Increasing dental attendance by poor families or families from deprived areas
The evidence summary is based on the original summary published in the BDJ (February 2010). It aims to identify and summarise studies that evaluate the effectiveness of different approaches for increasing dental attendance by families from deprived areas in the UK. It does not include detailed descriptions of the studies cited nor does it include information that was not presented in the literature.

The Curious about website encourages dental professionals to raise issues where a review of the available evidence would provide a useful resource for other dental professionals. Where there is a lack of evidence, the topic is considered for research and an award is made available.

These activities are sponsored by the Shirley Glasstone Hughes Fund, a restricted fund within the BDA Trust Fund.
Key finding

- The most effective approaches for increasing dental attendance in families from deprived areas are a mobile dental unit at school premises and a dental access centre.

Review question

This evidence summary was prepared in response to the following question: What is the effectiveness of alternative approaches for increasing dental attendance by poor families or families from deprived areas?

Key terms

Deprived:
A characteristic of areas or households which denotes low socioeconomic status or social deprivation.

Dental attendance:
A frequency or proportion visiting a dentist within a particular period; or attending the dentist within a given period; registration rate.

Families:
Households with children and/or poor/deprived households in general.

Effective:
Some increase in a measure of dental attendance (or proxy).

The case for action

Oral health has improved remarkably over the last 40 years. In 1968 37 per cent of adults (16 years and over) in England and Wales were edentate while in 2009 the figure for England, Wales and Northern Ireland combined stood at 6 per cent. Though there has been a profound change in oral health status a clear disparity exists between households in the highest occupational classification and those from the lowest. Socioeconomic factors are key determinants of oral health inequalities and despite on-going government commitments to tackle them they still exist in the UK.

The 2009 Adult Dental health Survey illustrates the impact of socioeconomic class on many areas of oral health and function (e.g. dentate adults, pain, decay, caries and urgent conditions) as well as perceived dental health with those in the lowest occupational classification groups fairing the worst. This divide is also visible in children in the UK with those from low socioeconomic status families showing higher caries prevalence, fewer caries-free teeth, fewer sealants and more untreated lesions.

It is recognised that those falling into the lower socioeconomic groups are among the least likely to use dental services even though regular dental attendance is associated with a better quality of life and better oral health.

The evidence

Overall, from the studies located, the two approaches most effective in increasing dental attendance in families from deprived areas are a mobile dental unit at school premises for child patients and a dental access centre for adults.

The evidence collected, describing different approaches for increasing dental attendance by families from deprived areas, has been grouped under headings according to the intervention setting.

School dental screening

Three studies in children focused on school dental screening. A mobile dental unit in primary school grounds is the most effective method to increase dental attendance in children. The mobile unit increases attendance, treatment acceptance and completion and removes barriers to care such as travel to clinic, remembering the appointment and family circumstances.

Less successful approaches involve a ‘new model’ of dental screening using specific referral criteria and delaying screening until after children needing treatment are identified. Both approaches increase dental attendance but the majority of children derive little benefit as many children with unmet dental needs do not access dental services.

A health visitors and GDPs collaborative

Access to dental care for 0-2-year-olds improves with a community based dental registration and access programme. Oral health education and dental registration vouchers given to mothers of new infants by health visitors increases dental registration although
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this increase does not extend to older preschool children in the household.

A dental health promotion display in a shopping centre
A dental health display targeting adults in the shopping centre serving a deprived area increases the number of parents taking their children to the dentist. The display effectively increases knowledge and raises awareness of risk factors but is less effective at enticing people themselves to the dentist.

A dental access centre
Dental access centres offer treatment to a different patient population than neighbouring 'high street' practices. Patients are more likely to be smokers, have worse oral health, be more likely to attend only when in pain, be less likely to view dental attendance as important, be under 35 years old and be dental charge-exempt.

Methods

Search strategy
The following resources were searched:

- Ovid MEDLINE (limited to dental journals and the UK)
- Centre for Evidence-Based Dentistry
- Cochrane Oral Health Group
- Centre for Reviews and Dissemination
- American Dental Association

Search terms for Ovid MEDLINE were ‘attendance/health services accessibility’ and ‘socioeconomic factors/poverty/deprivation’ combined with ‘dentist’.

Searches were originally carried out in September 2009 and repeated in February 2015.

Results
Six publications were found. All were observational studies with a low quality of evidence.

References

9. French A D, Carmichael C L, Furness J A, Rugg-Gunn...


