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An Audit of a Child Protection Basic Awareness Programme within the Dental Hospital Setting: Are we Effective or Not?

Short Report

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Children are vulnerable individuals and unfortunately, for a significant minority, abuse and/or neglect are part of everyday life with over 2,000 children in Scotland currently on the Child Protection Register (Scottish Executive, 2005a). It is therefore of vital importance that all health professionals who have contact with children are aware of their responsibility to protect them.

Abuse and neglect commonly present with oro-facial signs and symptoms; indeed, it has been reported that up to 60 per cent of abused/neglected children present with injuries in the head and neck region (Becker *et al.*, 1978; Naidoo, 2000). Hence, one particular group of healthcare professionals who are in an ideal position to identify abuse/neglect are members of the dental team (Cairns *et al.*, 2004, 2005). One form of neglect that dentists are in a unique situation to diagnose is dental neglect which has been defined as:

> 'the willful failure of a parent/guardian to seek and follow through with necessary treatment to ensure a level of oral health essential for adequate function and freedom from pain and infection' (American Academy of Pediatric Dentistry, 1995).

Dentists are, therefore, a vital link in the child protection chain and although statutory reporting of suspected abuse or neglect is not mandatory amongst the dental profession, failure to do so could be considered professional misconduct (Cairns *et al.*, 2004). Nevertheless, a recent study has revealed a significant proportion

'Up to 60 per cent of abused/neglected children present with injuries in the head and neck region'

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'An easily accessible educational resource via the internet'

of dentists have suspected abuse in one or more patients during their career, although only 8 per cent have reported their suspicions, with those who had received postgraduate training more likely to report their suspicions (Cairns *et al.*, 2005). More recently, the Department of Health, England has provided guidance for the entire dental team in relation to child protection in the form of an easily accessible educational resource via the internet (Harris *et al.*, 2006).

To date, previous studies have been targeted at the primary dental care setting, primarily amongst general dental practitioners. The present audit, however, was undertaken within a dental hospital setting, an area not previously investigated. As such, the aims of these audits were firstly, to ascertain the level of staff knowledge and secondly, the improvement and retention of information in relation to child protection issues following an interactive training session from the Tayside Child Protection Team (TCPT), NHS Tayside.

Methods

Study Design

These audits were designed as a prospective, questionnaire-based study, undertaken over a six-week period between December 2004 and January 2005 within the Unit of Dental and Oral Health, Dundee Dental Hospital and School, NHS Tayside. All staff from the Unit were invited to attend an interactive training session provided by three members of the TCPT. Without prior notice, staff were asked to complete a questionnaire both prior to (Audit One) and also, following the training session (Audit Two). Whilst questionnaires were completed anonymously, staff were grouped according to job title, that is, dentists and dental care professionals (DCPs); the latter group encompassed dental therapists, hygienists, nurses and radiographers. Finally, the questionnaire was re-issued to staff six weeks following the intial audit cycles (Audit Three). Following completion and analysis of all three questionnaire cycles, results and answers were presented to the group.

'The questionnaire was re-issued to staff six weeks following the intial audit cycles'

Training Intervention, Questionnaire Design and Assessment

The aim of the interactive training session was to increase staff knowledge and awareness regarding the dental teams role in child protection. Verbal presentations and small focus group case discussions were employed. The questionnaire was developed by the TCPT and sought details relating to responsibility, risk factors and categories of abuse with all these areas discussed during the training event. The questions are summarised as follows.

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With the exception of the first question, a range of answers was possible, although there was a maximum overall score allocated for each questionnaire:

1. Is child protection a matter for the dental team?
2. Name five categories of abuse or neglect.
3. List five indicators that may alert you to concerns about child abuse.
4. What risk factors might increase the likelihood of abuse to a child?
5. List the actions that you would take if you were concerned about a child.
6. When would a child be in immediate danger and what action would you take?
7. List all the key people who can help you if you have concerns about a child.

Data Analysis

Due to the small numbers involved in the audit statistical analysis was not completed and results are presented as given below.

Results

Sixteen sets (five dentists, 11 DCPs) of questionnaires were returned for Audits One and Two whilst only ten sets (five dentists, five DCPs) were completed for Audit Three. For all cycles of the audit, all the dentists responded that child protection was a matter for the dental team. Regarding DCPs, 8/11, 10/11 and 5/5 agreed with this statement at each audit cycle, respectively. Thereafter, however, due to small sample sizes (indicative of the number of staff within the Unit) it was not possible to make further inter-group comparisons between the dentists and DCPs. Instead, data for both groups at each audit cycle were combined. Concerning categories of abuse, for all audit cycles, staff demonstrated greater awareness of physical and sexual abuse compared with emotional abuse and neglect. Regarding neglect, there was an increase in the proportion of individuals recognising this as a category of abuse from 5/16 in Audit One to 9/10 in Audit Three.

'All the dentists responded that child protection was a matter for the dental team'

In relation to indicators of abuse, an increase in recognition of failure to thrive as a category was observed during the audit cycles. As shown in Figure 1, both behavioural problems and also the presentation of multiple bruises were the most frequently cited indicators mentioned by the majority of respondents in Audits One and Two.

Concerning risk factors which may increase the likelihood of abuse, substance misuse/abuse was recognised in all audit cycles with an increase in this declaration between Audits One, Two and Three. In addition, as Figure 2 demonstrates, there was increased recognition of the dysfunctional family as a potential risk factor for abuse.

'Increased recognition of the dysfunctional family as a potential risk factor for abuse'

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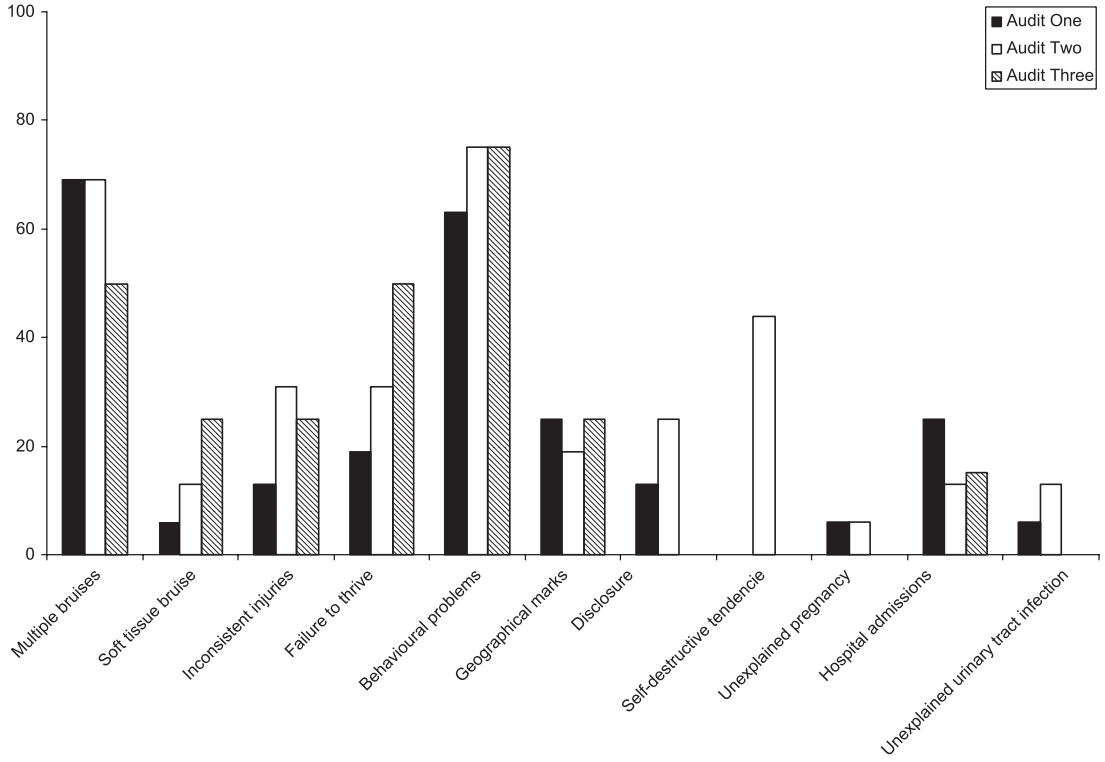

Figure 1. Proportion of responses for both dentists and DCPs according to indicators of abuse.

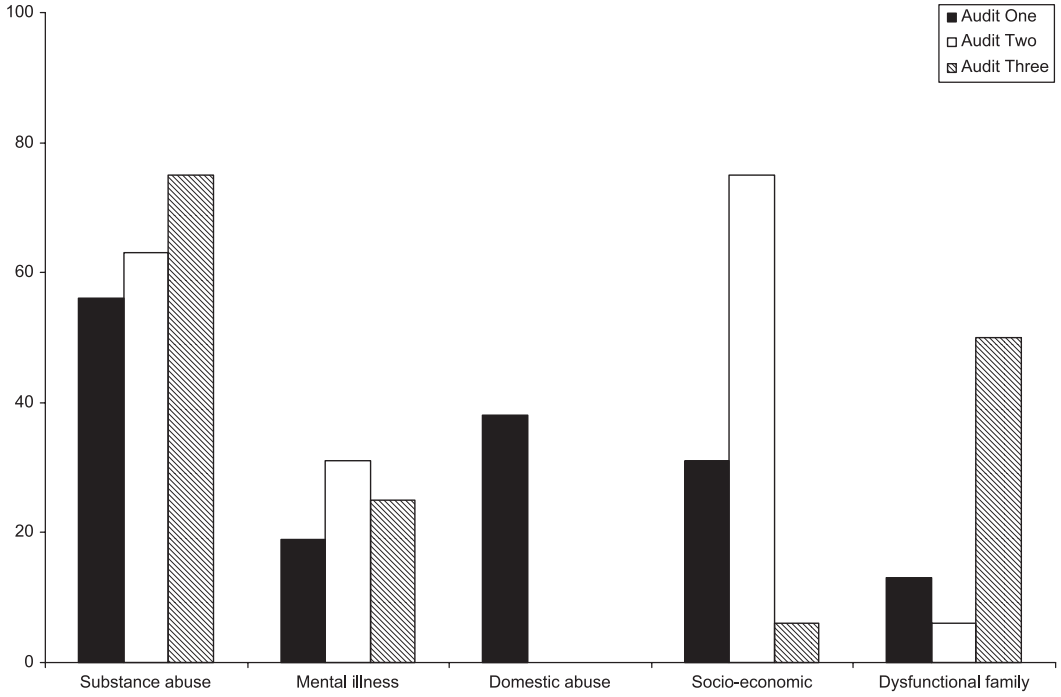

Figure 2. Proportion of responses for both dentists and DCPs regarding risk factors for abuse.

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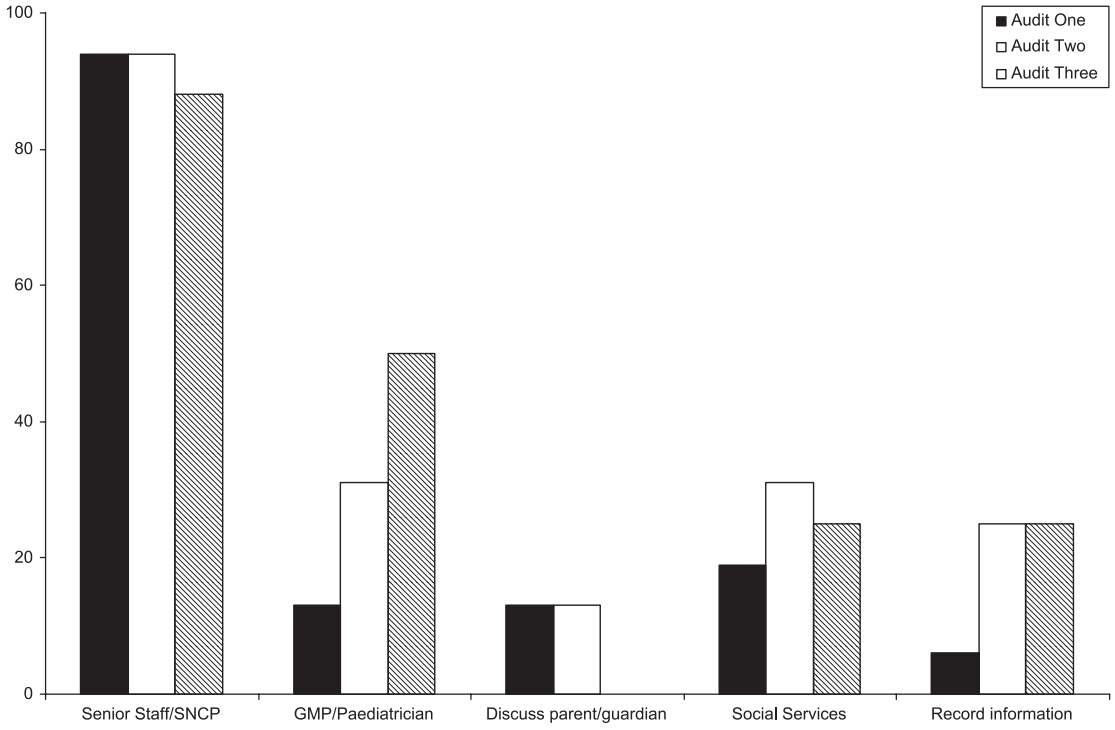

Figure 3. Proportion of respondents indicating the actions which they would consider taking where there was concern regarding a child.

Regarding what action staff would take if abuse/neglect were suspected, the majority of staff indicated that their concerns would be discussed either with a senior member of staff or a member of the child protection team, that is, the Senior Nurse for Child Protection (SNCP), whilst only a minimal number of people would air their anxieties with the accompanying parent/guardian (see Figure 3). A quarter of respondents noted that they would record their findings in a patient's case records. Concerning other professional agencies with whom staff would share information, the most common response for Audit One was social services. In Audit Two, the Senior Nurse from the Child Protection Action Group was noted as a relevant contact by the majority of respondents. Other individuals cited included: general medical practitioner; paediatrician; police and the children's reporter.

Discussion

The role of the dental team in relation to child abuse/neglect has been defined thus:

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> '(dentists) should be aware of the problems of child abuse, be able to identify and report suspected cases of child abuse, to document injuries and to insist on follow-up of treatment to oro-facial injuries' (Ten Bensel and King, 1975, pp. 348–358).

Without training, the dental team may be unaware of the issues of child abuse/neglect, be unable to recognise it and consequently, be unable to follow-up any suspected cases appropriately. Overall, the results of these audits have revealed that staff awareness of child abuse/neglect was less than optimal prior to the TCPT training session. To date, however, there appears to have been no similar hospital-based dentist/DCP's child abuse/neglect audit or reports of training programmes with which to compare the results of this study, the limitations of which must be highlighted including the small sample size and reduction in response at Audit Cycle Three. The extent to which these results can be generalised to other settings is, as a result, limited.

'Staff awareness of child abuse/ neglect was less than optimal prior to the TCPT training session'

In 2002, the Scottish Executive published the report '*It's Everybody's Job To Make Sure I'm Alright*', which emphasised that all individuals who have contact with children, including all those in the dental team, should be aware of child protection issues. Furthermore, previous workers have commented on the involvement of DCPs in child abuse education courses, stating that

> 'many dentists allowed their office staff to attend (the course). . . . some dentists no doubt recognise the importance for the entire dental office to have information on identifying and reporting child abuse' (Von Burg and Hibbard, 1995, pp. 57–63);

'The importance for the entire dental office to have information on identifying and reporting child abuse'

hence the inclusion of dental nurses and dental radiographers in the TCPT training session. Initially the DCPs demonstrated a lesser awareness of their role in child protection issues. This appeared to improve immediately after and six weeks following the training session, although the numbers were small and there was a substantial dropout amongst this group.

In relation to categories of abuse, physical abuse was the most commonly cited type of abuse at all stages of the audit, compared with neglect. This is disappointing given that 45 per cent of children placed on the Child Protection Register Scotland in 2005, following a case conference, were categorised as (physical) neglect cases (Scottish Executive, 2005b). Conversely, previous reports from the USA have noted that episodes of neglect were noted in just over 20 per cent of 1248 documented cases of abuse, compared with physical abuse which was detected in 41 per cent of cases (da Fonseca *et al.*, 1992). Perhaps the results of these audits are not surprising given that the physical abuse of the head and oro-facial

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regions are generally exposed and clearly visible to the dental team in comparison to other forms of abuse.

Regarding factors which might increase the risk of child abuse, previous reports have suggested that although more cases of child abuse have been identified in lower socio-economic groups, child abuse encompasses all social classes (Welbury and Murphy, 1998a). In addition, parents/carers who have suffered abuse during their own childhood may continue the cycle of abuse (Creighton, 1988). Within these audits, respondents identified both these areas as well as substance abuse/misuse as a potential risk factor; these characteristics have been noted previously by other authors (Welbury and Murphy, 1998b). Possibly one reason why the majority of respondents may have mentioned substance abuse/misuse is that it may be visually obvious within the dental setting; whereas the opportunity to discuss a guardian's social history is unlikely to be discussed at a routine dental check-up.

'Child abuse encompasses all social classes'

Overall, less than half of respondents in this audit declared that they would contact any person other than a senior colleague if child abuse/neglect were suspected; this observation has been noted within other studies (Jessee, 1999; Welbury *et al.*, 2003). Local guidelines operational within NHS Tayside have indicated that the initial referral be made either to the SNCP or the on-call paediatrician. Staff awareness of these local guidelines has been increased via the interactive training session and these audits. Anecdotally, however, respondents suggested that training in a didactic form or written information might have been more effective than the interactive workshop (personal communication), although due to the limited size of the study this finding cannot be generalised to other dental hospitals. Previously, staff have suggested that written, rather than verbal information is a preferred and more effective method of educating dentists. This may be of importance for the future development of inter-agency training events for the dental team (John *et al.*, 1999; Needleman *et al.*, 1995).

'Training in a didactic form or written information might have been more effective'

The Scottish Executive's report has provided evidence which confirms that staff involved in the protection of children and young people are often inadequately trained for the task (Scottish Executive, 2002) with less than 5 per cent of dentists reporting that they had received training at undergraduate level (Cairns *et al.*, 2005). In evaluating the effectiveness of this particular intervention, a self-assessment of knowledge improvement may have been useful in association with the internal audit (Keys, 2005). It is disappointing that the results from these audits would suggest that, although knowledge in most areas did increase, retention of knowledge appeared less than optimal, particularly with respect to indicators of child abuse. This highlights the need for further training within this area and perhaps modification of the training format.

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Conclusion

Deficiencies in knowledge regarding child protection issues have been highlighted and knowledge generally improved amongst the dental team within this particular dental hospital setting. Continued basic awareness training, particularly in relation to the recognition of dental neglect, would be beneficial.

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