Child protection:
the dental therapist survey

Do dental therapists feel sufficiently trained and empowered to report suspected cases of child abuse? **Barbara Chadwick**, **Jane Davies**, **Shannu Bhatia**, **Colleen Rooney** and **Neil McCusker** conducted an investigation to find out.

Adapted from a *BDJ* article.[1]

In 2007 Professor Barbara Chadwick and her colleagues from Cardiff University School of Dentistry set out to identify the training, experience of and barriers to reporting child abuse among dental therapists in the UK. They sent a postal questionnaire to all 851 practising dental therapists in the UK that were registered with the GDC in October-December 2007.

Four hundred and twenty (49%) of the dental therapists (DTs) responded, although 24 of the questionnaires were incomplete and excluded.

One hundred and thirty-five of the respondents had suspected child abuse and 112 of them (83%) recorded their suspicions in the patient record. In line with current guidance most DTs would discuss a case with a dentist.

This article outlines the factors influencing Professor Chadwick's investigation and discusses the results and conclusions of the questionnaire.

Recognising abuse

Child abuse and neglect should be of particular concern to those who work with children. As many signs of physical abuse present in the oro-facial region, dental professionals are well placed to recognise it. Indeed they may be the first professional to suspect a non-accidental injury.

Following the Laming Report into the death of Victoria Climbié the role of all healthcare professionals in child protection has been highlighted.[2] The GDC clearly state in their Standards Guidance that the dental team has a responsibility to find out about local procedures for child protection.[3]

In May 2006 all NHS dental practices in England and Scotland received a Department of Health funded handbook, *Child protection and the dental team*,[4] to assist their dental teams in primary care.

There is evidence that dentists feel unprepared to deal with child abuse and are reluctant to report suspected cases; however, there were no data on the training, perceptions and experiences of UK dental therapists in this area prior to this study.

The questionnaire

The following definition of child abuse was given on the questionnaire: 'inflicting harm to, or failing to act to prevent harm to a child physically, emotionally, sexually or by neglect.' The questionnaires were sent with a covering letter explaining the purpose of the study and a prepaid return envelope; replies were anonymous. The questions asked identified: practitioner demographics; training and education in child protection; suspicion and action on suspicion; knowledge of local procedures and national guidance; and factors that might influence a decision to refer a suspected case.

The respondents

Almost all of the 396 respondents to the questionnaire were female; the majority (330) worked in England; 38 in Wales; 22 in Scotland; five in Northern Ireland and one worked in both England and Wales. Nearly half the DTs had been qualified under ten years; 25 had been qualified between ten and 19 years; 70 had been qualified between 20 and 29 years and 105 DTs had been qualified for over 30 years. Three didn't answer the question.

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Training

One hundred and forty-six of the DTs recalled receiving child abuse/protection training during their undergraduate studies; 248 reported undergoing training since qualification; while 66 respondents could recall neither undergraduate or postgraduate training. Table 1 shows the stages at which training was received related to the number of years qualified. This shows that the percentage receiving undergraduate training falls as the number of years since qualification increases. In contrast the number reporting postgraduate training increases as the number of years since qualification increases.

Place of work

Two hundred and fifty-five respondents worked in General Dental Services; 132 worked in Community Dental Services; 31 worked in Hospital Dental Services and 51 worked in other environments – such as the armed forces, private practice, a combination of workplaces or corporate bodies. Seventy of the DTs worked in two or more environments.

Suspecting abuse

Just over a third (135) of respondents had suspected child abuse in one or more patients in their practising lifetime. Most indicated that they had seen a single case but the reported range was 1-10 suspected cases. Of those suspecting child abuse 112 recorded it in the notes. Overall 72 of the DTs indicated that they had suspected child abuse but not reported it. The longer the DTs had been in practice the more likely they were to have suspected abuse. Those who had received postgraduate training were also more likely to have suspected child abuse in their patients.

Referring suspicions

When asked to indicate who they would refer a suspected case of child abuse to or discuss one with, almost half of the respondents (191) selected 'principal dentist or other dental colleague'. The next most popular choice was a paediatric colleague (161), followed by social services (108), the police (29), or the NSPCC (28). Multiple answers were allowed for this question.

Respondents were asked to indicate from a list of possible options what factors, if any, might affect their decision to refer a suspected case. Seventy percent (278) reported lack of certainty over their diagnosis and more recently qualified DTs were most likely to let this factor influence their decision. Two hundred and forty-two DTs were concerned about family violence to the child and 109 were worried about the risk of family violence to

themselves. Fear of consequences to the child from intervention of statutory agencies was an issue for 207 DTs while a lack of knowledge of referral processes was indicated as a possible concern by 153. For 121 DTs fear of litigation might influence the decision. Only seven respondents would let concerns about the impact on the practice (financial, time taken etc) influence them.

Guidelines

Two hundred and thirteen DTs (54%) had seen their local area child protection guidelines and 192 (48%) had a copy of *Child protection and the dental team*.[4] Two hundred and seventy-two (68%) of questionnaire respondents indicated that they would welcome further training in child protection.

DISCUSSION

The questionnaire described in this article was based on a similar questionnaire that was sent to Scottish dentists in 2005. Although the responsibilities of dentists and dental therapists are different, many of the clinical variables are similar and allow direct comparison. This earlier survey will be referred to in this article as the Scottish survey.

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Dentists – DTs

Thirty-seven percent of DTs recall specific teaching in child protection during their training whereas only 19% of dentists in the Scottish survey did. The suggestion that emerged from the DT survey that the topic of child protection was not part of older courses or that the teaching had been forgotten was evident in the Scottish survey too. It is of concern that although the GDC emphasises the role of the dental team in child protection, 16% of DTs can recall no training in child protection at all. However, this figure is considerably lower than the 80% reported in the Scottish survey.

The number of DT respondents who had suspected child abuse in one or more patients during their career (34%) was similar to the number in the Scottish survey. More DTs recorded their findings in the dental notes (83%) than the dentists did in the Scottish survey (56%). *Child protection and the dental team* gives clear guidance and suggests appropriate note keeping guidelines for the dental team, so it is encouraging to note that the majority of DTs are recording their findings.

However, 18% of DTs indicated that they had suspected and not reported their

concerns. While there is evidence that training can increase awareness of child abuse it does not appear that training alone empowers members of the dental team to act on their suspicions.

Research shows that dentists, like DTs, also indicate that they find the decision to refer a case to social services difficult. It is therefore important that DTs should feel confident and empowered to report cases in their own right if, following discussion with a colleague, concern still remains. A referral should be made to social services and followed up in writing within 48 hours.

There is evidence that dentists, educated to recognise signs and symptoms of abuse and neglect, are five times more likely to report it than those who have not, so ensuring confidence as far as possible in their diagnosis is important. For DTs, who work to a dentist's treatment plan and who are not used to making a dental diagnosis, this may be a particularly important issue. However, child protection guidance makes it quite clear that the threshold for referring a child to social services is **having concern**; the practitioner does not need to be sure of the diagnosis before doing this.[4]

While fear of violence to themselves upon reporting a suspicion is understandable on the part of dentists and DTs (around a third of Scottish dentists reported this concern, a similar number to DTs), the welfare of the child is paramount and **all health professionals should refer if they are in doubt**.

It is disappointing that just over half of DTs were worried about the consequences to the child from the intervention of statutory agencies, as failing to report a case can be life-threatening. This suggests that members of the dental team may not understand the role of these agencies.

CONCLUSIONS

This survey suggests that like dentists, dental therapists are reluctant to refer suspected cases of child abuse, although most do record their suspicions in the patient dental record. Postgraduate training increases the likelihood that a suspected case will be recognised. Suspicious DTs usually discuss a case with a dentist, however, dentists are also reluctant to refer so it is likely that many suspected cases are not referred on to social services.

Familiarity with guidelines and improved communication lines with other health professionals would facilitate better child protection practice. Undertaking child protection training in a mixed group of health care practitioners rather than only with other dental workers would go some way to breaking down some of these barriers. Mechanisms that encourage dental therapists and the dental team to report suspected child abuse are still required.

Table 1 Stage at which 393 DCPs who gave details of years qualified received training in child protection/abuse

	Years Qualified			
	<10	10-19	20-29	30+
Training (%)				
None	35 (18.1)	5 (20.0)	14 (20.0)	11 (10.4)
Undergraduate alone	74 (38.3)	3 (12.0)	2 (2.9)	1 (0.9)
Postgraduate alone	40 (20.7)	9 (36.0)	45 (64.3)	89 (84.5)
Undergrad & postgrad	43 (20.7)	8 (32.0)	9 (12.9)	5 (4.8)
Total undergrad	118 (61.1)	11 (44.0)	11 (15.7)	6 (5.7)
Total postgrad	83 (43.0)	17 (68.0)	54 (77.1)	94 (98.5)
Total	**193 (49.1)**	**25 (6.3)**	**70 (17.8)**	**105 (26.7)**

NB: Three respondents did not declare the number of years since qualification (1 had received no training, 1 undergraduate training and 1 both undergraduate and postgraduate training)

'All health professionals should refer if they are in doubt.'

1. Chadwick B L, Davies J, Bhatia S K, Rooney C, McCusker N. Child protection: training and experiences of dental therapists. *Br Dent J* 2009; in press.
2. Department of Health. The Victoria Climbié Inquiry. Report of an inquiry by Lord Laming. London: The Stationery Office, 2003.
3. General Dental Council. Standards Guidance: *Standards for dental professionals.* London: General Dental Council, 2005.
4. Harris J, Sidebotham P, Welbury R. *Child protection and the dental team: an introduction to safeguarding children in dental practice.* COPDEND, 2006.