Journal of the Royal Society of New Zealand

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/tnzr20

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To cite this article: Heuiwon Han, Jane Koziol-McLain, Kate Diesfeld, Samuel D. Carrington, Zac Morse & Amanda B. Lees (01 Dec 2024): Protecting children in Aotearoa New Zealand: a review on legal and professional frameworks for oral health practitioners, Journal of the Royal Society of New Zealand, DOI: 10.1080/03036758.2024.2430597

To link to this article: https://doi.org/10.1080/03036758.2024.2430597

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Published online: 01 Dec 2024.

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JOURNAL OF THE ROYAL SOCIETY OF NEW ZEALAND
https://doi.org/10.1080/03036758.2024.2430597

REVIEW ARTICLE

Protecting children in Aotearoa New Zealand: a review on legal and professional frameworks for oral health practitioners

Heuiwon Han [a,b], Jane Koziol-McLain [b], Kate Diesfeld [c], Samuel D. Carrington [d], Zac Morse [e] and Amanda B. Lees [c]

[a]Department of Oral Health, School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand; [b]Centre for Interdisciplinary Trauma Research, Auckland University of Technology, Auckland, New Zealand; [c]School of Public Health and Interdisciplinary Studies, Auckland University of Technology, Auckland, New Zealand; [d]Te Arawa, Ngāti Whakaue, Ngāti Pikiao, Ngāti Hurungaterangi, Ngāti Rongomai, Ngāti Te Kahu o Ngāti Whakaue, Sir John Walsh Research Institute, Te Kaupeka Pūniho Faculty of Dentistry, Ōtākou Whakaihu Waka University of Otago, Ōtepoti Dunedin, Aotearoa New Zealand; [e]College of Dentistry, American University of Iraq-Baghdad, Baghdad, Iraq

ABSTRACT
The United Nations Convention on the Rights of the Child asserts that all children have the right to protection from abuse and exploitation. In Aotearoa New Zealand, the prevalence of child maltreatment requires vigilant action from oral health practitioners (OHPs), who are often among the first in the position to recognise signs of abuse and neglect due to their frequent interactions with children in dental settings. The Dental Council of New Zealand sets professional requirements, highlighting practitioners' roles in responding to potential signs of maltreatment. Multiple statutes, including the Oranga Tamariki Act 1989 and the Family Violence Act 2018, govern OHPs' responses. Despite this, there is a notable gap in OHPs' confidence and understanding of their child protection roles, underlining the need for clear guidance on the legal and professional requirements that inform their responsibilities. This paper critically examines the professional responsibilities and policies governing OHPs in Aotearoa New Zealand regarding child protection responses. It also proposes the development of equity-focused guidelines, that are informed by Te Tiriti o Waitangi, emphasising culturally responsive practices, collaborations with Māori health providers and clear protocols for child protection responses.

ARTICLE HISTORY
Received 6 August 2024
Accepted 12 November 2024

KEYWORDS
Child abuse; child maltreatment; child neglect; dental; dental practitioners; equity; oral health therapist; paediatric dentistry; professional guidelines; safeguarding children

Introduction

The United Nations Convention on the Rights of the Child (UNCRC) (1989), which is the most widely ratified treaty, asserts that all children have the right to safety from harmful influences, abuse, and exploitation. In Aotearoa New Zealand, oral health practitioners (OHPs) often find themselves at the forefront of identifying child maltreatment

CONTACT Heuiwon Han heuiwon.han@aut.ac.nz
Supplemental data for this article can be accessed online at https://doi.org/10.1080/03036758.2024.2430597.
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due to their regular contact with children. This is especially important given the high rates of child abuse and neglect (CAN) in the country, with recent reports consistently highlighting the need for proactive interventions (Oranga Tamariki 2023). OHPs, through their frequent interactions with children and adolescents, have the potential to detect and respond to child protection concerns. However, there is uncertainty surrounding their professional responsibilities in responding to these cases.

The World Health Organization defines child maltreatment, which is often referred to as CAN, as:

> (t)he abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (World Health Organization 2022).

The negative immediate and long-term consequences of child maltreatment are well-known (Leeb et al. 2011; Avdibegović and Brkić 2020; Berber Çelik and Odacı 2020; Mehta et al. 2021). These consequences range from permanent physical and mental health impairments (Mehta et al. 2021) to increased risks of various health, emotional and social conditions, such as depression and anxiety, in adulthood (Leeb et al. 2011; Avdibegović and Brkić 2020; Berber Çelik and Odacı 2020).

Unfortunately, in Aotearoa New Zealand some children and adolescents are not adequately protected from maltreatment, which prevents them from growing up in safe, loving and nurturing environments. In the 12 months to 31 March 2023, there were 51,600 reports of concern to Oranga Tamariki (the New Zealand statutory agency responsible for the welfare and protection of children and young people under the age of 18) and 37,800 assessments or investigations (Oranga Tamariki 2023). Considering that there were approximately 1,166,000 children on 31 March 2023 (StatsNZ 2023), this equates to 4.4% reports of concern and 3.2% assessments or investigations of the total child population (Oranga Tamariki 2023). In the same period, 6,550 family group conferences were held, leading to 780 new entries to the care and protection custody of the chief executive officer of Oranga Tamariki, which increased the total number of children in care to 4,400 (Oranga Tamariki 2023).

Colonisation has profoundly affected Māori; this is especially so with regard to child protection laws, in which the Crown's failures have been significant (Cox 2021). Historically, Aotearoa New Zealand's approach to child welfare did not adequately consider Māori perspectives or incorporate tikanga Māori (Māori customs) (Worrall 2016). Reports such as Puao-te-Ata-tu (day break) (1988) highlighted systemic issues in social services that led to disproportionately high numbers of Māori children in state care, reflecting a lack of culturally appropriate care and a breach of Te Tiriti o Waitangi principles (the foundational treaty in Aotearoa New Zealand, establishing a partnership between Māori and the Crown) (Ministry of Social Development 1988; Hyslop 2021). More recent reviews and investigations, such as those by the Children's Commissioner, continue to reveal that tamariki Māori (Māori children) are over-represented in the child welfare system, underscoring ongoing colonial impacts and the urgent need for reforms that respect Māori governance and enhance partnership models as per Te Tiriti o Waitangi (Keddell and Davie 2018; Keddell et al. 2022). It is crucial that any future actions and

reforms are realigned to better serve Māori communities, fostering environments where tamariki Māori can thrive within the embrace of their culture and heritage (Hyslop 2021; Worrall 2021). In accordance with Te Tiriti o Waitangi, health practitioners, including OHPs, have a crucial responsibility to partner with Māori to address health and social disparities, ensuring equitable access to protection and support for all children and their families to uphold their rights and dignity (Child and Youth Wellbeing 2022). It is critical for OHPs to recognise their unique position to protect children from potential harm.

In Aotearoa New Zealand, free dental care is provided to children and adolescents under 18 years of age (Te Whatu Ora 2024). Children and adolescents have regular contact with OHPs in various dental settings, such as general dental practices, specialists' practices, community clinics, school-based clinics and Māori oral health services. For some children and adolescents, regular dental visits may be their sole interaction with healthcare professionals, given that routine medical check-ups are not common for many. Furthermore, they are often assessed by OHPs at schools without parents or caregivers. OHPs' unique frontline position to identify and respond to concerns of child maltreatment enables them to detect signs and symptoms early and to intervene to avert severe health and social outcomes. The potential responses by OHPs may encompass referring children and families to child welfare agencies or family assistance groups, as well as engaging in collaborative and interdisciplinary approaches with partners, including other health practitioners, social practitioners, and school staff, to assist families in exploring their journey to access adequate support. The response should be equity-focused, underpinned by Te Tiriti o Waitangi and aim to improve outcomes for Māori to reduce health and social inequities (Child and Youth Wellbeing 2022).

Two Aotearoa New Zealand-based studies have emphasised the key role that oral health therapists and dental therapists can play in child protection (Tilvawala et al. 2014; Han et al. 2022). In the most recent survey, 74% of participating oral health therapists and dental therapists reported they had encountered one or more suspected cases during their careers (Han et al. 2022). However, only 21% reported concerns to child protection agencies, such as Oranga Tamariki or the New Zealand Police. Interestingly, while almost all participants (99%) considered responding to child maltreatment concerns as a part of their professional role, fear of false reporting (70%) and lack of knowledge on how to report potential cases (56%) were evident. Although the study did not include all OHPs (including dentists and dental specialists), and its results cannot be generalised to all OHPs, the findings indicate there is room for improvement in identifying early signs of CAN and responding to support children and their families.

The World Health Organization (2020) advocates globally scaling up the collaborative prevention approach to enhance the effectiveness of prevention and implementing training and support services. Some countries, including Australia, mandate that OHPs report suspected CAN (Australian Institute of Family Studies 2023). In contrast, there is no legal mandate for OHPs in Aotearoa New Zealand to report cases of suspected child maltreatment. Instead, OHPs must apply clinical judgment on a case-by-case basis and be guided by their own ethical principles and professional standards (DCNZ 2021a, 2021b, n.d.). However, the professional standards for OHPs do not provide detailed protocols on how to fulfil their responsibilities when it comes to suspected or actual CAN. Further, no research to our knowledge has explored the professional requirements by which

OHPs in Aotearoa New Zealand are governed. As statutes influence OHP practice, it is critical to understand their relevance to provide collaborative care and facilitate adequate support for children and their families.

This review aims to address two key objectives: (1) to critically examine the professional requirements for OHPs in child protection responses in Aotearoa New Zealand, and (2) to propose the development of equity-focused guidelines informed by Te Titiri o Waitangi, which emphasise culturally responsive practices. This examination will review relevant legislation such as the Oranga Tamariki Act 1989 and the Family Violence Act 2018, alongside professional standards established by the Dental Council of New Zealand (DCNZ) and other professional bodies. This paper will analyse these documents to clarify OHPs' professional responsibilities in child protection contexts. The scope of this review only considers Aotearoa New Zealand legislation and professional standards that influenced the practices of OHPs as of July 2024; it does not consider any international legislation or dental standards.

Materials and methods

The primary sources for this review included comprehensive legal documents and professional guidelines from Aotearoa New Zealand. An extensive examination of government legal databases, publications from professional regulatory bodies and publications from professional associations was undertaken. Key documents selected were based on their relevance to the roles and responsibilities of OHPs in child protection. These sources directly related to the legal obligations and professional guidelines affecting OHPs' practice, with a particular emphasis on child protection. Priority was given to the most recent documents to reflect up-to-date legal standards and professional expectations, especially if multiple versions or amendments were available. Specific legislation such as the Oranga Tamariki Act 1989 (Supplementary material 1) and the Family Violence Act 2018 (Supplementary material 1), alongside professional standards issued by the Dental Council of New Zealand (DCNZ) and guidelines by the New Zealand Dental Association (NZDA) were included in the review.

Information extracted from the selected sources encompassed OHP guidelines on managing cases of child maltreatment, ethical obligations, and procedural directives. The narrative analysis involved a critical evaluation of professional guidelines to determine their implications, and potential gaps in addressing concerns related to child abuse and neglect. The analysis was conducted by an interdisciplinary research team with expertise in dental professions, Hauora Māori, family violence, health law, health ethics, and interdisciplinary health research. The analysis included interpreting practical implications for OHPs in clinical settings and assessing how sources support the practitioners in identifying and responding to child protection issues.

Findings

A total of four Aotearoa New Zealand statutes, three government departments' guidelines, two regulations, one dental regulatory authority scope of practice document, and one dental professional association policy statement are included in this review.

OHPs' roles in child protection

While the Oranga Tamariki Act 1989 and the Family Violence Act 2018 do not impose a legal duty on OHPs to report suspected CAN, these statutes underline the important role that OHPs play in recognising and responding to CAN within their professional scope. The Oranga Tamariki Act 1989 (Supplementary material 1) aims to promote the well-being of children and young people. The Oranga Tamariki Act 1989 emphasises the need for a supportive, safe, and caring environment for children and young people. It establishes the principle that their welfare and best interests are paramount considerations in any action or decision affecting them. Specifically, Section 14 of the Oranga Tamariki Act 1989 (Supplementary material 1) deals with the reporting of children or young people in need of care or protection. While it does not explicitly mandate OHPs to report, it provides a framework for anyone who believes that a child needs care or protection to report their concerns to the appropriate authorities; in most cases would be Oranga Tamariki. OHPs, through their professional interactions, may become aware of signs of neglect or abuse and, although not legally mandated under this statute, are ethically encouraged to take appropriate action based on Section 14 of the Oranga Tamariki Act 1989.

In community oral health and paediatric dental practices, the Oranga Tamariki Act 1989 plays a critical role in shaping clinical and safeguarding protocols, with particular emphasis on the child's welfare and well-being as the foremost consideration. Section 13 of the Oranga Tamariki Act 1989 underpins this principle, mandating that the welfare and best interests of the child or young person be the primary focus in all decisions and actions concerning them. This principle not only guides OHPs in clinical decisions but also leads them towards vigilant safeguarding practices, ensuring that the child's best interests are always at the forefront. Furthermore, Section 18 of the Oranga Tamariki Act 1989 (Supplementary material 1) advocates for the principle of early intervention, reinforcing the importance of identifying and intervening early upon any signs of neglect or abuse within the dental care setting. This proactive approach is instrumental in preventing more severe complications, highlighting OHPs' role in child protection concerns, thereby facilitating timely support and intervention for the child or young persons in a collaborative manner.

Also, the Code of Health and Disability Services' Rights (the Code) may be a source of OHPs' duties in this regard. They are in the schedule of the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996. Skegg (2015) observed that while the Code is expressed in terms of rights, clause 1(2) states that "Every provider is subject to the duties in this Code." OHPs are health providers for purposes of the Code. Right 4(2) provides that "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards." Right 4 (3) states that "Every consumer has the right to have services provided in a manner consistent with his or her needs". Right 4(4) states "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer". Thus, OHPs' patients are entitled to these rights and reporting CAN in appropriate circumstances could minimise the potential harm to their patients.

Although there is no legal mandate for OHPs under the Oranga Tamariki Act 1989 and the Family Violence Act 2018; the Crimes Act 1961 may be relevant. Section 515 refers to the duty to provide necessaries and protect vulnerable adults from injury: "Every one who has actual care or charge of a vulnerable adult and who is unable to provide himself with necessaries is under legal duty—

(a) to provide that person with necessaries, and

(b) to take reasonable steps protect that person from injury."

Skegg (2015) argued that Section 151 "should not be interpreted to discriminate against young people, depriving them (in effect) the right to necessaries that is provided for people who are eighteen years of age or older" (p. 661).

Also, the duty of a parent or guardian to provide necessaries and protect from injury is contained in Section 152: "Every one who is a parent, or is a person in place of a parent, who has actual charge of a child under the age of 18 years is under a legal duty—

(a) to provide that child with necessaries, and

(b) to take reasonable steps protect that child from injury."

Skegg (2015) noted both Section 151 and Section 152 apply to those who have "actual care or charge" of these categories of people and create the duty to "take reasonable steps" to protect the person from injury. When a duty applies and is breached, it could lead to a criminal conviction, if the other elements of the relevant offences are present.

Potentially relevant offences are detailed in Sections 195 and 195A of the Crimes Act 1961 (Supplementary material 1). Section 195 applies to ill-treatment or neglect of a child or vulnerable adult and Section 195A refers to the failure to protect a child or vulnerable adult. Of relevance to OHPs, these sections apply to "a person who is a staff member of any hospital, institution, or residence where the victim resides" (Section 195(2)(b), Section 195A(2)(b)). OHPs, including paediatric dentists, oral and maxillofacial surgeons, community dentists and oral health therapists, are involved in providing specialised care to children and adolescents within hospital settings. If there is a major departure from the standard of care expected of a reasonable person, the duty holder may be liable for imprisonment not exceeding 10 years (Section 195(1), Section 195A(1)). An overview of the offences and advice to nurses and health workers more generally on how to best protect their patients was reported by Barnett-Davidson (2012). In her view:

> … (I)f a nurse has a suspicion based on evidence that another person poses a risk of serious harm to their patient, s/he should act on such suspicion and err on the side of caution, rather than waiting for clear knowledge … (I)t is essential nurses have good systems in place where they work that facilitate reasonable steps they must take to protect such patients (Barnett-Davidson 2012, p. 31).

Thus, understanding the broader legal context surrounding child protection is essential for OHPs.

Reporting and information sharing

Section 66C of the Oranga Tamariki Act 1989 (Supplementary material 1) and Rule 11 of the Health Information Privacy Code 2020 (issued under the Privacy Act 2020) (Privacy Commissioner 2020) specify the legal requirements for using and disclosing private and confidential information. Two statutes provide that OHPs can use patients' information for the purpose of preventing or reducing the risk of child maltreatment and can disclose it to child welfare and protection agencies or independent people if disclosing the information is reasonably believed to assist them in acting to protect patients from maltreatment. Both the Privacy Commissioner (2015) and Oranga Tamariki (2019) have practical guidelines to assist professionals, including health practitioners when disclosing the personal information of vulnerable children and their families.

The capacity to use and disclose personal information is further reinforced by the Family Violence Act 2018 (Supplementary material 1). It aims to stop and prevent family violence from recurring. This involves recognising signs of family violence, interrupting the use of violence and keeping victims safe. Section 19 of the Family Violence Act 2018 includes an OHP as a social services practitioner, which is defined as "an individual who is providing education, health, or other social services" and "registered with an authority as a practitioner of a particular health profession under the Health Practitioners Competence Assurance Act 2003". Section 20(4) of the Family Violence Act 2018 indicates practitioners "may disclose the personal information" on reasonable grounds that the disclosure will or may help other agencies or practitioners to stop and prevent family violence and are allowed to share information or upon request for family violence response purposes. Also, Section 24 of the Family Violence Act 2018 (Supplementary material 1) states that practitioners "must consider disclosing personal information". This indicates the importance of documenting considerations and responses taken for information disclosure. The Ministry of Justice (2019) published a practical guideline on sharing personal information safely under the Family Violence Act 2018. The legislation clearly outlines the responsibilities and supporting documents that guide OHPs when making the decisions to disclose personal information to protect children from CAN. This information is important to OHPs.

Some organisational child protection policies and guidelines encourage informing the child concerned or their family about the proposed disclosure to child protection agencies. This may have led to increased concerns about the OHPs' own protection and avoidance of confronting family, which were reported in the local study (Han et al. 2022). Section 66K of the Oranga Tamariki Act 1989 (Supplementary material 1) requires consultation to be undertaken with the child concerned or their representative about the proposed disclosure if any information is to be disclosed under Section 66C of the Oranga Tamariki Act 1989. OHPs are required to "inform the child or young person concerned or their representatives about the proposed disclosure, including the purposes and likely recipients of any disclosure". Section 66 K of the Oranga Tamariki Act 1989 also specifies that any reasonable assistance should be provided, and any views expressed about the proposed disclosure should be considered.

OHPs are placed on the very frontline of the response, which can be challenging, as they are not necessarily experts in child protection. Considering that many OHPs work in isolation, particularly in rural and remote areas, the lack of opportunities to

discuss concerns with colleagues or other social practitioners could hinder effective communication. Also, working in isolation will hinder OHPs from discussing the plan with families to disclose their concerns, which would act as a significant barrier. However, Section 66 K of the Oranga Tamariki Act 1989 states that these actions must be taken "if it is practicable and appropriate to do". OHPs are not expected to and should not put themselves in a situation that compromises their own safety and well-being while responding to CAN. Having an open conversation with families can help identify the necessary support that could lead them to provide safe and nurturing environments for children. The Privacy Commissioner (2015) states that "if informing the person would prejudice the purpose of collection, or would be dangerous to any person, then telling the person concerned may be waived in that instance" (p. 4).

Aotearoa New Zealand professional requirements

The DCNZ sets competencies, such as required knowledge, skills, attitudes, and behaviours, to ensure that OHPs practise safely, competently, and professionally in their scope of practice. All registered OHPs are expected to understand all competencies and provide care in accordance with those competencies. In terms of child protection requirements, even though competencies differ for each profession, DCNZ expects all OHPs to be able to "act to protect the interests of tamariki [children], mokopuna [grandchildren], rangatahi [youth] in cases of suspected neglect or abuse by disclosing information to a relevant authority or person" (Standard 1.10) as a part of their professional role (DCNZ 2021a, 2021b). Registered OHPs are required to respond to any child protection concerns. However, the DCNZ does not provide a specific policy or guideline on child protection.

In addition to the DCNZ Standard, the NZDA, a professional association representing dentists and dental specialists, published the Code of Practice: Child Protection in 2018, which states that:

> (d)ental practitioners and their staff have a responsibility to be mindful of, and vigilant for, signs that a child may be being maltreated. They must be familiar with the perioral signs of child abuse and neglect. If a practitioner has concerns about the welfare of a child, they must act. (NZDA 2018, p. 5)

Although not all OHPs are guided by this Code due to varied professional backgrounds and not all being members of the NZDA, the Code outlines professional requirements, provides practical guidance and defines dental neglect. Dental neglect is a common form of maltreatment that often challenges OHPs when they encounter untreated advanced carious lesions or untreated dental trauma (Kiatipi et al. 2021). The NZDA Code (2018) states that untreated oral disease and a neglected dentition could suggest a possibility of child maltreatment. However, it is important for OHPs to avoid making automatic assumptions, as neglect is applicable when there is a persistent failure, not as a result of caregivers' lack of knowledge, awareness, or accessibility (NZDA 2018). A 'stepwise' approach to suspected dental neglect cases is proposed for OHPs to manage dental conditions by first providing necessary preventive and restorative care, followed by assistance from other professionals and agencies if the situation does not improve (NZDA 2018).

Discussion

Legal and professional frameworks for child protection

Although there is no explicit duty for mandatory reporting of suspected CAN by OHPs' professional guidelines and legislation provide frameworks for safeguards for child protection. Also, it is crucial to remember children's right to safety under the international treaty UNCRC, which is also supported by the Oranga Tamariki Act 1989. OHPs are required to ensure children's rights are realised and protected. While education regarding child protection responses is included in undergraduate oral health education programmes in Aotearoa New Zealand, more comprehensive training is required and OHPs should develop their knowledge across their careers. Integrating child protection topics into their ongoing professional development plans can significantly enhance their knowledge and responsiveness. Professional associations and public dental services can play a significant role in providing relevant opportunities.

Indeed, employers that are state services, such as Te Whatu Ora (Health New Zealand) are required to have child protection policies that are available to all employees, according to Section 17 of the Children's Act 2014. By extension, employers should routinely train employees regarding the child protection policies.

Most legal and professional frameworks focus on detecting and reporting potential maltreatment cases. By complying with both, OHPs can play a crucial role in preventing child maltreatment and averting severe consequences (Figure 1). Despite the challenges in assessing their effectiveness, early intervention approaches to child protection are viewed by children, mothers, and service providers as essential and beneficial in preventing maltreatment (McCarry et al. 2021). These strategies have potential applications for broader family contexts, addressing the needs of various family members involved in care and support. It is critical to focus on prevention and early intervention before crises

Figure 1. Roles of oral health practitioners in child protection responses.

escalate. When OHPs believe that children or families need health, financial, or social system support, they can work collaboratively with others, such as public health nurses or social workers, to obtain resources to assist families. For OHPs working in school settings, safeguarding practices should be coordinated with school staff (Ministry of Education 2024). Therefore, establishing connections with local community support agencies and relevant professionals can be essential for ensuring timely and effective responses.

The regulatory body (DNCZ), professional associations, and other relevant stakeholders should collaborate to develop a comprehensive guideline aimed at equipping OHPs with the necessary tools for early detection and intervention in potential child maltreatment cases. This guideline should not only outline the procedures for reporting to child protection agencies such as Oranga Tamariki and the New Zealand Police but also highlight OHPs' potential proactive role in guiding families towards accessing essential government and community resources. Importantly, the document should be informed by Te Tiriti o Waitangi and be culturally sensitive. This approach is crucial in Aotearoa New Zealand, where addressing social and health inequities is a significant public health priority (Ministry of Health 2023a, 2023b). Equity-focused guidelines should emphasise the importance of culturally responsive practices within oral health care, particularly in child protection contexts. These guidelines must recognise the unique needs of Māori communities, ensuring OHPs engage in culturally safe practices that respect Māori perspectives on health and well-being (Keddell and Hyslop 2019). A key component of these guidelines would involve collaboration with Māori health providers and other community-based services to support tamariki Māori and their whānau (family). This approach aligns with the principles of Te Tiriti o Waitangi, which call for partnership, active protection and equity (Durie 2004; Came and Griffith 2018). As Came and Griffith (2018) highlighted, culturally responsive care fosters positive health outcomes by building on the strengths and resilience of Māori communities and is especially vital in supporting equitable approaches to child protection. Culturally informed protocols for identifying and reporting CAN should be developed, ensuring OHPs are equipped to address these concerns in ways that promote trust and positive health outcomes for Māori (Hyslop 2021). The implementation of such guidelines would also involve targeted training for OHPs, focused on improving their cultural competency and ability to engage with Māori in a manner that upholds mana within the healthcare system (Keddell and Davie 2018).

With appropriate resources, the guideline could be promoted to OHPs through effective channels and accompanied by training opportunities on its implementation. Importantly, the guideline must be revised regularly to ensure the most up-to-date information is delivered to OHPs (Han et al. 2024). Universities should consider adopting a comprehensive training module to facilitate practical learning, moving beyond conventional lecture-based teaching. It has been suggested that case-based learning with various educational designs, including the use of adult actors, can be instrumental in building critical thinking skills for future OHPs (Ivanoff and Hottel 2013). Scaffolding learning across different year levels and disciplines can encourage students to learn about complex and realistic problems while developing critical judgment skills (Ivanoff and Hottel 2013).

Strengths and limitations

This review summarises OHPs' duties regarding child protection in Aotearoa New Zealand by consolidating information from legislation and professional guidelines. It highlights the standards set by the DCNZ and the policy guidelines issued by the NZDA, along with various practical guidelines from government departments, including Oranga Tamariki and the Privacy Commissioner.

Despite its comprehensive scope, this review has several limitations. First, the focus is restricted to Aotearoa New Zealand's legislation and professional guidelines without incorporating empirical research or in-depth analysis of international standards. This limitation may restrict the applicability of findings to other jurisdictions and may overlook insights from international practices that could be relevant or more effective. Second, the review adopted a narrative approach rather than a systematic methodology due to the focused scope on OHPs and child protection responses, the need to synthesise diverse sources including legislation and professional guidelines, and the limited availability of empirical research in this specific area. Finally, the review acknowledges the complexity and potential variability in how legal standards and professional guidelines are interpreted and implemented across different settings. This variability can lead to inconsistencies in practice, which might affect the implementation of child protection measures within the dental care setting.

Recommendations for further research

The high prevalence of child maltreatment in Aotearoa New Zealand is well-documented (Oranga Tamariki 2023) and the critical role of OHPs in child protection is recognised. Yet evidence of OHPs' knowledge, attitudes and experiences regarding child protection is lacking. Although prior studies (Tilvawala et al. 2014; Han et al. 2022) offered valuable insights, their scope was limited to surveys focusing solely on oral health therapists and dental therapists. Broadening the research to include a wider range of OHPs, such as dentists and dental specialists, would enrich the understanding of OHPs' current approaches to child protection. Also, directly engaging with practitioners and related stakeholders would help create more tailored and effective OHP training programmes, policies, and practices to safeguard children. Insights from international contexts on how other countries are supporting OHPs may strengthen Aotearoa New Zealand's approach to child protection in oral healthcare settings (Han et al. 2024). Examining these international practices could reveal innovative strategies and practical methodologies. Adopting and adapting successful international models to suit Aotearoa New Zealand contexts could substantially enhance the child protection system in oral health care. To effectively address the high prevalence of child maltreatment in Aotearoa New Zealand, it is crucial to understand the impacts of colonisation and institutional bias on the current inequitable health and social systems (Keddell and Hyslop 2019). Further research is required on how critical knowledge could be integrated into OHP training programmes and engaging with Māori communities to develop culturally safe and equitable child protection measures in oral healthcare.

Conclusion

The engagement of OHPs in child protection within Aotearoa New Zealand is underpinned by legal and professional frameworks. The law and professional standards

explored in this article have significant implications for OHPs' roles in child protection and health promotion in Aotearoa New Zealand. This review emphasises the need for robust, equity-focused guidelines for OHPs that integrate principles from Te Tiriti o Waitangi, promoting culturally responsive practices in child protection contexts. Further, strengthening partnerships with Māori health providers and community organisations is essential to ensure these practices are effectively implemented and truly beneficial. To support the health and well-being of the nation's youth, it is significant that OHPs receive comprehensive training that equips them to recognise and respond to CAN, demonstrating their collective commitment to protecting Aotearoa, New Zealand's younger generation.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethics and integrity statement

This research was conducted as a synthesis of existing literature and did not involve new data collection with human participants; therefore, it did not require approval from an ethics review board.

ORCID

Heuiwon Han http://orcid.org/0000-0002-6780-3209
Jane Koziol-McLain http://orcid.org/0000-0003-3453-023X
Kate Diesfeld http://orcid.org/0000-0002-8117-551X
Samuel D. Carrington http://orcid.org/0000-0002-7155-1358
Zac Morse http://orcid.org/0009-0003-7259-9892
Amanda B. Lees http://orcid.org/0000-0003-4563-3402

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