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Carrington, Ann, Croker, Felicity, Lee-Ross, Amanda, Keogh, Sandra, and Dewar, Simone (2023) ***Critical reflections on an interprofessional collaboration to develop domestic violence curriculum in an undergraduate dentistry program.*** **Reflective Practice, 24 (2) pp. 183-196.**

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Please refer to the original source for the final version of this work:

https://doi.org/10.1080/14623943.2022.2154753

Critical reflections on an interprofessional collaboration to develop domestic violence curriculum in an undergraduate dentistry program

There is growing recognition of the critical need to incorporate Domestic Violence (DV) curriculum into dentistry degrees. Interprofessional collaboration between Social Work, DV sector and Dentistry developed and delivered the Dentistry and Domestic Violence – Recognise, Respond and Refer (DDV-RRR) program within an undergraduate dentistry degree in Australia. This article presents our critical reflections on the collaboration, development and delivery of this program. Selected questions from Fook's critical reflection model were utilised to guide the reflection process. Key learnings from this process include acknowledging inherent challenges, power and barriers in collaborative projects; importance of interprofessional collaboration for best practice; and the importance of interpersonal/professional relationships for forming and maintaining interprofessional collaborations. We share the learnings from our critical reflections as an example of how interprofessional collaboration enhances the development and delivery of DV curriculum in one undergraduate dentistry course.

Keywords: Interprofessional collaboration, Critical reflection, Domestic violence, Dentistry, Social Work, Domestic violence sector, undergraduate students

Introduction

Dentistry and Domestic Violence

There is growing recognition of the critical need to incorporate Domestic Violence[1] (DV) educational material into dentistry degrees. Currently, various models to develop and deliver DV educational material to dentistry students are utilised internationally. Models include brief one-off workshops with a focus on didactic instruction, as well as role-plays for students' observation and participation (Buchanan et al., 2021; Danley et al., 2004; Everett et al., 2013; Gibson-Howell et al., 2008). Another involves students engaging in an on-line webinar (McAndrew et al., 2014). More broadly, educational programs for dentistry students about trauma, including DV, utilise trained actors to simulate the dentistry clinical setting (Raja et al., 2015). While another model requires students to complete preparatory material in

conjunction with a video demonstration and small group role-plays (Brown et al., 2021). The innovative Dentistry and Domestic Violence – Recognise, Respond and Refer (DDV-RRR) program is one such DV educational program for dentistry students and is a pioneer within the Australian dentistry context.

Incorporation of DV educational material into dentistry degrees is crucial due to the seriousness and pervasiveness of DV (Australian Institute of Health and Welfare (AIHW), 2018; World Health Organisation, 2013, 2018). Research indicates that violence perpetrated by a current or previous intimate partner is the predominate form of violence against women[2] (World Health Organisation, 2013). Furthermore, statistics from the World Health Organisation (2018) show that 30% of women are affected by physical or sexual violence across their lifetime. In addition, data indicates 30 – 40% of homicides of women result from intimate partner violence (United Nations Office on Drugs and Crime, 2019).

Dentists are uniquely positioned to identify patients who experience DV. Dentists routinely assess the head and neck where signs of physical trauma are often visible, as well as encountering more subtle manifestations of DV such as anxiety, depression and triggered trauma (Australian Institute of Health and Welfare, 2017; Australian Institute of Health and Welfare (AIHW), 2018; Coulthard et al., 2020; Coulthard & Warburton, 2007; Kenney, 2006; Nelms et al., 2009; Raja et al., 2014). In addition, dentists can initiate dialogue with victim-survivors[3]in a confidential space due to the individual nature of dental appointments (Coulthard & Warburton, 2007; Kenney, 2006; Nelms et al., 2009). Training dentists to recognise and respond to DV contributes to a comprehensive, community-based response to DV (Domestic and Family Violence Taskforce, 2015).

Interprofessional collaboration

The DDV-RRR program is developed and delivered by an interprofessional collaboration involving James Cook University (JCU) Social Work, JCU Dentistry and, from

the DV sector, the Cairns Regional Domestic Violence Service (CRDVS. The interprofessional collaboration between Social Work, Dentistry and the DV sector is a key feature we identify as contributing to the extensive achievements of the DV-RRR program (see forthcoming).

Relevant literature shows interprofessional collaboration enhances DV education and training provided to undergraduate students and professionals in the health sciences. Patel et al. (2014) identified that limited inclusion of DV educational material in dentistry degrees is due, in-part, to lack of relevant knowledge and experience in academic staff. As such, interprofessional collaboration involving workers with direct experience of supporting victim-survivors can address current limitations in DV curriculum (Ambikile et al., 2021). Specifically, workers from the DV sector bring to DV educational material their 'on-the-ground' knowledge and skills, and 'stories' from victim-survivors (Femi-Ajao, 2021; Nelms et al., 2009). In terms of Social Work, Petrosky et al. (2009) drew on their own 15 year interprofessional collaboration to identify that Social Work contributes knowledge of social theory, and skills related to working with victim-survivors. Involvement of dentistry within an interprofessional collaboration, enables generic DV educational material to be adapted to reflect the dentistry context (Buchanan et al., 2021). While incorporation of academic staff in an interprofessional collaboration ensures DV educational material conforms to tertiary-level standards (Ambikile et al., 2021).

Moreover, interprofessional collaboration models this important element of professional practice to undergraduate students (Kuliukas et al., 2017; Szilassy et al., 2013). In turn, this modelling prepares students to value and engage in their own interprofessional collaborations as students, and subsequently as practitioners (Abel et al., 2012).

This article presents our critical reflections on the development and ongoing delivery of the DV-RRR program. We provide a brief background to the DV-RRR program, and

outline our critical reflection process before sharing the learnings from this process. Finally, we close this article by discussing our key learnings in relation to extant literature. In sharing the learnings from our critical reflections, we aim to provide an example for other professionals who may be developing a DV education program of how interprofessional collaboration enhances the development and delivery of DV curriculum to undergraduate students.

Background

In 2015 some final-year JCU Bachelor of Dental Surgery (BDS) students reported that DV was a challenge they encountered in clinical practice, for which they felt unprepared. In response to students' concerns, we developed the innovative Dentistry and Domestic Violence – Recognise, Respond and Refer (DDV-RRR) program.

The DDV-RRR program incorporates, and extends, established content and delivery methods for DV education to dentistry students. Innovative features of the DDV-RRR program include: scaffolded content, skills-based activities, gendered analysis of DV, and inter-professional collaboration. The DDV-RRR program is informed by critical feminist social work theory with a gendered analysis of DV and supports a collaborative approach (Carrington, 2014, 2020a; Morley & Dunstan, 2016). In addition, the DDV-RRR program is underpinned by a Participatory Action Research (PAR) model (Alston & Bowles, 2019; Healy, 2001; Van-Acker et al., 2021; Wadsworth, 1998).

In the process of writing an article providing a detailed description and evaluation of the DDV-RRR program (see forthcoming), we engaged in an additional critical reflection process about our experiences in developing and delivering the DDV-RRR program. Our critical reflections yielded rich data that we realised was of significant importance in its own right, hence, presented here in a separate article.

Critical Reflection Process – Methodology

The aim of the critical reflection was to elicit learnings, informed by critical theory, on the overarching process of developing and delivering the DDV-RRR program, not yet captured through our ongoing reflections as part of the PAR cycle. Our purpose was to use these learnings to further refine our interprofessional collaboration process, and to enhance the [name of program removed to ensure integrity of blind review] program's curriculum content and delivery methods.

Our critical reflection involved all members of our interprofessional collaboration from JCU Social Work, JCU Dentistry and the CRDVS. In addition, a research assistant provided support with the critical reflection process, and contributed to writing this article.

As a team we identified five critical reflection questions (presented in the next section) adapted from Fook's (2015) critical reflection model. We then provided our individual responses in writing with a word limit of 400 words per question. We then met via video/telephone conferencing to discuss our responses and to develop a shared understanding and overarching reflections (Author 4 was unable to attend but provided a response to the notes of the meeting circulated).

The material generated from our individual critical reflections, and overarching reflections were further analysed and drawn together on behalf of the interprofessional collaboration members by Author 1, and member checked throughout the write up process.

It is acknowledged that 'Researcher bias' could be seen as a limitation of this process (Creswell, 2009). However, the 'emic /insider' positionality of the authors is considered to enhance the richness of the learnings drawn from our critical reflection process (Alston & Bowles, 2019; Van-Acker et al., 2021) and was relevant to the informal aims and purpose of the critical reflective process.

Interprofessional collaboration members

To position the knowledge, skills and expertise of the [name of program removed to ensure integrity of blind review] interprofessional collaboration members, and to contextualise the learnings from our critical reflections we provide a brief introduction to each of the members, including the research assistant. Dr Ann Carrington (AC) is a Senior Lecturer in Social Work at JCU and has nearly 20 years' practice and research experience in the areas of domestic violence, sexual assault, men's violence against women (Carrington, 2017) and curriculum design and development (Carrington, 2020b; Goldingay et al., 2016). Dr Felicity Croker (FC) is Adjunct Associate Professor with Dentistry at JCU. Informed by 40 years of clinical practice, teaching and research across disciplinary boundaries in regional, remote and disadvantaged communities within Australia and the Asia Pacific, Felicity applies a broad interprofessional focus to educating socially accountable health practitioners. Sandra Keogh is the Chief Executive Officer of the Cairns Regional Domestic Violence Service and has been with the service since 2005. Sandra also worked as the Integration Manager for the DFV High Risk Team in Cairns and Rape and DV Services Australia as a Men's Behaviour Change Counsellor. Amanda Lee-Ross is the former CEO of Cairns Regional Domestic Violence Service and has worked in the field of DV for twenty years. She served on two Queensland Ministerial Advisory Councils on Domestic and Family Violence from 2008–2012 and was awarded Cairns Woman of the Year in 2020 for her advocacy work. Simone Dewar (SD) was the research assistant for the critical reflection. She is a Social Worker in private practice and undertakes sessional work in the university sector. Her previous social work roles in the community sector include working with victim-survivors of sexual violence and domestic violence.

Critical Reflections

Individual critical reflection

The process of writing individually allowed for each voice within our collaboration to be heard and included. These individual written reflections provided the material for our subsequent overarching reflection. In this section, for each of the five critical reflection questions, we present the understanding we developed through the critical reflective process. While there is some commonality and shared perspectives, there is also divergence. As such, our quotes illustrate some of the dynamics, complexities, and nuances present in such a collaboration. The order in which we present quotes from members changes for each question to reflect our egalitarian approach of working, and to avoid privileging one voice over another. Minor grammatical edits have been made to the quotes to enable clarity

Question one: What assumptions did I bring to the collaboration and the design, development and delivery of the DDV-RRR program from a Social Work / Dentistry / Sector perspective?

Identifying and examining assumptions is central to critical reflection (Fook, 2015). Responses to this question highlighted gender, collaboration and expertise as areas of importance, but with different members positioning the influence of their perspective regarding these elements. A3, A4 and A1 focused on protecting the knowledge/theoretical base and pedagogy associated with the gendered nature of DV, and a feminist informed collaboration. A2, however, while recognising the need to seek knowledge outside of the dentistry discipline, expressed concerns and assumptions about the inclusion of a feminist and gendered analysis and how that might be received within Dentistry and by students.

> General assumptions informed from my social work and feminist perspective were the need to include the sector in the collaboration, and the importance of including a gendered analysis, feminist, intersectional and critical perspectives. (A1)

> We are the experts in this space… if we are not a part of this project, they will de-gender it and buy into myths… Felt sure that A1 would try not to de-genderize the content but would 'dentistry' be comfortable with this? (A3 & A4)

> I was unsure about how the gendered analysis would be received, but this did not emerge as a contentious issue with the young, culturally diverse demographic. The skilled and effective delivery of the gendered content by A1, A3 and A4 has been compelling / incontestable. (A2)

The collaboration enabled us to make explicit our assumptions, and undertake adjustments to the DV educational material and delivery methods that enhanced students' learning experiences, while maintaining elements identified as important by different members.

Question two: How did my Social Work / Dentistry / Sector values, knowledge and skill influence the collaboration and design, development and delivery of the DDV-RRR program?

Critical reflection involves articulating currently held values, and the process by which these values were acquired (Fook, 2015). Reflecting on our individual responses, we recognised that the values, knowledge and skills of each member were strongly linked to, and informed by, their held assumptions. While concepts around feminism, gendered analysis and collaboration were still present, individuals highlighted other elements of importance. A2 expressed how DV educational content and skills development could be adapted to the clinical dentistry context. A1 focused on elements of critical reflection and transformative learning. While practical knowledge and skills, a focus on safety and unintended consequences were presented by A3 and A4.

> Facilitated authentic learning by providing the dentistry perspective on what happens in clinical practice and students' experiences so that the DV content could align with their program… (A2)

> Developing the content from this perspective [critical feminists] would require the students to engage in this material and critically reflect on their own values and beliefs and to challenge and let go of some of the dominant discourse and myths they may hold about this topic/practice area… (A1)

> A gendered analysis was important… Kept a lens on safety and highlighting unintended consequences [and] trauma-informed practice… Being realistic about what the dentistry students could do at the end ie. not turning them into DV workers but informed and 'safe hands' for the survivors... (A3 & A4)

Bringing these three sets of values, knowledge and skills together informed by our assumptions allowed us to adapt elements of the DV educational content to ensure it is academically and practically robust, and relevant to the specific needs and context of the dental students.

Question three: What perspectives are missing?

Fook (2015, p. 448) articulates that an "openness to other, perhaps contradictory, perspectives does not mean having to give up one's own perspective". Our responses to this question again highlight our different positioning. A3 and A4 focused on who else could be educated, while A2 and A1 focused on different perspectives that could be brought in to enhance the DV educational material.

> Had not thought to educate the cohort of supervisors… Perhaps more attention to and from others in the relevant departments so that when staff left there was continuity of the program. (A3 & A4)

> Student / graduate voices on the value of the program for their practice… Victim-survivor perspectives on the experience of visiting the dentist and how this can be improved by trauma informed care… Working with individuals in vulnerable populations: cultural perspectives, how to RRR when on placement in remote Indigenous communities …Clinical supervisors and other members of the dental team. (A2)

> It has been difficult to get the perspective of the dentists… The other perspective that is missing is that of the patient although, I acknowledge that there are a number of tensions and ethical issues here that would need to be considered. (A1)

Conversation based on these types of reflections, as part of our interprofessional collaboration, help to make the DDV-RRR program more robust and relevant, and highlights additional perspectives that can be incorporated.

Question four: How did institutional power and the power of each discipline influence the collaboration and design, development and delivery of the DDV-RRR program?

Explicit exploration of power is one element that differentiates 'critical reflection' from other reflective practices (Fook, 2015). Interesting, all members articulated that the collaboration was a collegial experience, due in-part, to each person being attentive to power at the micro/individual level. However, each member also identified different concerns with power at the macro/structural level.

> Our project has been very dependent on collegiality between individuals…. And although I was able to influence decisions within Dentistry, I overlooked some significant macro considerations. (A2)

> I think one of the biggest issues was the power of Dentistry… As a group of individual people collaborating, we did give some attention to this and tried to implement processes to minimise where possible…There is inherently a power imbalance between the university and external partners. (A1)

> At the macro level …at the beginning the power dynamic was not too bad… as the project became more successful… the power dynamic shifted…We often felt pressure to be present (when we had resource constraints) in order to ensure that the Domestic and Family Violence sector (and our deep survivor-focussed knowledge) was still visible within the project and acknowledged as being from the sector…. (A3 & A4)

Our quotes highlight the critical importance of recognising power within an interprofessional collaboration, and the influence of different levels of power - micro/individual and macro/structural power - on the DDV-RRR program.

Question five: How has my thinking changed and what might I do differently?

Critical reflection engenders changes in thinking and behaviour (Fook, 2015). Responses to this question highlight the micro/individual and macro/structural levels of consideration in the development and delivery of the DDV-RRR program. A1 highlights the opportunities for critical reflection and professional development. While A3 and A4 articulate the tension around recognition of services and being recompensed for their work. FC adds support to this point.

> This project has provided me with an opportunity to be professionally humbled by recognising that although there may be 'expert' or specialised knowledge and practice informing responding to DV, being open to learning more about the specific contexts and other discipline perspectives allows for the expert knowledge to be adapted and to become more sophisticated in responding to specific or nuanced contexts. (A1)

> Charge a fee… Get the supervisors on board earlier… Pitch to discipline heads earlier… Succession planning for the project. (A3 & A4)

> In hindsight, there are so many things we could have done differently given time and resources. But this whole project grew organically and was highly dependent on the goodwill, extensive time and commitment of CRDVS and Social Work to educate this workforce. (A2)

Our quotes show key learnings from our experience of developing the DV-RRR program, specifically adaption of expert DV knowledge to the dentistry context. In addition, our reflections highlight the continued issue of securing ongoing funding to ensure all members are adequately recompensed for their work.

Overarching Reflection -Discussion

The key overarching learning from our critical reflection process is that, despite the challenges, interprofessional collaboration is central to the extensive achievements of the DV-RRR program. We suggest interprofessional collaboration is best practice as it brings together the knowledge, values and skills of three distinct disciplines: Social Work, Dentistry, and the DV sector. In the following section, we discuss three key learnings on interprofessional collaboration that emerged from our overarching critical reflections on the development and delivery of the [name of program removed to ensure integrity of blind review] program in relation to existing literature. The key learnings are: challenges, power and barriers; importance of collaboration for best practice; and importance of interpersonal/professional relationships.

Challenges, power and barriers

Our critical reflections highlighted that challenges, power issues and barriers are likely inherent in interprofessional collaboration at both micro/individual and macro/structural levels, and if not managed well could damage collaborative relationships or impact the sustainability of such programs.

> At the beginning the power dynamic was not too bad, except that [institutes name removed for blind review] held more power due to the constraints of timetabling and there was little accommodation for the Non-Government Organisation (NGO) in managing capacity around this, so sometimes felt the tension of having to juggle this with our NGO service's needs. (A3 & A4)

> As a group of individual people collaborating, we did give some attention to this [power] and tried to implement processes to minimise where possible. There was one time the collaborative team received some small monies for our work and as a team we identified that it should go to the CRDVS. (A1)

> Given the success of the program and ensuing publicity [I assumed] that JCU as an organisation would support funding the DDV-RRR and ensure its sustainability. This remains uncertain despite significant acclaim and media presentations by the team. Ongoing program delivery cannot rely on just the goodwill of colleagues and their willingness to participate in community service. (A2)

It is interesting to note how our respective positions within the university or DV sector influenced our responses. A3 and A4 consistently bring our attention to the inherent power dynamics between the university and the DV service, and how this played out in practicalities such as schedules and allocating resources. The quote from A1 illustrates how as a group we tried to ameliorate some of the power issues through discussion and negotiation. While FC identifies additional barriers to securing ongoing funding for the DDV-RRR program.

Similar to our experience, Busch-Armendariz et al. (2011) found many "benefits, strengths, and challenges" (p. 1203) from their interprofessional collaboration involving academic staff and DV sector workers. Likewise, Abel et al. (2012) noted that critical to the success of their DV educational program developed between a university and several DV services, was being attentive to the roles and macro/structural issues within the interprofessional collaboration and is comparable to our process in the development and delivery of the DDV-RRR program.

Importance of Collaboration for Best practice

Our critical reflections illuminated that interprofessional collaboration is worth the considerable time and effort we invest in this way of working and is central to the extensive achievements of the DDV-RRR program. We, therefore, suggest that interprofessional collaboration be considered best practice in the development and delivery of DV educational material.

> Supportive of keeping us engaged in the project (at a micro level – A2/A1 protective of sector info and ethical and collegiate) rather than jettisoning us once they had the sector materials and knowledge. However, not convinced that at the macro level this would continue if A1 and A2 were both gone. (A3 & A4)

> … so that the DV content could align with their program. To provide a facilitative 'bridge' between the discipline and dental profession, Social Work and the community sector. (A2)

> From my experience as a social worker in field and in academia, I am aware how this topic can be co-opted, neutralized to make people feel comfortable… and to avoid this I have been a strong advocate that the collaboration needs to be present through all phases and ongoing. Social work and the sector are not afraid of sitting with tensions or feeling the uncomfortable, rather these are our tools in transformative learning so by having the ongoing collaboration ensures the core principles are maintained and not lost. (A1)

It is noteworthy that we focus on different aspects of the benefits of interprofessional collaboration. A3 and A4 mention that each member contributed specific knowledge and skills to the interprofessional collaboration, and how this was valued by other members. The quote from A2 also spoke to this point and articulates how she was the 'bridge' that enabled DV material to be adapted to fit the dentistry context. Furthermore, as shown by A1, we acknowledge the continued involvement of the three perspectives of academic Social Work, DV sector, and Dentistry ensures the DDV-RRR program is balanced and effective and mitigates the risk that areas of content are minimised or omitted, or over-emphasised.

In addition, our reflections showed that, not only does our interprofessional collaboration mean we develop and deliver the DDV-RRR program informed by these three perspectives, but it also enables us to be reflexive in practice. This reflexivity entails being able to change and adjust the DV educational material and delivery methods to the complexities, nuances, and ongoing and emerging challenges in a manner that continually takes into account our varying positions. Echoing our learnings, Busch-Armendariz et al.

(2011); Farmer-Dixon et al. (2016); Kuliukas et al. (2017); and Petrosky et al. (2009) discuss, in relation to their interprofessional collaborations, that being reflex enables DV educational material to become more robust and relevant to the target audience.

Importance of interpersonal/professional relationships

A significant learning from our critical reflections is that our interpersonal/professional relationships are central to the strength of our collaboration. This point was consistently articulated by all members.

> Whilst there is inherently a power imbalance between the university and external partners, I believe that much of the practical elements of this were ameliorated through individual relationships. (A1)

> Our project has been very dependent on collegiality between individuals…With communication, - regular and effective engagement - to avoid misunderstandings and maintain collegial relationships with partners in the DV sector, Social work, and with the dental profession (academic / clinical coordinators, clinical contexts, Australian Dental Association etc.). (A2)

> On an individual (micro) level – A2, A1, A4 and A3 – very collegiate between each other, no power play. (A3 & A4)

We acknowledge that an investment of time, communication skills, and openness to learning from each other are needed from all members throughout the collaboration process. This enables us, as our quotes highlight, to use the strength of our interpersonal/ professional relationships to navigate the inevitable challenges that occur within our collaboration. This includes power at the micro/individual and macro/structural level as highlighted by A1, and S3 and A4. While tensions arising from differing theoretical perspectives and practical approaches are addressed through regular communication and effective engagement, as expressed by A2. Furthermore, our interpersonal/interprofessional relationships supports us to continue working in the complex, and critical area of DV.

Similar to our experience, Busch-Armendariz et al. (2011) articulates that their interprofessional collaboration involved a "consensus-building model [that] takes considerable time and resources"(p. 1204). Also comparable to our process, is the experience of Petrosky et al. (2009), who drawing on their own long-term interprofessional collaboration in the area of DV education of dentistry students, highlight the benefits of this way of working outweigh the considerable time and effort required.

Conclusion

Based on the key overarching learning from our critical reflections, we suggest interprofessional collaboration is best practice in the development and delivery of DV educational material. Interprofessional collaboration brings together the knowledge, values and skills across distinct disciplines. In this case, the curriculum content and delivery methods of the DDV-RRR program are informed by Social Work academia and the DV sectors' experience of working with victim-survivors and is adapted to the clinical dentistry context. While there may be inherent challenges, power issues and barriers in such projects, well developed interpersonal/professional relationships make collaborations not only possible but professionally rewarding. Ongoing DV education of tertiary dentistry students is essential, and the benefits of interprofessional collaboration outweigh the considerable time and efforts it requires.

Acknowledgements, to be inserted after peer review to ensure blind review integrity is maintained.

Notes

1. The authors use the term DV to denote specific dynamics and tactics within a spouse-type relationship. The authors acknowledge that over time, and to be inclusive, the term 'Family Violence' was introduced in some jurisdictions. Family violence is a broader definition and includes family members such as brothers and sisters, aunts

and uncles, mothers and children. There is, however, usually a different dynamic in relation to family violence. In light of the term Family Violence, the term Intimate Partner Violence began to be used to identify the 'old' definition of DV. The authors adopted the term DV to reflect the theoretical orientation of the [name of program removed to ensure integrity of blind review] program, and to convey the context and dynamics related to spousal-type DV.

2. National and global statistics show that DV is predominately perpetrated by men, and predominately experienced by women and children. The authors acknowledge that DV is perpetrated by women, however, understanding the context surrounding women's use of violence against men is particularly important. The authors also acknowledge that DV is experienced by men, perpetrated and experienced by people in same-sex relationships, and is perpetrated and experienced by people who identify as a non-binary gender. As such, an intersectional lens in relation to DV is important to the authors.

3. The authors conjoin the terms 'victim' and 'survivor' to enable people who have experienced DV to choose language that reflects their experience. The term 'victim' denotes DV is a crime, and 'survivor' acknowledges peoples' strengths and resilience.

4. Recognising the vital importance of interdisciplinary and intersectoral collaboration to the success of this program, Dentistry has advocated for funding support for educators. Since writing this article, negotiations have achieved some positive outcomes. This justification for funding will be strengthened by the Australian Dental Council's requirement that from 2023 all dental and oral health professional graduates are competent with "Recognising, assessing, and responding to domestic and family violence risk, prioritising safety, providing information, and referring as required" (p.13). Reference - Australian Dental Council (ADC). (2022). Professional competencies of the newly qualified dental practitioner.

Acknowledgments

The authors wish to acknowledge the contributions of the student researchers Casey Townsend, Winson Chan, William Shields, Nausheen Mohamed Muhajir, Aviral Aggarwal, John Dawoud, Gurleen Boparai, Manesha Mahendran, Shantelle Mazai, Lyn Nguyen,

Andrew Li, Crystal Lenegan-Dry and Fatima Ali. We would also like to thank Colleen Gage from Cairns Regional Domestic Violence Service for her recent contributions to the program. The authors would also like to extend our appreciation for the support and or work enabling this program across the academic Colleges at James Cook University; Dr Kris McBain-Rigg, Dr Geoffrey Booth, Dr Andrew Lee, Dr Clara Jo, Ass. Prof. Nonie Harris and Ass. Prof. Abraham Francis.

Disclosure statement

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

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References

Abel, S., Kowal, H. C., Brimlow, D., Uchin, M., & Gerbert, B. (2012). A Collaboration to Enhance Oral Health Care for Survivors of Domestic Violence: Women's Domestic Violence Shelters and Nova Southeastern University's College of Dental Medicine. *Journal of Dental Education*, *76*(10), 1334-1341. https://doi.org/https://doi.org/10.1002/j.0022-0337.2012.76.10.tb05388.x

Alston, M., & Bowles, W. (2019). *Research for Social Workers: An Introduction to Methods, 3rd Edition*. Routledge.

Ambikile, J. S., Leshabari, S., & Ohnishi, M. (2021). Curricular Limitations and Recommendations for Training Health Care Providers to Respond to Intimate Partner Violence: An Integrative Literature Review. *Trauma, Violence, & Abuse*. https://doi.org/10.1177/1524838021995951

Australian Institute of Health and Welfare. (2017). *Hospitalised Assault Injuries Among Women and Girls*. https://www.aihw.gov.au/reports/injury/hospitalised-assault-injuries-women-girls

Australian Institute of Health and Welfare (AIHW). (2018). *Family, domestic and sexual violence in Australia*. AIHW.

Brown, T., Mehta, P. K., Berman, S., McDaniel, K., Radford, C., Lewis-O'Connor, A., . . . Woo, B. (2021). A Trauma-Informed Approach to the Medical History: Teaching Trauma-Informed Communication Skills to First-Year Medical and Dental Students. *MedEdPORTAL*, *17*, 11160. https://doi.org/10.15766/mep_2374-8265.11160

Buchanan, C., Kingsley, K., & Everett, R. J. (2021). Longitudinal Curricular Assessment of Knowledge and Awareness of Intimate Partner Violence Among First-Year Dental Students. *International Journal of Environmental Research and Public Health*, *18*(11). https://doi.org/10.3390/ijerph18116039

Busch-Armendariz, N. B., Johnson, R. J., Buel, S., & Lungwitz, J. (2011). Building Community Partnerships to End Interpersonal Violence: A Collaboration of the Schools of Social Work, Law, and Nursing. *Violence Against Women*, *17*(9), 1194-1206. https://doi.org/10.1177/1077801211419330

Carrington, A. (2014). The Vortex of Violence: Moving Beyond the Cycle and Engaging Clients in Change. *The British Journal of Social Work*, 44(2), 451–468. https://doi.org/10.1093/bjsw/bcs116

Carrington, A. (2017). Accountability: Whose Responsibility Is It? A Commentary on 'Men as Allies in Preventing Violence Against Women: Principles and Practices for Promoting Accountability'. White Ribbon Australia. https://www.whiteribbon.org.au/awcontent/whiteribbon/documents/White-Ribbon-Australia-Men-as-allies-in-preventing-violence-against-women.pdf

Carrington, A. (2020a). Feminism Under Siege: Critical Reflections on the Impact of Neoliberalism and Managerialism on Feminist Practice. In B. Pease, S. Goldingay, N. Hosken, & S. Nipperess (Ed.), Doing Critical Social Work (pp. 226–240). Routledge.

Carrington, A. (2020b). Online and blended methods for teaching interpersonal skills and teaching professional online interpersonal skills in social work. Advances in Social Work and Welfare Education, 21(2),22–35. https://www.anzswwer.org/wp-content/uploads/advances_2020_Vol212_Chapter2-1.pdf

Coulthard, P., Hutchison, I., Bell, J. A., Coulthard, I. D., & Kennedy, H. (2020). COVID-19, domestic violence and abuse, and urgent dental and oral and maxillofacial surgery care. *British Dental Journal*, *228*(12), 923-926. https://doi.org/10.1038/s41415-020-1709-1

Coulthard, P., & Warburton, A. L. (2007). The role of the dental team in responding to domestic violence. *British dental journal*, *203*(11), 645-648. https://doi.org/10.1038/bdj.2007.1066

Creswell, J. (2009). *Research design: qualitative, quantitative, and mixed methods approaches* (3rd ed.). Sage.

Danley, D., Gansky, S. A., Chow, D., & Gerbert, B. (2004). Preparing dental students to recognize and respond to domestic violence: The impact of a brief tutorial. *Journal of the American Dental Association*, *135*(1), 67-73. https://doi.org/10.14219/jada.archive.2004.0022

Domestic and Family Violence Taskforce. (2015). *Not now, not ever. Putting an end to domestic and family violence in Queensland.* QLD Government.

Everett, R. J., Kingsley, K., Demopoulos, C. A., Herschaft, E. E., Lamun, C., Moonie, S., . . . Chino, M. (2013). Awareness and beliefs regarding intimate partner violence among first-year dental students. *Journal of Dental Education*, *77*(3), 316-322. https://doi.org/10.1002/j.0022-0337.2013.77.3.tb05472.x

Farmer-Dixon, C., Thompson, M. F., Young, D., McClure, S., & Halpern, L. R. (2016). Interprofessional Collaborative Practice: An Oral Health Paradigm for Women. *Dental Clinics of North America*, *60*(4), 857-877. https://doi.org/https://doi.org/10.1016/j.cden.2016.05.005

Femi-Ajao, O. (2021). Perception of Women with Lived Experience of Domestic Violence and Abuse on the Involvement of the Dental Team in Supporting Adult Patients with Lived Experience of Domestic Abuse in England: A Pilot Study. *International Journal of Environmental Research and Public Health*, *18*(4). https://doi.org/10.3390/ijerph18042024

Fook, J. (2015). Reflective Practice and Critical Reflection. In J. Lishman (Ed.), *Handbook for Practice Learning in Social Work and Social Care, Third Edition : Knowledge and Theory*. Jessica Kingsley Publishers. (pp. 440–454).

Gibson-Howell, J. C., Gladwin, M. A., Hicks, M. J., Tudor, J. F. E., & Rashid, R. G. (2008). Instruction in dental curricula to identify and assist domestic violence victims. *Journal of Dental Education*, *72*(11), 1277-1289. https://doi.org/10.1002/j.0022-0337.2014.78.8.tb05789.x

Healy, K. (2001). Participatory action research and social work: A critical appraisal. *International Social Work*, *44*(1), 93-105. https://doi.org/10.1177/002087280104400108

Kenney, J. P. (2006). Domestic violence: a complex health care issue for dentistry today. *Forensic science international*, *159*, S121-S125. https://doi.org/10.1016/j.forsciint.2006.02.025

Kuliukas, L. J., Oehlers, K., & Berlingeri, J. (2017). An interprofessional day of hi-fi simulation of Family and Domestic Violence with midwifery students and social work students. *Journal of Interprofessional Education & Practice*, *6*, 33-36. https://doi.org/10.1016/j.xjep.2016.12.003

McAndrew, M., Pierre, G. C., & Kojanis, L. C. (2014). Effectiveness of an online tutorial on intimate partner violence for dental students: A pilot study. *Journal of Dental Education*, *78*(8), 1176-1181. https://doi.org/10.1002/j.0022-0337.2014.78.8.tb05789.x

Morley, C., & Dunstan, J. (2016). Putting gender back on the agenda in domestic and family violence policy and service responses: Using critical reflection to create cultural change. *Social Alternatives*, *35*(4), 43-48.

Nelms, A. P., Gutmann, M. E., Solomon, E. S., DeWald, J. P., & Campbell, P. R. (2009). What victims of domestic violence need from the dental profession. *Journal of Dental Education*, *73*(4), 490-498. https://doi.org/10.1002/j.0022-0337.2009.73.4.tb04720.x

Patel, N., Bailey, E., Mahdmina, A., Lomax, A., & Coulthard, P. (2014). Domestic violence education for UK and Ireland undergraduate dental students: a five-year perspective. *J Dent Educ*, *78*(8), 1162-1166. https://doi.org/10.1002/j.0022-0337.2014.78.8.tb05787.x

Petrosky, M., Colaruotolo, L. A., Billings, R. J., & Meyerowitz, C. (2009). The integration of social work into a postgraduate dental training program: a fifteen-year perspective. *Journal of Dental Education*, *73*(6), 656-664. https://doi.org/10.1002/j.0022-0337.2009.73.6.tb04745.x

Raja, S., Hoersch, M., Rajagopalan, C. F., & Chang, P. (2014). Treating patients with traumatic life experiences : Providing trauma-informed care. *Journal of the American Dental Association*, *145*(3), 238-245. https://doi.org/10.14219/jada.2013.30

Raja, S., Rajagopalan, C. F., Kruthoff, M., Kuperschmidt, A., Chang, P., & Hoersch, M. (2015). Teaching Dental Students to Interact with Survivors of Traumatic Events: Development of a Two-Day Module. *Journal of Dental Education*, *79*(1), 47-55. https://doi.org/10.1002/j.0022-0337.2015.79.1.tb05856.x

Szilassy, E., Carpenter, J., Patsios, D., & Hackett, S. (2013). Outcomes of Short Course Interprofessional Training in Domestic Violence and Child Protection. *Violence Against Women*, *19*(11), 1370-1383. https://doi.org/10.1177/1077801213513857

United Nations Office on Drugs and Crime (UNODC) (2019). Global Study on Homicide: Gender-related killing of women and girls 2019. UNODC: Vienna. https://www.unodc.org/documents/data-and-analysis/gsh/Booklet_5.pdf

Van-Acker, K., Cleas, E., Deleu, H., Gulinck, N., Naessens, L., Schrooten, M., . . . Moustache, A. (2021). Participatory Action Research and urban social work: Strategies for navigating the challenges of participation and reciprocation. *Journal of Social Intervention: Theory and Practice*, *30*(1), 3-21.

World Health Organisation. (2013). *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO clinical and policy guideilnes*. World Health Organisation.

World Health Organisation. (2018). *Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women.* World Health Organisation.