Domestic Violence Education for UK and Ireland Undergraduate Dental Students: A Five-Year Perspective


Abstract: The purpose of this cross-sectional study was to ascertain whether undergraduate dental students in the United Kingdom and Ireland are receiving formal teaching on recognizing and managing domestic violence (DV) as part of their curricula. A questionnaire was sent to all dental schools in the UK and Ireland in 2007 and again in 2012, requesting information on whether the subject was taught, by which specialty it was taught, and whether schools felt it was important to include in the curriculum. In 2007, twelve of the fifteen dental schools completed and returned the questionnaire, for a response rate of 80 percent; in 2012, eleven of the sixteen dental schools responded, for a response rate of 69 percent. The main findings were that, in 2007, 50 percent of the responding schools were providing teaching about DV and the majority of this teaching was delivered by oral surgery and pediatric dentistry departments. In 2012, only 45 percent of the responding schools were teaching DV, with 60 percent of this teaching being delivered by pediatric dentists. This study’s findings suggest that DV is an undertaught area in UK and Irish undergraduate dental curricula. Some schools recognized the importance of DV teaching; however, they have been unable to implement it because of a full curriculum and lack of appropriately trained staff amongst other reasons.

Dr. Patel is Academic Clinical Fellow in Oral Surgery, The University of Manchester School of Dentistry, Manchester, UK; Dr. Bailey is Academic Clinical Fellow in Oral Surgery, The University of Manchester School of Dentistry, Manchester, UK; Dr. Mahdmina is Specialist Registrar in Orthodontics, University of Liverpool Dental Hospital, Liverpool, UK; Mr. Lomax is Principal Clinical Research Scientist, GSK Consumer Healthcare, Brentford, UK; and Dr. Coulthard is Dean, Professor of Oral and Maxillofacial Surgery, and Consultant Oral Surgeon, The University of Manchester School of Dentistry, Manchester, UK.

Direct correspondence and requests for reprints to Dr. Neil Patel, The University of Manchester, School of Dentistry, Coupland 3 Building, Coupland Street, Manchester M13 9PL, United Kingdom; neil.patel@manchester.ac.uk.

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Domestic violence continues to be an issue faced by societies on a global scale. An estimated 1.2 million females and 677,000 males aged sixteen to sixty-five in England and Wales (8 percent and 4 percent, respectively, of the population as a whole) were victims of domestic violence in the year 2009-10. At least 29 percent of women and 16 percent of men in England and Wales (over 7.3 million adults) have experienced it. Domestic violence can be deadly. Since 1995, approximately half of all female murder victims aged sixteen or over in England and Wales were killed by their partner or ex-partner. This extreme violence is not limited to female victims, with 12 percent of male murder victims killed by their partners or ex-partners during the same time period, though in 2009-10, that figure reduced to 5 percent (twenty-one offenses).

Domestic violence was recently redefined by the United Kingdom’s government as follows:

Any incident or pattern of incidents of controlling, coercive, or threatening behavior, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.

Controlling behavior is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance, and escape, and regulating their everyday behavior.

Coercive behavior is an act or a pattern of acts of assault, threats, humiliation, and intimidation or other abuse that is used to harm, punish, or frighten their victim.
guidelines on domestic violence (DV), specifically including how social care, health services, and those they work with can identify, prevent, and reduce its incidence. Some of this guidance is relevant to dentists. The guidelines state that dental services have a responsibility in the safeguarding of children and young people who are affected by DV and that dentists should receive training to respond to disclosures of DV in a way that is sensitive and ensures people’s safety.  

Health care professionals are mandated to report child abuse/neglect and elder abuse/neglect to the appropriate authorities. Consequently, these topics are commonly included in the educational curricula of health professionals including dentists and other oral health care professionals.  

The General Dental Council in the UK states that dental professionals are responsible for “putting patients first and acting to protect them.”  

The council goes on to say that dental professionals have a responsibility to raise concerns they have about potential abuse of children or vulnerable adults. It is the dental professional’s responsibility to know whom to contact and to keep this information up-to-date. If DV is suspected, the dental team should report it to social services in the first instance. It is important that records are kept and that the patient consents to this information being shared.  

If in doubt about how to handle such a situation, dental professionals are advised to contact their defense unions for further assistance.  

The dental professional’s role in safeguarding vulnerable populations has grown in recent years to include adults in addition to recognition of abuse in children. The dental team is not expected to give advice to individuals experiencing DV on what action they should take. Instead, the dental team is expected to identify DV victims and provide information to them about where to find help. The UK Department of Health has published guidance for health care professionals including dentists on how to respond to DV.  

Due to the nature of dentistry, patients are often unaccompanied during examination and treatment sessions. Consequently, dental professionals are in a unique position to undertake inquiry about DV when they recognize warning signs. The purpose of identification of DV by members of the dental team is referral to the appropriate agencies.  

Since head and neck injuries account for 65-75 percent of physical trauma that occurs during DV incidents, dentists and other dental care professionals have a particular part to play in identifying DV. Furthermore, the knowledge and skills of dental professionals are often necessary to treat the orofacial injuries sustained by DV victims. In spite of this, the undergraduate dental curriculum often does not include teaching of DV topics. Because of this absence, dentists may well observe injuries but not consider DV as the cause, or they may be afraid to address the issue with the potential victim. DV training at both the predoctoral and postgraduate levels may increase the numbers of suspected DV victims being identified and referred for help.  

DV is a major public health concern in the UK. Domestic violence costs the country approximately £23 billion a year as it is one of the most common causes of non-fatal injuries. Knowledge of the subtle signs of DV, whether physical, emotional, or mental, is an important factor in correctly identifying and assisting victims. The UK Social Services Inspectorate reported in 1995 that “a goal for the future must be to include domestic violence as a subject in the core training of all health and social work professionals.”  

The inspectorate recommended that all health professionals be given basic information and taught about the nature and prevalence of domestic violence and steps that should be taken to support disclosure and prevent further violence. This education is to begin at the undergraduate level and continue in specialist training and continuing professional development. The inspectorate encouraged educational institutions to review their existing teaching and assessment approaches to ensure that DV is incorporated wherever relevant and forms part of the basic training for all health care professionals in understanding human and family relationships.  

The UK National Domestic Violence training forum has identified three training level requirements: 1) core training for health professionals, 2) additional training for health professionals with specialist responsibilities, and 3) in-depth training for professionals with a therapeutic specialty, clinical supervisors, or managers. The UK Department of Health has stated that the appropriate level of training for dentists and dental care professionals should be core training, which should ideally begin at the undergraduate level.  

Welbury et al. have shown that if training is not provided, dentists are likely to feel underprepared to assume their role with confidence in DV referral and screening. Warburton et al. have further demonstrated that even a brief DV training intervention, such as a lecture, can be effective in increasing awareness and knowledge and changing attitudes. In a survey of private dental practitioners by
regarding their attitudes and behaviors about DV, 87 percent of the respondents reported not feeling comfortable screening for DV. One of the main reasons they gave for not screening was a lack of training and education. The American Dental Education Association (ADEA)’s policy statements include an item encouraging dental and allied dental education institutions to include DV education in their curricula, including “instruction in how to recognize all signs and symptoms . . . observable in a dental visit,” reporting procedures, and information on state and federal regulations (p. 935).

To date, there has been a lack of research into the teaching of DV in undergraduate dental curricula in the UK and Ireland. The aim of our study was therefore to identify current trends in teaching of undergraduate dental students in recognizing and managing victims of DV by surveying dental school leaders in 2007 and again five years later, in 2012.

**Methods**

This research was a cross-sectional study to assess teaching patterns regarding DV in the undergraduate dental curriculum that did not require Institutional Review Board approval. A questionnaire consisting of a mixture of open and closed questions was developed and sent to each of the existing university dental schools in the UK and Ireland. The questionnaire was not tested for reliability or validity.

For Part I of the study (in 2007), contact details for undergraduate curriculum coordinators were identified by contacting the head of school in all fifteen institutions established at the time. Questionnaires were then sent to the coordinators with a covering letter and postage-paid envelope for their return. The letter reminded the respondent to consider colleagues in other disciplines who may engage. For Part II of the study (in 2012), the heads of all sixteen schools then established were e-mailed with the questionnaire attached, and respondents were asked to email their results back to the principal investigator.

Respondents were advised that their responses would be kept confidential in accordance with the Data Protection Act and that no institution/individual would be identified in any report or publication. A reminder letter (for Part I) or email (for Part II) with another copy of the questionnaire was sent if the original was not returned within fourteen days. After one additional reminder, no further contact was made if there was still no response.

**Results**

**Part I: 2007**

In 2007, twelve of the fifteen dental schools completed and returned the questionnaire, for a response rate of 80 percent. Of these, only six schools reported teaching DV in their curricula. The majority of schools taught DV as part of pediatric dentistry and/or oral surgery; one dental school covered DV as part of its dental public health teaching. A broad range of teaching modalities were reported in teaching the subject: lectures (n=5), small-group work (n=1), computer-aided learning (n=1), and video learning (n=1). Other participating schools did not specify their teaching methods. Assessment of DV teaching included essay questions, short answer questions, oral exams, multiple-choice questions, and extended matching questions. The aims reported for each school’s DV course included the following: “awareness of forensic dentistry”; “awareness of etiology of trauma to primary dentition”; and “understanding causes and circumstances of domestic violence.” Only one school specifically required understanding the definition of DV and appropriate dentist responses.

Five of the six schools that did not teach DV at the time reported having no intention of teaching the subject in the future. Interestingly, two schools that initially claimed to teach DV, although in a limited way, stated later in the survey that they did not intend to teach the subject in the future. Three of the six schools not teaching DV reported thinking it important to include in the undergraduate curriculum, whilst three did not. Reasons for not thinking DV education was important were “hardly core curriculum,” “curriculum already overburdened,” and “not essential/core subject.”

**Part II: 2012**

There were sixteen dental schools in 2012, with one new school teaching a four-year program for postgraduate students. The response rate to this study was 69 percent (n=11). Of the eleven respondents, only five reported DV teaching as part of the undergraduate curriculum. Three schools reported teaching the subject as part of multiple disciplines (all including pediatric dentistry). One school reported teaching it as part of a special study module, and two schools included some DV teaching in their “ethics, law, and professionalism” modules. When respondents
were questioned about learning outcomes from the teaching, the most common responses were “how to recognize signs of domestic violence” and “the role of the general dental practitioner.” Teaching methods used to introduce students to DV included lectures, seminars, DVDs, and small-group scenario teaching. The number of hours spent learning DV topics ranged from 2.5 to 4.5 hours during the five-year program. It was unclear from the results at what stage in the five years this learning took place. Assessment of the subject also varied, with only two schools formally testing knowledge.

Of the six dental schools that did not teach DV, two said they planned to include the subject in their curriculum, whilst four had no intention. When asked if the schools thought DV teaching an important part of the curriculum, eight replied it was important, and two replied it was not. The reasons for the latter responses were “do not see relevance,” “already full curriculum,” and “it is not a need to know subject.”

All UK dental schools participated in either the 2007 or 2012 questionnaire, with seven schools participating in both. Four schools that participated in the 2007 questionnaire did not reply in 2012, and three schools that participated in the 2012 questionnaire had not taken part in 2007. Over the five years, most schools providing DV teaching continued to teach the subject. One school maintained its position on not providing DV teaching, whilst one school reported thinking DV important and planning to introduce it in 2007 but in 2012 changed its opinion, reporting that it was no longer an important subject for undergraduates.

Discussion

The response rate was similar for our two questionnaires. When we compared the results of the two surveys, there was divided opinion on the role of DV teaching in the undergraduate curriculum. Approximately a third of the total schools participating in the two years stated they taught DV at their institution. However, there was no increase observed in the number of schools teaching DV in the 2012 survey. There was an increase in the number of schools that reported thinking the subject was important and were looking to introduce DV teaching as part of their curricula. These findings may suggest that dental educators are increasingly aware of the prevalence of DV and that dental students are being informed about the physical and behavioral indicators of DV and the role a general dental practitioner is expected to play in the management of DV victims. We hope that dental students then translate this knowledge into daily practice.

As the results suggest, DV education can be incorporated into many parts of the undergraduate curriculum. The subject may be incorporated alongside recognizing non-accidental injury in child patients or collectively as part of a behavioral science course. The use of simulated patients and workshops has also seen an increase in popularity. These modalities could act as tools to effectively convey DV information to dental students.

It was very disappointing to find that approximately half of the schools did not see the value in DV teaching and did not think its inclusion was important for undergraduate dental students. Over the five-year period between questionnaires, DV education has become more widely recognized as an important subject for dentists, so it is surprising that some schools still reported feeling that the subject lacks importance. The beliefs of course directors may influence the scope of DV teaching in the undergraduate curriculum and into which discipline it fits best. Reasons given in our survey for why DV teaching was not incorporated at some schools included lack of curriculum time, lack of expertise to teach subject, thinking it was not important to address the issue at the undergraduate level, and lack of awareness of the increasing health care impacts of DV. Moreover, some schools may have been reluctant to respond to the questionnaire, perhaps due to lack of awareness of DV education being relevant to undergraduate dental training. Although our study examined a limited sample size, its participants consisted of most of the dental schools in the specified countries, and the results will inform a larger future study.

Conclusion

This study found that not all dental schools in the UK and Ireland provided teaching and learning related to domestic violence responsibilities in dentistry in 2007. The content type and amount of time devoted to this subject did not change much over the five-year study period. Some schools recognized the importance of DV education but had been unable to implement it because of a full curriculum and lack of appropriately trained staff.
REFERENCES


