

Introductory comment: The Early Childhood Oral Health Program was developed by the Centre for Oral Health Strategy NSW in 2007. It seeks to positively affect the oral health status of children at an early age by focusing on prompt and appropriate referrals from child health professionals, early management of dental disease by oral health professionals, and increased family focus in oral health services. The program is a key strategy for public oral health services in NSW.

NSW Health includes oral health as an assessment item in the My First Health Record (Blue Book) child health checks from 6 months of age till 4 years.

The Commonwealth government has demonstrated its commitment to early intervention and prevention by providing Medicare item Numbers for a Healthy Kids Check at 4 yrs of age.

Today's training is designed specifically to support child health professionals to implement the oral health risk assessment component of the 4 yr child health check. It has been developed to provide **support** and to **complement existing skills and knowledge**.

The Early Childhood Oral Health Guidelines are useful for revision and as a reference source. Copies are available from the Better Health Centre (see last page) or from the Centre for Oral Health Strategy website.
http://www.health.nsw.gov.au/policies/gl/2009/pdf/GL2009_017.pdf

As primary health providers for families with infants and young children you can affect real health benefits by early identification and prevention of dental disease.

Objectives

- Recognise risk factors for tooth decay
- Identify early signs of tooth decay
- Conduct an oral health risk assessment
- Provide preventive advice to parents and caregivers
- Understand the referral process to oral health services

By the end of this presentation, participants will be able to:

- Understand the role of the child health professional in assessing children's oral health, particularly children aged 0 -5 years.
- Describe the process of tooth decay and recognise the different stages of Early Childhood Caries (ECC).
- Be able to conduct an oral health risk assessment and Lift the Lip screening as defined in the ECOH program guidelines.
- Identify strategies to prevent early childhood caries and provide anticipatory guidance and education to parents and/or caregivers.
- Understand the referral process and provide contact details of oral health services to parents/caregivers.

Caries prevalence

- **40%** of children aged 5-6 years already have caries

- **72%** of caries is untreated

Child Dental Health Survey 2007 NSW



Approximately:

40% of children aged 5-6 years have evidence of dental decay

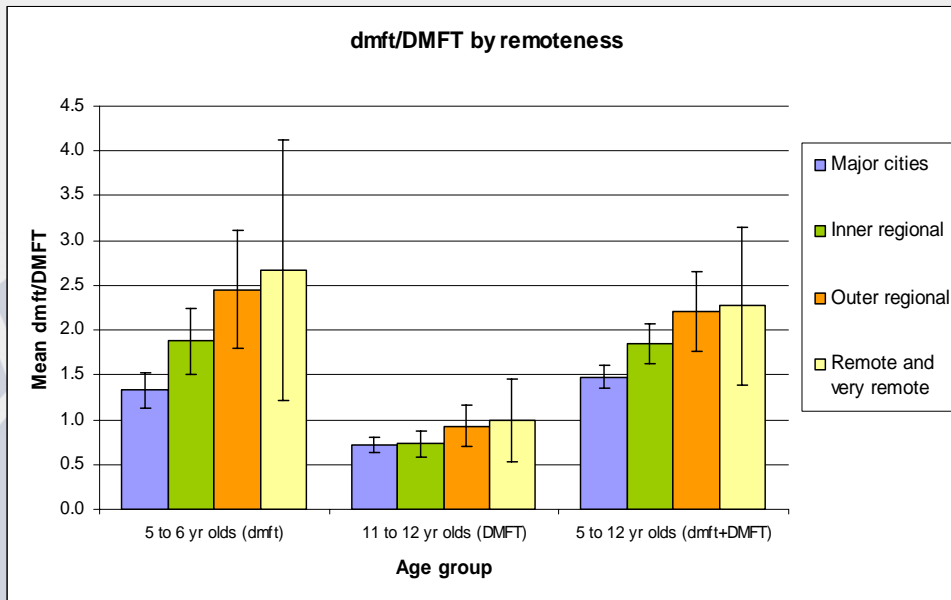
72% of the disease is untreated

Significant and consequential disparities in oral health continue for low-income, minority and special needs children.

Reference:

Centre for Oral Health Strategy NSW, 2009. The New South Wales Child Dental Health Survey 2007. www.health.nsw.gov.au/cohs

Distribution of disease

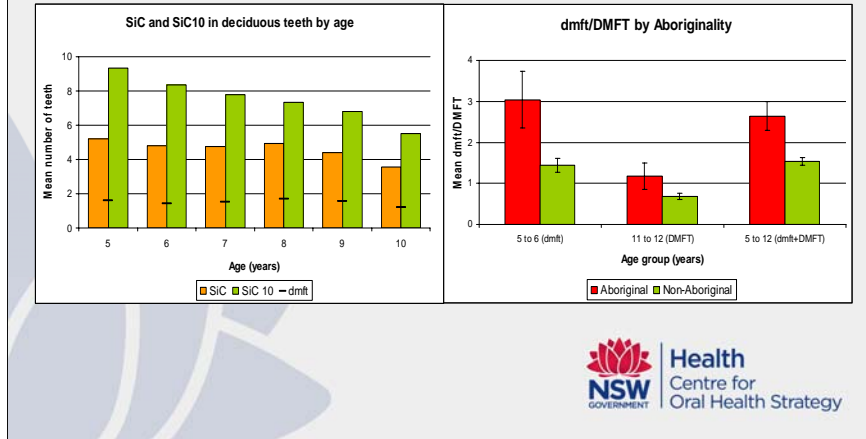


Data from the NSW Child Dental Health Survey 2007 of primary school children provides solid evidence of the disparity in oral health in NSW.

Dental decay is measured by counting the total number of teeth that are decayed, missing due to decay, and filled. dmft = baby teeth, DMFT = adult teeth. The lower the score, the better the dental health.

This graph demonstrates how children experience greater decay with increasing remoteness.

Distribution of disease



The mean dmft of 5 year olds in NSW is 1.62. When the majority of children have no caries experience, reporting on the mean (or average) can mask the true extent of the disease in children who suffer the most dental disease.

The Significant Caries Index (SiC) reports on the mean dmft of the 30% of the population with the highest caries scores. The SiC10 reports on the mean dmft of the highest 10% of children.

The dmft at age 5 for SiC is 5.2 and for SiC10 it is 9.35. When these data are analysed by Aboriginality, the rates of disease double and the situation is similar for children who have immediate treatment needs, whose parents are centrelink cardholders and who live in remote and very remote locations.

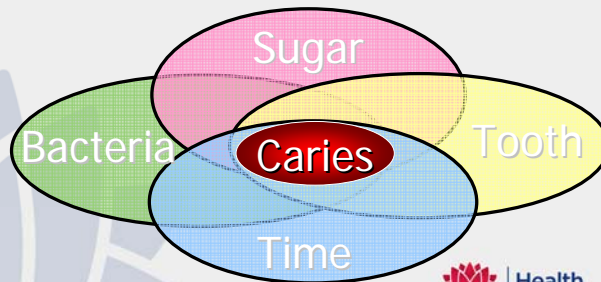
Yet visits to the dentist for children aged 0-5 years still infrequent and episodic, with attendance mainly occurring when the disease process is advanced.

Reference:

Bratthal D. *Introducing the Significant Caries Index together with a proposal for a new global oral health goal for 12 yr olds.* International dental journal, 2000, 50(6):378-84

Definition of ECC

Early Childhood caries (ECC) is a severe and rapidly progressing form of tooth decay that affects infants and young children



Tooth decay is an active process of tooth destruction resulting from interactions between teeth, food, and bacteria. The growth of the bacteria is determined by the amount and kind of substrate available for metabolism, the state of oral hygiene, and the presence of fluoride.

ECC is a severe and rapidly progressing form of tooth decay that affects the upper front teeth that erupt early and are least protected by saliva (hence the Lift the Lip slogan).

1. Bacteria: The disease is initiated by bacteria (primarily *Streptococcus Mutans*) but the presence of bacteria alone will not result in tooth decay. However, if conditions are favourable (i.e. baby takes a bottle to bed at night and the bacteria is present), it can progress rapidly.

2. Sugar: The bacteria in the mouth converts sugar to acid. This acid erodes the enamel, eventually leading to a cavity that will need to be treated by a dental clinician. Sucrose is the fermentable carbohydrate most frequently implicated in tooth destruction but it is important to note that the bacteria can use all fermentable carbohydrates, including cooked starches.

3. Time: Frequent consumption of fermentable carbohydrates is more important than the quantity consumed.

4. Tooth: The bacteria are mainly transmitted in the first 30 months from mother or primary caregiver to the infant. The earlier a child's mouth is "colonised", the higher their risk of caries*. Saliva plays a critical role in protecting teeth and slowing the disease process. When we sleep the saliva flow slows down and, if a baby has a bottle of milk at night, the milk pools in the mouth and the rate of tooth breakdown is rapid. Fluoride also has a critical role, mainly through its topical effect on tooth enamel and, to a lesser extent, systemically on developing enamel.

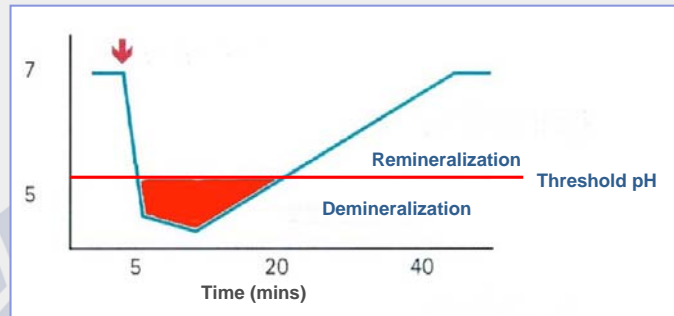
* **Note:** Do not place too much emphasis on the transmission of disease. We do not wish to adversely affect the mother/child attachment. **The biggest cause of ECC is prolonged inappropriate and prolonged use of a baby bottle.**

References:

Cameron A & Widmer R. Handbook of Paediatric Dentistry 2nd Ed 2003

Dela Cruz G, Rozier R, Slade G. Dental screening & referral of young children by pediatric primary care providers. Vol 114 No.5, 2004

Caries process: single sugar exposure



Below pH 5.5 calcium is lost from enamel

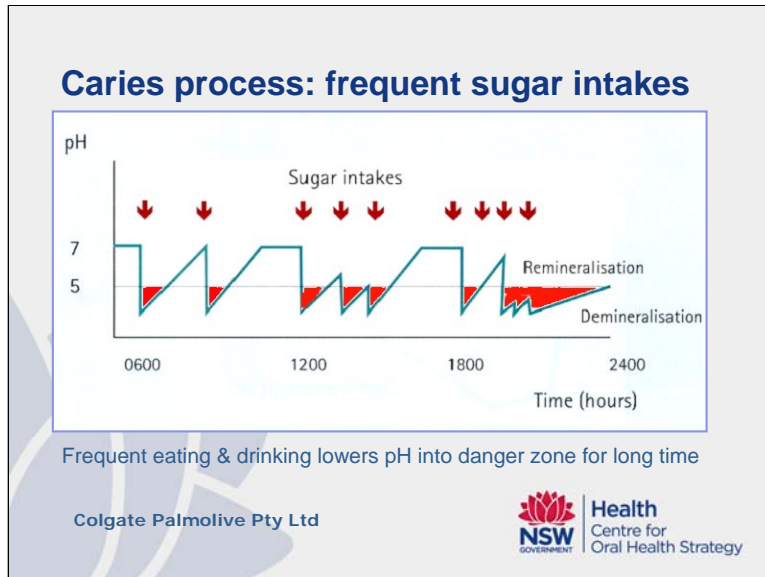
Colgate Palmolive Pty Ltd

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The Stephan Curve describes the changes in pH occurring within dental plaque when it is subjected to a challenge, typically with a foodstuff.

When challenged with a fermentable carbohydrate, the pH within plaque drops rapidly and then rises back to the resting pH more slowly.

Factors affecting the shape of the Stephan Curve include the microbial composition of the plaque; the nature of the fermentable substance; the rate of diffusion of bacterial metabolites, salivary components such as bicarbonate and the fermentable substance; salivary access to the plaque; saliva flow rate.



Cariogenic challenge is the area of the Stephan Curve below the critical 5.5 pH.

This diagram highlights the importance of the frequency of cariogenic challenge to the risk of developing caries.

Reference:

Newcastle University UK, Bite-sized tutorial: Stephan Curve, Clinical Relevance
<http://www.ncl.ac.uk/dental/oralbiol/oralenv/tutorials/stephancurves2.htm>

Nature of ECC

- Mostly preventable
- Detectable
- Reversible
- First significant acquired pathology



12 month old with decayed incisors
Dr Norman Tinanoff



The nature of ECC is that it is:

- Mostly preventable with use of fluorides – water, toothbrushing
- Detectable early
- Reversible if treated early enough – research has indicated that early access to oral health care is critical in reversing the disease and preventing future disease
- Often the first significant acquired pathology in children
- May serve as a sentinel for other health-behaviour related risks for disease, plus Caries in baby teeth is the best predictor of caries in the permanent dentition
- **Can be used as a marker for social determinants, parental knowledge and care giving.**

References:

Mouradian W, Wehr E, Crall J. Disparities in children's oral health and access to dental care. JAMA 2000, 284:2625-2631

Edelstein B. Disparities in oral health and access to care: findings of National Surveys. Ambulatory Pediatrics, 2002. Vol 2, Issue 2, Pg 141-147

Predictors

- Poor oral hygiene
- Prolonged and inappropriate bottle use
- Frequent consumption of high sugar foods
- Coating pacifiers with sweeteners
- Family members with active tooth decay



Behavioural Risk factors that contribute to ECC:

- Irregular oral hygiene regime. Parents and caregivers not brushing their own teeth daily. Delayed commencement of tooth brushing.
- Frequency of food intake and consumption of fermentable carbohydrates, eg juice, milk, formula, soft drinks
- Infants and children tend to snack “graze” , which contributes to the frequency of food intake.
- Past caries experience – consider siblings and parents. During pregnancy, visit to the dentist is recommended to eliminate active decay.

Note: Although there are many risk factors for tooth decay, the local effect of dietary sugars has a fundamental role in the disease.

Reference:

Sheiham A. Dietary effects on dental disease. Public health Nutrition 2001 (4): 569-591.
Cambridge University Press

Predictors

- No fluoridated public water supply
- Low education/income
- Culturally and linguistically diverse
- Special health care needs

Environmental risk factors put Certain population groups at increased risk:

Lack of fluoridated water has a significant impact on families living in remote and rural locations (including many Aboriginal communities). As well as being disadvantaged by lack of fluoridation they are also less likely to receive other preventive interventions due to poor access to services.

Level of education can affect understanding of disease prevention. Low education often equates with low income which also impacts on ability to seek care, buy oral hygiene products.

Cultural background and level of acculturation can affect individual knowledge, attitudes and beliefs concerning oral health as well as influencing dietary habits, putting refugees and immigrants at increased risk.

Special health care needs eg, Downs syndrome, cleft lip/palate and medically compromised people are compromised in their ability to access services and maintain a preventive regime.

This has profound implications for society's most vulnerable groups who are also more likely to i) have the highest rates of exposure to risk factors such as smoking, substance abuse, physical inactivity and poor nutrition; ii) make the most use of primary and secondary health services but the least use of prevention and health promotion services; and iii) are much more likely to die earlier and experience higher rates of illness and disability than people from the least disadvantaged groups.

Reversible

Healthy teeth



White spot demineralisation



1. Oral Health Services WA
2. Edelstein & Foley, 2006
3. Oral Health Services Tasmania

ECC typically, but not necessarily starts as a dull white band on the smooth surface of the tooth at the gum line, followed by yellow discolouration.

This early stage is often referred to as white spot lesions.

Depending on many factors, including saliva pH, removal of plaque, fluoride presence, and modification of substrate, **white spot lesions can become remineralised**. Ideally **this is the time to begin treatment interventions, primarily using fluoride products**.

Note: If left untreated, white spots will progress to cavities (holes in the teeth).

No longer reversible



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Frank cavitation is the next stage in ECC:

- Discolouration of the enamel near the gums.
- Darker stained areas combined with rough chalkiness on tooth surface
- Large pits.
- Destruction of tooth enamel.
- White chalky edges to cavities.

Note: This can only be treated by surgical repair at a dental clinic or, more commonly at this young age, under general anaesthesia in hospital.

Rampant decay

18 month old child



Drs Cameron & Widmer



Dr Norman Tinanoff



Eventually only a small amount of tooth enamel remains and the crown of the tooth breaks off leaving only a decayed stump. At this stage the tooth is dead and abscesses will form.

This will impact on diet and normal growth: The child may not eat enough or may have a modified diet that does not contain all the nutrients required for healthy growth and development.

Baby teeth are important to:

- Hold the **space** of the dental arch until the **permanent teeth** erupt. Early loss can lead to expensive orthodontic treatment.
- **Assist in normal development of facial structure.**
- **Improve self esteem.** Children with ECC may be reluctant to smile and be embarrassed about the appearance of their teeth.

Consequences of Dental Caries

- Pain
- Problems sleeping, eating
- Decreased learning capacity
- Post-operative morbidity
- Social dysfunction



Department of Public Health,
Connecticut




Poor oral health can profoundly affect a child's health and well being. Early tooth loss caused by advanced tooth decay can result in failure to thrive in young children. Dental problems can result in many hours lost from attending school, costly emergency dental care, and hospital-based medical and surgical treatments under GA. Poor oral health has been related to decreased school performance, poor social interaction and fewer achievements later in life.

Research into postoperative morbidity. Majority of children who undergo general anaesthesia suffer next day morbidity and many still have symptoms a week later. Most children were dentally anxious following a general anaesthesia for dental reasons – related to induction distress and postoperative morbidity.

Children are often unable to articulate their oral pain. Teachers may notice a child who is having difficulty attending to tasks or who is demonstrating the effects of pain – anxiety, fatigue, irritability, depression, and withdrawal from normal activities, but cannot understand these behaviours if they are not aware that the child has a dental problem.

References:

Bridgman CM, Ashby D, Holloway PJ. *An investigation of the effects on children of tooth extraction under general anaesthesia in general dental practice.* BDJ, 1999

Harrison M and Nutting L. *Repeat general anaesthesia for paediatric dentistry.* BDJ Vol 189. No. 1 July 2000

Hosey MT et al. *Dental Anxiety, distress at induction and postoperative morbidity in children undergoing tooth extraction using general anaesthesia.* BDJ Vol 200 No. 1 Jan 2006

'Open Wide' Connecticut Department of Public Health

Why have collaborative partnerships?

- Access to families with young children
- Early intervention critical to prevention
- Prevention requires a variety of strategies
- Child health professionals are effective educators



Research has indicated that access to early oral health care is critical in the early identification and prevention of tooth decay which can prevent widespread destruction of the teeth and expensive dental treatment in a hospital under general anaesthesia.

Dental Professionals have:

- limited access to infants and young children, generally only seeing them once the disease process is advanced, and
- limited expertise in engaging with and guiding new parents.

On the other hand, Child health professionals:

- see families regularly (have access to families)
- are experts in preventive strategies (already have skills, to influence)
- can advocate for oral health to be included in general health
- can assess the need for referral (engage with and guide new parents)
- can provide basic oral health messages (can establish family patterns).

There is also compelling evidence to suggest that Child Health Professionals can be effective oral health educators following a brief education session.

Reference:

Gussy M, Waters E, Walsh O, Kilpatrick N. Early childhood caries: current evidence for aetiology and prevention. J Paediatrics and child health. 2006, Vol 42, Issue 1-2, Pg 37-43

Vulnerable families: Case 1



Interactive treatment planning
Mackie IC & Blinkhorn AS
ISBN 1 898274 07 X



Lindsay, 3 years of age.

- 1. Reason for attendance:** Lindsay is the son of an agoraphobic mother and regular visits to the dentist are very difficult. Lindsay's father was concerned that his front teeth had snapped off following a minor fall.
- 2. Personal History:** he has had pain "on and off" for months but sleep pattern has not been disturbed.
- 3. Medical Hx:** Asthmatic – currently taking 2mg of Ventolin syrup twice a day, with one dose taken at bedtime. Mother thinks medicine may have weakened his teeth. Painful teeth – 2 teaspoons Panadol given at bedtime every night for past 12 months to aid sleep. No other medical problems.
- 4. Dental Hx:** this is Lindsay's first dental visit.
- 5. Social Hx:** Mother housebound by agoraphobia, father on shift work so finds visiting the dentist difficult. Lindsay is an only child. Mother suffered post-natal depression which is further manifested by the current agoraphobia problems.

Clinical examination: Rampant caries, anterior open bite.

Note: Anterior open bite is caused by overuse of bottles, dummies or finger/thumb sucking. This does not usually require clinical intervention unless the habit persists until the permanent teeth begin to erupt (approx age 5-6).

Reference:

Mackie IC, Blinkhorn AS. Interactive treatment planning manual for children with active caries. Eden Bianchi Press UK. ISBN: 1 898274 07 x



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Treatment:

As Lindsay is asthmatic, plus there are social problems, a hospital admission is recommended.



Treatment:

1.6 upper teeth and 4 lower teeth extracted under GA. One lower molar and one upper molar restored at the same time but if unsuccessful, consider these teeth as candidates for future extraction.

2.Preventive advice – dietary, fluoride toothpaste and sugar-free medicines.

Outcome:

The father did not keep a recall appointment and failed to respond to a reminder letter.

This case demonstrates why a partnership approach to disease management and family support is essential. If primary health professionals are aware that the family has failed to keep dental appointments they can intervene and assist with transport, emotional support etc.

Consequences of Dental Caries: Case 2



Mackie IC & Blinkhorn AS, ISBN 1 898274 07 X



Chantelle, 3 years of age.

1. **Reason for attendance:** Chantelle was brought to the surgery by her parents because they were becoming worried about the appearance of her front teeth and intermittent pain on eating.
2. **Personal history:** She is the third of four children. Her older brother and sister both suffered early loss of primary teeth because they “came through bad”. Her mother thinks that her children have inherited “soft teeth” – their father had dentures by the age of 25 yrs.
3. **Medical Hx:** Fit and well.
4. **Dental Hx:** Chantelle has never been to a dentist before.
5. **Social Hx:** Father unemployed, 4 children in the family under six years of age, and they live in a public housing flat.

Note: Communication skills play an important role in behaviour guidance. The most important tool you have is your own genuine concern and caring for the children and their families. Interview and involve the parents to develop strategies that are most likely to be successful for the family. Try not to be critical about their lack of understanding of the problem.

Reference:

Mackie IC, Blinkhorn AS. Interactive treatment planning manual for children with active caries. Eden Bianchi Press UK. ISBN: 1 898274 07 x



Clinical examination: Rampant caries, Sinus 51.



Chronic abscess 75.

Treatment:

1. Extract carious teeth under general anaesthetic (all 10 upper teeth and 4 lower teeth).
2. Follow up with preventive advice:
 - a. Stop using the bottle
 - b. Fluoride toothpaste recommended
 - c. General dietary advice given to the family.

Outcome:

The whole family attends regularly for preventive advice.

Traditional treatment

36 months old: repaired but not healthy

- Necessary
- Costly and traumatic
- Can recur



Dr Norman Tinanoff



Surgical repair is necessary to restore function and/or relieve pain. If not treated, it can significantly impact on quality of life through pain and problems with sleeping, eating and behaviour.

When treatment requires hospitalisation the costs increase dramatically. The cost of a GA procedure in the public sector is conservatively estimated at \$3000. This compares with the cost for early intervention (3 appointments plus provision of fluoride products) which is estimated to be approximately \$300. If siblings are also treated the potential for savings increases.

Treatment does not stop disease progression (repaired but not healthy), and recurrence is frequent, frustrating and costly.

A Glasgow study found that, of 5,000 children treated annually under GA, 25% returned for further extractions within the same year.

References:

Bridgman CM, Ashby D, Holloway PJ. An investigation of the effects on children of tooth extraction under general anaesthesia in general dental practice. BDJ, 1999

Hosey MT et al. Dental Anxiety, distress at induction and postoperative morbidity in children undergoing tooth extraction using general anaesthesia. BDJ Vol 200 No. 1 Jan 2006

Effects of prolonged bottle use: Case 3



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Sophia, 3 years of age.

Reason for attendance: Toothache, disturbed sleep patterns

- 1. Personal History:** Both parents work long hours running a restaurant on the South Coast of NSW. They relied heavily on the Sophia's grandmother who came to live with them from Italy to help care for her.
- 3. Local environment:** No fluoride in local water supply and family on tank water anyway. Community believes strongly in natural remedies.
- 4. Diet Hx:** Not many sweets given but child relied heavily on bottles – poor eating habits. Grandmother put to bed with a bottle of camomile tea and honey (traditional Italian use for the calming effect; honey used as a “healthier” alternative to sugar).
- 5. Medical Hx:** Child had sleeping and settling difficulties. Frequent antibiotics for middle ear infection. Visits to the doctor included examination of tonsils but the doctor did not look at the teeth. Iron deficiency – anaemia.
- 6. Dental Hx:** Tooth brushing was irregular at night because, while the parents understood the importance of good oral hygiene, they were not present in the evenings. The grandmother traditionally only brushed in the morning and did not realise that teeth should be brushed before bed.

Clinical Examination: Rampant caries - 15 out of 20 primary (baby) teeth affected by decay.

Treatment: Limited access to GA in country areas. Child was treated in the dental chair using intensive behaviour management techniques. Underwent extensive dental work over many years. Constant re enforcement of oral hygiene and diet to family through regular recall appointments.

Outcome: oral health is now stable (at 10 years of age).

Intervening early makes sense

- Child with one cavity in their baby teeth is 5 times more likely to develop new cavities
- Child with decay = adult with decay
- Treatment of established problems is not sustainable



There are strong arguments for shifting the focus of service provision to children aged 0-5 years:

- A UK study found that children who presented on their first visit to the dentist with one cavity in their baby teeth are five times more likely to develop new cavities in their baby teeth than those who were caries free when they presented.
- Reviews of caries risk prediction models conclude that the presence of carious lesions in the primary incisors is the best predictor of future caries development.
- Economic returns on initial investments are much higher in the early years than when children are older.

These findings have profound implications for the management of the dental care of young children.

References

- Tickle M, Threlfall AG, Milsom KM, Blinkhorn AS. The occurrence of dental pain and extractions over a three year period in a cohort of children aged 3-6 years. *Journal of Public Health Dentistry*. doi:10.1111/j.1752-7325.2007.00048.x
- Li Y, Wang W. Predicting caries in permanent teeth from caries in the primary teeth: an eight year cohort study. *J Dent Research*, 2002. Dec 81 (8):561-6
- Heckman JJ & Masterov DV 2004. *The productivity argument for investing in young children*. Committee on economic development working paper No 5, Washington, DC: Committee on economic development

Why do we need your help?

- Access to families with young children
- Prevention of painful disease
- Focus action on high risk groups
- Build sustainable programs



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By the time that children start school, any child that is likely to develop tooth decay already has the disease. Yet visits to the dentist for children aged 0-5 remain infrequent and episodic, mainly occurring when the disease process is advanced.

Why worry?

Early childhood is the time when most lifetime habits are established. It offers the greatest opportunity for prevention of disease which, in turn, can contribute to better health in adulthood.

We can't do this without you. Child health professionals:

- see families regularly (have access to families)
- are experts in preventive strategies (already have skills, to influence)
- can advocate for oral health to be included in general health
- can assess the need for referral (engage with and guide new parents)
- can provide basic oral health messages (can establish family patterns).

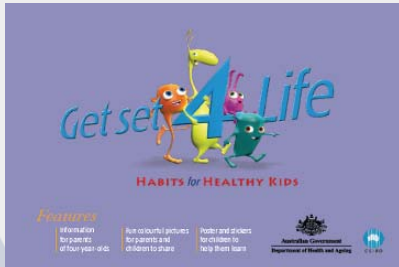
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References

- Gussy M, Waters E, Walsh O, Kilpatrick N. Early childhood caries: current evidence for aetiology and prevention. J Paediatrics and child health. 2006, Vol 42, Issue 1-2, Pg 37-43
- Dela Cruz G, Rozier R, Slade G. Dental screening & referral of young children by pediatric primary care providers. Vol 114 No.5, 2004

Prevention a National priority



Item Name	Item No.
Health assessments, GPs	701, 703, 705, 707
Health assessments, PNs & registered Aboriginal Health Workers	10986

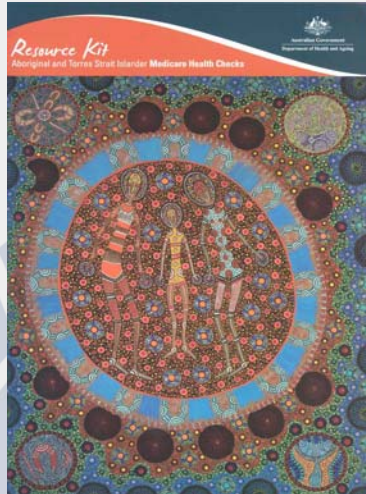


The Commonwealth Government has demonstrated its commitment to early intervention and prevention by providing Medicare item numbers for GPs, Practice Nurses and registered Aboriginal health workers to conduct a Health Assessment for children aged 4 years.

At 4 years of age it is often too late to prevent ECC. If a child has risk factors and no preventive action has been taken, they will more than likely already have tooth decay.

However, the 4 year check still provides an opportunity to ensure that all children start school dentally fit and involves GPs and Practice nurses in identification of oral disease and referral to dental services for the first time.

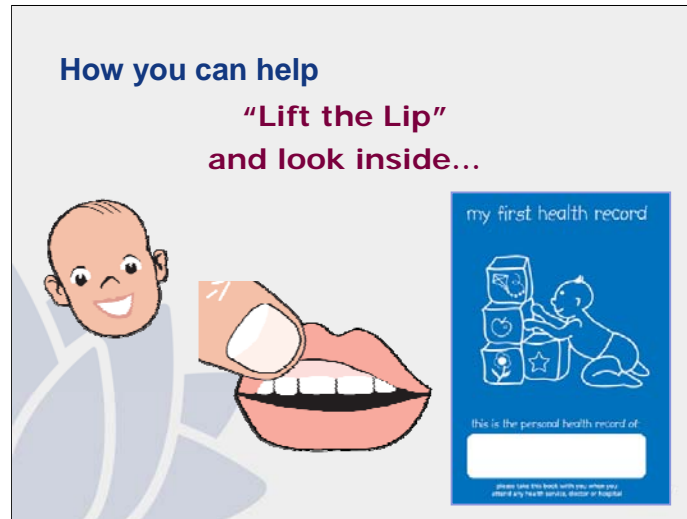
Prevention a National priority



Item Name	Item No.
Aboriginal and Torres Strait Islander Health Assessment	715



The Medicare item number 715 provides a child health check for Aboriginal children aged 0-14 years. This includes an oral health assessment so it is important that everyone who conducts Aboriginal child health checks understands the risks for and signs of dental disease.



The Lift the Lip slogan is an international term that is simple to understand and very easy to comply with. Since 2007 the NSW Health Personal Health Record has included information on oral health, along with prompts to lift the lip and to assess risk factors for oral health. The inclusion of oral health in this health record has been a major driver for oral health to develop and cement collaborative partnerships with general health professionals.

To recap:

- ECC is prevalent, predictable and preventable.
- child health professionals are better placed to engage with and influence new parents than are oral health professionals.
- Establishing clear referral pathways for early intervention is critical to good oral health.

The Child Personal Health Record (Blue Book) 2007 contains precise accurate oral health information :

- Prompts to lift the lip and check for oral health risk factors from 6 months of age and at every child health check thereafter to 4 years of age.
- Additional questions about bottle use, teething and toothbrushing at the 12 month child health check.

Lifting the lip allows us to assess the condition of the top front teeth – the first teeth to be affected by ECC. Decay in these teeth is often overlooked because the top lip covers the affected area.

Knee to knee examination



Westmead Centre for Oral Health



It's a partnership – parents, child health professionals, oral health professionals.

Due to current resources, oral health staff cannot see every child aged 0 to 5 years. However, we need to see any child that is at risk promptly. This is why we ask that primary health providers:

- Identify children at risk by assessing behavioural/socio-environmental risk factors.
- look for and recognise the signs of dental disease.
- Know where to refer for dental treatment.

Commonly asked question: “When should my child have their first (dental) check up?”

Answer: “ideally by their first birthday” (Either by an oral health professional or a Child Health professional with training in oral health)

There are different ways to conduct a Knee to knee Lift the Lip assessment:

In this example the child sits on their parent's lap, facing the parent. The parent gently leans them back so their head is resting on the health professional's lap. With gloved hands, the health professional lifts the lips and checks the health of the teeth and surrounding soft tissues.

If you are conducting the checks in a preschool environment, sit in a chair and ask the child to stand in front of you. A small torch could be helpful.

What to look for:

- ✓Pale pink, moist gums.
- ✓No ulcers, lumps or sores.
- ✓The teeth should have a whitish hue, be smooth and glossy, except for the biting surfaces of the back molar teeth, which will be grooved and pitted.

Danger signs:

- Plaque – colourless film that forms on the teeth. Can be easily removed with gauze.
- White spot lesions
- Gross cavities.

(refer to page 3 in the ECOH Guidelines)

Tip: If a toothbrush is available you can use it to assist you in your examination

Referral to oral health services

- Discuss findings
- Public/private options
- Fax referral form

The form is titled 'NSW HEALTH ECOH' and is for a referral to oral health services. It includes the following sections:

- PATIENT INFORMATION:** Includes fields for Medicare Card No., Reference No., Home phone No., Mobile No., and Work No. There are checkboxes for 'Interpreter required' and 'Aboriginal health officer required'.
- REFERRING PRACTITIONER CONTACT DETAILS:** Includes fields for Name, Profession, Signature, Practice Name & Address, Phone, and Email.
- REASON FOR REFERRAL (optional):** A text area for the referring practitioner to provide details.
- PARENT/GUARDIAN CONSENT TO FORWARD FORM:** A section for the parent or guardian to sign, stating they consent to the form and their child's details being sent to the Public Oral Health Services for a dental appointment.
- Referring practitioner forms signed here for a verified intake number for processing:** Includes a field for 'Area Health Service office use only' and 'Processed on (DATE)'. There is also a 'Destination AHD' field.

Procedure:

1. Dental need identified
2. Public/private treatment options discussed
3. Private – advise parent to make an appointment with their family dentist. Make a note in their file
4. Public – complete referral form. Parent must sign consent
5. Fax form to oral health services
6. Oral health services will send feedback after client has been appointed/treated.

Note: A list of contact numbers for public oral health services can also be found in the ECOH guidelines (Page 31).

If contacting a public oral health service directly, parents should be informed that they will be dealing with a call centre and should have their Medicare card handy.

Contact details for private practitioners can be found on the ADA website (refer to ECOH guidelines pg 31).



Every parent/primary caregiver should receive a copy of the Lift the Lip brochure, or the Aboriginal-friendly See my Smile brochure.

- Aims to shift the locus of power so that parents can take responsibility for their children's health and wellbeing.
- contains simple messages, and relies heavily on graphics, translated into 15 languages

Healthy mouths for kids - clear and simple messages Eat well; Drink well; Clean well; Play well; Stay well.

Posters are available for display in clinics and waiting rooms.

Oral health resources, including the ECOH guidelines, may be ordered from the Better Health Centre:

- Ph: 02 9887 5450
 - Fax: 02 9887 5452
- (website provided on final slide)

Clean well ...



Important to assist and supervise children until at least 7 yrs of age:

- Standing or kneeling behind the child in front of the sink or mirror is often the easiest way to effectively brush a young toddlers teeth.
- Toddler sits or stands in front of adult, both facing a mirror where possible.
- Adult stands behind toddler, supporting the head and looking directly into mouth. Adult can support the child's chin with one hand and brush teeth with the other hand.
- Standing behind the child minimises the risk of the child reversing away from you if you were to attempt to brush the child's teeth standing in front of them.

For toddlers:

- Over 18 months of age, use a small smear of fluoridated toothpaste on a small soft toothbrush.
- Specially designed fluoride toothpaste with low fluoride levels are available for children younger six years of age.
- Encourage child to spit out toothpaste. Children should not swallow toothpaste.
- Don't rinse.
- Nothing to eat or drink after brushing at night.
- Reinforce good behaviour.

References

Australian Research Centre for Population Oral Health. The use of fluorides in Australia: guidelines. Aust Dent J 2006; 51(2):195-9



Encourage drinking of **tap water** from an early age, this is the **preferred in between meal drink**.

With regard to fluoridation of public water supplies:

1. **Effective** – proven population decay reduction
2. **Safe** – constant monitoring of the fluoridation process and continuous research for more than six decades has affirmed the safety of water fluoridation
3. **Equitable** – benefits the entire community
4. **Cost-effective** – 13:1 return on investment over 25 yrs (conservative calculation)
5. **Requires no behavioural change** – provides consistent and reliable results
6. **Enjoys community support** – continuous NSW health Survey since 2005 shows 85% community support

NH&MRC Public Statement 2007:

Recommendation: Fluoridation of drinking water remains the most effective and socially equitable means of achieving community wide exposure to the caries prevention effects of fluoride.

Australian Research Centre for Population Oral Health guidelines:

- Fluoride supplements in the form of drops or tablets ... should not be used.
- Supplements rely on compliance by parents and children at home and have shown little benefit. The younger the children, the weaker the benefit but the greater the risk of dental fluorosis.

References:

Australian Dental Association: Fluoride Now. <http://www.ada.org.au/oralhealth/fln/fluoridation.aspx>

NHMRC Public Statement: The efficacy and safety of fluoridation 2007. www.nhmrc.gov.au

Australian Research Centre for Population Oral health. *The use of fluorides in Australia: guidelines*. Aust Dent J 2006; 51(2):195-9

Eat well ...



Discuss food choices to meet daily dietary needs and offer advice to support good oral health. For example:

Eat cheese to finish a meal (creates a buffer to prevent acid attack on teeth).

Restrict frequency of consumption of sugary foods and sweet drinks. For example, sweets (if used as a reward or special treat) should be eaten at meal times.

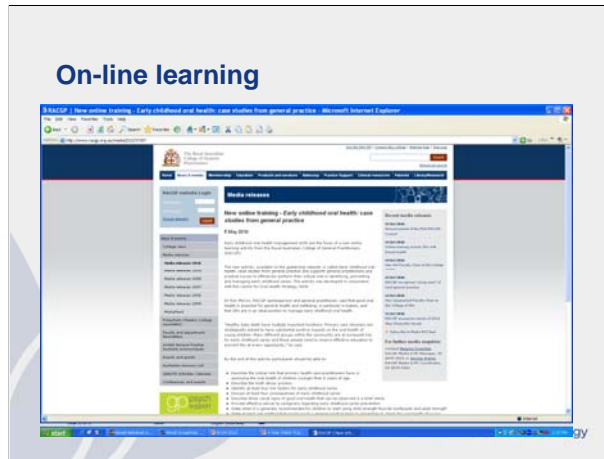
Choose sugar free medication (tablets as an alternative – when child is old enough).

Limit grazing between meals to 2-3 healthy snacks per day (young children need to “graze”).

Reference:

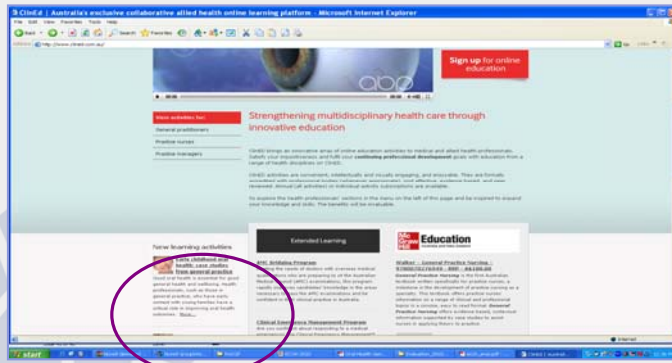
Commonwealth of Australia, 2003. Dietary guidelines for children and adolescents in Australia, National Health and Medical Research Council, Canberra.

On-line learning



RACGP Members may also access on-line learning in Early Childhood Oral Health. Undertaking this module will reinforce today's learning.

On-line learning



<http://www.clined.com.au/>



Access to the oral health activity is available to non RACGP members on the Clin-ed website. Oral health activity is currently FREE.

Thank you for your time and attention



www.health.nsw.gov.au/cohs/resources.asp



Order details for resources to be advised in 2011.