral health and yet 20% (2010 UK[1]) persist in smoking. The general public is aware that they should brush their teeth twice a day and yet 25% of us in the UK (ADHS 2009[2]) still don't.

Dental caries is a largely preventable disease, yet 0.5% of the UK GDP is required to fund dental care and oral health constitutes about 5% of total healthcare expenditure across EU countries.[3] Around 3% of the NHS spend in England goes to dentistry (cf. 7% on cancer); on what could on the whole be a preventable disease.[4]

However, prevention discussion aside I now go back to the important point in *this* paper: dental neglect is a form of medical neglect. The study looked not only at general dental neglect (DN) levels amongst adolescents in a deprived UK community but also drilled right down to examine DN in specific high risk groups such as 'looked after' children, those with special educational needs and refugees. This detailed information could help inform the next step following the recognition of neglect, ie finding a solution. The authors are certainly keen to determine the causes of child DN in their future research, particularly in high risk groups; and express a wish to work with local dental health services to help protect these groups and adolescents from DN.

The authors also anticipate that the 'paper may open debate among dental health professionals to acknowledge and recognise the prevalence of dental neglect among young people in the UK'. So the motion is: are dental professionals guilty of missing the problem of dental neglect amongst young people?

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 213 issue 10.

Ruth Doherty
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IN BRIEF

- First epidemiological paper to assess the prevalence of two types of dental neglect (DN) (neglect of dental prevention and of dental treatment) for adolescents in a deprived inner city setting.
- May open debate among dental health professionals about the recognition of DN prevalence among young people in the UK and that failure to obtain dental treatment for children in the UK could amount to DN.

RESEARCH

COMMENTARY

This research describes a well conducted piece of longitudinal research addressing an important topic. The authors are to be congratulated for their innovative and novel approach to the area of dental neglect.

In our attempts to conduct research into complex phenomena we make assumptions and decisions that have an influence on the conduct, findings and interpretation of our research. One set of vitally important decisions concerns the operationalisation of the concepts we are trying to measure. In deciding how to measure a concept we are driven not only by theory, but also by practical and ethical considerations, and perhaps at some level by our assumptions of society's norms and expectations. 'Dental neglect' is an emotive topic and the accusation of neglect carries with it pejorative implications for parents and carers. NICE defines dental neglect as occurring if 'parents or carers have access to, but persistently fail to obtain, National Health System (NHS) treatment for their child's dental caries (tooth decay)'.[1] Key components of this include: access; persistence and failure to obtain treatment. To what extent do the operationalised measures of neglect identified in this manuscript reflect those key components?

'Neglect' here is divided into two, strongly related, components which appear to be analogous to the concepts of 'caries experience' and 'unmet need'. Dental prevention neglect was identified as 'indicated by the experience of at least one dental condition and/or dental pain'. On this basis I know of at least three dentist colleagues whose children demonstrate DPN. Similarly if dental treatment neglect comprises 'the presence of at least one untreated dental condition and/or experience of dental pain', the prevalence is likely to be high. Furthermore, both operational definitions of the 'neglect' construct are composite measures of different aspects of dental disease; namely dental caries, dental trauma and dental pain. As such, they suffer the shortcomings of composite measures.

I welcome the debate on the prevalence of neglect – it is important that we are aware of and sensitive to this potential blight on young lives. However, we must exercise caution in its definition if we are not to risk trivialising the serious by association with the everyday.

J T Newton
Professor of Psychology as Applied to Dentistry
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1. National Institute of Clinical Excellence. *Clinical Guideline 89: When to suspect child maltreatment.* London: NICE, 2009.

AUTHOR QUESTIONS AND ANSWERS

1. Why did you undertake this research?

We believe this research may open up the debate on recognising and assessing dental neglect for children and young people in the UK. Although dental neglect has been officially recognised as a subtype of child neglect in the UK, there is still some reticence on the part of dental health professionals to acknowledge and appreciate that the failure to obtain dental treatment for children in the UK amounts to dental neglect.

2. What would you like to do next in this area to follow on from this work?

The authors would like to move towards testing one of the most conceptually well established aetiological models of child neglect in dentistry for UK children and young people. This model takes into account the interplay of social, political, family and individual factors to explain the aetiology of child neglect and specifically dental neglect. We would like to identify which factors would protect children and young people from experiencing dental neglect, especially for those identified as high risk groups (refugees, children with special educational needs). These findings may facilitate local dental health services to prioritise the type of early interventions that these families may need. The investigation of these factors from a life course perspective would be most informative.