Community Dental Health (2023) **40,** 3–8
Received 14 July 2022; Accepted 4 December 2022

doi:10.1922/CDH_00153Doughty06

Dental Public Health in Action

Dental Public Health in Action: Delivering a domestic violence and abuse screening and identification training programme in North Staffordshire-based dental practices

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Domestic violence and abuse (DVA) is a significant public health problem both globally and in the UK. Dental professionals are aptly place to detect the signs of DVA and support patients to disclose DVA. However, dental professionals may lack confidence to identify and refer patients experiencing DVA; training needs in these areas were identified in Staffordshire. Glow DVA charity and the local Dental Public Health teams worked collaboratively to develop DVA training and resources specific to the needs to the dental team; these were provided to participating dental practices in the North-Staffordshire region. Feedback from the training was positive and the training was refined to better meet the needs of the dental team.mKey challenges included obtaining dental team buy in, securing funding for the continuation of the initiative and minimising the disruption to the dental team when attending training sessions or when managing a DVA disclosure. The implementation of the training highlighted the importance of DVA champions within the third sector organisations to develop and evolve the project, within dental practices to support implementation, and within the local Dental Public Health team to facilitate dental team buy-in and sustained engagement. Future plans include developing the patient-facing resources, finding ways to formally accredit dental teams for taking part in the DVA programme, and evaluating the impact of the training programme on DVA screening, identification and referral.

Keywords: *prevention, health promotion, intervention, domestic violence and abuse, dental teams*

Impetus for action

Globally, the lifetime risk of women experiencing intimate partner physical or sexual violence is 30% (World Health Organisation, 2013). The Crime Survey for England and Wales (2020) reports that 5.5% of adults aged 16 – 74 years (2.3 million) had experienced domestic abuse in the year ending March 2020 (Office for National Statistics (ONS, 2020). The Home Office (2019) estimates that the annual cost of domestic abuse in England and Wales is approximately £66 billion (Oliver *et al.*, 2019). The greatest costs are the physical and emotional harms incurred by victims (£47 billion), cost to the economy from reduced productivity (£14 billion), and health service costs (£2.3 billion). During the Covid-19 pandemic, the incidence of Domestic Violence and Abuse (DVA) increased markedly, bringing media attention to the need to improve support for people experiencing intimate partner violence (Roesch *et al.*, 2020). Though DVA is a gendered phenomenon, it is important to recognise that both men and women can be victims and aggressors of DVA. However, there are importance differences, namely that women are likely to experience more DVA, to be hurt more seriously and to be killed than male victims of DVA (Women's Aid, 2022).

Dental professionals are aptly placed to detect DVA in the dental setting (Coulthard and Warburton, 2007). Further, women agree that the dental setting is an acceptable space for DVA screening and disclosure and respond positively to enquiries about DVA from the dental team (Femi-Ajao, 2021; Nelms *et al.*, 2009). On average, 75% of DVA-related injuries present in the head and neck region (Coulthard *et al.*, 2020). Therefore, the dental professional might be the first to identify bruising and marks to the patient's neck, cheek, and ears, broken or missing teeth, trauma to the mouth or facial bones. Other indicators of DVA may include behaviours such as unease during appointments, difficulty keeping appointments or controlling behaviour from a partner, e.g. speaking on the patient's behalf. However, despite these compelling arguments in favour of DVA identification and screening and numerous DVA interventions in other healthcare settings including sexual health services and general medical practice, little has been done to train the dental team to screen for and manage disclosure of DVA (Coulthard *et al.*, 2020; Coulthard and Warburton, 2007; Devine *et al.*, 2012; Sprague *et al.*, 2016). Research suggests that the dental consultation itself and power dynamic inherent between the dentist and dental patient could be a trigger for victims of abuse (Raja *et al.*, 2014, 2015).

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In 2015, a local survey was undertaken by the Dental Public Health team in the West Midlands to understand how dental teams could have a positive impact on violence prevention. Of the 82 dental professional participants, 83% had not received or could not remember receiving any DVA training. Though 82% believed that they could spot a victim of DVA if they presented with physical manifestations of trauma, only 2% would routinely enquire about DVA in the absence of these signs. Two-thirds (63%) of respondents did not feel confident to manage a suspected case of DVA. Almost all (96%) wished for further training and information about local support services. Issues that were specifically identified included not knowing where to signpost locally, how to approach patients with DVA questions, or how to manage cases. For example, respondents gave the following free-text responses to the survey:

"I have only received training as part of adult safeguarding-not enough training specific to domestic violence."

"Other than taking detailed notes, photos, x-rays and advising the patient to report the matter to the police, I've no idea what else I could do to help manage the case besides provide dental treatment where possible."

"I was shocked to read how prevalent it is. So I must have seen and missed cases in my practice. I would like to do better."

In response to the survey findings a DVA training programme and resource package was developed and implemented in the Stoke-on-Trent and North Staffordshire area over the past five years. This article will present the approaches taken to design and deliver the programme.

Solution suggested

1. Development of a DVA training session

Glow (formerly Arch) are a charity, support network and service partner providing education and support to anyone feeling or being victim to an abusive relationship. Between January and July 2017, Glow were commissioned by Stoke-on-Trent City Council to deliver 3.5-hour DVA training sessions for members of the dental team. The aim and objectives of the course were to increase dental professionals' knowledge of DVA by exploring the extent and impact of DVA, challenging common beliefs and assumptions, discussing the stages of change model, providing insight into why victims may stay in abusive relationships, and identifying dental and psychological trauma that may be cause by domestic abuse. Furthermore, dental teams were supported with ways to ask patients about DVA and support DVA disclosures.

The training was co-developed by DVA advocates at Glow alongside Dental Public Health professionals. Advocacy and support services for adult and child victims of DVA have been provided by Glow for over 30 years. Extensive hands-on experience with victims and perpetrators of DVA was combined with case studies, local data, service evaluations and survivor consultations to design the training programme. Consultation with key dental professionals and data from the above survey were used to tailor the training to the needs of dental professionals. Several published DVA resources provided information and evidence to underpin the content of the training programme (Domestic Abuse Intervention Programs, 2017; Home Office, 2018; Standing Together, 2020).

The training covered common signs of DVA, how to engage in screening and identification of DVA, and how to respond to a disclosure and manage a patient following a DVA disclosure. In addition, the dental teams were given resources including dental floss keyrings and lip balms with the phone number of DVA services embedded in the bar code, leaflets, survivor cards, posters and safety plans. Dental teams were offered ongoing peer support following the training and "lunch and learn" knowledge updates. All members of the dental team including dentists, dental hygienists/therapists, dental nurses, managerial and administrative staff. Most attendees were female.

This initial training led to the development of a long-standing relationship between Glow and the local Dental Public Health team who were able to negotiate funding to support the continued embedding of the intervention within the area.

2. Developing a comprehensive DVA campaign

In 2019, Glow was selected as one of eight national Pathfinder pilot projects taking place across England. The Pathfinder pilot project ran from 2017 to 2020. The initiative was led by a consortium of expert partners (Against Violence and Abuse (AVA), Identification and Referral to Improve Safety (IRISi), Standing Together Against Domestic Violence) and engaged nine clinical commissioning groups and 18 NHS Trusts across England. was to provide an opportunity to develop initiatives that support healthcare professionals to recognise the signs of domestic abuse, respond appropriately to concerns and disclosures and help to end domestic abuse for good. The Pathfinder project aimed to inform The Whole Health Model, a coordinated and consistent approach to commissioning of integrated care pathways and capacity building of NHS staff to respond to DVA across acute, mental health and primary care services. Glow's focus was mental health and dental services.

Glow addressed the Pathfinder pilot project brief by designing the "Here To Help" campaign. The campaign aimed to raise DVA awareness within the dental practices, deliver guidance on implementing a safe space for patients to disclose DVA and to incentivise the embedding of DVA training into dental practice by providing accreditation / certification for the attainment of gold standard DVA practice. The DVA champion support group established during the first round of training delivery was involved during the development of the campaign. Staff at Glow together with the dental champion support group members co-developed the campaign and decided on six essential steps to support dental patient victims of DVA: (1) appoint an in-house DVA champion, (2) identify a safe, direct referral pathway for local domestic abuse services, (3) display DVA posters and leaflets in public areas, (4) have safe spaces for DVA disclosure, (5) implement and maintain a DVA policy, (6) attend annual DVA refresher training.

Dental practices would be equipped with both the training and tools to respond effectively to disclosures, provide a safe space for disclosures, avoid asking questions

in front of others, consider utilising one-to-one time when taking radiographs as a means speak to patients on their own and to know how to document concerns. As part of the campaign, participating practiced were provided with a DA policy so they were fully aware of what they needed to do should they have concerns or following a disclosure which included reference to safeguarding. Unfortunately, the Covid 19 pandemic halted the full local roll out of the pilot campaign. In Figure 1, the intervention components, patient resources, and Here to Help campaign are mapped alongside the processes used to deliver the intervention and manage a DVA disclosure.

Outcome

The initial training sessions were attended by 153 dental team members across 26 practices. All team members were invited. Feedback from dental professionals has been largely positive. Of the 148 feedback forms collated, all felt that the objectives had been met and as a result all participants felt that their knowledge after the training was excellent or good. Before training no dental professionals ranked their knowledge as excellent.

As the programme expanded between the 2017 launch and present time, it became increasingly comprehensive

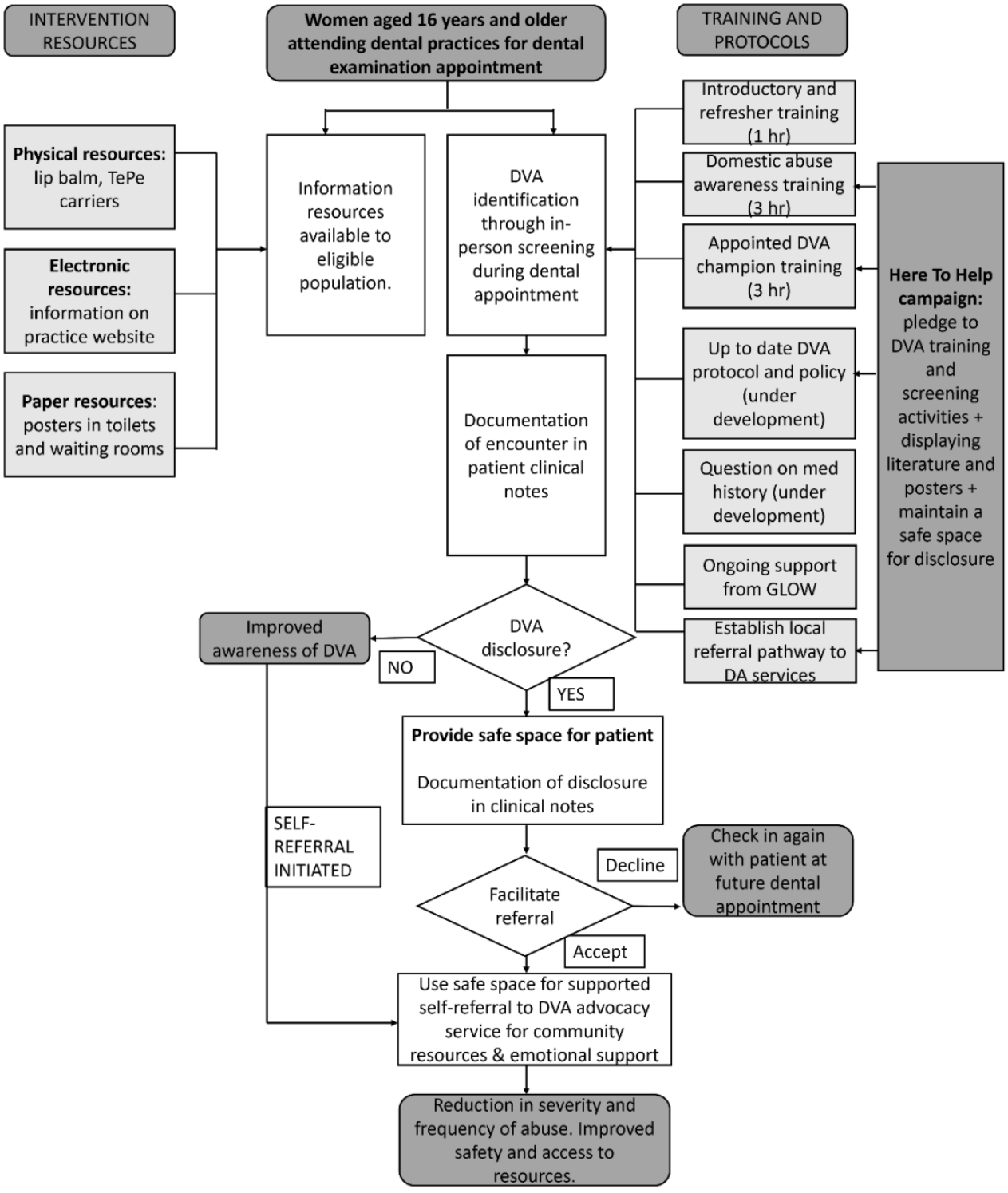

Figure 1*. Glow intervention process map.*

and in addition to the initial 3.5-hour dental team training, a 1-hour introductory session was introduced and a 3-hour training session for appointed DVA champions. More bespoke resources were designed for use in dental settings including co-produced DVA policies and procedures, red flag alerts for clinical notes, information for dental practice waiting room televisions, social media posts and websites, and TePe carriers which discreetly contained phone numbers for DVA advocacy and support agencies. The training programme has been strengthened by producing survivor videos, continuing to coordinate peer support groups and developing screening questions for patients.

Several key practices in the Stoke-on-Trent and North Staffordshire area have taken local ownership to develop their in-house approaches to DVA by introducing information to their websites and enabling a rapid-exit feature that immediately closes the web browser to ensure patient safety when viewing information about DVA.

Challenges and how these were addressed

Third sector challenges

Dental team "buy-in" was a notable third sector challenge, with some teams reticent to participate in the project because of time constraints and uncertainty about relevance to their clinical role. To address these issues, a local Oral Health Improvement Lead acted as a DVA champion. The DVA champion enabled Glow to understand how to meet the needs of the dental team and supported dental teams to understand how DVA screening and identification could be embedded into their clinical practice. Additionally, CPD certification of the programme increased dental professionals' willingness to attend training sessions. Securing consistent funding to continue the project posed limitations for third sector involvement. Small pockets of funding were available through the Shropshire and Staffordshire Local Dental Network budget of NHS England and Improvement and the Pathfinder initiative. However, long-term funding is crucial for the project to be sustained by a dedicated DVA worker. The DVA lead for the project had competing priorities that limited the time available to develop and evolve the initiative.

Clinical challenges

The business of the clinical environment and competing priorities posed challenges for the dental teams implementing DVA screening. Glow and the Dental Public Health team aimed to ensure that training and subsequent implementation of DVA screening were as straightforward and minimally burdensome as possible for dental professionals. In response to this challenge the 1-hour lunch-and-learn style introductory training was introduced to minimise time away from clinical duties. Additionally, some practices chose to integrate DVA screening questions alongside Covid-19 screening questions and were routinely asking all patients about their safety at home.

Disruption to clinic schedules following a disclosure of DVA was a cause for concern for dental practices. In response to this challenge, practices were encouraged to identify a confidential space, known as a "safe space" where discreet conversations and referral processes could take place following a disclosure of DVA. In these spaces, patients can contact DVA services to discuss their options and can initiate a self-referral. Though dental professionals may initiate the introductory conversation on the patient's behalf, the patient is empowered to take forward the conversation with the DVA services within the supportive environment of the dental practice. If patients do not want an immediate referral, the safe space will remain available for them to utilise in the future. By using this approach following DVA disclosure, the burden to the dental professionals' time and disruption to usual workflow is minimised.

Dental Public Health challenges

Another key challenge was to elicit the best approach to measuring the "success" of the intervention, i.e., intervention effectiveness as measured by onward referral to DVA services. The reason for this challenge is that victim referral (or self-referral) into DVA advocacy and support services often takes a convoluted path with multiple points along the journey that lead to the initiation of help-seeking behaviour. It takes most DVA victims (85%) at least five help seeking encounters before they get effective support (Safe Lives, 2015). Given the complex nature of DVA, intermediate outcomes that could be used in future iterations of the project include documentation of identification of DVA in clinical notes, or documentation of interactions where patients have been asked about DVA (Feder *et al.*, 2011).

At the time of intervention delivery, DVA services were not collecting data about which healthcare services were responsible for contributing to the decision to seek help through professional or self-referral. This challenge was addressed by communicating with the service leads to convey the importance of obtaining more detailed data that could provide insight about referral sources from health care, including dental practice.

Alternative outcome measures, such as the proportion of the target population (women aged 16 years and over) screened for DVA posed data collection challenges for two reasons. First, dental professionals commonly failed to document conversations about DVA in the clinical notes; this has subsequently been addressed as part of the training. Secondly, the dental software searching and reporting functions were not capable of identifying episodes of DVA screening and identification from the clinical notes. With several dental software programmes on the market, no one-size-fits-all approach was available to resolve this issue and each programme required a unique solution for data collection processes. Dental teams have shown willingness to contact their software support to find solutions and the process is ongoing.

Learning points

A fundamental learning point from the early phase of the project was the value of having dedicated DVA champions at three points: (1) within the third sector DVA organisation to develop and evolve the project, (2) within each dental practice taking part in training to support implementation, and (3) within the local Dental Public Health team to facilitate dental team buy-in and sustained engagement.

Although DVA disclosure may not be an everyday occurrence in dental practice, when dental professionals provide resources and information, are alert to the signs of DVA, are willing to ask uncomfortable questions, and know how to offer support and referral, their actions can change lives for victims of DVA. As the training has developed dental teams have been encouraged to adopt a holistic approach and to think 'family' whenever there are concerns about a patient, e.g., episodes of "Was Not Brought" where DVA may affect the ability of a parent to bring their children to the dentist.

One female patient who self-referred to a local Staffordshire DVA support service after seeing a poster in the dental waiting room explained:

"I didn't know where I could turn to get help until that point. Look at me now, I'm no longer with him and me and my daughter are safe. I'm even getting my confidence back and becoming the old me again. That day in the dentist changed my life forever, in ways I never thought possible."

Future implications

Those teams that have already been trained require refresher courses / updates or continued participation in peer support groups facilitated by DVA service providers to maintain their skills. In addition, most attendees to the training sessions are female. Under-representation of male dental professionals attending the programme needs to be addressed, to ensure that all members of the dental team are adequately trained to screen for and identify DVA. There has been increasing interest from organisations including Health Education England in the Midlands to educate newly graduated dentists about DVA during their foundation training year.

Following the passage of the 2022 Health and Care Act, Integrated Care Systems (ICS) have been formalised as legal entities, possessing statutory powers and responsibilities. Key aims of ICS include improving population health outcomes, tackling health inequalities, enhancing productivity and value for money, and broader social and economic development supported by the NHS. Identifying and responding to DVA in dental practice is aligned with the aims of the ICS by creating opportunities for collaboration and joined-up support from DVA agencies and dental services, integrating the efforts of these health and care services to ensure joined-up support to better meet the needs of the population (The King's Fund, 2022).

Toward this end, the next steps include continuing to find ways to easily embed the programme into dental practices including: refinement of policy and guidance documents, continuing to encourage uptake of the "Here to Help" pledge programme, introducing DVA screening to medical history forms and distributing a short DVA video to display in practice waiting rooms that have screens. Further, formal evaluation of the intervention will explore intervention effectiveness and measures of acceptability to dental professionals and patients with a view to underpinning the intervention with evidence-based measures of effectiveness that can be replicated nationally.

Conclusion

The dental setting offers a unique opportunity to identify dental patients affected by DVA and to provide them with resources and safe spaces to encourage disclosure and linkage to services. However, the development and implementation of a DVA screening intervention, referral process and dental-specific DVA resources presented a number of challenges for third sector, Dental Public Health and clinical teams. These were overcome by refining the intervention to meet the needs of the clinical environment. To evaluate the intervention further, understanding processes required to collect data the computerised clinical notes and decisions about the appropriate outcome measures to determine the effectiveness of the intervention are imperative.

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