Safeguarding children in dentistry: 1. Child protection training, experience and practice of dental professionals with an interest in paediatric dentistry.

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ABSTRACT

Following several highly publicised inquiries into the deaths of children from abuse and neglect, there has been much recent interest in the role and responsibility of all health professionals to protect children at risk of maltreatment. The findings of a postal questionnaire, sent in March 2005 to 789 dentists and dental care professionals with an interest in paediatric dentistry working in varied settings in the UK, are presented in a two-part report and discussed in the context of current multi-agency good practice in safeguarding and promoting the welfare of children. This first part explores reported child protection training, experience and practice. There was a significant gap between recognising signs of abuse and responding effectively: 67% of respondents had suspected abuse or neglect of a child patient at some time in their career but only 29% had ever made a child protection referral. The dental profession is alerted to the need to ensure necessary appropriate action to safeguard children is always taken when child abuse or neglect are suspected.

INTRODUCTION

On 31 March 2008 there were 29,200 children in England who were the subject of a child protection plan (previously referred to as ‘on child protection registers’) because they were suffering, or were at risk of suffering, significant harm because of abuse or neglect.[1] It is known that many more are vulnerable to maltreatment. In the published findings of a high profile inquiry in 2003 into the death of an 8-year-old girl, Victoria Climbié, Lord Laming made recommendations about procedures and training for all agencies in regular contact with children.[2] The need for child protection training for all health professionals was highlighted.

Dental professionals (dental practitioners and dental care professionals) have regular contact with children and families, some of whom will have no other contact with healthcare services. Oro-facial trauma in children commonly presents to dentists[3] and signs of physical abuse often present in the oro-facial region.[4,5] Dental professionals are therefore in a good position to recognise and report suspected cases of abuse and neglect in order to safeguard and promote children's welfare. Indeed, UK dental professionals are required by government guidance to work together with others to safeguard children[6] and by ethical standards guidance to find out about and follow local child protection procedures.[7] However, previous research has shown that dentists feel unprepared to take on such a role and are unsure what to do if they suspect that a child has been abused.[3,8,9]

In 2005, the Department of Health (England) commissioned a working group to develop an educational resource on child protection for primary-care dental teams[10] in association with the Committee of Postgraduate Dental Deans and Directors (COPDEND). As part of the project all members of the British Society for Paediatric Dentistry (BSPD) were contacted with an invitation to share examples of good practice or learning needs. This gave the opportunity to carry out a study, prior to widespread implementation of the changes recommended by Lord Laming, with a group of dental professionals with a common interest in children's dentistry. The aim of the study was to investigate the training and experience in child protection of BSPD members, to investigate their reported practice in child protection referral and to identify potential barriers to making such referrals.

METHODS

A self-administered postal questionnaire was sent in March 2005 to all 789 UK-based members of the BSPD: dentists and dental care professionals (DCPs) working in all types of practice settings: hospital/academic, salaried services and general practice. Overseas members received the mailing 'for information only' and the investigators were excluded. The questionnaire was based on one previously used by a co-author,[9] adapted both to incorporate all categories of child maltreatment (emotional abuse, sexual abuse and neglect, in addition to physical abuse) and to include DCPs in addition to dentists. The amended version had been piloted with a small group of DCPs to confirm its clarity and effectiveness in eliciting the required information. Reassurances regarding the strict procedures observed for anonymity were explained in a covering letter. A reply-paid envelope was enclosed for return of the completed questionnaire. A repeat mailing was sent to non-respondents 10 weeks later, based on a numerical coding to ensure respondents' anonymity.

Advice taken prior to commencing the work indicated that ethical approval was not required for a study of this nature. Approval from BSPD Council was obtained to permit mailing to the society's membership.

The questionnaire also included a section on dentists' management of children with neglected dentitions, to be reported in the second part of this two-part report.

A data capture sheet was created and data were entered into a spreadsheet using double data entry and electronic verification. Statistics were generated using Statistical Package for Social Sciences (SPSS Inc.) and data were tested and comparisons made using 2-way Chi-squared and Mann-Whitney U tests.

RESULTS

Five hundred and twenty three replies were received. After exclusion of 10 returned from invalid addresses and 23 from retired members, 490 completed questionnaires were available for analysis (62.1% response rate). Responses came from a wide geographic area with all UK postgraduate deanery areas represented. Demographic data are presented in Table 1.

Child protection training

The findings regarding child protection training are shown in Table 2a. Twenty six percent of respondents reported child protection had been included at undergraduate or initial training level. Significantly more reporting this were female (p=0.034) and more recently qualified (p=0.000).

Eighty seven percent of respondents had undergone some form of post-qualification child protection training. This included significantly more specialists in paediatric dentistry than non-specialists (95.6% v 82.9%, p=0.000), more female than male respondents (88.5% v 81.0%, p=0.035), more working in the salaried services than in other job types (p=0.000), and fewer GDPs (p=0.002). There was also evidence of a tendency for those who had undergone such training to have been qualified for longer (p=0.064).

Of those who had received post-qualification training, for 24% (n=102) this had been delivered only ever as a single lecture and for 8.5% (n=36) only ever by a dentist alone acting as trainer. Thirty three percent had received multi-agency training, where this was described as training delivered by health professionals with social services, police and education. Other options were training delivered by other health professionals, with or without a dentist.

Previous post-qualification training was associated with significantly more awareness of local multi–agency training courses (40.7% v 14.3%; p=0.000). Eighty percent of respondents acknowledged their need for further training in child protection. Significantly fewer requesting this had already had training (78.0% v 92.2%; p=0.011).

Child protection experience and practice

The findings regarding child protection experience and practice are shown in Table 2b. Approximately two out of three respondents had previously seen a case suspicious of abuse but fewer than one in three respondents had ever made a child protection referral. This represents a 38% gap between recognising and responding in cases of suspected abuse. When those who had ever referred were compared to those who had never done so, there was no significant effect of gender, years since qualifying or job type. Previous post-qualification child protection training was associated with significantly more suspecting abuse (70.8% v 47.0%; p=0.000), knowing that anyone can refer (87.6% v 53.0%; p=0.000) and making a referral (32.8% v 7.6%; p=0.000).

Nearly a third of respondents confirmed, in answer to an additional question, that they had at some point in the past suspected abuse but decided not to refer the child. There was no significant difference in the proportion of respondents who had ever done this according to gender, years since qualifying, job type or previous post-qualification child protection training.

Of those who had suspected abuse, 82% recorded their observations in the clinical records. Significantly more of those who did make a record had undergone post-qualification child protection training compared to those who had not received training (86.7% v 56.7%; p=0.000). There was no significant difference according to gender, years since qualification or job type.

The frequency distribution of respondents by the number of occasions on which they had suspected and referred abuse in the preceding five years is shown in Figure 1. Sixty eight respondents (15.9%) had suspected three or more cases in the preceding five years yet only seven respondents (1.5%) had referred three or more cases in that time.

Eighty seven percent of respondents agreed that they would prefer to discuss their concerns about a child with a dental colleague before taking any further action. Significantly more of these were more recently qualified (p=0.002).

Responses to the factors which might affect the dental professional's decision whether to make a referral when suspecting abuse are shown in Table 3.

DISCUSSION

This cross-sectional study was carried out with a large group of individuals with an interest in paediatric dentistry and encompassed a wide geographical spread. BSPD is a charitable educational society with a stated aim of promoting the oral health of children. The membership includes teachers and opinion leaders in the field and the society publishes guidelines on the dental care of children. Members may be specialist paediatric dentists, other specialists (e.g. orthodontists), salaried and community dentists, interested general practitioners and dental care professionals. Their views are important as many are dedicated to and experienced in treating children and some practise dentistry predominantly or exclusively for children.

Our response rate of 62.1% compares well to that achieved in other postal surveys of this nature.[3,9,11-13] Response rates are known to be reduced when questions of a sensitive nature are included.[14] BSPD membership data were not available for comparing the demography of responders with non-responders. However, since

responses were received from 135 specialists in paediatric dentistry (60.5% of the 223 on the General Dental Council's specialist register[15]), and all but a few specialists were BSPD members, it can be estimated that the proportion of specialists amongst responders was representative.

It is relevant that the study took place prior to the General Dental Council's inclusion of an explicit statement about child protection in revised standards guidance,[7] emphasised in a subsequent statement.[16] Furthermore, at the time, child protection training was not uniformly a mandatory requirement for employees of healthcare trusts.

Child protection training

The finding of a rate of reported undergraduate child protection training of 26% is similar to that found in GDPs in Scotland in 2003 (19%)[9] and dentists in California prior to 1998 (28%).[11]

A high proportion of respondents (87%) had undertaken post-qualification training, comparing very favourably with 16% as found in both the aforementioned studies.[9,11] The likely explanation for the magnitude of the difference is that dental professionals choose to attend training relevant to their field of interest. Even so, it falls short of achieving Lord Laming's recommendation, in the report of the inquiry into the death of Victoria Climbié, that "all those working in primary healthcare services for whom contact with children is a regular feature of their work" should receive training.[2]

In the majority of cases, post-qualification child protection training had been provided by other health professionals or other agencies. This is good for two reasons: firstly, these are the people working daily in child protection and, secondly, it gives dental professionals the opportunity to meet staff whom they might contact for advice

or to refer a child. However, 24% had received training only ever in the form of a single lecture and 8.6% only ever from a dentist alone. Brief training interventions may be satisfactory for raising awareness but are unlikely to equip dentists fully with the knowledge and skills needed to carry out the challenging task of recognising concerns about a child and responding effectively. Similar cautions have been offered in relation to domestic violence training in a study which also warned of generating possible false confidence in staff.[17] However we found that a high proportion (78%) acknowledged their need for further training, even if they had received previous post-qualification child protection training.

Child protection concerns and referral – mind the gap!

Sixty seven percent of BSPD members had suspected abuse but only 29% had ever made a child protection referral. It follows that there is a gap between recognising signs of abuse and responding effectively. Thirty two percent confirmed this, when asked directly if they had ever suspected abuse but decided not to refer. Under contemporary guidance[18,19] there may have been cases where the initial concerns raised were discussed with suitably experienced colleagues, deemed not to require child protection referral but to require arrangement of other support for the family. However this is unlikely to account fully for the discrepancy, leading to the conclusion that potentially one third of suspected cases of abuse are not referred. We consider that the magnitude of the gap may indicate that on numerous occasions members may have been able to initiate intervention to save a child from continuing maltreatment but failed to do so.

In addition, those who had suspected abuse did not always record their observations in the child's records. Incomplete record keeping and exchange of

information have been repeatedly identified as contributing to previous failures to protect children.[2,20-22]

To our knowledge, the proportion who had ever suspected abuse (67%) is higher than demonstrated in previous studies worldwide with general dentists[9,11,12,23-29] and amongst the highest with those with an interest in paediatric dentistry.[13,24-27] This may be due to increased knowledge or vigilance in the study group or may reflect a higher prevalence of maltreatment in their child patients. Furthermore, the gap between the proportion who had ever suspected abuse and the proportion who had ever referred a child (29%) is wider at 38% than previously observed. In making such comparisons it should be noted that some of these studies restricted their enquiries to physical abuse alone.

Previous post-qualification child protection training was found to be associated with certain markers of knowledge or good practice (suspecting abuse, knowing that anyone can refer, making a referral) but a cause and effect relationship must not be inferred. This could simply reflect that the dental professionals chose to attend training because they had encountered such clinical situations before or because they had a pre-existing positive attitude to promoting children's welfare.

The magnitude of the gap between recognising and responding to concerns about child maltreatment, in a cohort with such a high uptake of post-qualification child protection training, raises the possibility that training prior to 2005 increased dental professionals' ability to recognise signs of abuse yet did little to encourage or enable them to refer children for help.

Sadly these findings may tend towards that of a 'best case scenario' since one might expect, if anything, a tendency to over-report action taken rather than under-

report, given the media attention in recent years in all parts of the UK to the tragic consequences of failed communication about abused children.[2,20]

Perceived barriers to action

Factors influencing professional judgements when identifying and referring child maltreatment are wide ranging. The process of assessment and decision-making has been described as 'both a head and heart activity.'[30] Dentists' self-reported barriers to referring child abuse have been widely investigated in both quantitative[3,9,11,12,25,26] and qualitative studies.[8]

Lack of certainty about the diagnosis was perceived to be the biggest barrier to referral in this study, as also reported by Cairns *et al*.[9] This is of interest because a dentist is not required to make the diagnosis of abuse before making a referral. That is the shared responsibility of a multi-agency child protection team. The threshold for referral to such a team is when the dental professional has concerns that a child may be at risk of significant harm. Help and advice is always available from local sources if uncertain how to proceed and guidance for health professionals is expected shortly from the National Institute for Health and Clinical Excellence (NICE).[31]

Fifty two percent indicated that fear of the consequences to the child from intervention might affect their decision to refer. This suggests that dental professionals may mistrust or have misconceptions about current child protection practice. The reality is that children's services (formerly social services) are often able to work with families to help them make their own arrangements for the protection of their child. It is estimated that fewer than 1% of children referred end up in judicial proceedings,[32] and in such circumstances 'the child's welfare shall be the court's paramount consideration.'[33]

Thirty five percent of respondents were concerned about confidentiality and 29% about litigation; lower than in comparable studies.[9,26] Either through training or, alternatively, through their regular work with children, this cohort may be more aware of their ethical responsibilities,[34] the legislative framework that allows them to share information where the need to safeguard the child's welfare overrides the need to keep information confidential, and that they themselves will be protected against legal action if they act 'in good faith.'[35]

Thirty two percent reported lacking knowledge of referral procedures. Access to a copy of the local child protection procedures was higher at 62% than previously reported for GDPs in Scotland[9] but still falls short of ideal. Local procedures may not have been circulated effectively from Area Child Protection Committees (now replaced by Local Safeguarding Children Boards (LSCBs)) to dental services or within dental teams themselves. Alternatively, if received by dental teams, procedures may have been discarded due to apathy or perceived irrelevance.

Closing the gap

The findings of this study cannot be taken to represent a current picture of UK dental team child protection training and experience as a whole. Most significantly, the majority of dental care for children in the UK is provided by GDPs working as independent contractors, unlike the salaried working circumstances of 90% of these respondents. Certain factors associated with general dental practice have been identified as potential inhibitors to dentists taking a role in child protection.[8] Salaried employment status is likely to place fewer barriers in the way of the dental team both receiving training and adopting a child protection role.

However, the message from successive studies is that dental professionals find child protection to be a difficult and challenging area of work. This particular study

shows that this is no different for dental professionals who are committed to paediatric dentistry, despite previous child protection training. Measures now need to be taken to ensure that *all* dental professionals are not only competent to recognise signs of child maltreatment but also to always take action to report it. We need to close the gap between recognising and responding.

As others have recommended in the past, improvements in child protection training are necessary.[3,8,9] It should be included in all pre-registration training curricula for dentists and DCPs. We consider the topic should also be specified as mandatory for continuing professional development. Reports of child protection training initiatives for general medical practitioners[36-38] give helpful practical insight into how this can be achieved for professionals with busy working lives. Training should include discussion of the perceived barriers to referral, address common misconceptions and ensure an adequate emphasis on response to child maltreatment, not simply its recognition.

Some authors have focussed their recommendations on the need for better information, advice and reporting protocols for dentists.[13,26] Provision of concise, dentally-relevant guidance is a potential solution. To this end since the time of this study and informed by its findings, a Department of Health (England) funded educational resource has been provided for dental teams in primary care. Published as an open-access website, www.cpdt.org.uk, and equivalent hard-copy booklet, it includes a summary 'flow chart for action' on a single A4 sheet.[10] Dental practices need to supplement this with additional local information since procedures are locally determined by LSCBs, Formal evaluation of the resource is pending.

In our study 87% of respondents agreed that they would like to discuss a case with a dental colleague prior to making a referral, as did 81% of GDPs in Scotland.[9]

However, the low levels of experience of making referrals we observed suggests that, at the present time, there may be very few adequately experienced paediatric dentists in the UK to provide comprehensive advice on child protection to colleagues. We recommend that the referring dentist or DCP should always seek further advice from child protection advisors in health or children's services.

There is currently no uniform requirement nor manner of ensuring that, at a local level, all dental professionals have ready access to the training, information and support needed in order to fulfil their child protection responsibilities. It is the joint responsibility of dentistry and the multi-agency child protection services to see that this happens.

In the words of one researcher, "Dentists are just one example of a health service discipline that needs to move from accepting they may have a role, to a position of being effective, accountable practitioners acting in accordance with established policies and procedures and as part of an inter-professional network."[39]

CONCLUSION

This study describes the child protection training, experience and practice of UK dental professionals who have an interest in paediatric dentistry. Greater uptake of post-qualification child protection training than previously reported in dental professionals was found. Despite this, a wide gap was demonstrated between the number of BSPD members suspecting abuse and those taking action, in terms of both child protection referral and record keeping. The majority of respondents acknowledged their need for further training. Such training should address identified barriers to making referrals and should be accompanied by information and support in order to enable the effective safeguarding of child dental patients.

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LIST OF FIGURES AND TABLES

Table 1 Demographic data.

Category	**Respondents**	
	n	**%**
Gender (484)		
Male	126	26
Female	358	74
Years since qualified/working in dentistry (490)		
Less than 10	85	17
10-19	117	24
20-29	208	42
More than 30	80	16
Job type (532[†])		
General dental practitioner	55	10
Salaried service dentist	286	54
Hospital/academic dentist	162	31
Dental care professional	27	5
Other	2	0.4
Specialist in paediatric dentistry (486)		
Yes	135	28
No	351	72

Figures in brackets indicate number of responses to item.

[†] >490 as some respondents have >1 job type.

Table 2 Reported **(a)** child protection training and (**b)** experience and practice.

	Respondents	
	n	**%**
(a) CHILD PROTECTION TRAINING		
Child abuse/child protection included in undergraduate or initial training (483)	128	26
Have attended child abuse/child protection training since qualification (489)	423	87
Acknowledge own need for further training (470)	376	80
Aware of multi-agency child protection courses in local area (478)	178	37
(b) CHILD PROTECTION EXPERIENCE AND PRACTICE		
Agree dental team well placed to recognise signs of abuse (485)	456	94
Ever suspected abuse of a child patient (488)	329	67
Know anyone can make a child protection referral (488)	405	83
Ever made a child protection referral to social services/police/NSPCC* (485)	142	29
Ever suspected abuse but decided not to refer (429)	153	32
Prefer to discuss suspicions with a dental colleague before taking action (474)	414	87
Have seen a copy of their local Area Child Protection Committee Procedures (481)	296	62
Attended a child protection case conference (484)	43	9
Attended court as a witness in a child protection case (484)	9	2
Sat on a multi-agency child protection committee (484)	29	6

Figures in brackets indicate number of responses to item.

* National Society for the Prevention of Cruelty to Children.

Table 3 Factors affecting the decision to refer in cases of suspected child abuse.

Factor	Respondents agree	
	n	**%**
Lack of certainty about diagnosis (469)	368	78
Fear of family violence to the child (459)	244	53
Fear of consequences to the child from statutory agency intervention (458)	240	52
Concerns about confidentiality (453)	159	35
Fear of family violence to self (449)	144	32
Lack of knowledge of referral procedures (452)	143	32
Fear of litigation (452)	132	29
Impact on the practice (458)	19	4

Figures in brackets indicate number of responses to item.

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Concerns about anonymity may have affected the response; the most likely effect being those wanting to conceal past failure to refer in a climate of increasing realisation of the responsibility of all members of society to take action when abuse of a child is suspected. Amongst those who did respond,

In addition, the National Institute of Clinical Excellence is currently developing guidance for health professionals on 'When to suspect child maltreatment.'

There were low levels of attendance ever at case conferences or court cases, or of participation in Area Child Protection Committees.

Those dentists who are called upon to give advice to dental colleagues should concentrate on acting to assist and enable the referrer to approach child protection advisory services, rather than on becoming an expert in diagnosis. They themselves should have ready access to and resources for appropriate further training, supplemented with supervision and support. The latter are recognised as essential for health professionals working in child protection, in recognition of the stressful nature of the work.[36] This will require working across professional boundaries to build strong working relationships with colleagues outside dentistry, for example with paediatricians and safeguarding children nurses.

A consultant or specialist in paediatric dentistry might be considered an appropriate colleague from whom to seek advice.

The answer is likely to lie in provision of training coupled with support.[8, 32] Whilst,

In some areas healthcare trusts have appointed named dental professionals to successfully lead this work. We contend that all LSCBs should secure dental

representation at an appropriate level within their safeguarding structure to take this forward.