

Submission to the Second Action Plan under the National Plan to End Violence against Women and Children 2022–2032

I am a Specialist Paediatric Dentist and Senior Lecturer in Paediatric Dentistry at The University of Western Australia. My clinical, teaching and research work includes child safeguarding, family and domestic violence, trauma-informed dental care and integration between oral-health and child-protection services.

My comments focus on **Priority Area 3: Children and young people in their own right** and **Priority Area 5: System integration and workforce**.

Oral healthcare should be part of the safeguarding system

Oral healthcare is largely absent from current universal-service responses to violence against women and children. Dental professionals provide care across childhood and adulthood, examine the mouth, face, head and neck, may encounter oral and facial injuries, maintain longitudinal clinical records and may receive disclosures of violence, abuse or neglect.

Their role is not to investigate or determine whether violence has occurred, but their role is to recognise possible safeguarding concerns, respond safely to disclosures, document objective clinical findings, understand reporting and referral obligations, and contribute appropriately to multidisciplinary care.

Recommendation 1

Include oral healthcare within relevant universal-health-service actions under the Second Action Plan.

Violence and coercive control may restrict access to dental care through deliberate prevention of attendance, interference with healthcare decisions or use of appointments to monitor or locate a child or protective caregiver.

Missed appointments or incomplete treatment should not, by themselves, be interpreted as evidence of abuse or neglect. However, deliberate obstruction of dental care may result in untreated disease, pain, infection and avoidable tooth loss.

Priority Area 5: System integration and workforce

Dental professionals may encounter safeguarding concerns through disclosures, injuries, clinical history, interactions or patterns of healthcare access. The opportunity is not for dentists to diagnose family violence, but to ensure they can recognise concerns, respond safely and refer appropriately.

Oral-health workforce capability should include:

- recognition of possible safeguarding indicators;
- safe response to disclosures;
- trauma-informed and culturally safe communication;
- objective documentation of oral and facial injuries;
- relevant reporting obligations; and
- referral pathways

Recommendation 2

Include oral-health professionals in national safeguarding and family-violence workforce capability initiatives.

Develop nationally consistent capability principles, supported by jurisdiction-specific guidance on reporting, privacy, information sharing and referral.

Improve referral and information sharing

Integration must operate in both directions.

Dental professionals need clear pathways to child-protection, family and domestic violence and specialist support services. These services should also understand what relevant oral-health information may contribute to assessment and care.

This may include objective documentation of injuries, treatment needs, clinical history and patterns of healthcare access. Information sharing must be lawful, proportionate and directed to patient safety.

Recommendation 3

Develop and evaluate referral and information-sharing pathways linking appropriate oral-health services with child-protection and family and domestic violence services.

Initial pilots should focus on public, community, hospital and paediatric dental settings where multidisciplinary pathways can be evaluated.

Trauma-informed and culturally safe implementation

Trauma informed dental care should be developed with victim-survivors, including children and young people where appropriate, specialist services and oral-health professionals. Approaches affecting Aboriginal and Torres Strait Islander people should be developed with Aboriginal Community Controlled Health Organisations and relevant communities.

Evidence gaps

Australia has limited evidence on the relationship between oral health, dental access and family, domestic and sexual violence.

Priority research areas should include:

- oral-health needs of people affected by violence;
- barriers to accessing and completing dental care;
- safeguarding capability of the oral-health workforce;
- safety and acceptability of responses within dental settings;
- effective referral pathways;
- the value of dental documentation in multidisciplinary care; and
- outcomes of integrated service models.

Recommendation 4

Support Australian research and pilot programs evaluating the role of oral-health services within integrated safeguarding responses.

Evaluation should focus on safety, acceptability, cultural safety, workforce feasibility, referral effectiveness and measurable outcomes.

Conclusion

Oral healthcare should be part of Australia's broader safeguarding response.

Dental professionals should not investigate family violence or treat dental disease, missed appointments or behaviour as evidence of abuse or neglect. However, they may encounter injuries, disclosures and circumstances that raise legitimate safeguarding concerns.

The Second Action Plan should:

- **include oral health within universal-service initiatives; strengthen safeguarding capability across the oral-health workforce; establish clear referral and information-sharing pathways; and build the Australian evidence base through evaluated integrated models.**