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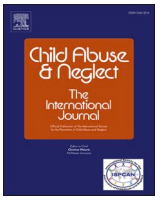

Exploring child abuse and neglect responses: Qualitative insights from oral health practitioners in Aotearoa New Zealand

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ABSTRACT

Background: Child abuse and neglect (CAN) remain significant concerns in Aotearoa New Zealand (NZ), with persistent inequities affecting indigenous Māori communities. Oral health practitioners (OHPs) are uniquely positioned to support CAN prevention and response through regular interactions with children via national dental care programs.
Objective: To explore the experiences and perspectives of OHPs in CAN prevention, identification, and response, and identify actionable strategies to enhance their responsiveness across dental settings.
Participants and setting: Twenty-one OHPs, including oral health therapists, dental therapists, dentists, dental specialists, and community oral health service managers, were recruited from diverse geographic regions and dental settings, including community clinics, private practices and school-based clinics.
Methods: A qualitative design was used, involving twelve semi-structured interviews and two focus groups conducted between August 2023 and August 2024. Reflective thematic analysis was conducted to ensure a deep, contextual understanding of participants' insights.
Results: Four themes were generated: opportunities to build relationships with families, needs for cultural and systemic awareness, collaborative approaches to child protection, and creating safer and more supportive practice environments. Two sub-themes emphasized the need for context-specific and straightforward guidelines and active workforce development in child protection.
Conclusions: OHPs' responses to CAN varied depending on access to training, organizational support, and contextual factors. Enhancing culturally safe, interdisciplinary training and establishing accessible, practical guidance are key strategies to support OHPs' protective role. Policy reform should prioritize these supports to ensure better outcomes for children and their families.

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1. Introduction

Most children in Aotearoa New Zealand (NZ) grow up in safe and nurturing environments. However, some require extra help from child protection agencies to safeguard them from harm. According to the Annual Report 2023/24 from Oranga Tamariki (the NZ statutory agency responsible for the welfare and protection of children and adolescents under the age of 18), approximately 60,000 required support services from Oranga Tamariki and its partners, such as New Zealand Police and community-based social service providers, and 4200 were in the care or custody of Oranga Tamariki. The adverse consequences of child abuse and neglect (CAN) significantly affect a child's health and quality of life, impacting their psychosocial well-being, academic performance, and overall development (Bradbury-Jones et al., 2021). Unfortunately, Māori (the Indigenous peoples of NZ) are disproportionately impacted (Oranga Tamariki, 2024) as colonisation profoundly affects Māori, especially in the early care and protection system (Cox, 2021). The colonisation has had and continues to have devastating and enduring impacts on Māori families. It has led to the loss of land, te reo Māori (language), and traditional knowledge systems, as well as disruption of Māori structures that traditionally supported child wellbeing (Moewaka Barnes & McCreanor, 2019). Colonial policies dismantled Māori social structure and diminished families' authority to raise children according to tikanga (Māori custom) (Cox, 2021).

Upholding the rights of children to safety and protection is a shared responsibility that extends beyond social practitioners. It requires collaborative efforts from all sectors, including health, social services, and education, as well as active involvement from communities and the general public. The orofacial signs and symptoms of CAN, particularly those of physical and sexual abuse, are well-documented (Sarkar et al., 2021; Spiller, 2024). Importantly, a strong link also exists between CAN and poor oral health (Bradbury-Jones et al., 2021; Ford et al., 2020). Oral health practitioners (OHPs) are well-positioned to identify suspected dental neglect and recognize clinical indicators such as untreated early childhood caries, poor oral hygiene, and other signs of inadequate care that may indicate broader neglect issues (Bhatia et al., 2014; Bradbury-Jones et al., 2013; Kiatipi et al., 2021). Furthermore, they can provide support to families and refer them to appropriate support networks to address systemic limitations that may elevate the risk of CAN (Han, Koziol-McLain, Diesfeld, et al., 2024).

Systemic structures grounded in traditional Western health paradigms often clash with Te Ao Māori (Māori worldviews) and Pasifika worldviews, creating barriers to service access. Pasifika communities, much like Māori communities, experience the enduring impacts of structural inequities and systemic barriers (Sa'u Lilo et al., 2020). This misalignment has led to significant missed opportunities for delivering equitable and culturally responsive care (Palmer et al., 2019; Sa'u Lilo et al., 2020). Addressing these issues requires implementing partnership models that uphold Te Tiriti o Waitangi (the foundational treaty, establishing partnership between Māori and the British Crown) (Keddell et al., 2022). The principles of Te Tiriti o Waitangi, as articulated in Whakamaua: Māori Health Action Plan 2020–2025 (Ministry of Health, 2020), indicate that health practitioners, including OHPs, have responsibilities to uphold tino rangatiratanga (self-determination), actively partner with Māori, protect Māori health interests, and address inequities to ensure better and more equitable health and social outcomes, supporting all children and families to uphold their rights (Child and Youth Wellbeing, 2022).

In NZ, OHPs are one of the key forefront practitioners in the early detection and response to CAN (Han, Koziol-McLain, Morse, et al., 2024). The NZ government provides free dental care to children and adolescents under 18 years-of-age (Health New Zealand, 2024), which offers opportunities for OHPs to have regular contact with children and their families in various dental settings. NZ has numerous registered dental professionals, including oral health therapists, dental therapists, dental specialists, and dentists, who provide comprehensive preventive and restorative dental care for children. Oral health therapists and dental therapists specialize in preventive and clinical dental care (Bhatia et al., 2014; Bradbury-Jones et al., 2013). Generally, children from birth up to approximately 13 years old (school year eight) are eligible for free dental care provided by Community Oral Health Services (COHS) operated by Health New Zealand – Te Whatu Ora (2024). This care extends to adolescents from school year nine until they turn 18 years old and is delivered by private dental practices under the government's free dental care scheme (Health New Zealand, 2024). Hence, dental services are provided in various dental settings, including school-based community clinics, mobile dental clinics, and private dental clinics, with or without the presence of caregivers. If specialized care is necessary, such as treatments under general anaesthesia, referrals can be made to the public hospital system, which is equipped with comprehensive dental facilities and specialized expertise. For many children, these funded, regular dental visits may be their sole interaction with a healthcare professional, particularly as routine medical check-ups are not commonly scheduled for many families.

Although OHPs in NZ have no explicit duty to report child protection concerns, professional guidelines (Dental Council New Zealand, 2021) provide broad expectations around ethical conduct, patient-centred care, and cultural safety, and legislation, such as the Oranga Tamariki Act 1989 and the Family Violence Act 2018, provide broad frameworks for protecting children from CAN (Han, Koziol-McLain, Diesfeld, et al., 2024). OHPs can play a significant role in child protection through prevention, identification, and response strategies. Children and families requiring social and health support can be referred to child protection agencies, such as Oranga Tamariki, Stand Tū Māia, and Women's Refuge, or benefit from interdisciplinary approaches involving collaboration with other health and social practitioners (Han et al., 2024). However, this relies on individual practitioners' attitudes and perspectives toward CAN and their understanding of their roles in child protection. Currently, there is no standardised child protection training required for OHPs at the undergraduate level or as part of ongoing professional development, although some may receive workplace-specific training, especially within public health services.

A NZ-based survey of oral health therapists and dental therapists highlighted that 74 % of respondents had one or more suspected CAN cases during their careers; however, only 21 % reported their concerns (Han et al., 2022). Respondents identified fear of false reporting (70 %) and lack of knowledge of reporting (56 %) as potential barriers to being responsive (Han et al., 2022). These findings align with international studies (Al-Dabaan et al., 2014; Kugananthan et al., 2021), which have identified discrepancies between

OHPs' knowledge of CAN and their confidence and attitudes toward responding to potential CAN cases.

To support OHPs in responding to child protection concerns, there have been ongoing global efforts to provide profession-specific guidance and training. In the United Kingdom, for instance, the government-issued document, Safeguarding in general dental practice: A toolkit for dental teams (Public Health England, 2019) offers practical resources for recognizing and responding to CAN within dental settings. In the United States, the American Academy of Pediatric Dentistry (Tate et al., 2024) publishes and regularly revises a clinical report accompanying practical guidelines outlining the OHP's responsibilities in identifying and managing cases of suspected CAN. Furthermore, since 1996, national-level, dental-specific child protection training programs have been offered in the United States and other countries to strengthen the preparedness and confidence of dental professionals (Stechey, 2001). These international examples highlight the importance of equipping OHPs with clear protocols and training tailored to the dental context.

Although the NZ study (Han et al., 2022) provided some insights into the attitudes of NZ OHPs toward CAN, the survey design limited the in-depth exploration of individuals' experiences in responding to CAN, as well as their attitudes and perspectives toward their roles in child protection. Furthermore, it remains unclear whether international strategies are suitable for NZ, where OHPs often work in isolation in rural and remote communities and serve populations with distinct cultural needs. Strategies must be adapted to reflect NZ's diverse cultural landscape, particularly Māori and Pasifika communities. This study aimed to: (1) explore the experiences and perspectives of OHPs who provide regular dental care services in various dental settings in relation to CAN prevention, identification and responses, and (2) identify strategies that could enhance OHPs' responsiveness to CAN.

2. Method

This study was approved by the Auckland University of Technology Ethics Committee (AUTEC/22/172). All participants provided their written informed consent.

2.1. Study design and recruitment

Adopting a pragmatic approach (Creswell & Creswell, 2023; Gray, 2018), this study aimed to identify practical ways to support OHPs' responsiveness to CAN, recognizing the influence of complex social, historical, and professional contexts. Semi-structured focus groups were the primary method, with one-on-one interviews offered for those unable to attend. Participants were grouped as: (1) Therapists (oral health therapists and dental therapists), (2) Dentists (dentists and dental specialists), and (3) Managers (COHS managers). Focus groups facilitated collaborative discussions to explore their knowledge and shared experiences (Krueger & Casey, 2014; Tausch & Menold, 2016), while interviews provided deep, personalized insights. Combining the two methods enriched data for knowledge production and synthesis (Lambert & Loiselle, 2008).

For the Therapists and Dentists Groups, inclusion criteria required participants to be registered OHPs holding a valid annual practicing certificate with the Dental Council of New Zealand - Te Kaunihera Tiaki Niho (the regulatory authority for all OHPs in NZ) and to have provided dental care to children and adolescents within the past 12 months in any dental setting. For the Managers Group, inclusion criteria included holding a managerial role within COHS and having operational responsibility for the delivery of children's dental services.

Participants were recruited between April 2023 and August 2024. Oral health therapists and dental therapists were recruited through professional associations, including Te Ohu Pūniho Ora O Aotearoa – New Zealand Oral Health Association and Te Ao Mārama – Aotearoa Māori Dental Association. Research flyers were shared with members via internal emails and newsletters. Dentists and dental specialists were recruited through the New Zealand Society of Hospital and Community Dentistry, following the first author's presentation at its 2024 annual conference. The association, represents practitioners in public and hospital sectors, later distributed research flyers to its members via internal channels. For dental managers, a research flyer was shared with all COHS managers during their regular national meetings, where they convene to discuss national and regional community oral health-related agendas. For all three groups, interested participants contacted the primary author, who then provided the research information sheet, consent form, and the ability to ask questions about the study. The recruitment period lasted eight weeks for each group, and all interested individuals were included in the study after their eligibility was confirmed.

2.2. Data collection

Upon the return of consent forms and completion of the eligibility check, oral health therapists and dental therapists participated in one of two focus groups (90 min each) or an individual interview (45–70 min). To take a pragmatic approach, individual interviews were conducted with all dentists, dental specialists, and COHS managers due to the inability to find mutually agreeable times for a focus group. Given the national recruitment and the need to promote participant diversity, all data collection was conducted online. The interview questions were informed by the findings of previous quantitative research (Han et al., 2022) and a scoping review (Han, Koziol-McLain, Morse, & Lees, 2024; Han, Koziol-McLain, Morse, Lees, & Carrington, 2024). The questions were carefully worded to minimize assumptions or judgment and were pilot-tested and refined in collaboration with the interdisciplinary research team, including a Māori researcher, to ensure cultural sensitivity and relevance. The questions were designed to gather information about participants' views on their roles in child protection, their experiences in recognizing and responding to concerns about child abuse and neglect, the barriers and enablers to being more responsive, strategies to enhance OHPs' responsiveness and ways to address social inequities in child protection. To ensure that the process was culturally safe for all participants, the research protocol emphasized respect for participants' values, identities, and lived realities. Space was created during sessions for relationship-building, supporting a

safe environment where participants felt heard and acknowledged. Furthermore, the involvement of a Māori researcher in both protocol development and the interpretation of data from Māori participants helped ensure that the research process upheld cultural integrity.

The primary author conducted all focus groups and individual interviews. All sessions were conducted online, audio-recorded and transcribed. As the study addressed sensitive issues surrounding CAN, ethical measures were implemented to ensure the safety and well-being of the participants and researchers. Participants were allowed to withdraw their consent at any stage and were offered counselling services if they desired. The primary author, a registered OHP, made a conscious effort to maintain a moderator role without participating in discussions. The primary author took notes during the sessions to facilitate discussions and maintained a journal to aid in self-reflection on the process, which is a key aspect of reflective qualitative research. Debriefing with the research team occurred between sessions to share experiences and seek contributions on strategies for improvement, ensuring that lessons learned were integrated into future practices.

2.3. Data analysis

Qualitative data were transcribed and de-identified using the online transcription tool Otter.ai (Otter.ai, Inc., US). Vocalised pauses, such as 'um' and 'ah', were removed to enhance the clarity and readability of transcripts. The primary author reviewed and verified all transcripts for accuracy before importing them into NVivo v20 (Lumivero, US) for data management and analysis. To further protect participants' confidentiality and protect data sovereignty, all online transcription data were permanently deleted following upload into NVivo. In the NZ context, data sovereignty holds particular significance for Māori, as it affirms their right, guaranteed under Te Tiriti o Waitangi, to control the collection, ownership, storage, and use of their data. This extends beyond privacy; it is about upholding tino rangatiratanga (self-determination) and ensuring Māori retain authority over their stories, knowledge systems, and lived experiences (Lilley et al., 2024). Respecting Māori data sovereignty is essential in reversing colonial patterns of extraction and misrepresentation, and is a critical obligation for all researchers working with Indigenous communities globally (Carroll et al., 2023). A Māori researcher maintained sovereignty over the interpretation of the data from Māori participants, ensuring that their perspectives were analysed and represented in a culturally appropriate and respectful manner.

The research team followed the reflective thematic analysis (RTA) approach as described by Braun and Clarke (2022) to ensure that participants' subjectivity and their perspectives were respected and to embrace researchers' reflexive interpretations (Braun & Clarke, 2019; Byrne, 2022). RTA acknowledges researcher subjectivity and reflexivity as primary analysis tools, recognizing that "knowledge generation is inherently subjective and situated" (Braun & Clarke, 2022, p. 8). Authors have their own understandings of the topic, which could serve as resources in the analysis (Gough & Madill, 2012). In this case, the research team had varying interests in CAN, family violence, oral health, dentistry, culturally safe and responsive practices, interdisciplinary health practices, and oral health education. Researchers' professional and cultural backgrounds, including those with Māori and migrant identities, enriched the analysis by bringing attention to equity, cultural integrity, and the importance of context in understanding OHPs' roles in child protection.

The six-step RTA analytic process designed by Braun and Clarke (2022) was followed: (1) dataset familiarisation, (2) data coding, (3) initial theme generation, (4) theme development and review, (5) theme refining, defining, and naming, and (6) write-up. The primary author conducted the initial coding of all data. Other authors independently analysed selected transcript sections, followed by a research team discussion. This collaborative process involved clarifying the code labels and deepening the understanding of each category. Subsequently, theme development was undertaken collectively, articulating and defining ideas thoroughly to ensure a comprehensive analysis. Candidate themes that addressed the research question were identified, and related codes were collated (Braun & Clarke, 2022). The themes were then further collapsed together and split into new themes to ensure that the central organizing concept of each theme was clearly characterised (Braun & Clarke, 2022). When presenting direct quotations from participants, the following format (Group, Participant number), such as (Managers, P4) for the fourth participant from the Managers Group, was used to indicate group affiliation while maintaining confidentiality.

Table 1
Demographic distribution of study participants.

Participant characteristics	Count
Professional background	
Oral health therapists	9
Dental therapists	6
Dentists	3
Dental specialists	2
Non-dental profession	1
Geographic location	
Upper North Island	10
Lower North Island	7
South Island	4
Primary employment	
Public dental sector	15
Private dental sector	5
University dental setting	1

3. Results

A total of 21 participants were recruited from widespread geographic regions of NZ: 12 oral health therapists and dental therapists (Therapists Group), four dentists and dental specialists (Dentists Group), and five community oral health service managers (Managers Group). One manager was a non-dental health professional managing regional community oral health services, whereas the others had experience as a registered OHP in their working lives. Table 1 outlines the participants' characteristics, including geographical locations and primary employment sectors. For the Therapists Group, two focus groups were conducted (one with six participants and another with three participants), and three participants were interviewed individually through semi-structured one-on-one interviews.

Participants shared their understandings and perspectives on their roles in child protection, as well as their experiences involving child protection responses within the dental team and in collaboration with other healthcare, social, or educational providers. Focus groups and semi-structured one-on-one interviews provided opportunities for reflective practices, transitioning from deficit-oriented responses to strength-based approaches. The three participant groups shared similar themes; hence, data from the three groups were analysed together. Participants highlighted the current strengths of practitioners and the dental sectors in supporting children and families. The analysis identified four overarching themes (Fig. 1), (1) opportunities to build relationships, (2) cultural and systemic awareness of OHPs, (3) collaborative approaches to child protection, and (4) building safer and supportive environment, and two sub-themes under the fourth theme, (4-1) simple guidelines on identification and responses and (4-2) active promotion of workforce development on child protection to address the research aim of exploring the experiences and perspectives of OHPs regarding CAN prevention, identification and responses, and identifying strategies to enhance their responsiveness to CAN.

3.1. Theme 1: opportunities to build relationships

Participants recognized their important role in engaging regularly with children and their families across various dental settings, which offered valuable opportunities to build relationships and rapport with children, families, and communities. The government's free dental scheme for children enabled OHPs to provide care in both clinical and community contexts, sometimes without caregivers present. Participants emphasized the frequency and unique nature of interactions:

> *I do really think that, as health professionals, we* [*OHPs*] *are probably most exposed to children, other than their teachers.*
> (Therapists, P5)

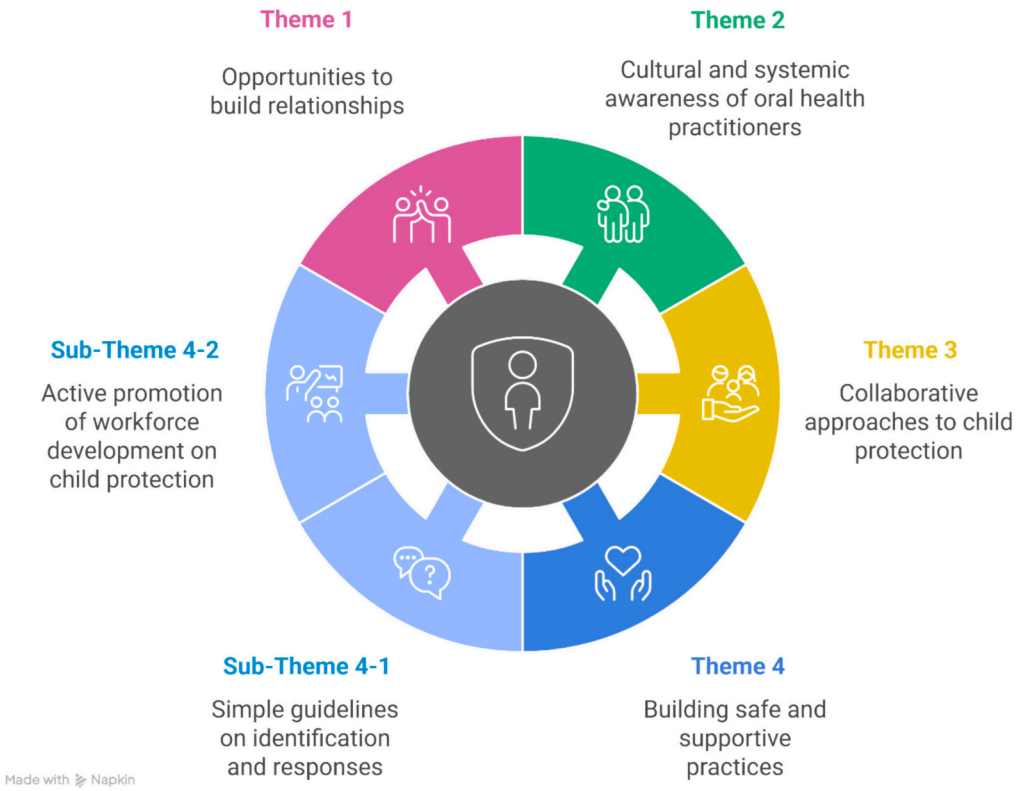

Fig. 1. Summary of themes and sub-themes.

That closeness and frequency of visits that we [*OHPs*] *get that other health professionals don't get. So, I would like to think that we would pick up a few things if you really know the children, the environment, and their families.*

(Therapists, P4)

These opportunities and relationships, primarily focused on achieving better and more equitable oral health outcomes, enabled OHPs to interact regularly with families and provide adequate support for nurturing children in safe environments. This allowed OHPs to engage in preventative approaches, detect any potential physical or behavioral signs of abuse or neglect, and take necessary steps to support children and families, as participants explained:

I draw the conclusion by watching how the child behaves around the parent as well… I see if children are quite comfortable with their parents… It seems okay if they don't seem frightened, or they don't seem too quiet and are not saying anything.

(Therapists, P5)

People within the community would make approaches to us [*OHPs*] *because we make whānau* [*family*] *more comfortable to actually ask for help and are able to talk to people* [*other professionals*] *to get the help that they need.*

(Therapists, P2)

Although OHPs were in that unique space, a deficit dilemma of limited organizational resources was presented, which hindered the provision of adequate oral health care for children. Participants expressed that the pressures of limited time and the demand of attending to a high volume of patients meant that critical child protection roles could be overlooked. One participant shared that:

We [*community dental teams*] *are just trying to develop a level of comfort by doing the best that we can, given what we have.*

(Managers, P2)

Participants noted increased challenges for OHPs working in private dental practices and rural areas in fostering meaningful relationships with children and their families due to heavy workloads and challenges in addressing the significant oral health needs of these communities, which, in turn, limited opportunities for relationship building. One participant described the working environment in a rural and low socioeconomic area as:

Imagine you're in a rural and low-decile area [*communities with lower socioeconomic status*] *where you're just on your own. It's just you and your dental assistant, and you have an office staff. That's it.*

(Dentists, P3)

Participants expressed the need for resources and support to utilize OHPs' opportunities and strengths in building relationships to "help children… to access the care that they need" (Dentists, P2), which can create safe and nurturing environments for children and their families.

3.2. Theme 2: cultural and systemic awareness of oral health practitioners

Participants recognized the complex nature of CAN and the diverse factors associated with children, families, and their communities. Particularly, inequitable access to oral health services and other health and social care services was emphasized as an influencing factor that could inadvertently contribute to the behaviors of caregivers:

Often, what we [*OHPs*] *see in the mouth in terms of dental neglect is only the first step; and actually, if dug a bit deeper, there are a whole lot of wider issues going on for some whānau.*

(Managers, P1)

Participants also acknowledged deficiencies in health literacy and education for caregivers, which were essential for nurturing children in safe and supportive environments and accessing adequate health and social care:

If they [*caregivers*] *see a hole, they see a hole. But they don't actually know the impact of all that* [*oral diseases*]*… A lot of health education and literacy are not there, even though we* [*OHPs*] *think they are common knowledge. It's actually not for many people.*

(Therapists, P1)

Some participants observed that Māori and Pasifika peoples often faced poorer health and social outcomes, including oral health inequities, compared to non-Māori and non-Pasifika peoples. Māori and Pasifika participants, in particular, shared that their communities were frequently misunderstood and encountered culturally insensitive care, which they felt acted as a barrier to accessing oral health services within the current oral health systems:

I [*Māori Pacific OHP*] *do find that my people, Māori Pacific people, are often misunderstood* (*by OHPs*)*, which is a barrier for them not wanting to come into services because of the vibe that you get* (*from OHPs*)*. It's an attitude that you get. It's a response or non-response that you get.*

(Therapists, P12)

Participants emphasized the importance of developing cultural awareness and a professional attitude that acknowledged the challenges faced by families influenced by inequitable systemic structures. They indicated that demonstrating genuine intentions to support children and families in overcoming these challenges was viewed as an integral part of child protection and responses.

Furthermore, participants highlighted the importance of providing informed and culturally sensitive care and support that aligns with the needs of children and their families was highlighted, ensuring that all interventions were appropriately tailored and respectful of cultural and social contexts:

> *There's a lot of generational stuff that happens… We* [*OHPs*] *see that* [*poor oral health*] *or potentially see that as neglect, but they* [*caregivers*] *don't. This is how they have always lived, or this is how it was. So you've got to be quite respectful and mindful of those things* [*generational norm*].
>
> (Therapists, P1)

3.3. Theme 3: collaborative approaches to child protection

Participants recognized the challenges in responding to CAN, citing their limited expertise and confidence in this area. A sense of fear and uneasiness associated with the nature of CAN was noted:

> *I understand that we have to protect children. But I find it almost intimidating if I actually notice something and actually suspect something – how to approach and how to actually respond.*
>
> (Therapists, P6)

A degree of uncertainty of their observations and a reluctance to take full responsibility in CAN responses, associated with limited confidence, were expressed among OHPs:

> *We* [*OHPs*] *are not trained in this* [*child protection*] *enough to, and we are not dealing with it every day. Having that intermediary person who you can go to and be like, 'This is what I'm thinking. This is what I want to say. Please do what you will do with that. 'If you feel like this needs further action, great, I'll back you up. If you need me to put this on record or whatever, I'll back that up. But I'm not sure. So can you help me?*'.
>
> (Therapists, P2)

To address these challenges, participants reported engaging with a diverse range of practitioners across health, social, and education sectors, recognized these interdisciplinary connections as essential for supporting children and their families. Strong views emerged that such collaborations enabled OHPs to better understand the families and communities that they served, deliver necessary oral health care, and support children experiencing abuse and neglect:

> *It takes a village to raise a child. I am so strong in collaborative practice because we* [*OHPs*] *all have different strengths. Although I think I might have certain qualities that are my strengths, I've got to find somebody else with those that aren't my strengths.*
>
> (Therapists, P8)

However, some participants faced challenges in engaging with interdisciplinary approaches due to resource limitations, time constraints, and ineffective and complicated organizational processes:

> *Your 15-minute recall appointment suddenly becomes two hours. By the time you think, 'Oh my God, I've got to do something about this', you need to do all the paperworks. There was just no way you would get that done in less than two hours.*
>
> (Managers, P2)

Limited trust of OHPs toward child protection agencies, such as Oranga Tamariki, was also noted, hindering effective interdisciplinary collaboration:

> *There is a lot of stigma around Oranga Tamariki … whatever you hear about them in the news, it's always to do, 'They took this kid off these parents', and 'they shouldn't have'. It's generally negative. And I feel like it is a barrier to us* [*OHPs*] *contacting them* [*Oranga Tamariki*] *or wanting to get them involved.*
>
> (Therapists, P2)

This reluctance was further emphasized by the fear of not knowing what actions were taken after disclosing patient information to other health and social practitioners, including Oranga Tamariki. The referral process was often described as one-way, rather than truly collaborative. Participants suggested that developing more collaborative relationships could help OHPs to understand the process better, engage in shared learning, and build confidence and resilience in taking actions to support children and families:

> *When we* [*OHPs*] *are involved with schools and social workers, they can report to us and ask whether we have noticed anything or if there is anything that we have concerns about. Then, we can report back to them. So it's not always us having to make that first move.*
>
> (Therapists, P2)

3.4. Theme 4: building safe and supportive environments

Building safe and supportive working environments for OHPs was identified as a critical factor in enhancing their responsiveness in child protection responses. Participants highlighted concerns about limited physical protection and psychosocial support, particularly in situations where organizational policies required them to inform caregivers and families when disclosing information to other

parties. These circumstances, coupled with a lack of guidance and support, contributed to feelings of personal vulnerability and fear of potential reprisals from caregivers. One participant described this apprehension:

> *Personally, to have to ring up a family of a child who I think is being neglected, I wouldn't. I just wouldn't because that is putting yourself at so much risk.*
>
> (Therapists, P10)

Furthermore, identifying signs of abuse or neglect and responding to concerns required courage and strong commitment to supporting children and families. However, some indicated limited organizational guidance on how to identify concerns, engage interdisciplinary support, or access well-being support during and after their response efforts. One participant described this experiences as:

> *Very emotionally difficult to deal with, knowing that I had no idea what was going on for the child.*
>
> (Therapists, P12)

3.5. Sub-theme 4-1: simple guidelines on identification and responses

Participants generally described a lack of guidance on engaging in child protection responses across both public and private sectors. They expressed a need for clear and simple step-by-step guidance on recognizing and responding to concerns, as well as on how to facilitate safe and appropriate actions when supporting children and families. While acknowledging their limited expertise in this area, some participants suggested a practical checklist that outlined observable indicators and provided a framework for when and how to seek further support from other health and social practitioners:

> *What is that level of report(ing)? If there was just a generic, and if (a child) meet two or three of these (indicators), you [OHP] might want to consider talking to a social worker first. And then if they say do the report, then do the report or (follow) some sort of pathway.*
>
> (Therapists, P2)

However, other participants acknowledged difficulties in creating one simple guide that addresses all potential child protection issues and different familial circumstances that OHPs could encounter in diverse dental settings, as there is "no one way to approach this" (Managers, P5). Participants strongly advocated for the development of a streamlined organizational guidance applicable across both public and private dental sectors. Some recommended that the regulatory body (the Dental Council of New Zealand) and the Ministry of Health take action by issuing supportive documents or practical guides to support OHPs in the prevention, identification and responses to child protection issues, ultimately building safe and supportive practices for OHPs:

> *Where does the responsibility lie regarding protecting and having safe processes in place for practitioners that you, as the dental body service, look after?*
>
> (Therapists, P12)

3.6. Sub-theme 4-2: active promotion of workforce development on child protection

Participants consistently emphasized the importance of active and ongoing workforce development to build confidence and competence among OHPs in recognizing and responding to child protection concerns. Education and training were seen not only as ways to enhance knowledge, but also as necessary to normalize child protection practices within the workplace:

> *It feels like we're overstepping (boundaries with families and child protection experts), but we actually aren't. But I think it needs to be normalized in our workplaces.*
>
> (Therapists, P5)

Participants indicated that undergraduate and in-practice education opportunities to develop OHPs' knowledge and competence in child protection response remained limited. Many emphasized that strengthening education in undergraduate and postgraduate dental curricula could play a crucial role in improving OHPs' ability to actively participate in child protection responses:

> *I think a huge thing would be to actually teach. That can make future dental practitioners, undergraduates, and postgraduates more comfortable in recognizing these issues, recognizing when to step in, feeling more comfortable about when and where to step in, and being able to have those conversations.*
>
> (Dentists, P3)

Generic training as part of a larger healthcare system or hospital network was not considered sufficient due to its limited relevance to daily dental practices. Participants emphasized the importance of regular, practice-specific training to address OHPs' challenges across various settings and building relationships for consultation pathways. Some participants strongly believed in the benefits of having mandatory requirements for child protection training, similar to resuscitation requirements, to ensure that OHPs are "keeping it at the forefront of our mind" and making it "less scary" (Dentists, P4).

4. Discussion

This study explored how OHPs in NZ perceive and engage with their roles in responding to CAN. The findings suggest that OHPs are uniquely positioned to contribute to child protection efforts due to their regular contacts with children and families in community-based and clinical settings. This aligns with international research that recognizes OHPs as frontline professionals in the early detection and reporting of CAN (Han, Koziol-McLain, Morse, Lees, & Carrington, 2024; Bradbury-Jones et al., 2021; Kugananthan et al., 2021). A key strength of this study is its focus on the underexplored perspectives of OHPs, highlighting a consistent willingness to support vulnerable children. However, in contrast to a jurisdiction with structured national guidelines (Public Health England, 2019; Tate et al., 2024) and workforce training (Stechey, 2001), the NZ context is marked by fragmented policy frameworks, inconsistent access to training and ongoing systemic inequities. These challenges undermine OHPs' confidence and capacity to respond effectively. These findings underscore the importance of systemic investment in child protection infrastructure tailored to oral health. Possible mechanisms for improving OHP engagement include the development of targeted and culturally safe education, clearer interprofessional referral pathways, and national policy guidance that affirms and enables the role of OHPs in safeguarding children.

4.1. Genuine intention of oral health practitioners to help children and families

Findings from this study suggest that OHPs working in both public and private sectors experience resource constraints that hinder their ability to meet the oral health needs of communities, thereby impacting their capacity to fulfill their roles in child protection. These constraints, along with limited organizational guidance and training opportunities, often leave OHPs feeling overwhelmed. Despite these challenges, the findings demonstrate that many OHPs leverage their strengths to support children and families to their fullest capacities. They recognize their unique positions to identify when a child or a family may need support, take action safely within their professional scope, and collaborate with experts across diverse disciplines to enhance child protection efforts; an approach that aligns with literature emphasizing the value of interdisciplinary engagement by OHPs in child protection responses (Bradbury-Jones et al., 2021; Han et al., 2024). Importantly, addressing violence cannot adhere to a standard prescriptive approach; rather, it emphasizes the critical importance of fostering strong relationships among care providers and with families and communities to address their diverse needs (Gear et al., 2024).

The Aorerekura: The National Strategy to Eliminate Family Violence and Sexual Violence (New Zealand Government, 2021) identifies six key 'shifts' needed to eliminate violence in NZ. Shift three, "towards skills, culturally competent and sustainable workforces", and shift five, "towards safe, accessible and integrated responses", are particularly relevant to OHPs (New Zealand Government, 2021). These shifts emphasize the importance of not only being capable of providing safe and coordinated care to children and families but also developing a workforce that is skilled and culturally aware of its roles in child protection. OHPS should understand their roles in identifying and addressing child protection concerns and contributing to the prevention and support of children and families in accessing adequate care and services required (Levin & Bhatti, 2024).

OHPs are not expected to investigate suspect CAN cases or resolve CAN issues, but they should remain vigilant to support children and families (Gear et al., 2024). This approach emphasizes the strengths of OHPs in establishing and maintaining relationships with children, families and communities. Through these connections, OHPs can contribute to early intervention and prevention strategies that are essential for preventing the severe health and social consequences of CAN (Colizzi et al., 2020).

4.2. Providing culturally safe care

Understanding oral health inequities in NZ and the need to provide clinically and culturally responsive and safe care to children and families is critical (Lacey et al., 2021). The findings from this study demonstrate a sound understanding of the impact of systemic inequities and the importance of culturally safe care for children and families from all cultures. Māori and Pasifika communities in NZ possess deep knowledge, resilience, and collective strength in advancing the health, social, and educational well-being of their families. However, systemic structures that do not align with Māori and Pasifika worldviews have created challenges in service access (Lacey et al., 2021; Smith et al., 2019). Historical impacts of colonisation are compounded by systemic inequities within mainstream child protection services that continue to alienate Māori and obstruct their right to care (Cox, 2021; Hyslop, 2021). Despite this, Māori and Pasifika-led initiatives continue to foster mātauranga (Māori knowledge)-informed health literacy and education, strengthening whānau well-being and addressing care gaps (Palmer et al., 2019; Sa'u Lilo et al., 2020). Addressing systemic issues necessitates the adoption of partnership models that align with the principles of Te Tiriti o Waitangi as outlined in Whakamaua: Māori Health Action Plan 2020–2025 (Ministry of Health, 2020). Continuing efforts and attention to support this partnership for the diversity of practices and cultures can lead toward better responses to the social needs of families and communities (Kennedy et al., 2022). The findings indicate that OHPs generally understand essential professional characteristics needed for effective practice, including mutual respect, empathy, authenticity, and culturally safe care. However, the application of these traits varies significantly in clinical practice. This variation suggests that practitioners are at different stages of their personal journeys toward cultural awareness and the delivery of culturally safe care to children and families (Wylie et al., 2021).

The Dental Council of New Zealand is on their journey of developing frameworks to support OHPs in providing culturally safe care. As of 1 January 2023, the cultural standard of care in the scope of practice documents transitioned from cultural competence (kaiakatanga ahurea) to cultural safety (haumarutanga ahurea) (Dental Council New Zealand, 2021). This change is intended to move beyond checklists, encouraging OHPs to self-reflect, deepen their cultural awareness, and recognize the significance of culturally safe care in achieving equitable health outcomes. This shift in mindset can support OHPs in their professional development journey to

become more equipped to address the cultural needs of children and families.

4.3. Supporting oral health practitioners in child protection

One of the key strengths of OHPs is their capability to connect with other practitioners in the health, social, and education sectors. Recognizing their limited expertise in responding to child protection concerns, participants emphasized both the importance of and their willingness to seek collaboration with experts from other disciplines, particularly in public sector settings, where interdisciplinary structures are more readily available. Enhancing support for OHPs to participate in interdisciplinary approaches not only leverages their capacity to be at the forefront of connecting with families and communities but also strengthens their role in fostering comprehensive care.

As highlighted in the findings, practical guidelines for effective interdisciplinary approaches in preventing and managing CAN, especially in cases of dental neglect, would be beneficial. These guidelines should align with Te Tiriti o Waitangi principles to ensure culturally safe practices. However, they should avoid being overly prescriptive, which could restrict OHP's flexibility to respond to families' unique cultural and well-being needs (Gillingham, 2006). For instance, the policy document from the British Society of Paediatric Dentistry clearly outlines factors, such as dental awareness of caregivers and access to dental care, that contribute to poor oral health outcomes and offers recommended management strategies (Ridsdale et al., 2024). This policy document is directly relevant to OHPs without being overly prescriptive. In NZ, the New Zealand Dental Association (2018) has a code for child protection, that defines CAN, provides orofacial indicators, and suggests management strategies for immediate concerns and dental neglect. However, this document requires updating to incorporate recent legislative changes. Ideally, the Dental Council of New Zealand should create a guideline incorporating Te Tiriti o Waitangi principles while encouraging effective interdisciplinary practices. This would ensure that all New Zealand OHPs can benefit from a current and culturally appropriate framework, while it can also assist experts of other disciplines in understanding the roles and strengths of OHPs in child protection responses.

In an interdisciplinary approach, reciprocity is essential for nurturing and fostering collaborative relationships (Brattabø et al., 2018). A notable issue in contemporary child protection practices is the absence of frequent feedback mechanisms following referrals to child protection and social services (Brattabø et al., 2018). The findings indicate a degree of reluctance among practitioners to engage with child protection agencies, as well as a desire to share responsibility rather than to bear it alone. These complexities may lead to a scenario in which practitioners may opt not to reach out, leaving significant concerns unrecorded and potentially unresolved. The ideal scenario involves consultative relationships in which decisions are made collaboratively, embracing the inherent uncertainties of complex child protection cases. Therefore, guidelines should promote a reciprocal nature and establish robust feedback mechanisms to enhance collaborative relationships. Collaborative processes can create positive experiences that enhance confidence, facilitate learning, promote helpful behavior patterns among OHPs, and foster relationship-building within the collaborative team. Such an approach will require substantial support from non-dental experts across various disciplines. However, other health and social practitioners can also leverage the unique position of OHPs to access children and their families, providing essential support and further enhancing the efficacy of child protection efforts.

While the findings primarily focus on the provision of care and support for children and families, participants also highlighted the need to strengthen protections for the physical safety and well-being of OHPs. Some organizational child protection policies and guidelines were described as inconsistent with the Oranga Tamariki Act 1989, particularly regarding when and how to inform families of disclosures to child protection agencies. This misalignment can lead to confusion and pose potential safety risks for practitioners. Accordingly, participants called for policy updates, system-level support and training that clarify these expectations and ensure OHPs are supported in acting in ways that are both safe and legally compliant to fulfill their responsibilities in child protection.

Lastly, as the findings suggest, implementing regular and relevant education programs that integrate various dental settings and foster interdisciplinary collaboration would substantially enhance OHPs' abilities and readiness to manage child protection cases in NZ. The literature highlights the advantages of having dental-specific education programs tailored to accommodate diverse learning styles (Al-Dabaan et al., 2016). By developing education programs specific to undergraduate oral health degrees and in-practice professional development, practitioners will be better equipped for potential encounters with CAN and empowered to be more proactive in CAN prevention and responses. As part of education programs, it would be beneficial to incorporate cultural safety components to emphasize the vital need for providing culturally safe care and supporting OHPs in addressing health and social issues. However, cultural safety education "should not be treated as a box to be checked on completion and should not take a one-size-fits-all approach" (Wylie et al., 2021, p. 329). Instead, it should recognize the various stages of each practitioner's personal journey toward culturally safe care and facilitate a long-term commitment to support those journeys (Wylie et al., 2021).

4.4. Strengths and limitations

This study explored the experiences and perspectives of a diverse group of OHPs, including oral health therapists, dental therapists, dentists, and dental specialists, who regularly interact with children and adolescents in a variety of dental settings, such as community clinics, private practices, and public hospitals. A key strength of this study lies in its ability to translate these practitioner insights into tangible, practice- and policy-relevant recommendations. These include the development of clear and context-specific child protection guidelines, integration of regular and culturally safe education and training, improved interdisciplinary collaboration, and the alignment of organizational policies with relevant legislation to ensure practitioner safety. Collectively, these findings offer valuable guidance for clinicians, service providers, and the regulatory body to enhance OHPs' responsiveness in child protection and support for families and communities.

Despite the diverse group of OHPs, the perspectives of children, caregivers, and stakeholders from the health, social, and education sectors were not included in the study. Exploring and incorporating external views and perspectives could have provided valuable insights into the broader systemic challenges and opportunities for improving child protection responses within oral health care, ultimately leading to more effective and comprehensive strategies. Furthermore, focus group sessions provide valuable opportunities to observe participants' reflective practices during their interactions, enriching the data collected. However, these sessions were only conducted with oral health therapists and dental therapists due to the inability to find a mutually agreeable time for other participant groups. This limitation may have impacted the depth and breadth of insights, particularly in relation to the experiences and challenges faced by dentists, dental specialists, and community oral health service managers.

4.5. Future research

Firstly, the perspectives of OHPs practicing in NZ and the barriers and enablers that influence their responses to CAN are well-documented. Implementing recommendations from the findings, developing a simple guideline and education programs in partnership with Māori practitioners and researchers, representatives from health, social, and education sectors, and the Dental Council of New Zealand would greatly enhance OHPs' contribution to CAN prevention and responses, ensuring culturally safe practices. Additionally, evaluating the clinical and professional impacts of these initiatives would ensure that the practices are truly beneficial to OHPs and, ultimately, to the children and families they serve.

Secondly, gaining insights into the experiences of children, caregivers, and professionals from the health, social, and education sectors can help identify gaps in current practices, enhance interdisciplinary collaboration, and lead to more integrated and culturally responsive approaches. Future research should incorporate these external perspectives to develop a more comprehensive framework for supporting children and their families.

5. Conclusion

This study highlights the critical role of OHPs in child protection in NZ and emphasizes the need for continuous development in education, policy, and collaborative practice to enhance their effectiveness. By embracing interdisciplinary collaborations and incorporating culturally safe practices, OHPs can better serve the diverse needs of children and families they encounter. These recommendations, aimed at enhancing responsiveness to CAN, are essential for developing more proactive, culturally safe, and effective child protection strategies within the oral health care sector. Future research should expand on these findings by integrating broader perspectives, thus enriching the strategies to support OHPs and ultimately improving outcomes for the children and families they serve.

Ethics and integrity statement

The authors declare no conflicts of interest in relation to this study. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. The data that support the findings of this study are available on request from the corresponding author.

Declaration of Generative AI and AI-assisted technology in the writing process

During the preparation of this work, the authors used ChatGPT to improve language and readability and Napkin AI to design an infographic. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

CRediT authorship contribution statement

Heuiwon Han: Writing – review & editing, Writing – original draft, Visualization, Validation, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Jane Koziol-McLain:** Writing – review & editing, Writing – original draft, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Samuel D. Carrington:** Writing – review & editing, Writing – original draft, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Amanda B. Lees:** Writing – review & editing, Writing – original draft, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Zac Morse:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Conceptualization.

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Data availability

The data that has been used is confidential.

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