

British Society of Paediatric Dentistry: a policy document on dental neglect in children

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Policy documents produced by the BSPD represent a majority view, based on consideration of currently available evidence. They are produced to provide guidance with the clear intention that the policy be regularly reviewed and updated to take account of changing views and developments.

Introduction

The United Nations Convention on the Rights of the Child, ratified by the United Kingdom in 1989¹, states specifically that children should be protected from all forms of neglect and negligent treatment, as well as having the right to enjoyment of the highest attainable standard of health and full development. In 2003, the government published *Every Child Matters*² which identified 'being healthy' and 'staying safe' as two of the five most important outcomes for children and young people. A 10-year strategy for delivery of these outcomes³ was produced in 2004. This document adopted safeguarding and promoting the welfare of children as one of its key standards.

Neglect

Neglect can be defined as the persistent failure to meet a child's basic physical and or psychological needs, likely to result in the serious impairment of the child's health or development⁴. It forms one category of child maltreatment. In England,

34 000 children became the subject of a child protection plan during 2008, of whom the highest proportion (45%) were considered at risk of neglect⁵. Neglect may be physical and/or emotional. Neglected children are known to be at risk of other forms of abuse.

Oral health needs

To reach their potential for optimal oral health, children have a number of needs: a diet limited in the amount and frequency of sugar intakes, a regular source of caries-preventive fluoride, daily oral hygiene, and access to regular dental care to enable them to benefit from preventive interventions and early diagnosis and treatment of dental disease when necessary. Young children are dependent on parents or carers to meet these needs.

Dental neglect

Dental neglect can be defined 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 or general health or development. It may occur in isolation or may be an indicator of a wider picture of neglect or abuse. This definition is a logical and simple extension of the accepted UK definition of general neglect⁴. It is consistent with the American Academy of Pediatric Dentistry's

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established definition⁶, although the use of the term 'persistent' rather than 'wilful' makes it wider ranging. It should be noted that, in this newly proposed definition, the diagnosis of dental neglect focuses on identifying unmet need rather than apportioning blame. As with many clinical conditions, there are multiple causes and contributory factors, all of which require careful consideration. There may be a wide range of family, environmental, or service reasons why oral health needs are not met, and these will be discussed later in the document.

Non-dental signs of neglect

It is important to recognize that, although extensive dental disease is an issue in its own right, it should be considered within the context of the wider clinical and social picture. It may be one sign of many which lead to a general diagnosis of neglect or abuse. Dentists should be aware of other signs⁷ and consider these in their diagnosis.

Impact of dental disease

There is no doubt that oral disease can have a significant impact on the health of children. Consequences of disease include severe pain^{8,9}, loss of sleep^{8,9}, time off school and interference with playing and socialization¹⁰. Long-standing disease can result in severe acute and chronic infection and damage to underlying permanent teeth. Reductions in body weight, growth and quality of life have also been demonstrated¹¹⁻¹³. Treatment of extensive symptomatic disease, either with or without the use of general anaesthesia, does in itself have risk of morbidity and may be distressing for the child. Furthermore, some of the effects of tooth loss in childhood are lifelong.

Identifying dental neglect

When a diagnosis of dental neglect is under consideration, a thorough assessment should be carried out. The diagnosis is not purely based on clinical findings; several other dental and non-dental factors need to be taken into account.

Evaluation of dental disease

Accurate diagnosis of the extent of dental disease and evidence of its previous treatment, if any, requires intra-oral clinical examination by a dentist. Dental caries is the commonest oral disease in children¹⁴, but other causes of oral pain, infection, trauma, and oral pathology should not be overlooked. Appropriate radiographs should be requested as necessary. Any predisposing factors should be noted (e.g. use of sugared medicines, dietary restrictions, and genetic or environmental anomalies of dental development).

Dental caries is an extremely common disease. Prevalence in 5-year-olds in Great Britain, for instance, has been estimated at 39.5%, the average number of teeth affected by caries being 1.57¹⁵. Therefore, although dental caries is a preventable disease, its presence *per se*, even in children with extremely high caries levels, cannot be regarded as dental neglect. It would clearly be a vast oversimplification to assume that there is a threshold number of carious teeth, beyond which a diagnosis of dental neglect can be made. Many variables determine levels of dental health in individuals including individual susceptibility, type of previous dental care received (which may differ according to dentists' philosophy and training), and regional and social inequalities, not only in disease experience but also in access to dental services and treatment. Careful consideration of all of these factors is required in reaching a diagnosis⁷.

Severe untreated dental caries which is obvious to a lay person or other health professional gives cause for particular concern. In these circumstances, dentists should welcome referral of children for full assessment. Several studies have shown the potential of trained non-dental healthcare professionals in identifying young children with caries¹⁶.

The impact on the individual child should be assessed by asking children themselves about their symptoms. Symptoms reported by parents and carers should also be recorded. Where possible, others who spend time with the child, such as nursery staff or teachers, should also be consulted. Available records of dental attendance should be examined to

determine the severity and duration of any previously reported symptoms and adverse events (such as previous attendance with toothache, episodes of severe dental infection, repeated antibiotic treatment, and repeated general anaesthesia for dental extractions).

Parental awareness

Presence of severe untreated dental caries may result from lack of parental knowledge of its causes or failure to implement recommended preventive practices accompanied by neglect to seek dental care. A parent or carer's own fear of attending the dentist may lead some to avoid seeking dental care for their child; such families require an empathetic approach. The situation may be exacerbated by circumstances of family stress or poverty. Lack of dental healthcare traditions, trust in the dental healthcare system and of parental confidence contribute to parental failure to take their children to dental appointments¹⁷.

Whether neglect is wilful or not, it is essential to remember that the welfare of the child is the paramount consideration¹⁸. The primary aim of intervention is not to blame the family, but to ensure that children receive the support needed to safeguard their welfare. A feature of particular concern is the failure of parents to respond to offers of acceptable and appropriate treatment^{6,7}.

Access to dental care

Past dental history should be documented including missed appointments. Children living in contemporary UK culture do not uniformly follow a pattern of regular dental attendance from the time their teeth first erupt, as recommended by the dental profession. National data on dental registration indicate variation according to the age of the child, social class, mother's reported attendance pattern and geographical location¹⁹. Such data may be helpful in estimating what constitutes reasonable dental attendance.

It is important to be aware that there are significant inequalities in access to dental care^{20,21}. Children living in deprived communities have the highest levels of dental disease

yet face the greatest difficulties accessing care. Availability of appropriate dental services may be particularly difficult in inner-city areas, rural areas and in areas where there is limited National Health Service provision.

Autonomy of the child

There is increasing recognition of the need to consult children and respond to their views when planning their treatment. Children's autonomy, that is, their freedom to make their own decisions, should be taken seriously^{1,22}. Thus, when assessing possible dental neglect in older children and young people, their competence to consent to or refuse dental treatment, and the effect this has had on past dental care, must be considered (see recommendation).

Vulnerable children

It is important to recognize that children who are most dependent on their carers and least able to communicate their need for help, such as preschool children and disabled children, are more vulnerable to all types of maltreatment²³. These children also require more support to maintain oral health²⁴ and are likely to be more vulnerable to dental neglect (see recommendation).

There is a paucity of literature concerning the oral health status of abused children, but what evidence there is indicates that abused children have higher levels of untreated dental disease than their non-abused peers²⁵⁻²⁷. Looked-after children are known to have increased and often unmet health needs and may face difficulties accessing healthcare services²⁸ (see recommendation). Other vulnerable groups include homeless families, travelling families, refugees and asylum seekers, and children of parents with chronic health or mental health needs.

Responding to dental neglect

When dental neglect has been recognized, a tiered response has been recommended, with three stages of intervention⁷, implemented according to the level of concern: (i) preventive dental team management; (ii) preventive

multi-agency management; and (iii) child protection referral.

Preventive dental team management

Dental care should be focused on relief of pain and other symptoms, followed by appropriate restoration of function and appearance. Several studies have shown that intervention for symptomatic dental disease, as measured by factors such as sleeping, eating and pain, significantly improved quality of life^{8,9,29}. In addition, children who were underdeveloped exhibited catch-up growth following dental treatment^{12,13}. Effective interventions do therefore exist and can be offered to families. These interventions should always be accompanied by measures to ensure prevention of further disease. Such an approach is inherent in contemporary paediatric dentistry; comprehensive guidance is available from the British Society of Paediatric Dentistry and other sources^{30,31}.

The aim should be to work *with* families, for example, by asking the simple question, 'How can we support you in looking after your children's teeth?', thus shifting the emphasis from blame to support and providing the opportunity for collaboration. The following guiding principles for the preventive dental team response have been recommended: raising concerns with parents, explaining what changes are needed, offering support, keeping accurate records, continuing to liaise with parents or carers and reviewing progress⁷.

In order to overcome problems of poor attendance, dental treatment planning should be realistic and achievable. Unnecessary demands should not be placed on the family to attend multiple appointments where it is avoidable nor to travel long distances for dental care when it could be provided locally. When relevant, an attempt should be made to identify the reasons behind any past adverse experiences of dental care and correct these in future care. If dental anxiety is thought to be the underlying reason for failure to complete planned treatment, it is essential to ensure that an appropriate choice of anxiety management techniques is available and has been offered.

Rigorous follow-up is mandatory and if dental care is interrupted by missed appointments, every effort should be made to re-establish contact with the family. Missed appointment policies should not be punitive and must take account of the needs of vulnerable families (see recommendation). Copying clinical correspondence for information to the general medical practitioner, and in the case of preschool children to the health visitor, is essential (see recommendation).

Preventive multi-agency management

If concerns remain or the situation is deteriorating, the dental team should seek parental consent to consult other professionals who have contact with the child to see if concerns are shared (see recommendation). This may include the child's health visitor, school nurse, doctor, or social worker if they have one. The dental team should, jointly with these other professionals, discuss any concerns about the child, and seek to clarify what steps can be taken to support the family and address the concerns. A joint plan of action should be agreed and documented, clearly stating roles and responsibilities and specifying a date for review. In some areas, action plans for children and young people are now coordinated by use of the Common Assessment Framework (CAF)³².

There will be times when it is not possible to obtain parental consent prior to sharing information, for example, following repeated missed appointments. In these instances, it may be necessary to take further advice; the underlying principle is that the child's welfare is paramount.

Child protection referral

If at any point there is concern that the child is suffering significant harm from dental neglect or showing other signs of neglect or abuse, a child protection referral should be made by following local child protection procedures (see recommendation). The reasons for referral should be made clear, specifying the concerns and what they indicate in relation to harm or potential harm to the child. In most instances,

parents should be informed, unless by doing so the child could be put at increased risk or any subsequent investigation could be prejudiced.

In England, practice guidance arising from recent legislation has detailed the duty of Local Safeguarding Children Boards to define thresholds for child protection intervention^{18,33}. Thresholds need to be evidence based yet, in the case of dental neglect, there is little relevant research to inform the process. In addition, thresholds must be appropriate to culturally acceptable patterns of attendance and levels of dental disease. Dental professional input to this process is essential to ensure appropriate interpretation of children's dental needs.

Contributing to the child protection process

Dentists may be requested to provide a report for a child protection case conference. This may occur either when dental neglect is the reason for child protection referral or as part of the comprehensive assessment of a child's needs when any child protection investigation is underway. The dentist should clarify the basis of any request for information and whether consent for sharing information has been obtained. In such cases, however, the professional and moral responsibility to share information in the interests of the child overrides the duty of confidentiality. If there is any doubt, it would be appropriate to take further advice³⁴. A routinely high standard of clinical record keeping is essential to support this process. On occasions when a case goes to court, the dentist may be required to attend as a witness to fact or be requested to act as an expert witness (see recommendation).

Putting systems in place to safeguard children

It is important to acknowledge that dental team involvement with safeguarding children is in its infancy. A discrepancy has been identified between the large proportion of dentists who have recognized concerns about abuse and neglect, and the relatively small number who have responded with appropriate

action^{35,36}. Furthermore, low levels of multi-agency working are reported³⁷, a fundamental requirement for the effective management of more severe cases of dental neglect. There is growing understanding of the barriers to dental team involvement in child protection^{35,36,38} (see recommendation).

Simple practical recommendations for implementing supportive clinical governance measures in primary care dental practices have been made⁷. More extensive consideration of dental neglect and a commitment to its prevention and management are now required in all types of service (independent contractor dental practices, salaried dental services, hospital dental services) and in all aspects of dental service planning, funding, and management at every level (individual practice, locality, national policy) (see recommendation).

At the present time, dental neglect is a field that has received little direct attention in the dental literature. The topic lies at the interface or, perhaps, falls through the gap between community and public health dentistry and paediatric dentistry. Collaborative working both between different dental disciplines and with other disciplines or agencies (e.g. medicine, social care) will be necessary to identify priorities for future research in order to establish an improved evidence base for provision of guidance for practitioners (see recommendation).

Recommendations

Treatment provision

- Severe dental caries in children should be considered a healthcare priority.
- Children who are at risk of abuse or neglect should also be considered at high risk of dental neglect and disease. These children should be high priority for preventive care and be given additional support to access dental services.
- Dentists treating children with dental neglect must follow local procedures and make a child protection referral when concerned about possible significant harm from abuse or neglect.

- Children's views must be considered, according to age and maturity, when planning appropriate and acceptable dental treatment.
- Local systems should be in place to ensure rigorous follow-up of all children who have dental disease but fail to attend their treatment appointments.

Working together

- Strong links should be established with other health and social care professionals to facilitate communication.
- When there are concerns about a child, clinical correspondence should be copied to the general medical practitioner.
- Working together should be seen as a two-way process for discussion, referral and support.
- Local Safeguarding Children Boards (in England and Wales) and Child Protection Committees (in Scotland and Northern Ireland) should consider inviting dental representation or advice.

Service organization

- Dental services should address the needs of vulnerable children and have systems in place to safeguard children.
- Dental services should consider developing care pathways for management of dental neglect in consultation with local agencies.
- Any future review of funding systems for dentistry should consider the impact of proposals on dentists' management and intervention in dental neglect.

Training

- All dental staff must have regular child protection training. For clinical staff, this must include recognition of signs of abuse and neglect, and how to respond when concerned about a child. This should be a mandatory component of dental training at every level: undergraduate, foundation training, special interest, and specialist training.
- Appropriately experienced members of the society are committed where possible to

working with local colleagues to provide dental input to local provision of child protection training for dental teams.

- Training and support in report writing and courtroom skills should be available for court witnesses.

Research

- Dental neglect in children should be considered a priority for future research.
- Suggested areas for research are: to investigate the relationship between oral health and child maltreatment, establish and test diagnostic criteria for dental neglect and thresholds for intervention, and investigate management strategies for severe untreated dental caries.

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