RESEARCH INSIGHTS

Domestic violence and abuse in dentistry

Dentistry responding to domestic violence and abuse: a dental, practice-based intervention and a feasibility study for a cluster randomised trial. *Br Dent J* 2022; https://doi.org/10.1038/s41415-022-5271-x

Domestic violence and abuse (DVA) can occur in the form of physical violence, sexual abuse, financial abuse, psychological abuse and/or controlling behaviour between individuals in intimate relationships or family members. There are approximately 15.4 million incidents of DVA annually in the UK, which can have short- and long-term consequences for an individual's physical and mental health. COVID-19 has highlighted an increase in DVA due to household isolation.

Dental health care professionals have a paramount role to play in handling DVA, as studies show 65–95% of assaults involve trauma to the face, mouth and teeth. As a result, dental personnel are in a unique position to recognise, document and refer DVA for appropriate assistance.

Currently, there are policy frameworks and National Institute for Health and Care Excellence quality standards on DVA which mention that healthcare professionals should be involved in identification, supporting and referring to specialist advocacy services. Uptake and implementation of these policies and quality standards are low in dental services. Furthermore, there is limited DVA training currently within dentistry and referral pathways.

Within dental services, there are many more barriers to identifying, referring and supporting victims of DVA; these include lack of training, presence of a patient's partner or children, concerns about offending patients, funding, IT limitations and a dentist's embarrassment about raising the topic.

Currently in general medical practices (GMPs), with regards to DVA advocacy, there is evidence-based training and a referral pathway that has been developed and commissioned nationally in over 40 areas. The Identification and Referral to Improve Safety (IRIS) care pathway has been used widely within GMPs to identify and support patients experiencing DVA and has been shown to improve the identification and referral of victims and survivors to appropriate specialist support agencies. The IRIS care pathway has never been used within GDPs, and this study aimed to explore the feasibility of adopting a similar intervention via a cluster randomised trial design in Greater Manchester GDPs.

Six GDPs were recruited for the feasibility study, with all practice staff receiving training over three workshops. The training was adapted to a dental setting. The dentists were keen to adopt the IRIS intervention and utilise the referral pathway; however, there were problems with translating the pathway from GMPs to GDPs. There were difficulties with the GDP software as it does not provide prompts and data collection due to there not being a unified dental IT system. Furthermore, coding for DVA diagnoses, procedures and outcomes has not been developed in the UK. This made it hard to prompt the staff and collect data digitally.

However, there was not enough quantitative evidence available, and as such more data from more areas in addition to Greater Manchester is needed.

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Why did you decide to undertake this study?

Identification of domestic violence as the cause of injury is the role of all healthcare professions to whom patients present. Guidelines reference dentistry, but dental teams have not actively engaged as there has been little awareness and no training. We wanted to know if dental professionals would consider that it was indeed part of their role. Some of our GP colleagues have training and a defined referral pathway that has been shown to be effective in increasing identification and referrals to domestic violence agencies. We wanted to see if this model could be effective in dental practices.

Did any of the results surprise you?

Yes, I really wasn't confident that dental professionals would recognise their critical role in identification of domestic violence as their role within the practice of dentistry. We were delighted to learn that they developed a real understanding of the subject and embraced domestic violence identification and referral of patients as their dental responsibility. We were also interested to find that the dental team did not necessarily see the need to have personal contact with domestic violence agency advocates, which is a part of the standard model in many GP practices. We did struggle with the data collection as dental practices do not have the advantage of the unified IT and coding that GP practices have. We had hoped that this would not make a big difference to our study, but it did affect the quality of our data collection for development of a larger study.

What do you think the next steps should be considering your findings?

We are enthusiastic to take this work forward. We will further develop the educational tool for the dental profession, and having established a referral pathway for identified patients, we will further refine this pathway. We will continue to promote the critical role of identifying domestic violence in dental patients, particularly as most physical violence involves the face and mouth. We will also be encouraging the development of coding and IT in dentistry! ■