The Scottish dental practitioner's role in managing child abuse and neglect

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VERIFIABLE CPD PAPER

IN BRIEF

- Illustrates that 37% of Scottish GDPs have suspected child abuse/neglect but only 11% have referred a case.
- Identifies common barriers to referral.
- Suggests the majority of Scottish GDPs are willing to get involved in detecting neglect.
- Suggests there are large numbers of GDPs who have an appetite for further training in identifying and reporting suspected cases of neglect.

RESEARCH

Background In 2005 Cairns *et al.* published a paper (*Int J Paediatr Dent* 2005; **15:** 310–318) examining the role of the general dental practitioner (GDP) in child protection (CP) in Scotland. This involved a questionnaire sent out to Scottish GDPs in 2003. Subsequently in 2006 all UK dental practices were sent *Child protection and the dental team*, a manual detailing roles and responsibilities with regard to CP. During this time the profile of CP within dentistry increased. There has been no published research since 2006 investigating whether the gap between the proportion of GDPs who suspect child abuse/neglect in their patients and those who refer cases has changed. **Aim** The aim of this research was to investigate whether this gap has changed between 2003 and 2010. **Method** A postal questionnaire based on that used by Cairns *et al.* was sent to 50% of GDPs in Scotland in March 2010. **Results** The response rate was 52% (53% male). Some 29% and 55% of respondents had received undergraduate or postgraduate training in child protection respectively. Over two thirds (37%) had suspected child abuse/neglect in one or more of their paediatric patients but only 11% had referred a case. The most common factor affecting the decision to refer was 'lack of certainty of the diagnosis' (74%). Some 77% thought that abused/neglected children had an increased caries increment and 73% of dentists were willing to get involved in detecting neglect. **Conclusion** Dentists in Scotland appear to be suspecting and referring more cases of child abuse/neglect than previously. The vast majority are willing to get involved in detecting neglect.

INTRODUCTION

Dentists are in a position to identify physical abuse in their paediatric patients.[1–4] They may be even better placed to diagnose dental neglect as a stand alone health issue or as part of an overall picture of general neglect.[5] Additionally previous research has shown that children who have experienced abuse/neglect have a higher incidence of caries and other oral diseases.[6–8]

Previous work by Cairns *et al.*[9] published in 2005 showed that although 29% of dentists in Scotland in 2003 had suspected child abuse only 8% had referred these cases on to the appropriate authorities. This disparity has also been described in the UK by Welbury *et al.*[10] with regard to general dental practitioners (GDPs), by Harris *et al.*[11] for dentists and dental care professionals with an interest in paediatric dentistry and by Chadwick *et al.* for dental therapists.[12] The phenomenon of under-reporting is also an international problem.[3,13–19]

In 2006 all dental practices in Scotland were sent a document entitled *Child protection and the dental team*.[20] This is a training manual aiming to improve knowledge on the signs and symptoms of child abuse and neglect along with information regarding appropriate generic referral protocols. In addition to this, NHS Education for Scotland started to fund inter-agency postgraduate training courses for dental teams on the topic of child protection (CP). Training in CP is also a core topic in vocational training/dental foundation programmes and forms part of the undergraduate dental curriculum in UK dental schools.

In addition there have been recent discussions on issues of dental neglect as a stand alone issue and also its relationship to an overall picture of general neglect in children. This has led to the publication of guidance on this issue by the British Society of Paediatric Dentistry (BSPD).[21]

Overall responsibilities of UK dental teams with regard to CP are clearly outlined by the General Dental Council.[22]

AIMS

The aims of this research were to assess current knowledge and behaviours of GDP's in Scotland with regard to CP and to consider whether the increased amount of CP training had any impact on this. Another goal was to assess how willing GDPs are to get involved in detecting child neglect.

MATERIALS AND METHODS

A postal questionnaire based on that devised by Cairns *et al.*[9] was sent out to 50% of the GDP's in Scotland (n = 1,215). The questionnaire consisted of mainly closed 'yes or no' questions. The sample was selected by listing all the GDPs in Scotland by health board alphabetically and sending every second GDP a questionnaire. This

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unbiased selection system also gave an accurate representation from each health board. The original questionnaire was modified to include questions regarding neglect as well as abuse, and piloted with a small group of GDPs and recently qualified graduates. A prepaid return envelope was enclosed with each questionnaire. The questionnaires were posted in March 2010 with a covering letter. A second mailing was sent in July 2010 to non-respondents. All respondents were assigned a unique study number to ensure anonymity. Data was entered into an SPSS 17.0 database. Although there was missing data on some returned questionnaires all the received data was entered and where GDPs had not answered a particular question it was assumed that their response to a closed 'yes or no' question was 'no'. Where there is missing data for other questions the numbers of GDPs who did answer the question is reported in the results.

Statistical analysis

Statistical analysis was performed using SPSS 17.0. Analysis consisted primarily of observational statistics. Chi-squared analysis and the generation of p-values were used in cross-tabulations to explore comparisons.

RESULTS

Demographics

The response rate was 52%; this represents the views of 628 Scottish GDPs. Fifty-three percent of respondents were male. The majority of respondents had practices based in Greater Glasgow and Clyde (25%), Lothian (15%), Lanarkshire (10%), Tayside (9%) and Grampian (8%) health boards with the remaining respondents spread throughout the remaining nine health boards in Scotland. The majority of respondents worked in independent NHS practices (85%). Fifty percent of respondents were 20 years or more post qualification. These demographics were representative of the spread of GDPs in Scotland as a whole.[23]

Training and access to child protection guidelines

Twenty-nine percent (n = 185) of respondents had received formal undergraduate training in CP. Respondents were less likely to have received undergraduate CP training with increasing years since qualification (p <0.001). Fifty-five percent (n = 344) of respondents had received some postgraduate training in CP, most commonly a 'one-off' lecture.

Only 22% (n = 141) of GDPs who returned the questionnaire had been sent a copy of their local area CP guidelines when they first started work at their practice; however, 55% (n = 347) responded positively when asked if they had read the 2006 manual *Child protection and the dental team*.

In total 15% of Scottish GDPs in this sample had never had any form of CP training and nor had they read *Child protection and the dental team*.

Table 1 Factors influencing GDPs' decision to refer a suspected case of abuse/neglect

Factor influencing decision	%GDPs whose decision is influenced in this study	%GDPs whose decision is influenced in Cairns *et al.* 2005[9]
Concerns of impact on practice	6% (n = 38)	11%
Fear of violence to child	52% (n = 324)	34%
Fear of violence to GDP	31% (n = 195)	31%
Fear of litigation	35% (n = 220)	48%
Fear consequences to child from statutory agencies	46% (n = 286)	52%
Lack of knowledge of referral procedures	43% (n = 271)	71%
Lack of certainty of diagnosis	74% (n = 465)	88%

Table 2 Percentage of GDPs concerned about a child due to four different worrying behaviours

Option	%GDPs concerned
Irregular attendance	47% (n = 296)
Failure to complete treatment	43% (n = 270)
Returning in pain at repeated intervals	45% (n = 285)
Requiring repeat GA for extractions	37% (n = 233)

Table 3 Difference in percentage of GDPs concerned about a child due to four different worrying behaviours when training or reading *Child protection and the dental team* is considered

Option	%GDPs concerned about option in each group		
	With any training or seen manual	No training and never seen manual	P value
Irregular attendance	57%	38%	0.003
Failure to complete treatment	53%	32%	0.001
Returning in pain at repeated intervals	55%	38%	0.008
Requiring repeat GA for extractions	47%	34%	0.05

In all cases a higher proportion of the GDPs in the group who had received training or had read *Child protection and the dental team* were concerned about the options, than in the group who had not received training or read *Child protection and the dental team*

Practice

Thirty-seven percent (n = 235) of respondents had suspected child abuse/neglect in one or more of their paediatric patients but only 11% (n = 72) of all respondents had referred a case. This left 163 (26%) respondents who reported suspecting child abuse or neglect who either did not refer the case or declined to answer the question about referring. Of those 235 respondents who had suspected child abuse/neglect 94% (n = 220) had either had some form of CP training or had read *Child protection and the dental team*, this finding was statistically significant (p <0.001). When looking at the 72 GDPs who had referred 96% (n = 69) of those respondents had either had some form of CP training or had

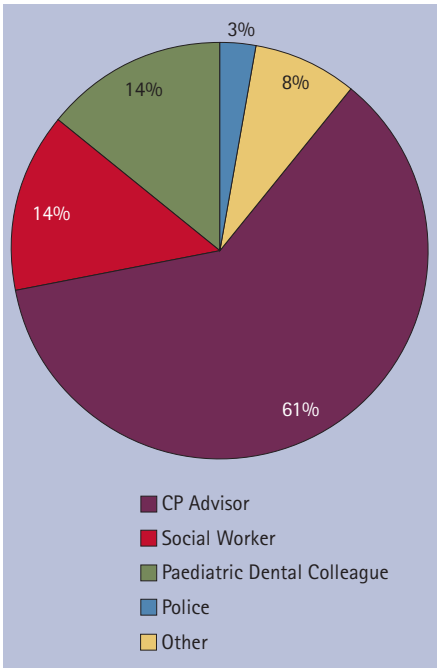

Fig. 1 Graph of agencies to whom GDPs would refer a hypothetical case of suspected child abuse/neglect

read *Child protection and the dental team*. Six percent (n = 37) of all respondents had seen a definite case of child abuse/neglect in the last six months. The questionnaire also directly asked, as a separate question, whether the GDPs had ever suspected a child was being abused or neglected but not referred the case. Seventeen percent (n = 107) admitted to this with 81% (n = 87) of these GDPs having recorded their observations in the patient's case notes.

Of all the GDPs who returned the questionnaire 77% (n = 485) the perception was that abused/neglected children had a higher caries increment.

Factors influencing practice

The GDPs were also asked about various factors that may affect their decision to refer a suspected case of child abuse/neglect (Table 1). The most common factor that affected their decision was 'lack of certainty of the diagnosis' with 74% saying this would affect their decision. The least likely factor to affect their decision was 'concerns about impact on the practice' with only 6% citing this as a factor influencing their decision to refer.

The GDPs were then asked, 'If you have pointed out a child's dental problems and offered appropriate and acceptable treatment did any of the following make you concerned about a child?' The percentages of GDPs citing each of the following factors as being of concern is shown in Table 2:

- irregular attendance
- failure to complete treatment
- returning in pain at repeated intervals
- requiring repeat GA for extractions.

When these results were cross tabulated with whether a GDP had received any CP training or had read *Child protection and the dental team* there was a significant difference between those who had training or had seen the manual compared to those who had not. For each of the four options (irregular attendance, failure to complete treatment, returning in pain at repeated intervals and requiring repeat GA for extractions) the proportion of GDPs who were concerned was higher for those who had training or had read the manual (Table 3).

Child protection procedures

Five hundred and ninety-three GDPs answered when asked what they would do in a hypothetical suspected case of child abuse/neglect and of these 60% (n = 358) would refer to their CP advisor. This is illustrated in Figure 1. The role of a CP advisor in Scotland is discussed later in this paper. A social worker was the next most common choice for referral (15%, n = 86) followed by a paediatric dental colleague (14%, n = 82), police (3%, n = 19) and other (8%, n = 46). 'Other' was most commonly the child's general medical practitioner (GMP). When asked if they would prefer to discuss their suspicions with a dental colleague before referring 88% (n = 526) agreed and a further 37% (n = 203) would choose to consult someone else before referring, most commonly the child's GMP.

Only 31% of all respondents (n = 193) knew who their CP advisor was. When looking at those GDPs with no training/had not read *Child protection and the dental team* only 2.4% knew who their CP advisor was compared to 38% of those who were trained or had read the manual (p <0.001).

Twenty-one percent (n = 129) of the responding GDPs were aware that inter-agency CP training courses were available in their area.

Most (63%, n = 398) felt that GDPs or other members of the dental team were well placed to recognize signs of abuse/neglect, however only 19% thought that GDPs were adequately informed about issues of CP. This was reflected in 73% (n = 458) saying that they would like further training to identify child neglect and 78% (n = 489) wanting further training on the mechanisms of reporting suspected cases of neglect. Eighty-eight percent of respondents thought that CP should be part of dental vocational training.

The GDPs were asked to indicate whether they agreed with the following statement, 'I am willing to get involved in detecting neglect', with a scale from strongly agree to strongly disagree. The spread of answers is shown in Table 4. This illustrates that 73% of GDPs who are willing to be involved in detecting neglect in their paediatric patients, with only 5% disagreeing they are willing to be involved and a further 19% neither agreeing nor disagreeing.

Out of all the responding GDPs only 1% (n = 4) sat on a multi-agency child protection committee and those that did were often involved through their church rather than as a dentist.

Table 4 Willingness of GDPs to get involved in detecting neglect

I am willing to get involved in detecting neglect	%GDPs
Strongly agree	21% (n = 132)
Agree	52% (n = 324)
Neither agree or disagree	19% (n = 120)
Disagree	3% (n = 19)
Strongly disagree	2% (n = 11)
Missing answer	3% (n = 22)

DISCUSSION

Training and access to child protection guidelines

Thirty percent of respondents had received CP training as an undergraduate. This

is higher than found by Cairns *et al.* in 2005. The more recently qualified dentists were more likely to have had CP training as an undergraduate. Some 55% of respondents had received postgraduate training in CP which is more than double that found by Cairns *et al.*[9] There has been an increase in the amount of CP training available to dentists in Scotland since 2005, most notably the inclusion of CP section 63 courses in Scotland. Child protection is also one of the topics covered in all vocational training schemes in Scotland. However, at present CP is not one of the GDC's core continued professional development topics, the authors continue to campaign to have this rectified.

Twenty-two percent of GDPs returning this questionnaire had been sent a copy of their local area CP guidelines. This is higher than found by Cairns *et al.*[9] and in the intervening seven years since the previous study all dental practices in Scotland were sent a copy of *Child protection and the dental team* manual. This study found that over half of the responding GDPs had read this document. However, as all the dental practices were sent the manual, which is also freely available online, it remains disappointing that this number is not higher.

Despite the increased proportion of dentists completing CP training/familiar with *Child protection and the dental team* there was a large number of GDPs who wanted further training in identifying and reporting cases of neglect (73% and 78% respectively).

Practice

Over a third (37%) of the dentists had suspected child abuse/neglect in one or more of their paediatric patients. This is higher than the results found by Cairns *et al.*[9] and may suggest an increased awareness of child abuse/neglect among dentists. A significant number of those dentists who had suspected abuse/neglect had either had some form of CP training or had read *Child protection and the dental team*. This suggests training and access to the manual may increase awareness. Alternatively, this difference could be as a result of dentists who have suspected cases of abuse/neglect actively seeking out training or reading the manual to help them in referring cases.

Seventeen percent of the dentists admitted they had suspected a case of child abuse/neglect but had not reported it when directly questioned about this issue. This is slightly lower than the results from the 2005 study[9] which may suggest that more of those dentists who do suspect cases are referring them. In addition the proportion who said they had referred a suspected case (11%) is also slightly greater than found by Cairns *et al.*[9] giving further support to this hypothesis. For the 17% who admitted they had suspected but not referred 81% of these dentists had recorded their suspicions in the clinical notes, which is higher than found in 2005.[9] Dental defence organisations stress the importance of maintaining accurate records. In suspected cases of child abuse/neglect it is important not only to document the clinical findings and supplement these with clinical images where possible but also to include what dental advice (for example, regarding diet and oral hygiene) has been given to the parent/caregiver. This is especially important in cases where the examining dentist may be called to give evidence in a CP case conference or hearing, as otherwise the parent or caregiver could argue that they had never been told what dental care, dietary modifications or oral hygiene measures were necessary.

It was the perception of the majority of respondents that children who are abused or neglected have a higher caries risk. Previous work by Green *et al.*,[6] Valencia-Rojas *et al.*,[7] and Montecchi *et al.*[8] have shown this to be the case in the USA, Canada and Italy respectively. The authors are currently involved in research to find out if this is the case in Scotland.

Factors influencing practice

The most common reason for not referring a suspected case of child abuse/neglect was lack of certainty of the diagnosis. Having had CP training did not appear to make a significant difference to this barrier despite dentists attending these courses being assured that it is not their responsibility to diagnose child abuse. This was also the most common reason for not referring in 2005;[9] however, the proportion of dentists who cited this as a reason is 9% lower in this study.

Fear of violence to the child and fear of consequences to the child from the involvement of statutory agencies were the second and third most commonly cited reasons for not referring. The proportion that cited fear of violence to the child was higher than that reported in the 2005 study[9] and this may reflect recent high profile deaths of children at the hands of their abusers in the UK.

The fact that GDPs are still concerned about the consequences to children from the involvement of statutory agencies may suggest that more inter-agency training is required. The topic of 'What happens next?' is covered in section three of *Child protection and the dental team*[20] and is also covered in CP training, but as this is something the dentist cannot control there may need to be further reassurances given about what happens after GDPs raise a concern. These reassurances can come from the national statistics for Social Work in Scotland which demonstrate that in the year 2010/11 out of 5,234 initial and pre-birth case conferences in Scotland, only 3,884 children's names were added to the child protection register, and many of these children were on the register for less than a year.[24]

Severe, untreated dental caries on its own is very concerning but it may also be part of the picture of generalised neglect and this has been well described in recent literature.[20,21,25] If a dentist has pointed out a child's dental problems and offered appropriate and acceptable treatment there are various factors that may then lead the dentist to have concerns about the child. In this study we asked the GDPs about four of these factors which are mentioned in the BSPD policy document[21] and *Child protection and the dental team.*[20] Nearly half of all the GDPs answering this question would be concerned by irregular attendance, failure to complete treatment, and returning-in-pain at repeated intervals with less being concerned about repeat GAs for extractions. A significantly higher proportion of GDPs who had child protection training or had read *Child protection and the dental team* were concerned about these issues compared to those without training or who had not read *Child protection and the dental team*. All these factors are indicators of dental neglect.[20,21] This suggests training in CP/reading the manual makes dentists more aware of the issue of dental neglect on its own, and as part of the wider picture of general neglect.

Child protection procedures

The majority of GDPs in this study would refer a suspected case of child abuse/neglect to their child protection advisor with the next most common referral agency being social work. This is encouraging as this study has already shown that the biggest barrier to referral is uncertainty over the diagnosis of abuse/neglect, so discussing your concerns with someone who is experienced in CP can be very reassuring for the dentist. This also ensures that each case can be investigated appropriately. Child protection advisors usually have a background in nursing and postgraduate qualifications in CP. In Greater Glasgow and Clyde there are six CP Advisors who all have a background in health visiting and, as well as their postgraduate qualifications, they have many years of experience in supporting and advising their colleagues in the health service. In other areas a similar role is that of the lead nurse for child protection.

Although 60% of respondents would refer suspected cases to their CP advisor only 31% knew who this person was. A significantly higher proportion of GDPs with training or who had read *Child protection and the dental team* knew who their CP advisor was. Identifying your local CP advisor is emphasised in child protection training. Additionally, in *Child protection and the dental team* an example flow chart of what to do if you have concerns about a child's welfare has a space to allow GDPs to write in the names and contact numbers of their local child protection nurse and in Scotland the details of the CP advisor could also be written here.

In this study 84% of respondents would prefer to discuss their concerns with a dental colleague before referring a suspicious case. It is likely that dentists feel more comfortable discussing their concerns with someone whose responsibilities and service they understand rather than a service they may never have dealt with. Similarly when the GDPs were asked if there was anyone not mentioned on the questionnaire that they would discuss a suspicious case with or refer a case to the most common answer given was the child's GMP. However GMPs may have similar barriers to referral as GDPs and therefore sharing information with a local CP nurse or advisor may be more beneficial. It is heartening to note that almost two thirds of dentists are willing to get involved in detecting neglect despite the barriers that they feel stand in the way of referring concerning cases.

CONCLUSIONS

Dentists in Scotland appear to be suspecting and referring more cases of child abuse/neglect than previously; however similar barriers to referral still exist. More dentists are receiving training on CP but there remains a very strong desire for further training. Most dentists also perceive that abused/neglected children have a higher caries increment. The majority are willing to get involved in detecting neglect.

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