Mouth matters - Management of dental neglect in childhood- the role of dentists and doctors

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Workshop Aims

- Background
- Case study
- Scenarios
- Key Points

Background

1. Dental caries – common preventable and treatable disease of childhood

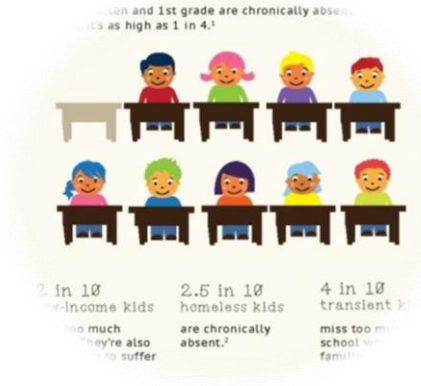
2. USA X 5 more common than asthma

3. Child Dental Health Survey 2013

- 31% 5 years – obvious caries primary teeth
- 46% 15 years- obvious caries adult teeth
- Commonest reason for 5-9 years to be admitted to hospital in England
- Age 15 years 10% had GA dental extraction
- Cost dental extractions £30 million/year NHS

4. Adverse Childhood Experience - USA Research 2015 – one ACE associated with slight increase in likelihood of poor dental health; combination of three or more ACEs more than doubled the likelihood

Impact of untreated Dental Disease – repeat symptoms from 1 tooth can be as problematic as multiple diseased teeth



Children's Basic Oral Health needs

Regular Fluoride source
- x 2 /day-
suitable strength
Fluoride

Limit frequency/amount
sugar snacks

X

From age 12
months

Last at night + 1 other

Case Study

- Single Parent family – 3 children (6,5,3 years)
- Poor attendance at school/nursery
- Frequent minor illnesses/infections
- Poor diet- all 3 children prolonged bottle use
- All 3 severe iron deficiency anaemia

Case Mx

- 6 year old – on bottle until 4.5 years
- 5 year old – 8 teeth extracted age 4 years, poor speech
- 3 year old –marked decay, DNA dental extraction
- On CPR- confirmed neglect
- Court Proceedings- Supervision Order
- Close liaison between dental/CPMS/SW
- Outcome????

Dental Neglect??

Definition- British Society of Paediatric Dentistry[1] 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.

Dental neglect – wilful neglect?

Severe dental disease may result from a parent or carer's lack of knowledge of its causation or from difficulty implementing the dietary habits and oral hygiene measures they would wish to; for example, because of family stress or poverty/child specific issues. This cannot be equated with wilful neglect of a child.

1. Harris JC, Balmer RC, Sidebotham PD. British Society of Paediatric Dentistry: a policy document on dental neglect in children. *Int J Paed Dent* 2009. Published Online: May 14 2009. DOI: 10.1111/j.1365-263X.2009.00996.x www.bspd.co.uk

Vulnerable children- at risk of undetected dental neglect

- pre-school children with limited contacts outside the home
- children whose lifestyles make access to regular dental care difficult, for example homeless families, travelers, asylum seekers
- those whose parents have mental health or alcohol/substance abuse problems
- children with disabilities are known to face additional barriers to obtaining dental care
- LAC may have a range of unmet health needs, including dental healthcare need

Role of Other Professionals in Dental Issues

- Health Visitors – regular attendance with young children
- Public Health Nursing – input across school age children
- Education: Nursery, Primary and Secondary arenas
- Family Doctors/Paediatricians
- Allied Health Professionals eg Speech and Language, Dieticians…
- Mental Health Teams
- Social Workers – FSIT
  - LAC
  - Disability Teams
- Voluntary Agencies working across the Community

Cause for Safeguarding Concern

1. Obvious dental disease:

Severe untreated dental disease, particularly that which is obvious to a layperson or non-dental health professional

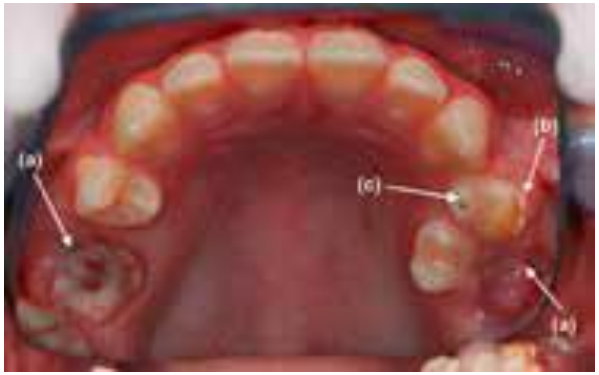
2. Significant impact on the child:

Evidence that dental disease has resulted in a significant impact on the child, such as toothache, difficulty eating, disturbed sleep or school absence

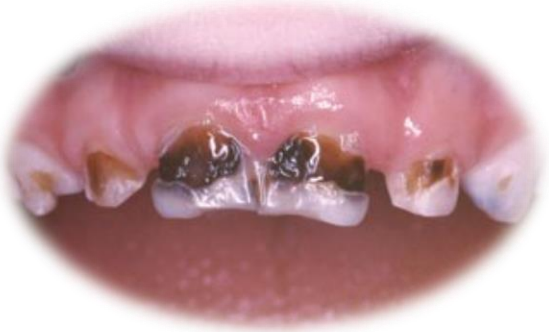
3. Failure to obtain dental care:

Parents/carers have access to, but persistently fail, to obtain treatment for the child, for example:

- **failure to seek dental care**
- **irregular attendance and repeated missed appointments**
- **failure to complete planned dental treatment**
- **returning in pain at repeated intervals**
- **requiring repeated general anaesthesia for dental extractions**



Scenario 1



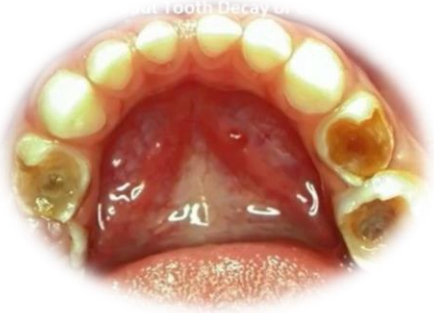
- 4-year old boy has caries in his primary incisors. Dental records show that the decay is not getting worse. He has never complained of toothache. He is due to start school soon. His parents are unconcerned by the appearance of his teeth. He cooperates well with dental treatment but sometimes misses appointments.

  He obviously has untreated carious teeth – but is it dental neglect?

  You need to consider:

  - What is the impact of dental disease on the child?
  - What other information do you need to make a decision?
  - What records would you make of your observations and decisions?

Scenario 2



- 9 year old with Aspergers
- Hates going to dentist – frequent DNA
- Refuses tooth brushing
- Only eats jam sandwiches and drinks juice
- Attended out of hours x 2 with dental abscess –refused oral antibiotics- admitted for iv treatment each time

He obviously has untreated carious teeth – but is it dental neglect?

Scenario 3

- 3 year old attends dentist out of hours with dental abscess – he is very distressed
- Child is seen to carry a bottle with a rusk in it
- Mother has MLD and states she has a fear of dentist so none of her kids go. She presents as having a good relationship with her children.
- 3 other children- 1 younger, 2 older
- Child has no speech and appears thin

- What do you need to consider?
- Who can dentist liaise with?

Scenario 4

- A P2 pupil in your class keeps falling asleep in lessons
- The classroom assistant notices he is not eating his break and only picking through his dinner avoiding hard food
- The normally pleasant child is grumpy and uncooperative in class
- This goes on for a couple of days and when you ask is he okay he finally says he has sore teeth at night.
- He says mum won't give him medicine

What are you going to do?

Is it dental neglect?

What more information do you need?

Key points- Examples of how paediatricians and nurses can assist:

- All children should be registered with a dentist by age 1 year – encourage carers
- Stop bottle feeding at night by age 1 year
- Reduce free sugars in diet
- Ensure vulnerable children are referred to CDS
- Copy dentists into clinic letters so they are kept in the loop
- Routinely include oral examination in child protection medical assessments, if any oral concerns involve CDS

DCby1
Dental Check by One

Decision making

Dental disease, like any other finding in cases of suspected abuse or neglect, should never be interpreted in isolation but always assessed in the context of the child's medical, social history and developmental stage. Care should be taken to consider this in the context of other relevant factors, such as:

- the multi-factorial causation of dental caries
- variation in individual susceptibility to dental disease
- differences in the treatment dentists provide (for example, whether they choose to manage caries in primary teeth by monitoring or restoration or extraction)
- respect for autonomy in healthcare decision-making when caring for older children and young people (who may decide to decline or delay treatment advised by the dentist) inequalities in dental health (for example, regional or social class differences in caries experience)

There is a need for further research to inform the dental team in making these decisions and in managing dental neglect.

Management Plan:

Dental issues can be a significant part of the overall picture of a neglected child – should be considered part of the investigation

1. Preventative single agency response - raise concerns with parents, offer support, set targets, keep records, monitor progress
2. Preventative multi-agency response - liaise with other professionals, check Child Protection Register, agree a joint plan of action, review at agreed intervals
3. Referral to social services - if the situation is too complex or deteriorating