Good morning everybody.

My name is Alan Small and I'm the independent Child Protection Committee Chairman in Falkirk and also Chair of the Scottish Borders Public Protection Committee. But I'm here today wearing my hat as Chair of Child Protection Committee Scotland, Neglect Subgroup. So this webinar is part of the Child Protection Committee Scotland 2024 Neglect series. We are delighted to be supported and couldn't do this without CELCIS and the Scottish Government's assistance. And this webinar is going to focus, exactly as it says in the slide there, 'Exploring the Complexities and Challenges of Dental Neglect for Children and Young People'.

We're going to be looking at some of the professional dilemmas, the preventative approaches, and also how we can take a trauma informed approach to facilitating access to treatment and interventions. We're going to discuss dental neglect and the impact it has the wider context and concerns that services may have regarding a child - remembering a definition of neglect, in fact, that it's not meeting a child's needs on a regular basis. And you know, health needs are up there amongst everything else, but not meeting a child's health needs can point to so many other factors in a child's life. So we know dental neglect can be a strong indicator of wider neglect. But it's not straightforward, as nothing is within the Child Protection arena. That's got added complexity due to the context of shortage of resources in the NHS. And while we're all completely aware of the fact that we've got a national shortage of dentists, and it's actually more and more difficult to access a dentist, lot of people have fallen off dentists lists and the pandemic had something to do with that, but we've also got the cost of living crisis and the fact that, I think in general society, but definitely parents experience more difficulties, more trauma, and some people just don't have the means to actually seek support.

So probably enough listening to me and I'm going to move on to our speakers. I got a short introduction, just to let you know how the day is going to go. We're going to start off with Dr Christine Park. Christine's a Senior Clinical Lecturer and Honorary Consultant for Paediatric Dentistry at Glasgow Dental Hospital, and Christine's going to explore the approach taken with NHS dentistry and the challenges at the present time and some of the potential solutions. So right into that issue that we're all aware of, followed by a bit of a double act, Dr Mairi Albiston and Dr Sally Jowett, both from NHS Education Scotland. Marie's a Clinical Psychologist and head of program, and Sally is a Principal Educator and specializes in transforming psychological trauma. And they are going to look at trauma and the psychological support approaches that have been developed in recent times, along with the growing awareness of the importance of trauma informed approaches and relationship-based practice. And then finally, finishing off the day, we've got Laura Wright, and Laura is an Oral Health Practitioner, and she's part of the Childsmile program at Inverclyde, and she's going to take us through some of the preventative approaches that can be used in the

community. As I say, at the end of that, and I'm going to have to leave this just before the end of the webinar, but my colleague, Joe McGinty, who's a Child Protection Co-ordinator from CELCIS, is going to lead the plenary session. Okay, I'm delighted to see we now have over 200 people on this webinar, and at that point I'm going to hand over to Dr Christine Park. Christine, over to yourself.

Thank you very much. Hopefully the slides are moving there. Fingers crossed. But welcome everybody and thank you for joining me today. As Alan said, my name is Christine. I've been involved in researching the role of the dental team in child protection for the last 15 years or so, and I could talk about this all day, but I am doing my best to curtail it to 20 minutes this morning, so hopefully by the end of my little chat today, you will have some sort of idea about the Professional Responsibilities of dental teams regarding safeguarding and protection of children, and also, hopefully you can have more of an idea about how dental teams might work together with your own agencies and also families to safeguard and protect children. But I'm going to definitely have an emphasis on what the dental team can maybe provide for you as well, to help you make decisions as you're going through your working days. So, from a dental point of view, we are governed by the General Dental Council as our body. So, they expect everyone who's registered with the General Dental Council has to be aware of procedures involved in raising concerns about possible abuse or neglect of children and vulnerable adults. So that includes dentists, dental nurses, dental therapists, also dental technicians and things as well. So, all dental professionals, whatever role they have, have a responsibility to raise concerns about possible abuse of neglected children or vulnerable adults, and it's their responsibility to know who to contact for further advice and how to refer. When I am teaching my undergraduates, what we teach them is a little bit about how dentistry and the things we might be concerned about fit into the well-being wheel and the overall well-being of children. Often we find that dentists are thinking, well, it will just be in the healthy bit, you know, dental health, that will just be in healthy but actually, the dental health of children feeds into a lot of other things, because if they have toothaches and not at school as much, so that impacts how well they are achieving if they've got front teeth that look very nice, that can affect their self-esteem. And it can actually also affect how peers interact with them as well. So, there's lots of areas that it can play into.

Sometimes dental teams get a wee bit antsy about sharing information. So General Dental Practices, are businesses, and sometimes they can be concerned about what information they can share and what information they can't. So, we do emphasize to them that information can be shared when safety is at risk or when the benefits of sharing information outweigh the public and individuals interest in keeping it confidential. Dental teams also have other people that they can contact if they've got any concerns and not sure what they can share, they have indemnity and indemnity providers can give them information as well. So

perhaps you might contact a dental practice in the future to ask a bit of information. They might seem a wee bit hesitant on the phone or however you're contacting them, and they might go away and get advice and then come back to you, rather than giving you the information right there and then, especially if it's not something that they're used to doing. So, the vulnerable children when it comes to dental neglect are the vulnerable children when it comes to general neglect as well. So, under-fives and kids who don't have as many lifelines, if you like, or external lifelines, as older children do, and from a dental point of view, they are regular attenders. So these are children who are repeatedly not brought to their dental appointments, or they repeatedly return in pain from their teeth, or they're exposed to risks of general anaesthetic, and especially if they are exposed to risk of general anaesthetic on more than one occasion. In general, the dental issues are the number one reason that children have a general anaesthetic in Scotland. It is, unfortunately, very well accepted by parents, but it is the number one thing that is the reason for it, for general anaesthetics, not just Scotland, but the rest of the UK as well. From our point of view when it comes to dental neglect, all of the kids who've got medical problems or disabilities, they're more at risk of dental neglect, as they are for neglect and other types of abuse, and also, they are more likely to have a serious impact on the rest of their general health or development. If they've got any dental disease, it tends to have a bigger impact on them. And care experienced children, as well, tend to be more vulnerable because they're moving about, they're seeing different dental teams. They don't always have that continuity of care with a specific team. So, families are able to move to any dentist they like - as long as they can get registered - at any time and the dentist that they were registered with initially won't automatically know that they've registered with someone else until they get their statement of dental enumeration through at the end of the month, which will tell them that, but they won't know until then. And families don't have to tell them if they are deregistering with the practice, and then that practice won't know who they've registered with in the future.

So when we're talking to our undergraduates and postgraduates, we are talking about our responsibility to contribute to the wider picture of children's well-being, bearing in mind that we might have opportunities that are really important, and if we have an opportunity to help a family, if it's missed, then it might not arise again for some time, and we know the consequences of that can be really damaging. Children still are getting checkups at the dentist or are entitled to check-ups at the dentist every six months or more than that. Obviously, it's changed slightly for adults as well. So, there is a thought that children might see dental teams more frequently than they might be accessing other types of healthcare because they're not regularly seeing a GP for anything, for example. So, when it comes to definition of dental neglect, there are two definitions that are about. There's the British one, which is the persistent failure to meet a child's basic oral health needs likely to result in serious impairment of a child's oral or general health or development. And that's the one that we work

to. The other one that floats about is the American Academy of Paediatric Dentistry definition, which is wilful failure, but we use the persistent failure, so they don't have to intend to dentally neglect their child, but it's just this persistent failure to meet their basic oral health needs.

We do have to resist erroneous assumptions, so dental caries has a multifactorial aetiology. There is variation in susceptibility on an individual level. We know that there are inequalities in dental health, regional inequalities and social inequalities as well, and so the most deprived areas have more caries, so the most deprived children have more caries than the more affluent peers. There are gross inequalities in access to dental treatment, so in access to general dental treatment and also in access to specialist paediatric dental care. So not every health board has any specialist paediatric dental input. If you're in Glasgow, you do, if you're in Edinburgh, you do, if you're in Dundee, that area. But if you're elsewhere, you have practices there are having to access specialist input from miles away if they need it. And there's also a lot of different treatment philosophies out there. So it might be that a child's got a lot of dental decay, and the dentist has decided they are going to do a preventative approach. So, the decay might still be really obvious, but you wouldn't be aware that there's actually something going on behind the scenes, and families could be engaging, but the teeth still could be looking not very good.

So how does it relate to general neglect? So severe dental disease can cause toothache which can lead to disturbed sleep and difficulty in eating or change in food preferences and lead to absence from school or nursery, and it also puts them at risk of teasing and from their peers, or perhaps getting repeated antibiotics if they have dental infections or repeat general anaesthetic or having severe infections, leading to big fat faces and that kind of thing, which can obviously also have an impact on their airway. So, it can be really serious, and we have had cases where it's actually led to brain abscesses as well. So, it can have a really severe and long lasting impact to children.

So, what does the research tell us about it? So, when it comes to caries, so dental decay, we know that children who are abused are eight times more likely to have untreated decayed teeth, and for children who are neglected, they also have more untreated decay, and they tend to have more plaque. So, a higher plaque index means that there's more plaque about in their mouth. They've got more untreated decay and more evidence of gingival bleeding. So that's bleeding from the gums, and that's related to having more plaque in their mouth as well. And in Glasgow, when we did a bit of research, back in 2009, but this has not changed actually, the patterns are still the same. What we found was that there were lots of children who were referred for comprehensive medical assessments who had identified welfare concerns, and we set up dental assessments as part of that comprehensive medical assessment, most of the children we saw were all more deprived in kind of social issues, but actually lots of them were registered with dental services, but that hadn't been discussed with the family, and no

information had been requested from those dental services before they came for the comprehensive medical assessment. So, unlike the medical notes, which were all there in abundance, there had been no contact with their general dental practitioner, and, in fact, hadn't even been asked whether they were registered with the dental practitioner. But even though so many of them were registered, there was still a big proportion of them who needed urgent dental care. So that means that they had active infection in their mouth, and they also had more untreated decay and more teeth missing due to dental decay than the national means. So, they hadn't received as much dental care as their general population peers.

So, we talked about the two definitions, the wilful and persistent neglect. So what is the difference? So, from the British Society of Paediatric Dentistry definition, dental neglect is where the dental problems have been pointed out, and afterwards families who are not engaging, so irregular attendance or repeatedly not bringing the children to their appointments or repeated late cancelations. So, we have this disguised non-compliance, where the family phone up and cancel quite late and always have another appointment rebook. So always looks as if they're going to come, but they can go for months or years without actually being seen. Or they are families where they pointed out the dental treatments. They've made a dental treatment plan and agreed appointments to come back and then the family don't complete the treatment. They're not brought back for all stages of the treatment. Maybe they're brought back to get them out of pain, but they're not brought back for future preventive treatment, or as families, where the children are only brought when they are in pain, or they're needing general anaesthetic for dental extractions, and especially more than once. So, you would hope that one big event where the teeth are so decayed we can't fix them, multiple teeth need to be taken out. We go for their dental general anaesthetic. They're back to having a healthy mouth, but with less teeth. And we hope at that stage that all the preventive treatment is then listened to that that doesn't happen again. So, when it does, that's quite a big thing for us.

Indicators of dental neglect is obvious dental disease, and it's obvious disease that you guys, who are not dental professionals, would be able to notice. So, you'd notice it as you're taking your own kids to school, that sort of dental disease that you can see when other children in the playground. It's dental disease that has an impact on the child. And in situations where practical care has been offered in a practical way that suits the family, yet they've still not been brought back for treatment. So, the practice is bent over backwards to try and accommodate families, but they're not brought back.

When dental teams are looking at managing dental neglect, they're following the guidance that comes from this previous document, child protection and the dental team, and also from the British society of Paediatric Dentistry policy document on dental neglect. So, it has three stages, which is a preventive dental

team management stage, a preventive multi agency management stage, and then the Child Protection referral. And it also has some standard letters in it that dentists and dental practices and therapists and hygienists, and what have you, can use to send to health visitors to try and engage this multi-agency management.

So, stage one is just the preventive dental team management. That's where the dental teams raise their concerns with parents offer support set targets. Those might be simple targets, like you need to brush your teeth twice a day with an appropriate strength of fluoride toothpaste, and they're keeping records, and they're monitoring progress.

Stage two is when they begin to liaise with the other professionals - so health visitor, maybe school nurse or doctor. Might be a social worker, if there is somebody involved as well. This also might be when children have a common assessment framework, the dental teams would be checking to see if there was a Protection Plan in place for the child. And this is where the agencies are working together, and again, a Joint Plan of Action.

And then the stage three for the dental teams is the Child Protection referral. So, in any complex or deteriorating situations, they are advised to follow the local guidelines and referring to social services if they have a concern. So, this is past the stage of liaising with the health visitor or what have you. This is when things are not getting any better and they're making a child protection referral.

So, this is an example, a three-year-old child who came to the dental hospital with multiple grossly carious teeth, and in the referral letter, the dentist said they were in pain. So, the family cancelled their first assessment appointment with me, then they failed to bring the child to the next two appointments. We tried to contact the family. No response. I contacted the dentist to say have they actually come back to you. Because they've not come to me. Because I hadn't seen them before, I didn't have all the doctor's details, so got the doctor's details, asked for the health visitors’ details, got in contact with the health visitor, and then the health visitor managed to visit and arrange a new appointment, and we gave the health visitor details of the appointment to help to ensure that they attended as well.

Another example is a family that we've seen with three children, so an eight-year-old, six year old and a six-month-old, who came for one of these comprehensible oral assessments as part of their comprehensive medical assessment. Now both of the older siblings had obvious ingrained dirt on their school uniforms. Their skin and hair was visibly dirty, and they both were smelly. They were the sort of children that I thought you must be getting picked on at school, and both of them had active decay.

Now it was just to point out that even though it's a dental team who are seeing this child, they will be able to note those bits about extra oral appearance. And dental teams are told that they can record them in their notes as well. What happened in this family is that you know the dad was blaming the children. You know they never brush their teeth when I tell them to. So, there's a bit of ignorance there, and families still in this day and age don't know that children need help with tooth brushing until they're seven years of age. But if you were never shown how to brush your own teeth, how can you properly brush your children's teeth if you're not able to do it, and nobody's ever shown you. So, there's a really important role, and Laura's going to talk about that more later. And in contrast, in this family, the six-month-old had beautifully clean, freshly laundered clothes. They actually had two teeth, and they were beautifully clean, not a speck of plaque on them. So, like other forms of abuse and neglect, it's sometimes not all the children in the family who are experiencing dental neglect, and sometimes it can just be a few of the siblings or one or what have you. But that gave us that bit of information that actually this family knew how to look after the teeth, but for whatever reason, the older children were experiencing dental neglect. So what happened in that situation was that we told the father of the family, these are the things that need to be done for your children's teeth, for their oral health, they elected back to their own dentist, which was fine, so I sent a copy of the report I had done on them back to the dentist, and I gave the dentist a phone to check that they were actually registered. And at that stage, that dentist was able to tell me that, yes, they're registered, but they always don't complete treatment, but when they're there, they're actually really good, and they let me do everything that I need to do, but we've made treatment plans before they fail to complete treatment. And then a few weeks later, she actually phoned me to say they've actually not returned again. And it was at that stage I contacted the social worker to see what's happened, and they'd actually been accommodated in a different health board, and then they had registered with another dentist. But as you know, in lots of cases, there's this lack of communication. So, the social worker hadn't let the registered general dental practitioner know, and the family hadn't let anyone know either, and it was only because I knew who everyone was that we were able to work out and close the circle here and close the loop. So irregular attendance and failure to complete treatment are alerting features of neglect, and those are things that dental teams will know about and will be able to tell you about when you're trying to gather information about children. So, we've got that little bit of information that some other services won't have. Information sharing is obviously essential, and I emphasize that on a couple of points. So especially for neglect, but also physical injury, the dental team can provide this little bit of information - part of that jigsaw that may be the first link in a chain and for a family in crisis, or maybe to prevent something awful happening to a child in the future. What do we expect the dental team to do is observe, record what they've done and communicate and refer to other people for assessment they are not expected to diagnose

neglect, although they may be able to diagnose dental neglect, but they not expected to be able to diagnose neglect.

So they're asked to share their concerns with the name person, if available, health visitors, school nurse, medical colleagues, and they're all expected to know who to go for if they need help and advice and if they need to refer in the future. So dental teams have all this information and should know what to do, and they get training as undergraduates, and there's also postgraduate training available for them. And as you saw at the start, the General Dental Council makes it plain that they need to know what to do. So just a final thought, because we know it's difficult and dental practices are businesses and people are scared about losing families from their practices, and we know that about 37% of dentists in Scotland will have had concerns about abuse or neglect for one of their paediatric patients at some point in their career, but only about 11% actually ever refer those onwards. And that kind of mismatch between those who suspect and those who refer is actually a global phenomenon, and it's been reported for years and years in the literature, and we've never really got to how to get that reduced. So, we know it's tricky. So, what I tell the teams that I teach is, if I'm ever not feeling confident or I'm upset by a parent's reaction, put myself back in the child's shoes, and then imagine myself as that child grown up, thinking that dentist saw me, knew I needed help and... What do you want the rest of the sentence to be?

So rather than the dentist having this fear of making the wrong decision, it's trying to support them and empower them to go with their gut, and they're always worried about complaints. So, what we say is, well, I'm sure you never, ever want a complaint in the future from a grown up realizing that you could have done something for them when they were a child, but didn't. And none of the dental team members ever want to be the last professional to see a child that something then awful happens to and unfortunately, we do sometimes have to look at dentist notes when there is some awful tragedy as well, which is obviously very impactful, not only for the child and their family, but for the wider community and for the professionals who've been involved.

So, thank you very much for listening. That is my whirlwind through my part of it, I've put my contact details up there, and I'm quite happy for them to be sent out as well, and I will hang around for the Q&A at the end. But if you want any further information or help with getting in touch with dental teams in whatever area you're in, or need to know who they are or how you would get in contact with them. Please don't hesitate to get in touch with me, and I'll do my best to help you from that point of view. So thank you very much.

Thank you, Christine, that was fascinating. And yeah, I think we could listen to that all day as well as you could speak all day. Good morning, everybody. I'm Sally Jowett, as Alan introduced earlier. So, I'm a Principal Educator on the National Trauma Transformation Program at NHS Education for Scotland. And I'll just let Mairi, my co-pilot today, introduce herself briefly before we get started with our presentation too.

Hello there, everybody. My name is Mairi Albison. I'm a clinical psychologist. I head a program for the Physical Health Workstream here in the Psychology Directorate in NHS Education for Scotland.

Thank you, Mairi. So Mairi and I will be talking today about the impact that psychological trauma and neglect can have in more of a broad, general sense, and thinking about how that might relate to people's experience and families experiences of dentistry, we're going to be giving quite a brief overview of what trauma is, the way that it can impact people, but also how powerful a trauma informed approach can be for people who are affected. So how we can make small adaptations to perhaps the care and the services that we provide in order to kind of support people to access the care that they need at the time that they need it. And just to say we know how common trauma and neglect is in the population, it's something that we'll be speaking to today. So, we're not going to be going into any detail about any specific experiences, but we'll be talking about trauma and its impact in more of a general sense.

So, I want to start off by going through our trauma tree here, which is probably a little bit too small to read, but I'll just go through it step by step. So, this really shows us the impact that psychological trauma and neglect can have across the widest range of health and social care outcomes. So at the roots of the tree, we have the different types of trauma and neglect that we might experience in life. So, we've got single incident traumas that might be one off events, perhaps a road traffic accident or even experience in a dental setting potentially, then we have also complex trauma, which is more that multiple prolonged, chronic experiences of trauma, abuse and neglect, which might be physical or sexual abuse or neglect, or perhaps exposure to domestic violence. And we know that the impact of that can be really unique to the individual. It's like a fingerprint. We couldn't really predict. It depends on the age that we are, that we experience it, how many events we've experienced, our relationships to the perpetrator. And all of that can lead to potentially, a wide range of different outcomes. Most people actually do recover from the impact of trauma without negative outcomes, because we have the right supports around us at the right time, but in the absence of those supports, we are at much greater risk of preventable outcomes across the wide range of health and social outcomes that we see here. So those outcomes are represented by the leaves of the tree, but the route to those outcomes is what we see in the trunk. So, we have the impact of trauma can lead to elevated sense of threat. It can lead us to be constantly aware of potential danger, trying to avoid anything difficult or bad happening to

us again, it's a very protective state to be in. And what that can mean for people, for children and young people and for adults, is that we might already be, kind of already experiencing heightened emotion in any situation, and then when we go into more challenging situations, we're much more likely to get thrown out of our ability to kind of cope and manage with that in a way that we might like to. So we might have that extra difficulty managing strong emotions. And if we think of the kind of typical anxiety that any one of us might experience in a new situation or perhaps a dental setting, it's not people's favourite. If we add to that the kind of heightened stress and sense of threat that we have in trauma, we can see how that might lead to different ways of coping with that and managing that. So, what we often see is potentially risky ways of managing the distress that can come along with that, and that's partly because of that heightened sense of threat, and maybe partly because of the way that we've learned to cope with that that works. So that might be using substances or alcohol as a really, really common way of people trying to kind of dampen or manage the really strong emotions that they feel in order to try and get the care that they need. But obviously that leads to other complications. We might see heightened, perhaps verbal or physical aggressions - people in that fight or flight mode when they are perhaps in that sense of threat. And what we also see really commonly is a difficulty with relationships, a difficulty trusting people, which just makes sense if you've had really difficult experiences with people in the past, it's going to be exceptionally difficult to put your trust in a relative stranger and to establish those relationships that are supportive if you've not experienced a healthy and reciprocal, balanced relationship before, people just don't necessarily know what to expect, what to look for, how to engage with that. For children and young people, in particular, if we think about attachment, when we've got difficulties and we need an adult to kind of meet our needs in the context of trauma and neglect, often, what children might experience is perhaps not getting their needs met and learning that actually, even If I cry or ask for help, help doesn't come, or maybe I'm not worthy of that help and support, or we might see, you know, people need to escalate those asks for help. You know, and I only get help if I really demand it or ask in really, really obvious ways, for example, so kind of more like externalizing behaviours, that kind of thing. So all of that combined means that it can be really, really difficult for people to access services and organizations across the board in society, and if we think about any service or opportunity that we have, most of them require us to travel to a strange place, see a stranger, in the case of dentistry and some medical settings, perhaps have an invasive or more intimate procedure, which is just going to be exceptionally difficult for people who've had an experience of trauma previously, and that goes for families and adults too. They were children ones as well, and they come with their own experiences. If they are in that sense of threat, it might be really difficult for them to engage and place that trust in somebody new, as Christine mentioned earlier, they might never have been taught how to brush their teeth or how to have healthy coping strategies. So we know that we each learn - we use what we have around us to cope, and

for some people that those are helpful coping strategies, and for some people, those more unhelpful coping strategies. The final thing to say here is that trauma can really affect the way that we view ourselves and the way that we expect to be viewed by others. So, if we have negative experiences with other people, we're going to be much more likely to expect blame and shame from other people around us. So, if we have missed appointments or finding it really difficult to come along one day, we might have an additional layer of fear or shame around how that's going to be perceived, and how that how we're going to be treated, and perhaps making people angry or disappointed, and we can see how it can have a bit of a snowball effect there. So that's in a nutshell, the potential impact that psychological trauma and impacts can have. We know that the more trauma and the neglect that we experience, the more likely we are to have these negative outcomes across the board, and in the most recent Scottish Health Survey, it was found that 15% of people in Scotland reported four or more adversities in childhood by the time that they were 18. And on top of that, we know that one out of four women have experienced a form of sexual violence. We know that 70% of the population have experienced some form of psychological trauma in their lifetime. So, we are working with people affected by trauma, whether we know it or not.

And that's just to summarize that here, that wherever we work, whether that's in a dentistry setting or a GP practice, or even a leisure centre, we are going to be coming across with people affected by trauma. It's really important that unless we proactively are aware of that and adapt what we do, people are going to face really significant barriers accessing the care that they need at the time that they need it, which can lead to delayed care or emergency care because people weren't feeling safe enough to access it earlier. And this is just to summarize a little bit of what I've said there about potential experiences that people have. There's more and more research coming out now with interviews with adults affected by trauma and their experience of dentistry, and some quotes that just really highlight just how challenging it can be for people who've had traumatic experiences, perhaps in the past, or going through them at the time. So, you know, going to an unfamiliar place, having to lay down for treatment, having the dentist hand over your mouth, risking making the dentist angry, all of the unfamiliar equipment and language can really heighten that sense of threat for people. So, in some ways, it's no wonder that people learn to potentially avoid going to that or struggling to engage with that regularly. Okay, so I'm going to hand you over to Mairi just now.

Hi, everyone. Yeah, I'm just going to give you some very key highlights here in terms of why we think it's very important to be considering a trauma informed approach with regard to dental settings. So, what we know is that there's a link between trauma, experience of trauma and avoidance on quite a large amount of different areas, but obviously dental avoidance is one of them, and dental treatments and dental assessments. So, we do know that, because of that, there's clearly going to be a link between poor oral hygiene and the experience

of trauma. Now, as just going on, from what Sally's been saying, the essence of trauma is essentially, quite largely, a breach. It's not always, but a large component of it is a breach of interpersonal boundaries. There's other types of traumas that are not like that, for example, things like tsunamis and things like that, but generally speaking, most types of trauma do involve a breach of an interpersonal boundary, and because of that, This then brings the area of dentistry to the forefront, because to do any kind of work on a person's teeth, requires a large degree of trust. Back to what Sally had said in the previous slide about the intimacy of the nature of this work. So, we're asking people to give up control, essentially temporarily and while they sit and have their examinations. And what we know is that can be quite difficult, particularly if somebody's been orally abused, they're going to be potentially terrified if they're going to be asked to undergo these difficult procedures. And that's a normal reaction, and it's normal to feel anxious as when we're going to the dentist, but obviously people who've been traumatized will have levels of anxiety that are to the point of causing significant difficulties, and we need to be more trauma informed. The work that Sally does in the trauma workstream is extremely important and helps our staff in Scotland and the NHS and partnership areas to become more aware of why it is important to think about trauma in this setting.

So just some key messages, really is that we need to be thinking about, does the person coming along, be they, the parent, be that the child have any history of trauma in their lifetime. We're not necessarily saying that people need to ask that, but we're always seeing it has to be in the back of our minds that this could be the case for anybody that we see, because it can have a cascading effect on our health and our attendance in dental and medical settings. And also, there's other peripheral issues that can affect our attendance as well and our ability to communicate. So, for example, cognitive, other communication difficulties, levels of awareness, concentration, all those other things that can have layering effects as well that we need to consider. But another take home message would be that, I guess if we have experienced trauma, we're more likely to have other mental health difficulties, significant mental health difficulties, such as depression, binge eating, which or self-induced vomiting, which we know had, can have a very highly detrimental effect on the teeth, and self-harm, substance abuse, all of those things can come hand in hand with trauma, and it's worthwhile thinking about in terms of tying it in more broadly.

So, we do know that people are much more likely to avoid the dentist if they have experienced trauma and have those poor oral health aspects to their teeth, and they're much more likely to be emotionally dysregulated. And I think there's it's going to be more, potentially more challenging to build a therapeutic rapport with people who have been in that situation. And we do know that people who have experienced torture and our refugees are much more likely to experience things like dental anxiety, and thereafter potentially dental avoidance, but not always, but still, there is more avoidance going on and potential for re-traumatization - possibly they could be experiencing flashbacks that you're

maybe not aware of, if they're in a dysregulated state and their bodies are trying to protect them, and they're going back to that time when they were traumatized. And obviously they can develop other types of dental difficulties like get grinding and facial tension.

To you, Sally.

Thanks, Mairi.

So just the final few slides from us here. So how can we respond to the impact of trauma, of what was just explained there in a trauma informed way? We don't have time to go through it all today, unfortunately, but we will point you in the direction of where you can learn a bit more. But essentially, the principles that we embed throughout our approach in any setting are these five petals in the flower, in the centre of the image here. So, if we can provide a relationship and an environment that's embedded with a sense of safety, we can build trust, we provide people with aspects of choice and collaboration and empower people in their treatment. Those are the key ingredients to helping people with that sense of threat and be able to overcome those barriers and start working and engaging with their care. Those have been chosen because those are the polar opposite of what people have typically experienced in traumatic relationships, which by their very nature have a very complete lack of choice, no collaboration, breach trust, no safety, very unsafe and very disempowering. So, if we can thread those principles into absolutely everything that we do, explaining to people each step that we take along the way, having informed consent, providing choice where and wherever we can, and empowering people with what recovery and treatment would mean for them, and how do they want to approach it. All of those things can make an enormous difference to people's care, and it really can be really small changes making a huge difference here when we're thinking about adapting the care that we do, whether that's pausing a little bit or changing the physical environment of our waiting room to feel a bit safer. I worked with a man just last year, actually, in a complex trauma service, and one of the things that we did was support him to work with his dentist more because he was avoiding it. He had decaying teeth and it got into a really bad state, but the dentist was incredible and really worked alongside him to bring these principles into everything that they did, and he was able to get treatment. And then his he started to feel more confident. He started smiling at his neighbours more, and it just had a really lovely snowball effect of helping him re-enter society, essentially. But what this diagram shows is it's not just down to us as individuals to provide those principles. It has to be embedded throughout the whole system that we're working in, so everything from the physical environment that we're working in to help that feel safe, but also through our policies and procedures. What happens when somebody doesn't turn up? Sometimes we see services because they have managed the throughput. There might be a letter that says each missed appointment costs the NHS however many pounds, and that can really trigger that sense of blame and shame and

make it really difficult for people to pick up the phone and rearrange or cancel because they've got that fear response there. So how can we find that balance between helping our letters and our policies, our systems reflect the principles that we have in the middle there, in order to really remove those barriers and support engagement with people in the longer term?

So, I'm conscious of time. So, I won't go through all of the quotes here. I just want to pick out one or two just to highlight what people can do differently. So, the one in the middle here, this is a quote from somebody who had a history of trauma, who was able to engage with their dentist, because they said that atmosphere is essential. I was able to rest. If they said we're going easy, we're going to go your tempo. He's so good at making me feel safe, not just throwing me in the chair, pulling me backwards, and off we go, which is how it was experienced previously. You will get the slides if you'd like to read these through in a bit more detail, but just for now, this is our plug. If you want to find out a little bit more, we've got a website with all of our freely available resources on there. Really encourage you to take a look. I'll just pop it in the chat. No, I won't. I'll pop it in the Q&A after we finish. And that is us. So, I believe I will be handing over to Laura. Thank you so much for your time. We are hanging out for the Q&A so if you've got any questions, please do let us know. Over to you Laura.

Hi there. Thanks very much. So, my name is Laura Wright, and I'm here to talk to you a bit about dental neglect and child protection. So, I work with Childsmile. And the aim is the picture of the healthy teeth on the left there that you can see, and not the decayed ones there on the right.

So, I'll tell you a wee bit about Childsmile. I don't know if any of you have heard of it before. Childsmile is a national program designed to reduce inequalities in oral health among young children. It's funded by the Scottish Government, and there are three main components, toothbrushing, Community and practice and fluoride varnish. So within my role, I'm involved in the toothbrushing program, we deliver that in early years establishments. I also work a bit in the community, doing sort of events and things like that. And we do work closely with local dental practices as well that are quite heavily involved in Childsmile.

So, I'll tell you a bit about my role. I work with Inverclyde Health and Social Care Partnership, Childsmile, and also under NHS Scotland. We deliver and implement the national toothbrushing program. It's delivered in all nurseries and targeted primary schools participate. So, it's only to do with SIMD areas. So that's the Scottish Index of Multiple Deprivation. So it's delivered in primary one and two and areas identified through SIMD. We attend parents' evenings, curriculum events. We deliver starting solids events with community nutritionists. We're involved in a 5 under 5 project, which is being delivered in Inverclyde at the moment, it's been piloted in Port Glasgow, as I said, we're

involved in community events. We attend toddler groups, Bookbug sessions. We deliver oral health education sessions to children within nurseries. We provide oral health intervention with families where it's required, and we signpost to dental services. We liaise with health visitors, school nurses, and family nurses as well.

So, is dental neglect a child protection issue? I think we've already addressed that following on from what Christine had said, yes, it is so dental neglect is known as the persistent failure to meet a child's basic oral health needs likely to result in serious impairment of the child's oral general health or development, and that was brought in by child protection in the dental team in 2013. So, it's not a new thing. This has been about for more than 11 years. It's not a new thing, but I think it's quite often not prioritized, and it's just really good to get the opportunity today to highlight that, along with colleagues as well, because as it's really, really important, and it's often not prioritized, and the umbrella underneath keeping children safe is everyone's responsibility, and I think that's really important as well, following on from what other people have said. You know, we've all got a part to play in child protection.

So, the importance of good oral health, and some of the things I'm going to discuss are sort of following on from what Christine has said, and the other girls as well. But I think it's really important, and it's not repetitive, even if we are all saying the same thing, you know, because all these different approaches, it's all really important, and it's all really valid. So, for good oral health, it obviously prevents ongoing dental issues. So, if before the treatment gets to the irreversible stage, it's really important to prevent ongoing issues, to get the treatment when it's required. It aids good general health. The baby teeth maintain for the space for the adult teeth. So ideally, the baby teeth should stay until they're lost naturally. People are under the impression the baby teeth don't matter, because you get another set of teeth. Baby teeth are, in actual fact, a really big deal. And I've done a presentation in this years ago, baby teeth are a big deal when I was doing some of my training. And they do matter. They're there, and they should be there until they're lost naturally. And just because they get another set of teeth, you know, doesn't mean it's okay for them to be lost before they should be. The teeth obviously support with eating. They assist with speech and a healthy smile improves a child's confidence as well.

So, problems associated with poor dental health. You can see the picture there in the top right, a poor we saw with some really badly decayed teeth there. So obviously the implications of that, as they're going to have pain, they're going to be suffering unnecessarily with that, it's going to then give them nutritional problems, that will affect their diet, and they won't be able to eat because it's uncomfortable. It can affect their speech. Obviously, we've talked again about some of these things already, sleep deprivation, it will disturb their sleep, because everything's always much worse at night if they're experiencing toothache. And as Christine had said, tooth extractions for children are normally

done under general anaesthetic, which obviously comes with risks for everyone as well. But I believe, as I was told by an anaesthetist years ago, that the risk for under five is actually doubled for the general anaesthetic. So quite often, when the child goes for anaesthetic, if there are concerns with the teeth, you know, they'll just take as many as they need, just to avoid them going back to another appointment. So, ones that are maybe looking decayed, and they don't think that they will comply with treatment, then they'll just do these lists, and they're absolutely horrific. I worked in the hospital prior to this role, and it's really not a nice attitude to the future dental treatment. So, it's the trauma for the child. If the child is, you know, they're going to theatre to have their teeth extracted, and they're waking up, there's all these different professionals there, all the lights and things like that. It's absolutely traumatic for them. And then they wake up, they come round from the general anaesthetic, they're feeling groggy and whatnot. And then they've absolutely no teeth. The anaesthetic wears off the pain, so that's really not going to help with their attitude to future dental treatment. It would interfere with their play and socializing. So, if they had siblings, they maybe wouldn't feel like interacting. If they were going to clubs out with school, they would miss them. They would obviously be absent from school or nursery, and in turn, the parents may have to miss work. So that has other implications as well, because not everyone's in a position where they would get paid, obviously, if they had to have time off work and things like that as well. So, it can have a whole lot of implications thereafter as well.

So, accessing dental services, so that does continue. On the NHS it continues to be increasingly difficult, especially in vulnerable and disadvantaged communities, due to lack of NHS dentists. So, it has proven quite difficult as well. The cost-of-living crisis - we've touched on also some of my colleagues here, does play a role, because basic purchases are prioritized over preventative dental treatment and associated travel expenditure to available services. Now, where we are in Inverclyde, it's very difficult for us. There's not a lot of practices. It does fluctuate from time to time, but there's not a lot of practices taken on NHS dental patients, and we can send them anywhere, so you don't have to sort of live within the area. So, for example, myself, I live in Ayrshire, and I travel to Glasgow to my dentist. That's not a problem for me and my family, because touch wood, we don't tend to have problems. We just go for our routine appointments, and that's not a big deal. We can attend every six months, or as recommended by the dentist, so that doesn't really impact us much going along, but for somebody that's really struggling for various reasons, financially, the travel expenditures to get available services, you know, it's not it's not there, it's not convenient for them. And if they are a vulnerable family, and they're less likely to go to an appointment if they're going to have to travel, and they've got the associated travel expenditure costs as well to get there. There was something called the Scottish dental reform that things all changed on the first of November last year, and fees and things were increased for NHS dentists. So hopefully that should make a positive impact, but it's still too early to see the benefits from that. The dentists have also changed as well. So some practices

just be guided by your dentist, or your client's dentist, your patient's dentist, they won't always want to see their patients every six months now, and a lot of people are up in arms on that. The dentist got a bit of bad press, which is very unfortunate for them, because there's a lot of good dentists out there. As Christine said, they're very much businesses. We're not allowed to recommend practices. We always just say to go to the local ones. We've got a list in our area, and we recommend them to go where it's convenient for them, or where it's taking on patients. But they do get a bit of bad press. But unfortunately, the fees didn't reflect, you know, the treatment time and things like that. It was a very difficult time for dentists. Anyhow, I'm digressing a bit there, but the fees have been increased and the dentists are not seeing some patients as regularly. It's not necessarily a bad thing. If your dentist only wants to see you every 12 months. It's probably because you're a low-risk patient, because they don't have concerns over your oral or dental health. So, you know, don't be offended by that, if anything, take it as a compliment. And that should hopefully free up their appointments and allow them to take on more NHS patients, and hopefully should allow more vulnerable families to be seen and to get in and to get treatment as well, because a lot of general dental practitioners have gone down the private route. But unfortunately, in vulnerable and disadvantaged communities, private treatment is not an option, so they rely heavily on NHS. So hopefully, in time that should make a big difference.

And Childsmile program participation is really vital in aiding prevention. So, we do a lot of work around sort of promoting... Dental decay is preventable, so we promote prevention. And a lot of the work we do, we work with children, with the toothbrushing program, and we work with families. There's a lot of education out there, and also there's extended duties dental nurses who do the fluoride varnish application. So, this is all vital in aiding prevention. It's just about getting the education out there, educating families and just supporting them. Sometimes they just need a wee bit of support and guidance. And as Christine has said before, toothbrushing should be supported up until the age of seven. Maybe some families aren't aware of that. And we work for the children in nursery, they get the opportunity to do it themselves, but it should always be supported by the parents. And most importantly, what we do within nurseries and schools as part of Childsmile should be in addition to at home, but it's not always. Sometimes, unfortunately, these we souls, it's the only opportunity that they're getting to brush their teeth, but it is really, really important, and it's vital.

So how do we identify dental neglect? So was not brought to multiple visits, so obviously a child can't take themselves. I work with children and families teams, so work with under-fives. They can't take themselves along to a dental appointment. They're relying on their parent or carer making that appointment for them and taking them to that appointment, and if any treatments required, taking them to subsequent appointments. So, you can't really put them down as a DNA in a practice that did not attend, because they're not choosing to not

attend. They're relying on somebody to bring them, and they're not being brought so that's a really important thing to highlight as well. If a child has high caries rate, which is just another word for decay, where extensive treatment is required, then that would obviously raise concerns as well. If they had to be referred for general anaesthetic for multiple extractions or even a dental clearance, which basically means the removal of all teeth, then that would raise concern. Children suffering with persistent pain and not being taken to the dentist. That would also raise concern. I have actually had an establishment that I worked with contact me, a nursery previously to say that the child was suffering from toothache, they've highlighted this to a parent at pickup, and this has gone on for a couple of weeks, and it's still not been dealt with. So, they raised the concern with me. I got in contact with mum, and it turned out that mum was a dental phobic. So, she hadn't taken the child along to the appointment, because it was traumatic for her. She was going to complete dental phobic, and she didn't want to pass on her fear and anxiety in relation to the dentist to that child. So, dad worked away. She was waiting for him to return from work, and he was due back, and she was hoping he could take the child along to the dental appointment, because she just couldn't do it, and she didn't want to pass on a fear and anxiety to the child, which was fair enough. So, there was a reason for that, but you can see why the establishment was alarmed that you know they've raised the concern, and why that's not been followed through. But I was able to speak to her offer a bit of support, and by the time the nursery contacted me, and I'd get in contact with her, dad was home, and we arranged an appointment. Child was taken along, problem solved. So sometimes, you know, there is, there's other things going on and there's a bigger picture, and it's important, you know, to look at that, but as long as we all communicate, then you know, usually you can get to the bottom, and it can be addressed.

So, should dental neglect or concerns of neglect be reported? Yes, it always should be reported, and we should document everything. As Christine had said already, and it's, you know, you might be that missing part of the jigsaw piece. And I'm sure within all of our roles, you know, everybody's on here today. This is to highlight child protection and dental neglect, but we've all done child protection training. I know myself, when I first started, 14 years ago with the NHS, the first set of training I done, it's all big stories that have been from the media, and it highlights these cases. And at the end of the event is when all these people speak up and say, oh yeah, you know, that was that was a bit worrying. I was a bit concerned about that. That was a bit strange, but it's no good. You know, these things are in the media, and some horrific things have happened to these children. By that point, it's too late. So, you know, don't ever be the last person to have contact. And if you've got any concerns at all, you should always address it, and you should always contact somebody and raise your concern, because it just might be relevant, and then it might encourage other people to raise concern as well. And if there's nothing, and it can be scary, and I appreciate that, but it wouldn't be taken any further if it was looked into and there was no concern, you know, I'm assuming that would be written off. It

wouldn't be going any further. So, if there's any concern, of course, then we should highlight that. Dental disease and decay is preventable. So historically, the focus has been in treatment rather than prevention. But now times have changed. So, for example, when I was young, I do have a lot of restorative treatment. I've had a lot of fillings over the years. But, when I was a lot younger, we used to go to the dentist, and it was just like, oh, yeah, you need a filling, that's fine, it doesn't matter. I've still got home my teeth. I've not lost any, but I've had quite a bit of treatment. Nowadays, there's a lot of people, you know, my age, even older, that have not even had any treatment, and that's becoming more and more common because it is preventable. So, I think that's really important that we focus on prevention, and that's a big part of the role that I'm in, and something that I'm really passionate about.

There's a lot of education out there. As I say, we work with children and their families. We do sessions with the children. We do oral health education sessions. We get down with the children in the floor. We play dentists. You know, we've got disposable mirrors, we've got gloves. We give them the whole experience of the dentist. It's all about promoting this friendly, caring image of the dentist. And the optimum goal is we want them to go along every six months or annually. You know, as the dentist would like to see them, we want them to go along. And it's a happy and it's a positive experience. They are sitting in the dental chair. They're having their teeth counted. They're getting a wee sticker. We'll see you back in six months or a year. We don't want them to go along and to be terrified, to be traumatized - their first experience of the dentist being you know, you need to be referred for general anaesthetic, waking up in that theatre with all these people, all the lights having been put to sleep and all your teeth removed. That is not what we want, and that is something that we can prevent. So, it's just about educating the families as well and breaking the cycle. Learned behaviour is something as well that I always refer to. And if you're brought up in an environment of, they don't have a good diet, they're not in a good routine of cleaning their teeth. They're not regular dental attenders. Then, you know, they're going to fall into that pattern, and then their families again. So, it's just all about educating families, educating children, educating professionals, and breaking that cycle so that in future we can keep these teeth for as long as possible.

Usually, dental neglect goes hand in hand with other forms of neglect, but not always. So, if it's just dental neglect, it shouldn't be just dental neglect, it's still neglect, and that should still be prioritized. An example of this, I was working in a nursery doing one of these oral health educations that I talk about we read a dental related story. We talk about experience the dentist. We play games with the children. We talk about safe times to eat sweet things, which is usually with a meal, so either as a dessert or, you know, straight after a meal is safer dentally for your teeth, because it's all about the frequency of the sugar. So, we teach this to the children. We talk about the families and at the parents’ events and things as well. But this child, I was doing the wee story, we were doing the

sugar game and things with them, this child highlighted herself to me as having no teeth. She put up that she had no teeth. So, at the end of I always go in and I speak to them, you know, we arrange a follow up. We have various contacts with establishments throughout the academic year, I was arranging a follow up appointment, and I said to them, oh, this wee one in the room. She highlighted herself to me like I wasn't aware of her. And they were like, Oh no, no. She was, you know, she was referred. She had the general anaesthetic. She said, her teeth all take now, yeah, but she's fine. And I said, all right, was there a contact made with a health visitor regarding this? No, there wasn't. So, I went back, we used the same system we can access that the health visitors access. And there was nothing mapped on here at all in relation to that child, nothing at all. But did the nursery when I mentioned dental neglect, you know, they said that's not neglect, like they refer to sort of sexual and things like that. And they also talk about, because the child was, you know, that was a nice family that we don't have concerns with this family. They're a lovely family. The child's well kept, you know, she's clean. We don't have concerns with them. It's just her teeth. But that child was four years old, and she's now starting school. She's been through this traumatic experience of being referred, going under general anaesthetic, having all her teeth removed, she's highlighting herself to me and singling herself out in front of all these children when we're doing the education session, they're all showing their lovely smiles and that we saw and she had actually been referred to speech and language as well, but then discharged because there was nothing they could do for her, because the reason she had the problems with her speech was to do with her teeth. Anyway, she wasn't involved with the toothbrushing within nursery either, because they were under the impression, well, she's got no teeth. But from showing me, I could see that adult teeth were starting to erupt, they were starting to pierce through the gum, and it looked to me, I can't diagnose because I don't work clinically, but it looked to me as if they were starting to get decay from just coming through because they weren't being brushed. She probably hadn't changed their habits in relation to diet and things like that. So, it's really, really important. And that's a really good example of there should have been contact made. There should have been a concern raised there with the health visitor, with ourselves, and we could have put some support in place for that family. Because, yeah, they might be a nice family. She might come from a nice home. But this needs to be addressed so that she doesn't go down the same route with her adult teeth. Because we all know after that, you don't get another set of teeth, and the next set of teeth, if she were going to get another set, it'd be a set you keep beside your bed at night, and hopefully, you know, we're not going down that road. So that family just needed a bit of support. We could have offered some oral health intervention. We could have worked with them just a wee bit of education. They maybe weren't aware.

Marketing's got a big part to play as well, because a lot of things are marketed as being healthy and they're not. So, this is a really important point as well to make. So, some families think they're doing the best thing because they're

buying, you know, organic things, things like dried fruit. You know, there's health benefits, but they're horrific for the teeth and the consistency of them and the sugar being released. So, it's just all about educating families and just supporting them. They obviously they didn't have a dentist. That child would have been born during covid time, and a lot of the ones in nursery were when obviously general dentists couldn't work, so children hadn't been, they're unregistered. So, this is somebody that slipped through the net, but the nursery wasn't concerned, because this was a nice family. They were from a nice home. She was a well-kept child. It was just her teeth, but the concerns still should have been raised, and then, you know, appropriate action put in place to support and guide this family, you know, with relation to the diet, cleaning, dental attendance, so we don't go down that same route again.

So, who should we contact? So, because I work with under-fives, it's the single point of access number to let the health visitor. So, I don't know if you're aware, but the health visitor is the named person for a child under five, so I've popped the phone number there, but that's obviously for Inverclyde, because that's the area that I work in. So, you would need to find out within your own area who that would be. Obviously social work, your local oral health team, which would for Inverclyde, would be ourselves, and we could support but you can look up and find out who that would be, just to offer a wee bit of support for families, and also a note of concern could be raised. And it may seem scary, as I've said, but it's all our responsibility, child protection, and that's really important. So, I've popped on some QR codes there as well. The first one takes you direct to the Childsmile website, and the second one is for NHS inform, and it just helps you find a local practice in your area. But there's also a sort of triage list that takes you through just if it's out of hours and things, who that you would contact to be seen, or if you're unregistered, if you don't have a practice.

So, thank you very much for listening. I'm Laura Wright, and I've fought my contact details there. I'm happy for anyone to contact me if you've got any questions in relation to any of this, or to signpost you. And if it's not something that I can answer, then I'd be happy to signpost you to someone who could answer. Thank you so much.

Thank you to all the speakers that was really excellent, really informative and really rich. And actually, we've kept pretty largely to time, given there was four people speaking there, so that was brilliant. I didn't want to stop the presentation because of the richness of the information that was being imparted. We've got a couple of questions in the chat already. We may not be able to get through them all, but I'm going to just try and get a few posed to yourselves. A lot of them seem to be around dental practice, kind of issues. And there's a question for Childsmile as well. Nothing so far about the trauma informed practice, but there's one here, I think that's quite interesting, just about the issue of struggling to get consent if urgent dental treatment is needed, and

needing a general anaesthetic for a child as the adult with the parental responsibility could not be contacted. Is there updated guidance that gives dentists the confidence to proceed with treatment? And I suppose that may be for yourself, Christine, in the first instance.

So, if it is urgent and they can't get in contact with the person who has parental responsibility, then it's like - every case is slightly different - but it's a judgment on the day, and what the risks and benefits of it would be, providing the treatment there and then, or what the risks would be in delaying it. Often, it's irreversible treatment. So, extractions, for example, are irreversible, so that can sometimes be the issue, and sometimes it can be complicated. If there is any court proceedings behind the scenes, if there's more than one person who's in looking for parental responsibility. So sometimes we do have to delay it, but if it is something that's in life threatening, if there's an airway issue because of an abscess on a lower tooth, for example, then, then they can go ahead and provide it, as long as it can be justified. So, the dental teams can always get advice from their own indemnity providers if they are concerned, or the specialist in paediatric dentistry. There's nothing particularly written for that particular context, but it is the general principles that we would follow, when we have struggled in any situation to get hold of person with parental responsibility. And sometimes there's nobody with parental responsibility. We've had that situation as well, or, you know, the perhaps parents are incarcerated overseas, things like that can be a challenge. But we've done all sorts of things, getting your phone calls to prisons overseas, things by zoom, to get parental consent that way, so there are sometimes ways around it. And I guess the main thing is not, not just to try and do it yourself. You know, use legal teams to help you. Use indemnity providers for advice. You know, reach out to specialists if you're not sure as well.

That's really helpful. I was going to ask; does it depend on the age of the child or young person? So, if they're over 12, does that make a difference? Can they consent to their own treatment?

So, I guess if they're deemed competent, then then they can. And so if we can consent, but they can also obviously withhold consent too and we wouldn't, you know, if someone was deemed to be competent and they didn't wish treatment, and for whatever reason, then, you know, we can't override that either. So, yes, but some children over 12, and if we, if we think that they are competent and they understand what's going to happen and the consequences, then they can consent for their own treatment yes.

Okay, the next question is for yourself, Laura. Someone asked about Childsmile. I think they are from NHS Grampian, but they're saying, would you work with a 15-year-old and their family? I have a child who has not attended the dentist for nine years, and the family are resistant to engagement with services.

Within the team that I'm under it's under five. But normally, Childsmile is just in sort of nursery and primary school, so it's not normally something we support with. However, I have had questions asked by other colleagues for other areas, and I have put them in touch because I know myself, my remit is under-fives, but sometimes, if they've got siblings or there's somebody else, if we can support them then, then we will, so it would just be dependent on your area, but normally, it's just nursery and primary school age children, that Childsmilel work with, but I'm sure if somebody could help you, they would, because I would. And sometimes the registration thing, we have difficulty registering children if the families are not registered. So sometimes, although your remits under five, it sort of benefits me to, you know, register the fact the whole family, because they would take the child on unless the parents are so, you know, sometimes there's a bit of leeway in who you look after.

Thanks, Laura. And it's good to know there is flexibility as well within the service, that's really helpful to know. There is a question here just about working with unaccompanied asylum-seeking children. Due to significant trauma, including abuse and torture, accessing dental care, although available to them, was often very re-traumatizing, especially as it was part of a medical assessment soon after arriving in the country. What is in place nationally to support this if they can't handle dental appointments? So, it's a question that kind of, I suppose, for all the panel, it's just about the trickiness of the complexity, I suppose, in terms of the trauma and considering that, and also just is there something in place nationally? We know, services for unaccompanied asylum seekers, you know, is a challenge as well. So, I'm happy for anybody to jump in there, who wants to start.

I suppose our safety net for the unaccompanied minors, for asylum seekers, is our public dental service. So, there is a public dental service in all of the health boards, so they would probably be the best contact for local teams if they're looking for someone locally to help access. So whether it's putting them in touch with that or if that's difficult, then at the dental hospitals, we do offer video appointments, and we can do that for people who are children or young people who are not able to physically come into a dental setting, but it would be getting in touch with who your local contacts are, and if there are specifics about specific cases, I don't mind people getting in touch with me, and I can try and put you in touch with whoever your local contact is. But certainly, there's lots of groups of patients who can't, you know, access the dental environment, or they have issues accessing it. So, we do offer video consultations and things as well. I think Sally's got a lot to add to that.

Yeah, it's a really, really good question, and I think just highlights the importance of that multi agency working and having that shared compassionate understanding of what the child's needs are and making sure that they're not falling between the gaps anywhere, because there might be so many professionals involved in those additional layers of barriers, for example, like

language or cultural barriers. From the trauma point of view, I suppose, just to highlight that all of the trauma informed practice resources that we have are available for any staff member and any team. There is a lot of really exciting work happening in both dentistry and also across people working with asylum seekers and refugees, but in terms of just what we can each do to contribute to that picture and have that shared approach. I think, yeah, it's on each part of the system to look into where we're noticing the impact of trauma and what we can do to adapt differently. I've worked with asylum seeking populations before in Trauma Services, and I think it's really on us to be doing that cross sector collaborative work, so reaching out to the dentist, if we can, and saying, you know, can we, as well as the dentist, maybe looking into and accessing resources to help them understand trauma and how they can adapt it. Can we also work alongside our mental health teams or CAMHS or GPs and that kind of thing, to have that shared approach, just like Christine and Laura have been saying throughout.

Thanks Sally, that's really helpful. So that collaborative approach is really kind of crucial to this. And part of what you answered, Christine has actually answered someone else's question. This seems to be from a student from Fife. Don't know if they are a dental student, but they're just asking about the public access dentistry, where children with particular challenges can go, and I suppose adults as well. Is this a universal service across health boards, or is its quite specific? And you've kind of answered that by saying there seems to be a service like that in all health board areas. So that would be somewhere where, like unaccompanied asylum-seekers or people with particular challenges, learning disabilities, etc. Could attend those services?

Yeah, often to get hold of them, sometimes you need to be referred by a local general dental practitioner. So that can sometimes be tricky, but there are dental services. And if they don't have their own dentist, but they are still needing access, then there will be local dental contacts too, that they can get hold of, or other professionals can get hold of, to get support put in place. And maybe they only have to go to the public dental service for a short time, and then they would go back to general dental practice as well. But sometimes they need that little bit of input, and before they go back to general dental practice.

Thanks Christine. Probably got time for one more question and this relates to, I suppose, looked after children as well, I'm just thinking about parental rights and responsibilities within that context. So, John Gallacher, Senior Social Worker, has asked if children are subject to a CSO, which a compulsory supervision order through the hearing system, where the CSO includes guidance, treatment, care and protection. Would dental treatment need separate parental consent. I suspect the answer to that is it would still require consent, but you can and Christine for that one.

Yes, so it does still need consent, especially if we're doing something that is not reversible. So sometimes the dental teams will get in contact with local authorities if the local authority has parental responsibility, or whoever else that's involved to get particular consent for that, especially if it's something interventive that we're planning. Sometimes that this compulsory supervision order that that's there that would cover checkups and things, but if there's something particular interventive that's happening, then most dental teams would probably write to a local authority or lawyers or whoever it is to just to check, especially if they're going to do something that can't be reversed in the future, and that, you know, in the future, someone could challenge why it was done at that time.

Thanks. That's really helpful. Might just have time to squeeze one last question. This is from Judith Tate, who is involved in a case review involving dental neglect, and she's keen to understand when or what year, the recognition of dental neglect as a child protection issue was established or embedded in practice and procedure? I think Christine, you probably know the answer that's off the top of your head.

So, the British Society of Paediatric Dentistry, they first published their definition in 2009 and so that was the first British definition of dental neglect. But research wise, dentistry has been publishing their input to child protection since, actually, not long after Henry Kempe's Battered Child Syndrome, so we're talking about 60 years or so of input. So, I guess the definition for the UK definition is 2009 that was established. But research wise, there is sort of discussion in the literature about it before that, using the different definitions, the American definitions, and things before that.

Okay, I'll try and squeeze one more question. This a really good question. It's on the trauma informed aspects, and it's from Shumela Ahmed from Resilience Learning Partnership. She's asked, how do we ensure that practitioners, whether that be dentists, social workers, health visitors, do not blame and shame people during exploration around their child's dental health or any other aspects about neglect, similar to overweight children families. How do we do this without shaming? And yeah, it's a question, I suppose for everyone on the panel.

I don't mind coming in, but I think Sally and others might want to come in as well. Our work stream are doing a national program on looking at motivational interviewing within dentistry settings. I know that doesn't quite answer all of your question, of course, but it's interesting because that is trying to change people in dentistry settings or consultation style, so that the words are coming out as not shaming. There's also an interesting module on stigma, and I've just recently worked for weight management services, there's an interesting training module on stigma and people who are overweight. I'm not aware of anything for that in dentistry settings, but it would be interesting to develop more training, teaching and training and Sally, how would you say that links in with the work that you do?

Yeah? Yeah, absolutely, yeah. And hello Shumela, I know shumela from other work, and I think Yeah. And I would also go back to the previous point about that collaborative approach, about it being a whole team thing, it's so, so important that we're not adding any experience of shame or blame to what is already an exceptionally difficult situation. So, I think supporting the whole team, both with individuals, but the whole team, so we have that shared understanding, compassionate understanding, of just how hard it can be for families to pick up the phone to walk through the door to wait in that really busy waiting room in what's already quite an anxiety provoking situation. So, I think if we're all able to have that shared understanding of just what the impact of trauma might be having on somebody and why they might be presenting in a way that for us can be quite challenging. It might be missed appointments or not reliably engaging with treatment and we're not necessarily sure why, or perhaps that really difficult verbal and physical aggression, potentially that all might just be pointing to the impact of trauma. And then if we kind of add to that sense of threat, because we find that difficult, because we do, we're human too. We have our own experiences of trauma and stress at work. If we come back to that with shame or rejection, it's likely to escalate or lead to people dropping out of treatment even further. So what we all want is for people to be able to access their care sustainably and safely, and that really requires each of us as individuals and as teams to have that shared understanding and to look after our own well-being, so that we're in a place where we can provide that for people, so that we're not pushed out of our ability to stay calm and manage those situations too. So, yeah, really good question. I think that's one of the key, key barriers for children and families in dentistry. To Christine, do you want to come in there?

I just want to add that when we are teaching the students to give oral health preventive advice, then they are taught to do it in a non-blaming way. But it can be difficult when people are being told this is entirely preventable, and then their child has caries or other issues that they're then blaming and shaming themselves. So often we're saying, right, this is the situation now, and we can deal with this now, and then we're going to stop this happening again. And these are the things that we can put in place to help you, but you are the one who's going to do most of the preventive. We can give you all the tools, but you're the one who's going to do it. But it comes down to style, I'm not sure every single dentist will have the same style. Obviously, lots of work being done with trauma informed training for dental teams and our dental students, which is wonderful. But what I would say is that if a family's not getting on with the particular dentist, they can register somewhere else that they are free to do that. And I guess it's keeping in touch, because there's different dentists for different people. You know, we are all human.

Thank you, Christine, and bang on 11 o'clock, we managed to keep the discussion going. We could probably go on for longer, but that is us out of time. So, I just want to thank everyone that's come along to speak today, Christine, Laura, Sally and Mairi. It's been excellent. I think it's comments in the chat just about how informative people have found it. The presentations will be available in due course, once we get the videos edited, and all the rest of the things we do. We do have a transcript, etc, and any presentations as well will be sent out to participants. But I just want to give a big thanks, and people can show their kind of appreciation with their reactions. There was lots of claps and love hearts during the presentation for everyone that was speaking. So just want to echo that again. And thank you very much, and I'll leave it there.

And we will be having further neglect learning webinar sessions, hopefully later on the year, on different topics. But this has been fantastic. Thank you very much.