

EDUCATIONAL REVIEW ARTICLE

The Role of the Dental Team in Child Protection- A Review

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Introduction

Child abuse and the protection of children is currently a high profile social problem. Child fatalities at the hand of abusers have raised the profile of child protection with politicians and the public. Public confidence in the services responsible for safeguarding children at risk of abuse and neglect has been weakened. Society's expectations are that children should be protected from abuse and that all organisations and personnel working with children, including the dental team, will be expected to know their roles and responsibilities.

In Scotland standard definitions of abuse and criteria for placing a child's name on the Child Protection Register were adopted nationally in 1993 following the recommendations of a joint steering group on Child Protection Information. The general definition of abuse is given as: "children may be in need of protection where their basic needs are not being met, in a manner appropriate to their stage of development, and they will be at risk from avoidable acts of commission or omission on the part of their parent(s), sibling(s) or other relative(s), or a carer (i.e. The person(s) while not a parent who has actual custody of a child)".

Five categories of abuse exist in Scotland through which there is much overlap. The categories are: physical injury; sexual abuse; non-organic failure to thrive; emotional abuse and physical neglect.¹

Prevalence of Child Abuse

In the 1980's at least four children in the UK² and 80 children in the USA^{3,4} were reported to die every week as a result of child abuse or neglect. More recent American literature approximated that 1,200 children died of abuse or neglect in 2000 (an increase from 1,100 in 1999). This figure translates to a rate of 1.71 children per 100,000 in the population.⁵ In Denmark the estimated frequency of mortality is much less at lower than 10 fatalities per year.⁶

Current figures in the UK would suggest that one to two children die per week. In Scotland child deaths from abuse are 10 per year.⁷ The main types of child abuse perhaps most easily recognised by the dental team are those of neglect and physical injury and we shall discuss these in turn.

Dental Neglect

The American Academy of Paediatric Dentistry⁸ has defined dental neglect as 'willful 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. No corresponding definition has been produced in the UK, and there has been limited debate of this issue to date.

In one study abused children were found to have eight times more untreated decayed teeth.⁹

Severe dental disease may result from a parent or carer's lack of knowledge of its causation, or from difficulty implementing the dietary habits and oral hygiene measures they would wish to, for example, because of family stress or poverty. This cannot be equated with willful neglect of a child. However, when the dental problems have been pointed out, and appropriate and acceptable treatment offered, the following may be indicators that give concern:

- irregular attendance and repeatedly failed appointments;
- failure to complete planned treatment;
- returning in pain at repeated intervals;
- requiring repeated general anaesthesia for dental extractions.

Every dental practice in Scotland has been issued with a child protection manual to help them through their child protection processes; this is entitled "Child Protection and the Dental Team, an introduction to safeguarding children in dental practice".¹⁰ Although this document was commissioned by the Chief Dental Officer for England, it has a short addendum for Scotland placed at the back of the manual which deals with differences in Scots Law and the way the local child protection process is run. This manual contains a proforma of a letter that should be sent to the child's health visitor, school nurse or medical practice highlighting the fact that the child has untreated decayed teeth, a plan for treatment has been offered but that the parent has failed to engage with this service. This is an important form of information sharing.

Physical Child Abuse

In an audit commissioned by the Scottish Executive in 2002,⁷ 30.7% of abused children were found to have suffered physical injury; the national statistic in 2000 was 37.7% and this was the most common form of abuse recorded.

Children of all ages are subject to physical abuse, but younger children, mainly four years and under are more commonly affected.^{11,12} These children have greater vulnerability, are less able to seek help and are far more likely to suffer from severe injury. Death as a result of child abuse is uncommon after one year of age.

One study from the USA indicated that of all deaths attributed to child maltreatment 80% were in children less than five years old.¹³ Violent abuse towards boys slightly outnumbers that towards girls.^{12,14} First-born children are more likely to be victims, and it is not unusual for only one child in a household to be physically abused with the other siblings unaffected.

Several studies have reported that at least 60% of the injuries to physically abused children are to be found in the orofacial region, these injuries include bruising, abrasions, lacerations, bite marks, burns and fractures.^{11,15,16,17} This high figure leads us to realise that the Dental Team are ideally placed to recognise these signs of abuse and we must be ready to act upon them. The study by Cairns et al¹² showed a lower proportion of detected intra-oral injuries compared with other studies,^{16,17} and this highlighted a training need for medical doctors carrying out child protection examinations or the need for input from specialised dentists. Dental teams may be the first or only group of professionals to see an "at risk" child especially if they are attending either for a routine check or because of dental trauma. The head and neck region is often the target of impulsive violence and orofacial injuries may occur in isolation or along with other injured body parts. The most commonly seen injuries are bruising, abrasions and lacerations, burns, bite marks, tooth trauma and eye injuries. The Criminal Justice (Scotland) Act 2003¹⁸ makes it illegal to shake a child, hit them with any form of object or hit them anywhere on the head.

Aetiology of Child Abuse

Environmental conditions combined with the personality traits of the abusing adult, and the inherent characteristics of the child, form the basis for child abuse to occur.¹⁴ Abusive adults have different personality traits and no particular profile is pathognomonic of abuse but many show trends towards violent behaviour. The majority of children are abused by people known to them, as much as 90% have been shown to know their perpetrator.¹⁹ All social classes are affected, but there is a higher prevalence in the lower social classes and in those of lower intelligence. Most crimes are committed in the child's own home.^{12,19} Many abusers have experienced similar abuse as a child.²⁰ If a parent has been abused then there is evidence that their child has a twenty times greater chance of being abused.²¹ A significant proportion of those convicted of child abuse have an existing criminal record for violence, which may have been domestic, or other criminal activity. Other factors contributing to the likelihood of abuse are drug and alcohol abuse,²⁰ unemployment and marital problems. Problems may also arise due to family bereavement or a recent family crisis. In the South African study 35% of perpetrators were found to be under the influence of drugs or alcohol at the time of the incident.¹⁹ Abusive parents often have unrealistic expectations of their children and show poor parenting skills. They may demand behaviour beyond the child's age or ability and may lack knowledge of, or refuse to recognise, basic principles of child development.^{22,23}

Children already at risk may heighten a tense situation with continual crying, tantrums or soiling their clothes hence provoking an already stressed parent or caregiver. The child may be handicapped,²⁴ the result of an unwanted pregnancy or fail to live up to their parent's expectations. For the most able parents these factors can cause domestic difficulty and frustration but, in combination with the factors already mentioned, can lead to emotional abuse, physical abuse, or neglect.

The audit commissioned by the Scottish Executive⁷ identified a number of reasons for abuse:

- Parents who lacked adequate parenting skills, often as a result of weaknesses in their own upbringing- in 14 cases parents were recorded as having experienced abuse or neglect in their childhood, a further 21 mothers and two fathers had been in care.
- Parents with addictions to alcohol or drugs who consistently or at times of pressure gave greater priority to their addiction needs than to their children's welfare.
- Parents who lacked effective budgeting and prioritising skills.
- Physically or sexually abusing adults within the family or extended family.
- Parents with mental health problems.
- Unstable family groupings which resulted in children being exposed to changing and often unsuitable parental role models.
- Bitter marriage or relationship break-ups where children's welfare became a source of conflict for parents.

Children who have been maltreated often have poor self-concepts, believe they have few friends, play with peers less often, and are less ambitious.²⁵ These negative self-images result from chronic rejection or neglect, physical or sexual assault, or emotional belittling or humiliation, and are reinforced with each additional incident of maltreatment. These children have difficulty feeling pleasure or joy and have negative outlooks for the future.^{26,27} They often view themselves as "worthless" or "bad", and feel that they deserve the punishment or rejection they receive.²⁸ As they grow up bitterness, resentment and the need to feel powerful can lead to the abuse of their own children.²¹ Even where abused children do not grow up to abuse their own children they are more likely to commit other offences. According to the National Institute of Justice in the States (1992), more than two-thirds of youthful offenders have a prior history of abuse and neglect.

The Role of the Dental Team

Diagnosis of child abuse is complex and multifactorial, and is well beyond the remit of any dental professional. It is imperative, however, that suspected cases are referred on for appropriate management. Opportunities for intervention may be sparse, and when physical signs are detected it is essential that steps are taken to help, as another opportunity with such clear evidence may not arise again for some time.

Child abuse may be a symptom of disordered parenting; the aim of diagnosis is to alleviate (if possible) the problems that the family is experiencing. Children continue to be at risk if they are returned to the home without any form of intervention from psychiatric and social services.

As the diagnosis of child abuse can be very difficult it raises obvious anxieties about the possibility of false diagnosis.²⁹ There are seven indicators to a clinician that may help in the determination of whether or not child abuse is occurring. None of these indicators are pathognomonic in isolation; neither does the absence of any of these factors preclude the diagnosis of child abuse.³⁰

- Frequently there is a delay in seeking medical assistance, or medical help may not be sought at all.

- The accident history is often vague, lacking in detail and may vary each time it is recounted. The story may also vary between the people recalling the event.
- The account of the cause of the accident may not be consistent with the actual injury sustained.
- The mood of the parents may seem unusual. Abusing parents are often preoccupied with their own problems and how quickly they will be able to return home, normal parents are full of anxiety and wish to ensure that their child is receiving the best possible care.
- The parents may act in a defensive manner rebutting accusations that have not actually been made.
- The child may have a sad or withdrawn demeanour, interaction with their parents may seem abnormal, they may even appear fearful.
- The child may say something about the incident that is different from the story given by the parent.

On examination, certain signs of trauma may be suspicious of non-accidental inflicted injury. A useful approach involves assessment of any injury in the context of the child's age group and level of development. Motor skills are critical milestones that define mechanisms of injury. Verbal skills influence ease of interpretation of the history. This age-focused approach is helpful for other reasons. One of the hallmarks of physical abuse is an inconsistency between an injury and the explanation offered, and explanation plausibility is often related to the developmental level of the child. Secondly, the motor skills of the child correlate with the amount of self-generated forces. Infants with little motor ability are unique in the extent of dependency on adults. Virtually all cutaneous bruises in the first six to nine months of life should be assessed for the possibility of abuse. In the USA a phrase describing this has been adopted; "you don't bruise 'til you cruise".

It should be noted that in contrast to early text on child abuse we are now aware that a torn labial frenum is not pathognomonic of child abuse and can occur accidentally.³¹ Likewise the theory of dating bruises has now been proven to be unreliable.³²

What should the dental team do?

Governing legislation varies between countries in the United Kingdom and there are differences in the way the Child Protection System is structured. Luckily for the dental team, involvement is essentially the same, and is outlined in the Child Protection manual mentioned previously. When a case is suspected thorough notes must be kept, including drawings and photographs of the suspect injuries. A note of any unusual behavior by the child or parent should also be recorded. The local child protection team (Child Protection Advisor) is available for help and discussion before any formal referral is made (Social Services). However, when a referral is made, the dental team should inform the family that they are making the referral to the local social services department. It is important to remember the reason for which you are referring; that is to help the family receive the support they need. Only if the child is in danger will a referral result in the child being removed from the family home. The purpose of intervention is to give the family the help required to enable them to cope with the pressures that have previously resulted in abuse. After any formal referral to social services you should contact them again 24 hours later to make sure that the referral is being dealt with.

Your involvement may end here or you may be asked to provide further evidence on your findings.

Recent studies into the role of the dental team have uncovered a need for interagency child protection training.^{33,34} Government guidance strongly suggests that the dental team should undergo this training, and it is only a matter of time until we are all mandated reporters of suspected abuse. It is our professional responsibility to ensure that we are adequately versed on our local child protection referral protocol. Under the commission of the previous Chief Dental Officer for Scotland the authors of this review in conjunction with area Child Protection Advisors have been delivering courses for the dental team on the subject of their role in Child Protection for the last four years and these section 63 courses are still available.

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