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REVIEW

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

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Abstract

The British Society of Paediatric Dentistry's (BSPD) first policy document on dental neglect was published online in 2009. It proposed a new original definition of dental neglect, discussed the identification of dental neglect and recommended adopting a tiered response, with three stages of intervention according to level of concern. Furthermore, it detailed how the dental team should both contribute to the child protection process and implement wider measures to safeguard and promote children's welfare. Since 2009, these concepts have been widely adopted in the UK and beyond. Furthermore, there have been significant advances in both research and practice. Policy documents produced by the BSPD represent a majority view, based on the consideration of currently available evidence, and are tailored to a UK working environment. Although this updated document's recommendations remain broadly unchanged, this version reflects the professions' progress in understanding dental neglect and minor updates to terminology and, following a consultation process, has been amended to address the needs of two main audiences—dental professionals and nondental health and social care professionals—in order to enhance interdisciplinary working.

KEYWORDS

child maltreatment, child neglect, child protection, dental neglect, safeguarding children

1 | INTRODUCTION

The United Nations Convention on the Rights of the Child (UNCRC),[1] ratified by the United Kingdom (UK) in 1991, states specifically that children should be protected from all forms of neglect and negligent treatment, as well as having the right to the enjoyment of the highest attainable standard of health and full development. In 2017, the 47 member states of the Council of Europe, which includes the UK, pledged to eradicate all forms of child maltreatment as part of the United Nations 2030 Agenda for Sustainable Development.[2] UK guidance[3] asserts the important role all professionals have in protecting children and taking action to ensure they have the best outcomes.

1.1 | What is 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 development.[3] It is recognised as taking a range of different forms: emotional, medical, nutritional, educational and physical neglect, abandonment and failure to provide supervision and guidance.[4]

In March 2021, 50 920 children in England were the subject of a child protection plan of whom 48% were considered to be at risk of neglect.[5] It is the commonest category of maltreatment, exceeding emotional abuse (at 38%) and substantially exceeding both physical abuse (7%) and sexual abuse (4%). Similar findings are reported for children on child protection registers elsewhere in the UK. In Scotland, Wales and Northern Ireland, neglect was a concern in 43%, 40% and 48%, respectively (note slight variations in definitions of reporting categories).[6–8]

There is no simple diagnostic test for neglect, and thresholds for intervention can be difficult to establish. The inclusion of 'persistence' in the definition of neglect reflects that it takes time and repeated assessments to establish that neglect is occurring. More rarely, a child may present with severe neglect, which clearly reaches the threshold at the time of presentation. Children who are neglected often experience other forms of childhood adversity and may be at risk of other forms of maltreatment.[9]

1.2 | 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 intake, 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 and carers to meet those needs.

2 | IDENTIFYING DENTAL NEGLECT

2.1 | Definition

Dental neglect is defined as the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of the child's oral or general health or development.[10]

Dental neglect may occur in isolation or may be an indicator of a wider picture of neglect or abuse. It may even be the first sign. When following our definition, first introduced in the 2009 version of this policy document, the diagnosis focusses 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 range of family, environmental or service reasons why oral health needs are not being met, and these will be discussed later in the document.

Why this paper is important to paediatric dentists

- Paediatric dentists must be able to identify and assess children who are experiencing dental neglect and manage it appropriately.
- This paper describes a tiered response, with three stages of intervention, according to level of concern.
- Recommendations of the British Society of Paediatric Dentistry are tailored to a UK context but are likely to be of interest to a wider international audience.

2.2 | Impact of dental disease

Untreated dental caries may have a significant impact on children's lives. Dental caries can cause pain, infection, and difficulty sleeping and eating.[11–13] Symptoms such as pain may result in children missing school or other important social activities such as parties and family time.[11,13,14] Dental caries involving the pulp can lead to the pulp becoming necrotic and infected. Untreated chronic infection may be associated with damage to the underlying permanent teeth, restriction in growth and iron deficiency anaemia[15] and may lead to an acute facial swelling requiring antibiotics or hospital admission in cases of systemic infection. Indeed, children have died in the United States of America (USA) as a result of infection related to untreated dental caries leading to sepsis and meningitis.[16]

Studies that have investigated oral health-related quality of life have found a correlation between the number of carious teeth and the impact experienced. It should be, however, noted that one extensively carious tooth may be responsible for a myriad of impacts, whereas several teeth with less extensive caries may cause fewer impacts.[12] Therefore, practitioners should take both the extent and number of carious teeth into consideration when assessing the impact that untreated caries is having on the child. Using age-appropriate patient-reported outcome measures may aid clinicians in assessing the impacts that a child is experiencing.[17] This can help parents understand why treatment is required and additionally can provide evidence of the

impact experienced should it be required to support a referral for dental neglect.

It is also worth considering the effect of untreated dental disease throughout the life course. Young people who experience delays to the treatment of their dental caries will require more invasive and extensive restorative treatment, which affects the long-term prognosis of the teeth. This may mean that they require dental extractions in future or present with unrestorable teeth. Loss of teeth has been shown to be associated with increased impacts and negative effects on oral health-related quality of life in adults.[18]

Children who have had treatment for dental caries report fewer impacts following treatment.[19,20] In addition, weight gain and catch-up growth have also been reported following the treatment of carious teeth.[21,22] It should be noted that the relationship between weight and caries is multifactorial and difficult to assess despite the common risk factors for both caries and obesity.[23,24]

Many children with extensive dental disease will require a general anaesthetic (GA) to manage their carious teeth. Indeed, dental treatment under GA is the most common reason for children to have a GA in England.[25] Whilst it has been shown that impacts reduce following the treatment for dental caries under GA,[19] the procedure is associated with morbidity and mortality.[26–29] Caries detected and treated at an early stage can reduce the need for dental treatment under GA as more minimally invasive techniques can be used to restore teeth, which even young children may be able to manage without pharmacological adjuncts.

Although dental disease is an issue in its own right, it should be considered within the wider clinical and social picture. It may be one sign of many, which leads to a general diagnosis of neglect or abuse (child maltreatment). Dental professionals should be aware of the other signs of maltreatment and consider these when assessing the child.[30] It is worth noting that children at risk of general abuse and neglect are more likely to have dental disease.[31]

2.3 | Assessing dental neglect

The dental team is in a privileged position as health professionals, in that children are often seen regularly along with their families.[32] Indeed, this is the only area of health where it is recognised that this should occur. Changes in the child's behaviour or demeanour can therefore be recognised as well as observing family interactions.

When children are assessed, a thorough history and dental examination is important, with a special focus on the social history and potential risk factors for maltreatment. Although dental caries is the most common cause of oral disease,[33] children may also present with a range of other oral conditions, including hard and soft tissue anomalies, pathology and injuries, which can have a significant impact on the child, and this should not be overlooked.

There may be many reasons why a child's oral health needs are not being met. A number of clinical and non-clinical factors need to be considered when diagnosing dental neglect.

2.3.1 | High levels of decay in the general population

Dental caries is extremely common with almost half of 15-year-olds and a third of 12-year-olds having obvious decay experience.[33] Dental decay is the leading reason for hospital admissions among 6- to 10-year-olds in England.[34] Therefore, although dental caries is a preventable disease, its presence alone, even with extremely high caries levels, cannot always be regarded as dental neglect. It is not possible to have a threshold number for carious teeth, beyond which a diagnosis of dental neglect will be made. There are numerous factors that contribute to level of dental disease, including the use of sugared medicine, diet restrictions and dental developmental defects. Individual susceptibility should be taken into account when considering a diagnosis of neglect. Although extensive caries is a significant indicator of neglect, it should not be considered in isolation from other possible signs.

2.3.2 | Parental awareness

Presence of severe dental decay may result from lack of parental knowledge and understanding of its causes. A parent or carer's own fear of dentistry may lead some to avoid seeking care for their child, and this should be managed empathetically. Failure or delay in seeking dental treatment or to follow dental advice given and failure to provide basic oral care, however, are characteristics of dental neglect[35] and the welfare of the child must always be the paramount consideration.

2.3.3 | Access to care and oral health inequalities

Oral health has improved over recent decades, but significant inequalities remain.[36] In 2019, 5-year-old children living in the most deprived area of the country were almost three times more likely to experience dental caries than children living in the least deprived areas.[37] Access to care varies significantly across the country and availability of appropriate services depends on various factors,[38,39]

including the COVID-19 pandemic.[40] It is worth noting that children who have recently immigrated to the UK may have previously had limited access to dental care. All these factors should be considered, when estimating what constitutes reasonable dental attendance.

Distinguishing between neglect and material poverty can be difficult. It is important to balance recognition of the constraints on parents' or carers' ability to meet their child's needs with an appreciation of how those in similar circumstances are able to meet those needs.[41]

2.3.4 | Care provision

The care received by a child may vary significantly according to the dental professional's treatment philosophy and training. Various different treatment approaches have been shown to be successful in managing dental decay,[42] thus requiring careful consideration to assess whether dental neglect may be present.

2.3.5 | Autonomy of the child

The rights of children to participate in decisions about themselves are enshrined in the UNCRC.[1] Their freedom to make decisions about their care is, and should be, taken seriously. When considering dental neglect, particularly in older children, their competence to consent to or refuse dental treatment and the influence of their preferences on their prior dental care must be considered.

2.3.6 | Vulnerable groups

It is important to recognise that children who are most dependent on their carers' and least able to communicate, such as preschool and disabled children, are more vulnerable to all types of maltreatment.[43] Children with disabilities often need additional support to maintain good oral health, yet may find it difficult to tolerate toothbrushing, making it challenging for parents or carers to meet their oral care needs. Under the UNCRC, they have a right to extra help and special care.[1] Considering how those in similar circumstances have been able to meet needs can help assessment when oral hygiene is persistently poor.

2.3.7 | Features of concern

Although the factors above may influence the decision to diagnose dental neglect, they should not be barriers to reporting concerns. The impact of disease on the child including severity and frequency of pain should always be considered. The child's welfare is the primary consideration.

Features of particular concern for dental neglect include the following[43]:

- obvious dental disease:
  untreated dental disease, particularly that which is obvious to a layperson or nondental professional;
- significant impact on the child:
  evidence that dental disease has resulted in a significant impact on the child; and
- failure to obtain care:
  parents or carers have access to but persistently fail to obtain treatment for the child.

3 | RESPONDING TO SUSPECTED DENTAL NEGLECT

When there are concerns about possible dental neglect, a tiered response is recommended, with three stages of intervention, according to level of concern[44]:

(i) Preventive dental team management,
(ii) Preventive multi-agency management and
(iii) Child protection referral.

Using a tiered approach gives parents and carers the opportunity to engage with support for their child to receive the care they need, with escalation possible if this is not successful. This model for management does not override any local procedures that are in place, but can be used in parallel. The tiers can run concurrently where following each sequentially would result in delay and additional harm. If there are significant concerns from the outset regarding dental neglect or other features of abuse or neglect, then it will usually be appropriate to make a child protection referral immediately.

If you have concerns about a child or young person, it may be helpful to speak to a senior colleague, the child's GP, a named nurse or paediatrician and/or your local child protection team. Any service providing dental care should ensure that access to local and government guidance about safeguarding is available to all staff. Locally produced threshold documents or continuum of need documents may be particularly helpful when deciding whether to escalate concerns. Some systems have now been simplified such that they do not require the practitioner to differentiate between a referral for support and a referral for child protection.

3.1 | Preventive dental team management

Working *with* families should be the aim of preventive dental team management, for example by asking the simple question: 'How can we support you in looking after your child's teeth?' This approach aims to shift the emphasis from blame to support and provides the opportunity for collaboration. Support can come from any member of the dental team, including dentists, dental nurses, dental hygienists, dental therapists, receptionists and practice managers. The following guiding principles are recommended when providing the preventive dental team response[44]:

- Raise concerns with parents and carers,
- Explain what changes are needed,
- Offer support,
- Keep accurate records,
- Set targets for improvement and
- Review progress.

Immediate dental care should focus on relieving pain and other symptoms, followed by restoration of function and appearance together with measures to ensure the prevention of further disease.[45] In order to support families and to help minimise missed appointments, treatment planning should be realistic and achievable. It is good practice to ask parents how they think they can contribute and then to set goals by shared decision-making. Avoid requesting families to travel long distances if treatment could be provided locally.

Dental anxiety is a known barrier to accessing care.[46] If dental anxiety, or parental anxiety, is thought to be an underlying reason for failure to complete planned treatment, this should be discussed. It is essential to ensure appropriate anxiety management techniques have been offered to children and young people requiring treatment.

Rigorous follow-up is mandatory, and if dental care is interrupted by missed appointments or repeated cancellations, every effort should be made to re-establish contact with the family. A change in terminology highlights this. Children rely on their parents/carers to bring them to appointments, so using the phrase 'was not brought' to appointments in place of 'did not attend' encourages the dental team to view the significance of the situation from the child's perspective. Use of an agreed 'was not brought' pathway can be helpful to facilitate and ensure a consistent approach,[47] such as that endorsed by the British Dental Association.[48]

3.2 | Preventive multiagency management

If concerns remain following preventive dental team management, parental consent should be sought to consult other professionals who have contact with the child. This could include the child's:

- Health visitor,
- School nurse,
- GP,
- Paediatrician,
- Social worker and
- Early help worker.

It may be appropriate to contact children's social care to enquire whether the child is known to them. If a child is or has been known to social services, they may have had concerns raised about them previously. Liaising with other organisations enables recognition of shared concerns and/or identification of ways to better support children and families, including referral for early help.

Serious safeguarding incidents have highlighted the importance of effective information sharing between relevant agencies.[49] As a result of this, many areas have established multiagency safeguarding hubs or equivalent. They aim to bring together professionals from a range of agencies into an integrated multiagency team and can provide support and guidance in decision-making when there are concerns about children (or adults). The dental team should, jointly with other professionals, discuss any concerns about the child and seek to clarify what steps can be taken to support the family and address concerns. A joint plan of action should be agreed and documented.

The child's interests are paramount and override those of the parents.[50] Although seeking parental consent for information sharing is normally best practice, seeking consent is not appropriate if gaining it would put a child at risk of significant harm. This includes neglect. Parents and Gillick competent children should normally be notified if information is to be shared about them, but this is not required if it could affect the child's safety. Consideration must be given to sharing information appropriately, and reasons should be recorded. Guidance is available on how to share under these circumstances.[51] Each area will have a consent policy usually written on the basis of current guidance and legislation.[3]

3.3 | Child protection referral

If at any point there is concern that the child is suffering or is likely to suffer *significant harm* from dental neglect or other forms of abuse or neglect, a child protection referral should be made. The referral must be made following local child protection procedures. The reason for referral should be made clear, specifying the concerns and what they indicate in relation to harm or potential harm to the child. The commonest reasons for child protection referrals made by dental professionals are dental neglect and

deficiencies in parental care relating to missed appointments.[52] In most instances, parents should be informed a referral is being made, unless by doing so the child could be put at increased risk.

The dilemma of reporting concerns of child maltreatment has been acknowledged.[53] Identifying whether to undertake a supportive role or a reporting role can be a challenge. Lack of certainty about diagnosis, fear of negative consequences and lack of confidence in suspicions of maltreatment have been found to be barriers to dental teams reporting, along with fear of litigation.[54–57] Research shows that dentists have a higher threshold for social services intervention than other healthcare professionals and families.[56] Confidence in reporting, however, does appear to be improving, with a recent study finding that the number of paediatric dentists who have suspected maltreatment but have not reported it has significantly reduced when comparing 2016 with 2005.[58]

When a referral is made, there are numerous possible outcomes, including no action taken. This may be disheartening for the dental professional who raised concerns but should not prevent future referrals being made as the information may accumulate and eventually result in action. Although reporting may be challenging, the General Dental Council's 'Standards for the Dental Team'[59] documents the duty dental professionals have, to raise concerns when patients are at risk. The underlying principle is that the child's welfare is paramount.[50]

4 | PUTTING SYSTEMS IN PLACE

Safeguarding is not only about responding to individual concerns regarding a child or young person. Changing the working environment to ensure that risks to welfare are minimised is also essential. This includes putting appropriate systems in place and making sure that staff are trained to use them[44]:

1. Identifying a member of the dental team to lead on child protection. The child protection lead should keep a list of up-to-date local contacts for child protection advice and referral and ensure that safeguarding procedures and policies are up to date and regularly shared with the team.
2. Producing a child protection policy statement. This should affirm your practice or organisation's commitment to protecting children from harm and how this can be achieved.
3. Having clear guidance in place on what to do if you have concerns about a child.
4. Ensuring high-quality record-keeping. This should include routinely enquiring whether the family have any support from social services.
5. Undertaking regular child protection training.
6. Following safe recruitment processes to protect patients.

Collaborative working between professionals is fundamental when there are concerns about a child. There are numerous examples of effective dental pathways, which help support vulnerable groups and ensure that both oral health and general well-being are considered and promoted.[47,60–63]

5 | RECOMMENDATIONS

5.1 | Treatment provision

- Managing severe dental caries in children should be considered a healthcare priority.
- Children experiencing maltreatment should be prioritised for preventive dental care and given additional support to access dental services.

5.2 | Working together

- Collaborative working should be actively encouraged, between professionals and with families.
- Dental teams should establish strong links with other health and social care professionals to facilitate communication.
- Services involved in implementing child protection and safeguarding systems in the local area should consider seeking dental input.
- An oral examination should be undertaken and documented by the paediatrician as part of a child protection assessment. Formal dental and oral soft tissue assessment should also be undertaken by an appropriately trained dental professional.
- An oral health plan produced by a dental professional should be incorporated into the health plan for looked after children and children on a child protection plan.
- Formalised and funded regional strategic leadership of the oral health aspects of child protection should be provided by a named specialist or consultant in paediatric dentistry.

5.3 | Training

- All dental team members who have contact with children or young people should undertake appropriate safeguarding training.

5.4 | Research and innovation

- Dental neglect in children should be considered a priority for future research, with the recommendation that attention be given to known gaps in the literature.[64]
- Forming a clinical excellence network (CEN) to discuss dental care for children at risk of maltreatment should be considered.

5.5 | Working environment

- In every setting where children and young people are seen by the dental team, systems must be put in place to minimise risks of harm.

AUTHOR CONTRIBUTIONS

JCH led and, with RCB and PDS, wrote the original 2009 policy document on which this updated version is based. LR led the review, conducted a focus group, updated the literature review, managed the consultation and drafted initial updates to the manuscript. JCH, FG, RCB and RS contributed new material and critically revised the manuscript. RS represented the Royal College of Paediatrics and Child Health. All authors read and approved the final submitted version.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Not applicable

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