Child dental neglect: is it a neglected area in the UK?

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IN BRIEF

- Raise the profile of child dental neglect as a public health concern in the UK.
- Support for a holistic approach to address dental neglect in children.
- Recognition of parental, professional, governmental and societal responsibility for child dental neglect.
- Outlines the limitations of existing UK community dental public health policies to reach children at risk of dental neglect.

OPINION

This commentary focuses on the condition of dental neglect (DN) in children in the UK. It is divided into three sections: the first section defines DN in children and its consequences, the second section discusses who may be responsible for dental diseases in children as a result of neglect and the third section proposes a holistic approach to address DN in children in the UK.

DEFINITION OF DENTAL NEGLECT (DN) IN CHILDREN AND ITS CONSEQUENCES

In 1997 the American Academy of Pediatric Dentistry[1] defined dental neglect (DN) as parents' failure to pursue the necessary dental treatment required to maintain the child's oral health and to ensure their freedom from pain and infection. In 2005 the Department of Health (DH) in the UK published guidelines[2] on child protection issues for dental health professionals and highlighted the importance of ensuring that all children and adolescents have access to preventive dental care and to treatment services for oral disease and injury. In 2009 NICE guidelines[3] in the UK officially recognised DN as a type of child neglect, something that raised the profile of child oral health on the public health agenda. The NICE recommendations are related to two aspects of DN: the parent's persistent failure to obtain NHS treatment for their child's dental caries when such NHS dental services were available, and the possibility of child maltreatment due to an absent or unjustifiable explanation for a child's oral injury. Despite the recognition of DN shown by these organisations, there is still some reticence on the part of dental health professionals to acknowledge and recognise that the failure to obtain dental treatment for children in the UK amounts to DN.

The consequences of untreated dental diseases for children and young people can be dramatic. DN in children can significantly harm not only their oral, but also their general health. Moreover, poor oral health causes pain and discomfort, the loss of self confidence and restricts a child's activities, function and concentration at school.[4,5] Studies have reported that millions of school hours are lost each year the world over as a result of DN.[4,6]

WHO MAY BE RESPONSIBLE FOR DN IN CHILDREN?

The issue of who is responsible for DN in children is a complex one. While both the American[1] and NICE[3] definitions of DN place responsibility solely on the child's parents or carers, this was criticised by Harris *et al.*[7] in their document *Safeguarding Children in Dentistry*. Furthermore, the most well-established etiological model of child neglect by Belsky[8] highlighted that while children's health, including oral health, is the responsibility of their parents it is also affected by the child's environment, for example, local NHS services, area of residence, poverty and culture. Belsky places high importance on these socio-economic determinants. Governmental failure to recognise and respond to the challenges that vulnerable families face – such as poverty, lone parents, and large families – may also amount to children's DN. Vulnerable families may be unable to promote good oral health in their children due to the unaffordability of fruit and vegetables and the unavailability of free toothpaste. Previous research by Finch *et al.*[9] have reported that these families may also be unable to access children's dental services because of the unavailability of NHS dental treatment, limited access to transportation to and from the health centres, language and cultural barriers and a lack of information.

It is important to acknowledge differences in parenting and to recognise parents' autonomy in making decisions about their children's healthcare. However, DN in children is a type of cruelty, which ranges from mild to serious, and state action could be justified under certain circumstances. The same cannot be said of adults for whom DN is a problem, with the exception of vulnerable adults, such as the elderly or those with disabilities. Once a case of child's DN is identified, the consequences for the family should be serious. Clearly, not all cases of child DN should result in legal action. However, while families can be held responsible, and even prosecuted, for refusing medical treatment on behalf of their children, it seems socially and professionally acceptable for a child to experience serious dental pain, to have difficulty in sleeping and eating and to have several abscesses without the authorities intervening. Neglected diseases have been cited by the World Health Organisation[10] as both a cause and consequence of human rights violations. Children affected by neglected diseases are considered vulnerable to

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violations of their human rights, including the right to enjoy health, life, non-discrimination, privacy, education and the benefits of scientific progress.

A key means of protecting children from DN, and a basic child's health right, is through regular contact with dental health professionals. However, school dental screening, an NHS initiative designed to identify children with oral health needs and potential neglected diseases, was terminated in 2006. Previous research had shown that screening had a minimal impact on children's dental attendance and therefore did not meet the DH's aim to improve the oral health of children and to reduce health inequalities.[11,12] Data from other countries showed full participation on screening programmes and full compliance, ie all children who received a letter asking to visit a dentist did it. This may be because the government introduced compulsory participation to screening programmes for children. Therefore, the issues here are culture and the extent of the government's responsibility to fight DN. School screening has not been replaced by any other universal means of identifying children in dental need and, what is more, the introduction of positive parental consent has reduced the rate of child participation in community health surveys. Recent research has shown that children with caries are more likely to be opted out of the community surveys than similarly deprived peers without caries.[13] How can we identify children at risk of DN if dental health professionals are not in regular contact with children? One of the obstacles to identifying children at risk of DN is the traditional model of dental health provision, in which families must attend dental clinics that often do not follow up a missed appointment. In contrast to this model, working closely with schools to identify children at risk of DN and developing services to identify and remove barriers to care (either preventive or therapeutic) could provide an alternative interdisciplinary and holistic approach to the problem of DN. Recent USA programmes[14] have demonstrated the efficacy of these school based preventive interventions. The *Munro Review of Child Protection*[15] by the Department of Education in 2011 recommended that local authorities and statutory partners should ensure the sufficient provision of local early help services, including health services, for children, young people and families. The report highlighted the importance of identifying when an 'early help offer' is needed by a particular child and his or her family, for example, when the family's needs do not meet the criteria for receiving children's social care services. Yet many of the most vulnerable children, in particular in deprived areas of the UK, never come into contact with dental health professionals who can assess their dental need for an 'early help offer', such as an effective preventive oral programme. These concerns were directly addressed in a recent initiative[16] which took place in a deprived area of London. This initiative achieved a 95% uptake of immunisation after target families were approached and financial support was given for geographically-based, high-quality integrated care networks. The innovative use of information technology for the active follow-up of defaulters and an increased knowledge of the demography of the children most difficult to reach also contributed to the initiative's success.

Recently, DN has been recognised internationally as a new area of oral health concern. The failure to frame the neglect of oral health in a way that may allow it to be incorporated into the public health agenda and translated into public interventions has been highlighted and criticised by Benzian *et al.*[17] If every child and young person has the statutory right to optimal health, including oral health, then freedom from DN could act as one of the most relevant dental indicators for assessing the success of a public health system, such as the NHS, in delivering this aim.

PROPOSAL OF A HOLISTIC APPROACH TO ADDRESS DN IN CHILDREN

Therefore, we propose a holistic approach to address DN in children in the UK:

- Moving towards a supportive public health approach rather than placing responsibility solely on parents and the family environment
- Developing and implementing an effective national strategy to reduce the barriers parents may face to obtaining dental treatment for their children, especially the most vulnerable ones
- 'Early help offer' services should be tailored to children at risk of DN
- Reviewing regulation and making parents aware of their responsibility for their child's dental health
- Assessing the reasons parents might refuse a dental examination for their child (just as it would be investigated if they did not allow a doctor to examine their child for a medical condition)
- Assessing why parents refuse to take the child to the dentist following a letter explaining that the child may need dental treatment.

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