

2019-02-19

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Recommended Citation

Crowley, Evelyn Frances Martha; Byrne, Gerald; and Duane, Brett (2019) "Reporting of Child Abuse and Neglect by Salaried Primary Care Dentists," *Irish Journal of Applied Social Studies*: Vol. 19: Iss. 1, Article 6. Available at: <https://arrow.tudublin.ie/ijass/vol19/iss1/6>

Reporting of Child Abuse and Neglect by Salaried Primary Care Dentists

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Vol. 19(1), 2019, 65-74.

Abstract

Mandatory reporting of child protection concerns was introduced in Ireland in December 2017 for certain professionals and individuals including all dentists. Previous to this date, Irish dentists only had an ethical obligation to report. International literature indicates that dentists see themselves as having a role in child protection. However, there appears to be a substantial difference between the numbers of dentists who suspect child abuse and neglect (CAN) in a given case, and those who refer the case to the relevant authorities. The aim of this study was to investigate, prior to the introduction of mandatory reporting in the Republic of Ireland, the reporting of CAN by salaried primary care dentists and to identify any barriers to reporting. Two cross-sectional surveys using web-based anonymous questionnaires were sent to all Salaried Primary Care Dental Managers (N=17) and Senior and General Dentists (N=239) in Ireland in March 2017. 64.7% (n=11) of Managers and 28% (n=67) of dentists returned questionnaires. It was found that although, 30.8% of dentists had suspected at least one case of possible CAN over the previous 12 months, only 8.1% of the HSE dentists had formally reported at least one case of concern over the same period. There were clear barriers identified to the reporting of concerns. These barriers need to be addressed if Irish dentists are to meet their legal obligations of mandatory reporting of CAN.

Key Words: dentist, public dental service, reporting, child protection, abuse, neglect.

Introduction

Detection of and response to child abuse and neglect (CAN) remains a serious challenge. Many professional groups across the world, for example, teachers, child health nurses, psychologists and doctors have been found reluctant to report child abuse concerns for a variety of reasons (Bunting et al., 2010; Crenshaw et al., 1995; Hawkins & McCallum, 2001; Kalichman et al., 1990). Dentists have been found equally hesitant. International studies have found that there is a substantial difference between the numbers of dentists who suspect CAN and those who actually refer cases (Al-Amad et al., 2016; Brattabø et al., 2016; Harris et al., 2013; Lazenbatt and Freeman, 2006; Uldum et al., 2010). Significant barriers to reporting of suspected cases by dentists have been identified. Many of the barriers reported are common across studies and include lack of certainty of diagnosis, fear of violence to the child, lack of knowledge of the referral process, concerns regarding confidentiality and the potential breakdown of the relationship between the practitioner and the family (Cairns et al., 2005; Harris et al., 2013; Lazenbatt and Freeman, 2006; Kvist et al., 2012; Kvist et al., 2014; Welbury et al., 2003). Researchers have recommended further investigation in order to improve the reporting of CAN (Park and Welbury, 2016).

Mandatory reporting of child protection concerns at or above a defined threshold was introduced in Ireland in December 2017 for certain professionals and individuals including all registered dentists. Previous to December 2017, Irish dentists had only an ethical obligation to report suspected cases of CAN to the Child and Family Agency (TUSLA) and/or a member of An Garda Síochána (Irish Dental Council, 2012).

The Health Service Executive (HSE) salaried primary care dentist (HSE dentist) is the only source of access to free dental care for children in Ireland. HSE dentists have contact with at least 35% of the population of children in Ireland every year (Woods et al. 2017) and may encounter children being currently abused and neglected, including dental neglect. Dental neglect has only recently been recognised as a child protection issue (Welbury, 2014). Dental neglect “may occur in isolation or may be an indicator of a wider picture of neglect or abuse” (Bradbury-Jones et al., 2013, p. 2). Dental neglect is defined in the UK as the persistent failure to meet a child’s basic oral health needs, likely to result in the serious impairment of a child’s oral or general health or development (Harris, Balmer and Sidebotham, 2009). Many of the consequences of dental neglect as a child are carried into adulthood (Ramazani, 2014). Dentists are key members of the health care team to alert relevant authorities when a child is experiencing dental neglect.

Prior to December 2017, HSE dentists had additional responsibilities in relation to reporting of suspected CAN than private dentists in Ireland. These responsibilities assigned to them by their Chief Officer included receiving and passing on information about suspected child abuse to the relevant authorities either TUSLA, the Child and Family Agency, or a member of An Garda Síochána (police force), if reasonable grounds for concern about a child existed (HSE, 2011).

Before mandatory reporting was introduced in Ireland in December 2017, TUSLA, the Child and Family Agency in Ireland, could not provide data separately related to the number of referrals of suspected child abuse victims from certain healthcare professionals included referrals by dentists. Therefore, the number of child protection reports made by dentists was unknown. The experiences of HSE primary care dentists in reporting suspected CAN have also not been investigated.

The consequences of non-reporting can be tragic for the abused and/or neglected child both in the short and long term (Gilbert et al., 2009; Norman et al., 2012). If Irish dentists are to play a greater role in child protection and fulfil their role as a mandated person, it is essential to increase the understanding of barriers to the reporting of CAN.

The aim of this study was to investigate, prior to the introduction of mandatory reporting in Ireland, the reporting of suspected CAN by HSE dentists and to identify any barriers and facilitators to reporting.

Methodology

Permission to conduct this study was obtained from the Health Services Management/Centre for Global Health Research Ethics Committee, Trinity College Dublin, in January 2017. In addition, approval was obtained from the HSE National Primary Care Research Committee and the Principal Dental Surgeon group (HSE Primary Care Dental Managers). The research questions included:

- What is the self-reported frequency of reporting of suspected CAN to the Child and Family Agency (TUSLA) and/or a member of An Garda Síochána by HSE dentists in Ireland over the previous 12 months?
- What is the relationship between the reporting frequency of suspected CAN by HSE dentists and personal, organisational and external characteristics?
- What are the attitudes of HSE dentists to reporting of suspected CAN to the Child and Family Agency (TUSLA) and/or a member of An Garda Síochána?
- What are the perceived barriers and facilitators to reporting of suspected CAN by HSE dentists to the Child and Family Agency (TUSLA) and/or a member of An Garda Síochána?

Two web-based anonymous questionnaires were designed using the online survey creator SurveyMonkey©. The questionnaires were designed using questions from similar international studies with wording adapted for Irish terminology and readability (Brattabø et al.2016; Cairns et al. 2005; Harris, Elcock, Sidebotham and Welbury, 2009; Kaur et al., 2016; Kvist et al., 2017; Welbury et al., 2003). Consent was implied by completing all or part of the anonymous questionnaire. The first questionnaire (Dental Managers) was sent by email via the secretary of the Principal Dental Surgeon (PDS) group to all 17 PDS Integrated Service Area (ISA) clinical primary care dental managers in Ireland. The second questionnaire (HSE Dentists Questionnaire) was sent via the Secretary of the PDS Group to each of the 17 ISA Dental Managers for distribution to all frontline salaried primary care HSE (Senior and General grades) dentists (N=239). Each questionnaire was divided into 2 sections with both closed and open-ended questions. Section 1 collected information regarding the reporting of child abuse and neglect prior to the introduction of mandatory reporting in Ireland in December 2017. Section 2 collected information on the observation of neglected teeth in children (this data is not presented in this paper). It was not made compulsory to answer every question, so some questions could be skipped. Apart from the online link to the questionnaire, a PDF copy was attached to the invitation email, providing the option to participate using the ordinary postal service. A reminder email, as per ethics committee approval, was sent two weeks following the initial invitation emails. Questionnaires were distributed on the 3rd March 2017 and the survey was closed on the 24th April 2017. Any questionnaires received by the postal route were entered by the researcher (E.C.) into the SurveyMonkey© database. The survey data collected were exported into SPSS computer software Version 24© for analysis.

Results

Dental Managers Questionnaire: Eleven questionnaires were returned, one from the Dublin/North East region, three from the Dublin/Mid-Leinster region, three from the Southern Region and four from the West. The response rate to this questionnaire (Managers Questionnaire) was 64.7%.

HSE Dentists Questionnaire: The exact number of HSE dentists who were emailed the web link to the HSE Dentists Questionnaire was not available to the researchers. This was because the email link was sent via the secretary of the PDS group to individual dental managers for distribution onwards to their staff. The Secretary of the PDS group was not privy either to this information. The Office of Workforce Planning reported in April 2017 that there were 239 HSE Primary Care Senior and General Dental Surgeons employed by the HSE in the community services in 2016 (Parliamentary Question 8269/17). This figure was used in calculating the response rate to the HSE Dentists Questionnaire. Sixty-seven valid questionnaires were

returned. The response rate within each geographical region (Table 1) was 26.8% (n=15) in Dublin/North East, 31.5% (n=17) in Dublin/Mid-Leinster, 35.7% (n=25) in the South and 16.9% (n=10) in the West. The national response rate to the HSE Dentist Questionnaire was 28% (n=67).

Table 1: The total population, number who responded and response rate of HSE primary care dentists (Senior and General Grades) within each geographical region

Region	HSE primary care dentists		
	Total population (n)	Responses (n)	Response rate by region (%)
Dublin/North-East	56	15	26.8%
Dublin/Mid-Leinster	54	17	31.5%
South	70	25	35.7%
West	59	10	16.9%
All regions (National)	239	67	28.0%

Frequency of reporting of suspected CAN by HSE primary care dentists in Ireland

Dental Managers Questionnaire: Four of the 11 Managers reported having at least one child protection standard report form completed by a member of staff in their area of responsibility over the previous 12 months. In total, 5 reports were made from 4 areas. Two of the reports were made in regard to a concern about dental neglect, two reports were made in the area of general neglect and one report was made regarding physical abuse concerns about a child.

Eight of the 11 Managers returned information regarding the number of children aged 0–15 years of age (inclusive) that resided in their area of responsibility. Using this information, the estimated reporting rate of child protection concerns in a 12-month period (2016/17) by the HSE salaried dental services was 0.0038 reports per 1,000 children in the population.

HSE Dentists Questionnaire: It was found that 20 of the 65 (30.8%) HSE dentists who answered the question reported they had encountered a situation over the previous 12 months that had caused them to suspect that a child was being abused or neglected. 16 of the 63 (25.4%) HSE dentists who responded reported to have raised concerns *informally* at least once over the previous 12 months about a child with either their line manager or the TUSLA Duty Social Worker. However, only 5 of the 62 (8.1%) dentists who answered the question reported to have *formally* reported (as per standard HSE protocol prior to December 2017) at least one case of concern about a child over the previous 12 months (Table 2).

Table 2: The no. and % of HSE dentists, who reported that they had suspected a case of CAN in the previous 12 months, who raised concerns informally at least once when they did suspect and, who formally reported at least one case of CAN in the previous 12 months.

	Number of dentists who responded to question	n	%
No. of dentists who suspected CAN in previous 12 months	65	20	30.8%
No of dentists who raised concerns informally in previous 12 months	63	16	25.4%
No. of dentists who formally reported in previous 12 months	62	5	8.1%

Due to the low level of reporting of suspected CAN in the population under investigation, it was not possible to investigate the formal reporting frequency of suspected CAN by HSE dentists and personal, organisational and external characteristics.

However, prior to formally reporting a suspected case of CAN, the dentist must first be aware of the signs of possible CAN. In an effort to understand factors that might be related to whether a dentist suspects a case of CAN, the relationship between those HSE dentists who suspected or did not suspect a case of CAN and personal, organisational and external characteristics were investigated. Chi square tests were conducted using the following variables - region dentist works in ($p=0.497$), years qualified (under 20 years, 20 years or more) ($p=0.097$), postgraduate qualification ($p=0.913$), undergraduate training received in child protection ($p=0.929$) and training received in current post ($p=0.152$). It was found in this study, that those dentists who were working at least 10 years in the HSE were more likely to suspect CAN in their patients than those HSE dentists who were working less than 10 years in the HSE ($p=0.048$).

Perceived barriers to reporting of suspected CAN by HSE primary care dentists

Table 3 below outlines the main concerns reported by HSE dentists in relation to making an official report about a suspicion of child abuse or neglect. Respondents were asked to tick all responses that applied in relation to barriers that they perceived to the reporting of suspected child abuse and neglect. Only seven HSE dentists (10.4%) reported having no concerns about making an official report about a suspected child abuse or neglect case. Some of the main concerns given were lack of certainty of the diagnosis (49.3%), fear of being identified as the reporter (35.8%), fear of violence or unknown consequences toward the child (34.3%), uncertainty about the consequences of reporting (32.8%), fear of violence to myself, other staff and/or my family (25.4%), lack of knowledge of the referral process (23.9%) and lack of confidence in the child protection service and their ability to handle such sensitive cases (20.9%). In the case of a dental neglect issue, 37.5% of the dentists said that they would prefer to support the family to attend with their child for dental appointments, rather than to report the case to TUSLA.

Table 3: Concerns reported by HSE dentists in relation to making an official report about a suspected child abuse or neglect case

Type of concern	n	% reporting
Lack of certainty of the diagnosis	33	49.3%
Fear of being identified as the reporter	24	35.8%
Fear of violence or unknown consequences toward the child	23	34.3%
Uncertainty about the consequences of reporting	22	32.8%
Fear of violence to myself, other staff and/or my family	17	25.4%
Lack of knowledge of the referral process	16	23.9%
Lack of confidence in child protection service and their ability to handle such sensitive cases	14	20.9%
Fear of litigation	12	17.9%
Fear of a negative effect on the child's family	11	16.4%
It is not the dentist's responsibility	0	0%
In the case of a dental neglect issue, I would prefer to support the family to attend appointments rather than to report the case to authorities.	25	37.3%

Twenty HSE dentists (31.7%) disagreed or strongly disagreed with the statement "I have clear guidelines regarding when and to whom I should report a child protection concern". Only 21 of the HSE dentists (31.3%) reported they had received undergraduate training in child protection. Of those who did receive undergraduate training, 14 (66.6%) reported the training had a dental/oral health component to the training. Fifty-seven (85.1%) of HSE dentists responded that they had received training in child protection in their current post. However, only 18 (31.6%) of those dentists responded that this training had a dental/oral health component to the course. Thirty-two (47.8%) HSE dentists reported that they had undertaken the Hseland.ie online "An Introduction to Children First" course. Eleven (34.4%) of those HSE dentists found this online training insufficient.

Thirty-four (50.7%) of the HSE dentists and 5 (45.5%) of the Dental Managers indicated that they would like child protection courses with a larger dental component. Child protection being a core Continuing Professional Development (CPD) topic was highly supported by the HSE dentists. 57 (86.4%) HSE dentists agreed or strongly agreed with the following statement "I think child protection training should be a core Dental Council CPD requirement".

All Dental Managers (n=11) felt that they and their staff needed further education and support in managing suspected CAN cases. Local dental department (in-house) guidelines were in place in some areas but there was a lack of uniformity. Some managers referred to the presence of 'informal' guidelines at a local level. Only two out of the 11 areas reported having local dental department guidelines in place in the area of dental neglect. Eight (72.7%) of the managers felt detailed guidelines with an oral health focus would be of assistance to them and their staff in managing suspected CAN cases. Ten of the 11 Dental Managers requested additional cooperation with the Child and Family Agency (TUSLA).

Discussion

Al-Amad et al. (2016) in a review of studies from 12 countries, estimated an average of 33% of dentists who indicated suspecting a child abuse case over their career, while only an average of 10% of dentists reported their suspicion over the 12 countries included in the review. The 30.8% of HSE dentists in this study who reported that they had suspected a case of CAN over a 12 month period and the 8.1% of HSE dentists who formally reported at least one case in the previous 12 months compares favourably to the average figures from the 12 countries in Al-Amad et al.'s (2016) review.

In 2016, 47,399 child welfare and protection reports were made to TUSLA, the Child and Family Agency in Ireland (TUSLA, 2017). This represented approx. 37.9 referrals per 1000 children with 3.4 referrals per 1000 children (9%) filed by all HSE Designated Officers, which includes HSE dentists. Although only eight Dental Managers returned information on the number of children residing in their area, the reporting rate by HSE dentists in those areas was estimated to be only 0.0038 reports per 1,000 children. Therefore, prior to the introduction of mandatory reporting in Ireland, it would appear that the number of child welfare and protection reports made by HSE dentists is very low.

Kvist et al. (2017) examined dental mandatory reports within one municipality of Sweden and found an average of 0.25 reports per 1000 children per year. The estimated reporting rate of child protection concerns in a 12-month period (2016/17) by the HSE salaried dental services in this study was found to be only 0.0038 reports per 1,000 children in the population, substantially lower than in Sweden. However, Sweden had mandatory reporting of CAN in place when their study was conducted, better oral health statistics than Ireland and free access to dental services for all children. Mandatory reporting may make Swedish dentists more obligated to report. Better oral health in the population may make neglected teeth, when they do occur, less socially acceptable and therefore more likely to be reported and acted on. Free access to oral care may make the diagnosis of parental neglect easier to decide over 'circumstantial' neglect, whereby parents who want to access services and information cannot do so because of financial or other constraints.

This study has highlighted clear barriers to the reporting of CAN by the HSE dentists including lack of certainty of the diagnosis, fear of being identified as the reporter, fear of violence or unknown consequences to the child, fear of violence to oneself, other staff and family, lack of knowledge of the referral procedures, lack of confidence in the child protection service and their ability and resources to handle such sensitive cases. Many of the barriers might be considered to be perceived, rather than real, and, therefore, have complex aetiologies. Innovative approaches may need to be taken to address the basis of these barriers if we are to improve further reporting of child abuse and neglect by dentists in Ireland.

Although in Scotland improved training in child protection alone did not substantially increase the reporting of CAN, further education is often the first step to improve reporting levels (Harris, Elcock, Sidebotham and Welbury, 2009). There has been a move in the HSE towards more online training of staff, to reduce costs and standardise training modules. However, the use of only online training of staff in child protection may not explore the many barriers that exist to reporting. Some of the barriers identified in this study, for example, lack of certainty of the diagnosis, uncertainty about the consequences of reporting, lack of knowledge of the referral process, lack of confidence in the child protection service and their ability to handle such sensitive cases could be reduced by more face to face training by staff with a focus on the oral signs of CAN. Involvement of other disciplines would also be beneficial. Multidisciplinary training would provide an opportunity for dentists to understand the roles of social workers,

teachers, medical staff and Gardaí. In addition, multidisciplinary training offers an opportunity for other health care professionals to understand the importance of oral health for a child's general health and development and to be alerted to the signs of dental neglect. There was strong support by HSE dentists for child protection to be made a core CPD requirement for professional registration (86.4%).

Consideration of introducing feedback systems about children at risk involving HSE dentists would seem appropriate considering the amount of contact time HSE dentists have with the child population compared with many other professional groups. International evidence has shown that the majority of children who dentists have concerns about, already have prior contacts with the social services (Kvist et al., 2017). Many of these children have high oral health needs with little access to regular dental services, so involving dentists in feedback systems would seem right and may have a positive effect on the child's oral and general health into adulthood.

The length of service in the HSE (10 years or more) was found to be significantly related to the suspecting of CAN. Increased professional and life experience would seem to lead to an increased suspecting of CAN. A mentoring system may be of benefit for new entrants to the profession.

Although 80% of the HSE dentists (n=16) who suspected a case of CAN made the effort to speak to someone informally, only 31.3% of this group (n=5) went on to report formally. Kvist et al. (2014), refer to this "unhelpful consultation" with colleagues or other professionals. In this study, it would seem that the informal discussion with either the social work department staff or dental colleague may be a major deterrent to reporting when a dentist has expressed concerns about a child. However, the importance of this informal discussion to support the dentist to make the decision whether to report cannot be overlooked either. Advice-givers are involved in assisting dentists to decide whether to report a suspicion or not. The attitude of these advice-givers to the reporting of CAN, including dental neglect should be investigated.

The estimated response rate for the HSE dentists' questionnaire was disappointing (28%). As the researchers were unable to determine the actual number of HSE dentists emailed the survey link, they used employment figures of HSE dentists in Ireland and each regional area from a point in time (April 2016) to estimate the number of HSE dentists who were sent the link. Due to HSE restrictions on staff recruitment during the period of the study, it is unlikely that there would have been a huge discrepancy between the numbers. It is more likely that some of the HSE dentists may have been absent from work due to maternity leave, sick leave and other types of leave and that the estimate of the response rate is a conservative figure. Although the questionnaires were anonymous, the sensitivity of the topic may have affected the response rate, with those dentists who had avoided their ethical obligations to report suspected CAN in the past, less likely to participate. As filling in the child protection standard report form is a rare and challenging event, the effects of recall bias should be minimal. The barriers identified in this study are similar to barriers identified in other countries by dentists. This would suggest that the findings in this study are generalisable to the whole population of HSE dentists.

Conclusion

This study set out to investigate the reporting of CAN and the barriers to reporting by HSE primary care dentists prior to the introduction of mandatory reporting of CAN in Ireland in December 2017. The study provides a baseline to measure changes in reporting of CAN

concerns by HSE primary care dentists in the mandatory reporting period that now exists. Prior to the introduction of mandatory reporting of CAN concerns by dentists in Ireland, it would appear that the level of reporting by dentists has been very low. This low level of reporting is comparable with other countries with non-mandatory reporting systems. The findings of this study indicate that HSE dentists do see themselves as having a role in reporting child protection concerns. However, there are significant barriers to reporting which need to be addressed if HSE dentists are to contribute further to safeguarding children and meet their new legal obligations under mandatory reporting of CAN that now exists in the Ireland.

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