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CHILDREN'S DENTAL HEALTH: THE NEXT FRONTIER IN WELL-BEING

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Brief Authored by:

Beverly A. Largent, D.M.D.
President Elect
American Academy of Pediatric Dentistry

Honorable Cindy Lederman
Administrative Judge
11th Judicial Circuit, Juvenile Division
Miami, Florida

Elizabeth Whitney Barnes, J.D.
Manager, Model Courts Division
Permanency Planning for Children Department
National Council of Juvenile and Family Court Judges

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Mary V. Mentaberry
Executive Director
National Council of Juvenile and Family Court Judges

Nancy B. Miller
Director
Permanency Planning for Children Department
National Council of Juvenile and Family Court Judges

OJJDP
Office of Juvenile Justice and Delinquency Prevention

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CHILD WELL-BEING

Since 1997 and the passage of the Adoption and Safe Families Act (ASFA)[1], courts hearing child abuse and neglect cases have been required to oversee the safety, permanency and well-being of children in the court's jurisdiction. For years courts have reviewed children's physical and mental health needs, and have worked with the agency and other stakeholders to ensure those needs are met. Now attention is being turned more closely to dental health issues, especially in light of the second-round of the Child and Family Service Reviews being conducted by the Department of Health and Human Services through the Administration for Children and Families' Children's Bureau. The stakes are high- in addition to failing to fully provide our most vulnerable children with appropriate safety, permanency, and well-being outcomes, failure in the reviews could result in loss of title IV-E funding, potentially in the millions nationwide.

Utilizing collaboration between the court and the agency, the Child and Family Service Reviews evaluate ASFA compliance by the agency and the courts in each state through case file review, data evaluation, and stakeholder interviews. The first-rounds were conducted between 2001 and 2004, and no state was found in substantial conformity in all areas assessed. Each state was required to craft a Program Improvement Plan (PIP) to address deficiencies identified in their respective reviews. The second round of the Reviews, taking place in 2007 through 2010 will evaluate the success of the PIPs.

The second-round of the CFSRs include as a component of the well-being evaluation, inquiry into the steps taken to ensure a child's dental health. Well-being Outcome 3, Item 22 asks: *Did the child receive periodic, age-appropriate physical and dental health examinations to ensure ongoing assessment of needs? If not, document the reasons why the agency did not conduct this ongoing assessment.* [2]

In addition to this in-depth assessment, the Reviews also require documentation of the dental health history of the child – dental services provided or not provided - with descriptions of the specific dental health needs of the child and how they were addressed. The review specifically requests documentation as to why services were not provided, such as through lack of agency efforts to secure services, lack of service availability in the community, lack of transportation for foster parents to take the child to appointments, etc.

A child's dental health can affect everything from her immune system and ability to physically develop normally, to her self-esteem and relationshiops with her peers. When the dental health issues affect an abused and neglected hild, the potential risks are even greater. Courts that hear child abuse and neglect cases are in the unique position of being able to work to improve the dental health of abused and neglected children.

BACKGROUND ON THE ISSUE

Early childhood tooth decay is rampant in the United States. The disease is defined as any decayed, missing or filled primary tooth in a child 71 months of age or younger (children under six years of age). This disease is the single most chronic disease of childhood and is five times more prevalent than asthma. It is a cause of significant pain, delayed development, loss of school days, and poor general health. The Surgeon General reports that 51 million school hours are lost each year due to dental related illness, and children from low income homes suffer nearly 12 times more restricted activity days than children from higher income families. The poor in America carry the largest burden of the disease, and Hispanic Americans can be the most vulnerable. Children from low income homes suffer two times more dental decay than their more affluent peers, and are more likely to be untreated. Oral diseases are progressive and cumulative and become more complex over time. More than 50% of 5-9 year old children have at least one cavity or filling, and 78% of 17 year olds have had dental disease.

Disparities in oral health and treatment can be directly related to low socioeconomic status. These disparities can be increased by lack of community programs such as water fluoridation, lack of transportation, or the inability for parents to obtain time off work. It is estimated that fewer than one in five Medicaid covered children receive a single dental visit in one year.

[1] 42 U.S.C. § 675 *et seq.*

[2] This Child and Family Review form, and other information about the review process can be found on the Children's Bureau website at: http://www.acf.hhs.gov/programs/cb/cwmonitoring/tools_guide/onsitefinal.htm

In October 2004, as reported in the journal, *Pediatrics*, studies showed that early childhood caries – tooth decay - can be prevented through early professional dental care, complemented with risk assessment, anticipatory guidance, and periodic supervision. Without preventive care, the impact of tooth decay on child development can be significant. The effects of poor oral health may be felt for a lifetime.

All children, and especially those in the child welfare system, should have a dental exam by the first birthday, and all should have two dental exams each year.

CHILDREN'S DENTAL HEALTH BASICS

Caries Risk Assessment

Caries risk assessment is the determination of the likelihood of the incidence of tooth decay during a certain time period. The process of tooth decay involves a combination of factors including diet, a susceptible host, and bacteria, which interplay with a variety of social, cultural, and behavioral factors. There is a high correlation between social status and risk. While caries risk assessment involves social as well as oral and behavioral factors, children in a low socioeconomic level are always placed in the high risk category. Children at high risk for dental disease should see the dentist at six months of age, and a "dental home" should be established for all children by their first birthday.

The Dental Home

Children's Dental Health Basics:

- *Is the child at risk for cavities?*
- *Has a dental home been established?*
- *How is the child's oral hygiene?*
- *How is the child's diet?*
- *Does the child receive fluoride?*
- *How is the child's caregiver's dental health?*

The "dental home" is a model for children's dental care that is inclusive of all aspects of oral health care resulting from the interaction between the child, parent or caregiver, and the child's dental professional, and results in a heightened awareness of all issues that impact the patient's oral health. The "Dental Home" is patterned after the "Medical Home" model developed by the American Academy of Pediatrics, and may be designed to follow the medical home model as a cost effective and higher quality health care alternative to emergency care. The dental home should provide comprehensive oral health care as well as acute care and preventive services, including providing a comprehensive assessment for oral disease, an individualized preventive dental health program, anticipatory guidance, dietary counseling, information about proper care of the child's teeth, a plan for acute dental trauma, and proper referral to dental specialists.

The dental home is initiated through a referral to a pediatric dentist, or a family dentist who is comfortable treating young children. Since a general referral is oftentimes a burden for families, providing parents or caregivers with a list of dentists who participate in the Medicaid System is helpful. Collaborations with the local Head Start or Early Head Start programs can provide names of providers to agencies and courts. Local dental societies can also be a valuable resource. Most dental associations have a website which includes the state name, for example The Kentucky Dental Association, and some states have Medicaid participants listed by name at the State Medicaid Web site. Names of pediatric dentists may also be obtained through the American Academy of Pediatric Dentistry website at **www.aapd.org in the "find a pediatric dentist" section**. While dental screenings in the school, school sealant programs, and school hygienists offer valuable services, they are not a substitute for the strong foundation of the dental home model.

Oral Hygiene

Good oral hygiene practices are the foundation of the prevention of oral disease. Children younger than six years of age are not capable of cleaning their teeth to the extent necessary to prevent disease, so it is imperative that parents or caregivers clean the child's teeth with a toothbrush a minimum of one time a day. Oral health care for infants can begin before the teeth erupt by wiping the baby's mouth clean with a soft, clean wash cloth after feeding. This removes the milk residue from the mouth of the infant, and prepares the child for the use of a toothbrush when the teeth erupt. Adults should recline children in the lap, lift the lip, and brush the teeth. Toothpaste is not necessary while the child is reclined, but can be used when the child is old enough to stand at the sink, with or without the help of the parent.

Diet

A good diet is necessary for oral health as well as general health. For infants, breast feeding is best. Toddlers and young children should be fed a balanced diet including fruits and vegetables. Sugary between meal snacks and frequent snacking should be avoided. Dietary practices which promote dental decay include at-will feeding with the bottle or sippy cup containing sugary liquids. Children should be weaned from the bottle at one year of age, and trained with a cup as soon as possible. The sippy cup is a training device, and should not be used as a pacifier. Children should be encouraged to drink from a cup as they approach their first birthday. Children should not fall asleep with a bottle. At-will night time breast feeding should be avoided after the first primary teeth begin to erupt. Drinking juice from a bottle should be avoided, and when juice is offered, it should be in a cup. Liquids other than water should be discouraged between meals. Under no circumstances should a child be put to bed with a bottle or cup containing any liquid other than water.

Questions which can be asked from the bench:

- *Has the child had a dental examination? When?*
- *What dental health needs does the child have?*
- *How are the child's dental health needs being met?*
- *How often does the child brush? Floss?*
- *How does the child receive fluoride?*
- *When is the child's next dental examination scheduled?*

Fluoride

Fluoride in the water and in toothpaste helps prevent tooth decay. Very young children who cannot expectorate efficiently should not use fluoridated toothpaste without supervision. Children at high risk of dental decay may have their teeth brushed by the parent with a smear, or pea sized amount of fluoride toothpaste on the toothbrush. Children who brush without supervision should be limited to non-fluoridated toothpaste. Unsupervised use of fluoridated toothpaste leads to ingestion of excessive amounts of fluoride, and possible flurosis or white spots on the permanent teeth. Children who drink bottled water may not receive the benefits of fluoride placed in the drinking water, which has been proven to reduce tooth decay. Bottled water should be checked to determine the fluoride content. Nursery water, which can be purchased at the supermarket, also contains fluoride.

Caregiver's Oral Health

Transmission of oral bacteria from the mother to the infant is a fact, and can happen when a parent with poor oral health kisses the child, or allows the child to eat from the same utensils. Parents, mothers especially, should also have good dental care as the first step in prevention of dental disease in the child. Unfortunately, this is not always possible in our society, due to disease burden, cost of care, and the time necessary to make the mother's mouth free of disease. Mothers should practice good oral hygiene, brushing and flossing, and topical fluoride rinses during pregnancy. They should refrain from kissing their infant on the lips or hands, and sharing utensils. The practice of pre-tasting food, or cleansing pacifiers with the mouth can result in transmission of bacteria. Any practice which allows the mother's saliva to contact the infant's mouth should be discouraged until good dental health for the parent is established.

Please see Page 8 of this *Brief* for recommendations of services and care specific to the age of the child.[3]

MODEL COURTS LEADING THE WAY

Every year February is designated as Children's Dental Health Month. Courts that hear child abuse and neglect cases can meet their ASFA obligations and assist their states in complying with the CFSR measures, by highlighting the importance of children's dental health during February, as well as all year long. Courts can serve as a forum to bring this issue to the forefront, from simply asking specific dental health questions at each hearing, to coordinating a community-wide effort to focus on the issue. The National Council of Juvenile and Family Court Judges Victims Act Model Courts[4] have volunteered to highlight the importance of dental health for abused and neglected children in their courtrooms during the month of February 2008.

[3] Clinical Guidelines from the AAPD 2006-2007 Reference Manual, p. 91.

[4] The Victims Act Model Courts project is supported through funding from the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and is committed to improved outcomes for abused and neglect children through implementation of best practices and systems reform efforts nationwide.

Through collaborative efforts with their child welfare agency, partner agencies, and local dental communities, Model Courts participating in Children's Dental Health Month will be:

- Handing out toothbrush kits to children in hearings;
- Inquiring about children's dental health at hearings;
- Educating the children and families about the importance of good oral health;
- Providing brochures on dental health to caregivers;
- Displaying posters with information on dental health; and
- Outreaching to dentists in the local community to collaborate with the court and child welfare stakeholders.

For the Model Courts, toothbrush kits are being provided through a generous donation by Procter & Gamble[5], and brochures and posters are being provided through collaboration with the American Academy of Pediatric Dentistry. Similarly, courts across the country can outreach to local businesses and organizations for donations of materials and time to implement such an initiative on behalf of abused and neglected children in the jurisdiction.

CONCLUSION

The *RESOURCE GUIDELINES: Improving Court Practice in Child Abuse & Neglect Cases*[6] presents best practice recommendations on questions to be asked by a judge at every stage of a child abuse and neglect case. From the initial hearing to permanency and review hearings, questions from the bench regarding the child's well-being can easily include inquiries as to the child's dental health, last dental appointment, how often the child brushes, flosses, how often the child receives fluoride, etc.

Judges have a legal mandate to ensure that children in the child welfare system have oral health care. In the past, most courts hearing child abuse and neglect cases did not consider the importance of dental health in the families that come before them. Now, with education on the prevalence of dental health issues and the ramifications on the overall health of a child who has poor oral hygiene, judges must consider oral health as part of a child's well-being. The mandate to adhere to the requirements of ASFA, as well as the collaborative need for the court and agency to review and monitor an abused or neglected child's dental health makes the court the perfect forum through which a child's dental health can be ensured.

[5]The Global Professional & Scientific Relations organization (GP&SR) within Procter & Gamble Professional Oral Health strives to help dental professionals improve patients' oral health and overall health. Through its relationships with professional dental associations, GP&SR works to deliver joint programs which enroll dental professionals to reach the public with Oral Health messages.

[6]*RESOURCE GUIDELINES: Improving Court Practice in Child Abuse & Neglect Cases* (1995). National Council of Juvenile and Family Court Judges, Reno, Nevada.

Recommendations for Pediatric Oral Health Care

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Age	6–12 months	12–24 months	2–6 years	6–12 years	12 years and older
Clinical oral examination[1]	•	•	•	•	•
Assess oral growth and development[2]	•	•	•	•	•
Caries-risk assessment[3]	•	•	•	•	•
Prophylaxis and topical fluoride treatment[4]	•	•	•	•	
Fluoride supplementation[5] [6]	•	•	•	•	•
Anticipatory guidance[7]	•	•	•	•	•
Oral hygiene counseling[8]	Parents/guardians/ caregivers	Parents/guardians/ caregivers	Patient/parents/ guardians/caregivers	Patient/parents/ guardians/caregivers	Patient
Dietary counseling[9]	•	•	•	•	•
Injury prevention counseling[10]	•	•	•	•	•
Counseling for nonnutritive habits[11]	•	•	•	•	•
Substance abuse counseling				•	•
Counseling for intraoral/ perioral piercing			•	•	
Radiographic assessment[12]			•	•	•
Treatment of dental disease/injury	•	•	•	•	•
Assessment and treatment of developing malocclusion		•	•	•	
Pit and fissure sealants[13]			•	•	•
Assessment and/or removal of third molars					•
Referral for regular and periodic dental care					•

1. First examination at the eruption of the first tooth and no later than 12 months.
2. By clinical examination.
3. As per AAPD “Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents.”
4. Especially for children at high risk for caries and periodontal disease.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. Appropriate discussion and counseling should be an integral part of each visit for care.
8. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child.
9. At every appointment discuss the role of refined carbohydrates, frequency of snacking.
10. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing.
11. At first discuss the need for additional sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
12. As per AAPD “Clinical guideline on prescribing dental radiographs.”
13. For caries-susceptible primarymolars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption.

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For more information please contact the:
Permanency Planning for Children Department
National Council of Juvenile and Family Court Judges,
P.O. Box 8970, Reno, Nevada 89507, (775) 327-5300
www.ncjfcj.org