# A survey of attitudes, knowledge and practice of dentists in London towards child protection. Are children receiving dental treatment at the Eastman Dental Hospital likely to be on the child protection register?

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IN BRIEF

- In the UK, specialists and consultants in paediatric dentistry consider dental neglect, as part of child abuse.
- A computerised system to track down children who have multiple admissions due to NAI or dental neglect is essential.
- Paediatric dentists see more cases of child abuse than any other group of dentists and so need more training to be able to recognise and refer these cases to the appropriate authorities.

RESEARCH

**Objective** To investigate the attitudes, knowledge and practices of general dental practitioners (GDPs), specialists and consultants in paediatric dentistry in London, towards child protection. Additionally, to determine if children attending paediatric dental casualty at the Eastman Dental Hospital (EDH) and those who need treatment of caries under general anaesthesia (GA) are on the child protection register (CPR). **Design** The survey was conducted by postal questionnaires with 14 closed questions. A total of 228 dentists were invited to participate in the study. Children who attended EDH and required treatment under GA or at paediatric dental casualty were checked against the CPR. **Results** The respond rate was 46% (105/228). Overall 15% (16/105) of dentists had seen at least one patient with suspected child abuse in the last six months, but only 7% (7/105) referred or reported cases to child protection services. Reasons for dentists not referring included: fear of impact on practice (10%; 11/105); fear of violence to child (66%; 69/105); fear of litigation (28%; 29/105); fear of family violence against them (26%; 27/105); fear of consequences to the child (56%; 59/105); lack of knowledge regarding the procedures for referral (68%; 71/105); and lack of certainty about the diagnosis (86%; 90/105). Of the 220 children attending for dental GA and casualty from October 2004 to March 2005, one child was found to be on the CPR. **Conclusion** More information and training is required to raise awareness of the potential importance of the role of dentists in child protection. Improved communication between dental and medical departments is important for safeguarding children.

## INTRODUCTION

A child is considered to be abused if he or she is treated in a way that is unacceptable in a given culture at a given time.[1] In Britain, at least one child per 1,000 under four years of age per year suffers severe physical abuse, for example fractures, brain haemorrhage, severe internal injuries or mutilation. An estimated one to two children die each week in England and Wales as a result of abuse or neglect.[2] There were 25,700 children on child protection registers in the UK at 31 March 2002.[3]

Child abuse is present in all cultures and socioeconomic backgrounds but is more apparent in the lower socioeconomic groups.[4]

### Oral health and child abuse

Dental caries, periodontal disease and other oral conditions, if left untreated, can lead to pain, infection and loss of function. Dental neglect, as defined by the American Academy of Paediatric Dentistry, is 'the wilful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection'.[5] Dental neglect adversely affects learning, communication, nutrition and other activities necessary for normal growth and development.[6] Abused children are 5.2 times more likely to have untreated, decayed primary teeth than other children.[7]

Research about the attitudes, knowledge and practice of dentists towards child protection has highlighted the role of dentists in child protection and helped to establish guidelines.[8] Dentists may be one of the first groups of professionals to encounter these children and are in a position to seek further help. The number of child protection referrals by general dental practitioners (GDPs) in London remains low, suggesting that dentists may need more information about child protection. Therefore part of this study was

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to determine the attitudes, knowledge and practice of dentists towards child protection in London. We chose to look at a cross-section of dentists with differing levels of postgraduate training to determine if the level of training was related to the level of reporting of child abuse.

We know from the Victoria Climbié inquiry that the main reason for failure in detecting abused children was the lack of communication between agencies.[9] Therefore a further aim of our research was to determine if children attending the paediatric dental casualty department at the Eastman Dental Hospital (EDH) and those requiring GA for treatment of caries were on the child protection register (CPR) held in University College London Hospital (UCLH). This information was not available to clinicians at EDH and may have revealed children for whom concerns had been already been raised regarding child protection, and thus provided further information to support children's healthcare needs.

## SUBJECTS AND METHODS

Ethical approval for the study was granted by the Central Office for Research and Ethics Committee (04/Q0505/72). To comply with the Data Protection Act 1998, the consent forms were separated from the main questionnaires upon arrival and were kept in a locked room at the EDH. The data taken from the questionnaires were entered into a password protected computer.

### Sample size selection

From 33 boroughs in London, five boroughs were randomly selected by SPSS random tables: Merton, Islington, Richmond, Hounslow and Wandsworth. GDPs were identified from each borough using the National Health Service (NHS) directory and the General Dental Council (GDC) lists. Forty GDPs were then selected randomly, giving a total of 200 GDPs.

All specialists and consultants in paediatric dentistry in London (28) were identified using the GDC specialist lists. Specialists and consultants in paediatric dentistry at the EDH were excluded as they had already participated in the piloting phase. Participants were assured that strict confidentiality would be maintained and results would be anonymous.

Questionnaires, along with an explanation letter, consent form and prepaid return envelopes with first class stamps, were posted to the 228 dentists. The questions were based on a questionnaire from a previous study, which were kindly offered by the authors.[10]

Attempts were made to improve the response rate by telephoning the dentists directly and sending the questionnaires by recorded delivery, as this was shown to improve response rates.[11] Many GDPs declined due to time and financial restraints, with the majority of refusals issued by receptionists on the dentist's behalf. It is recognised that without monetary incentives or involvement in continuing education schemes such as CPD courses, participation from GDPs is likely to be limited.

### Piloting of questionnaire

Prior to the start of the study, the questionnaires were piloted among the specialists and consultants in the unit of paediatric dentistry at the Eastman

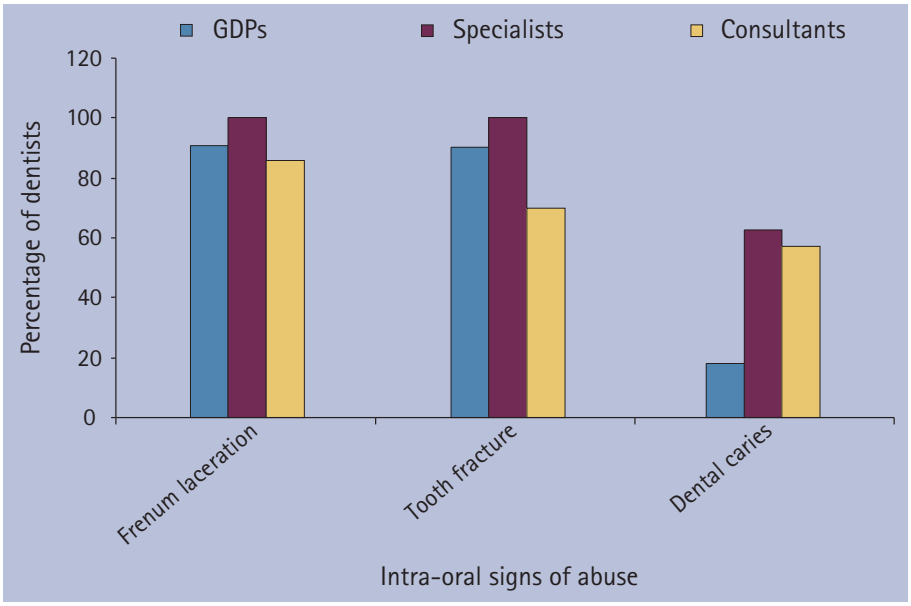


**Fig. 1 Percentage of dentist groups (GDPs, specialists and consultants in paediatric dentistry) who thought that fraenum laceration, tooth fracture and dental caries are intra-oral signs of abuse**

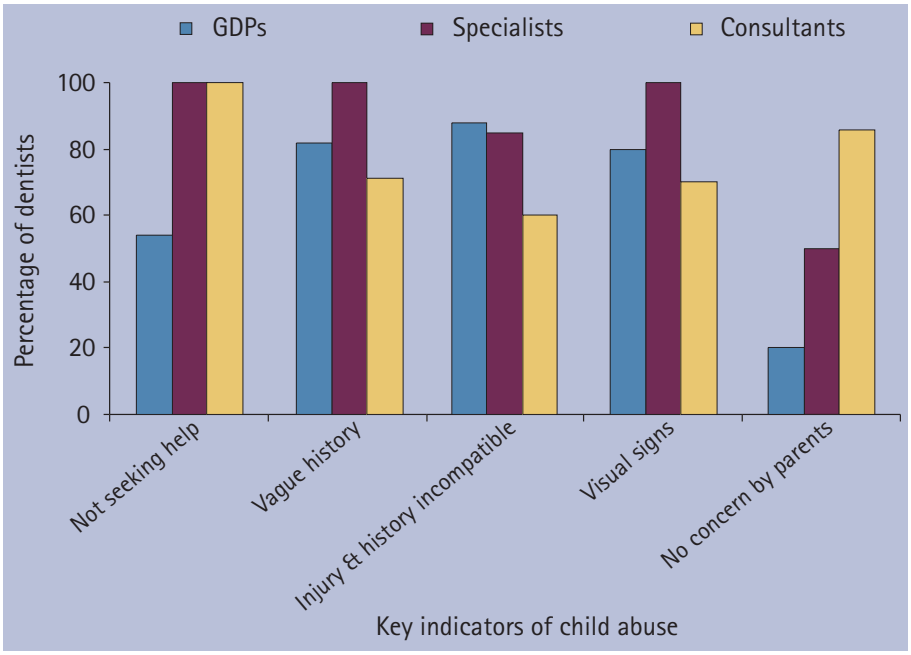


**Fig. 2 Key indicators of child abuse**

Dental Institute (EDI). The amendment of the questionnaires included the reduction of the number of the questionnaires from 20 to 14. The questionnaires were made to fit two A4 pages only and coloured ink was used for the headings of the consent form, information sheet and the questionnaires to make them more appealing.

From October 2004 to March 2005, children attending the paediatric dental casualty unit of the EDH and day stay theatres at EDH and Middlesex Hospital were recruited to the study. Only children who required treatment under general anaesthesia (GA) and those who attended paediatric casualty who resided in Camden and Islington Health Authority were included, as UCLH only holds the CPR for the boroughs of Camden and Islington.

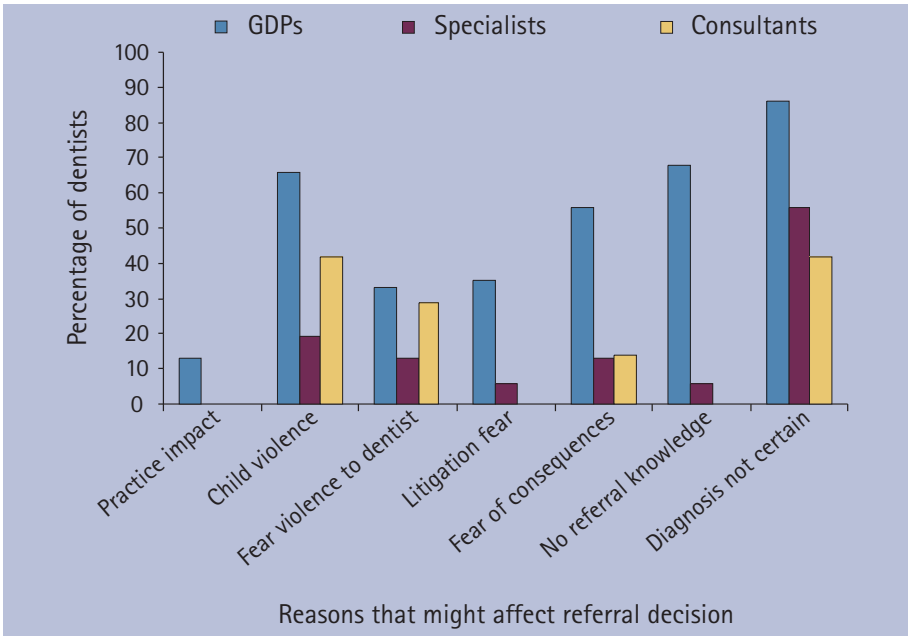


**Fig. 3 Reasons that affect dentists' decisions on whether to refer a child to the authorities**

## RESULTS

Of the 220 who attended the day stay outpatient theatre, one three-year-old boy had been placed on the CPR since 2001. This young patient had early childhood caries and needed multiple extractions and restorations under GA. He had been put on the CPR for neglect, and the patient was reported to the child protection officer and the social services team at UCLH.

The response rate for the specialists and consultants group was 82% (23/28), with a response rate of 41% (82/200) for the GDPs group, giving an overall response rate of 46% (105/228). The majority of GDPs worked in mixed practices (80%; 66/82), followed by the NHS (8.5%; 7/82), solely private practice (19.5%; 16/82) and the CDS (7%; 6/82). The dentists who worked in private practice saw the fewest number of children per week, and 78% (64/82) of those who worked in private practice had not seen any child protection guidelines and were not aware of child protection protocols in their area.

A third of GDPs (36.5%; 30/82) saw more than 20 children per week. In the other group, 75% (12/16) of specialists and 71% (5/7) of consultants in paediatric dentistry saw more than 40 children per week. In this sample, 15% (16/105) of *all* dentists had seen at least one or more suspected child abuse cases in the last six months. Only 6% (6/105) had ever referred cases to child protection services such as social workers, police or the National Society for the Prevention of Cruelty to Children (NSPCC), and only 8% (8/105) had seen their local child protection guidelines.

Almost all the groups of dentists agreed that fraenum laceration and tooth fracture could be the signs of abuse (Fig. 1). Current literature does not support the diagnosis of abuse on a torn labial fraenum in isolation.[12] In our study, 62.5% (10/16) of specialists and 57% (4/7) of consultants in paediatric dentistry thought that dental caries could be a sign of abuse by neglect, compared to 13% (11/82) of GDPs.

The knowledge of the key indicators of child abuse was variable for the different groups (Fig. 2). More specialists and consultants in paediatric dentistry were aware of the key indicators in detecting child abuse compared to GDPs. All consultants were willing to refer to social services, but only 62.5% (10/16) of the specialists group and 46% (38/82) of GDPs indicated they would refer suspected cases to social services. More GDPs preferred to refer cases to the NSPCC (34%; 28/82) than specialists and consultants (25% [4/16] and 14% [1/7], respectively).

### Reasons & decisions for not referring

GDPs, specialists and consultants in paediatric dentistry had many reasons for not reporting child abuse to authorities. Reasons for GDPs not referring included: fear of impact on practice (13%; 11/82); fear of violence to child (84%; 69/82); fear of litigation (35%; 29/82); fear of family violence against them (33%; 27/82); fear of consequences to the child (72%; 59/82); lack of knowledge regarding the procedures for referral (86.5%; 71/82); and lack of certainty about the diagnosis (86.5%; 71/82). Among specialists in paediatric dentistry, the main concerns were uncertainty about diagnosis (50%; 8/16) and fear of violence to the child (19%; 3/16). Similar results were obtained from the consultants in paediatric dentistry (Fig. 3).

### Attitudes towards child protection

While 44% (46/105) of dentists were willing to be involved in detecting child abuse, most preferred to discuss cases with colleagues (GDPs 63% [52/82], specialists 69% [11/16] and consultants 86% [6/7]), as opposed to reporting suspected child abuse to the police.

Encouragingly, 72% (59/82) of GDPs, 94% (15/16) of specialists and 71% (5/7) of consultants felt that dentists were well placed to recognise child abuse. All specialists and consultants felt that this topic is extremely important to their work, as compared to 80% (66/82) of GDPs. It was found that 79% (65/82) of GDPs wanted information and training on this topic, compared with 50% (8/16)

of specialists and 71% (5/7) of consultants in paediatric dentistry (Table 1).

**Table 1 Percentage of different dentist groups who feel that they are well placed to recognise child abuse, that child abuse is an important topic and that they need more information about it**

| | GDPs | Specialists | Consultants |
|---|---|---|---|
| Dentists are well placed to recognise signs of abuse | 51/82 (70%) | 15/16 (94%) | 5/7 (71%) |
| Child abuse is an important topic | 59/82 (78%) | 16/16 (100%) | 7/7 (100%) |
| More information required about topic | 57/82 (77%) | 8/16 (50%) | 5/7 (71%) |

## DISCUSSION

This study highlighted that dentists are aware of the importance of child protection and that 79% (65/82) of GDPs wished for further education in this area. According to Cairns *et al.*,[10] 11% of GDPs in Scotland do not refer cases due to fear of impact in their practice, compared to 13% (11/82) of the GDPs and none of the specialists and consultants in our study. Cairns *et al.* found that 34% of GDPs were not referring due to fear of violence to the child, compared to 66% (54/82) of GDPs and 12.5% (2/16) and 28.5% (2/7) of specialists and consultants respectively in this study. Fear of litigation affected the decision to refer in 48% of GDPs in Scotland,[10] compared to 28% (23/82) of GDPs, 6% (1/16) of specialists and none of the consultants in our study. Fifteen percent of GDPs in the Scottish study had seen child protection guidelines compared to 8% (8/105) in London.

To this end, the Department of Health in conjunction with the Committee of Postgraduate Dental Deans & Directors UK (Child Protection and the Dental Team Project) have recently supplied all NHS dental practices in the UK with a handbook on safeguarding children in dental practice (also available as a PDF file on www.cpdt.org.uk).[2] It is hoped that the handbook and website will highlight the role of dentists in child protection and explain how to manage a child with suspected child abuse.

There are approximately 22,000 children attending the EDH each year. Over the six-month period studied, 220 children attended the day stay theatre for GA and 489 attended the dental paediatric casualty department. Those who resided in Camden and Islington were identified and checked in the CPR held at UCLH. Although there were vague suspicions raised about three other children, only one was on the CPR for neglect. The child had required GA for conservation and extractions due to early childhood caries. The information regarding the dental care was then passed on his social worker and the child protection advisor at UCLH, helping to provide important information on the child's healthcare needs.

Although in this study it was found that one child was currently in the CPR, we estimated that there are may be at least five children who attend the EDH each year who are either in the CPR or are at risk of child abuse. This is because in this study the sample size was restricted to children who attended the EDH during a six-month period and resided in Camden and Islington, as this was the only CPR we had access to. In addition there were difficulties encountered when searching for names in the CPR, as in some cases the information written in the CPR was not enough to identify the children, such as the date of birth and the first name of the chid, and the information was not updated regularly.

The concerns raised about CPRs have been addressed by the updated version of *Working together to safeguard children – 2006*, which recommends the phasing out of CPRs, as well as the replacing of Area Child Protection Committees (ACPCs) with Local Safeguarding Children's Boards (LSCBs) to safeguard and promote children's welfare.[13] The need for continued communication between medical and dental paediatric teams is paramount for safeguarding children.

## CONCLUSION

It was concluded that dentists practising in London need more information and training to raise their awareness and impress upon them the importance of the role of dentists in child protection. A particular deficiency was noted in those GDPs working in private practice that may not have regular access to local child protection guidelines and referral procedures. Further education is required in the form of continuing professional development (CPD) courses and the Child Protection and the Dental Team Project Handbook,[2] to ensure dentists are up-to-date with current legislation and procedures and to improve sharing of information amongst healthcare agencies.

The need for improved communication between the Department of Paediatric Dentistry at the EDH and the main UCLH campus was highlighted by this study. The introduction of a hospital-wide computer system that will allow tracking of patients through all the hospital sites at UCLH is aimed at providing healthcare staff with additional information for children attending various departments for multiple appointments. It would be beneficial to have a mechanism so that children at risk of child abuse or on a CPR can be flagged up so that they can be closely monitored and not lost in the system.

This study has also raised the issue of whether or not dental caries can be considered as sign of neglect. As caries is a multi-factorial disease, with many contributing aspects, there is a need for future studies to further investigate this issue.

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