

Improving Oral Health, Identification and Care in the Dental Setting of Patients Experiencing Domestic Abuse: A Scoping Review

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Abstract

Aims

Domestic abuse affects an estimated 3.8 million people annually and often causes oral and facial injuries, yet dental professionals report limited preparedness to respond. This review aimed to synthesise evidence on dental-setting interventions that improve the identification, response to, and referral of affected individuals.

Methods

A modified scoping review was conducted following Arksey and O'Malley, JBI, and PRISMA-ScR guidance. Four databases and supplementary sources were searched in November 2025. Eligible studies were screened using Population-Concept-Context criteria and findings mapped by intervention type and outcome.

Results

Of 1,608 records identified, 17 studies met the inclusion criteria. Most interventions were educational programmes for dental professionals and students, which generally improved knowledge, confidence, and preparedness to respond to domestic abuse; role-play and patient-centred methods were particularly valued. Interventions commonly addressed identification, documentation, referral pathways, trauma-informed care, and interprofessional collaboration, but evidence of changes in clinical practice was limited, constrained by time, funding, training, and information technology barriers.

Conclusions

Educational and practice-based interventions can increase dental professionals' confidence to respond to domestic abuse, but it remains unclear whether this translates into an increased response rate. The evidence base is limited, and robust research is needed to evaluate implementation in routine practice and its impact on patient outcomes.

Key points

Dental professionals are well placed to identify domestic abuse given high rates of facial injury, but tailored, interactive training such as role-play markedly improves confidence and preparedness to respond.

Establishing clear interprofessional referral pathways and adopting trauma-informed care principles are essential to support patients, build trust, and facilitate safe disclosures within the dental practice.

To achieve sustainable clinical impact, educational training must be integrated with robust practice-level policies, safeguarding procedures, and ongoing wellbeing support for both patients and dental staff.

Introduction

Domestic abuse (DA) is a major public health issue, affecting an estimated 2.2 million females and 1.5 million males aged 16 years and over in England and Wales in the year ending March 2025.¹ The Domestic Abuse Act 2021 defines DA as physical, sexual, psychological, emotional, coercive, controlling and economic abuse between personally connected individuals,² and includes intimate partner violence (IPV), behaviour by a current

or former partner causing physical, sexual or psychological harm.³ For this review, DA includes related terms such as domestic violence, family violence and IPV, and can affect individuals of any age, gender, socioeconomic status, race, ethnicity, geographical location or sexual orientation.⁴ DA is associated with substantial physical, psychological and social harms, including depression, anxiety, post-traumatic stress disorder and substance misuse, which can themselves further compromise oral health,^{3,5} and may also adversely affect oral health directly, with higher levels of dental caries, periodontal disease and traumatic dental injuries reported among people who have experienced abuse.⁶

Dental professionals are well placed to identify and respond to DA because injuries commonly involve the head, face and mouth, including facial or intraoral bruising, lacerations, fractured or avulsed teeth, maxillofacial injuries and signs of non-fatal strangulation.^{7,8} Abuse may also present through coercive or controlling behaviours affecting attendance, communication and access to treatment,⁹ so dental settings provide opportunities to recognise abuse, support disclosure and facilitate access to specialist services.

Professional guidance recognises a role for the dental team in responding to DA. NICE recommends training to identify abuse, respond appropriately to disclosures and refer patients to specialist support services.¹⁰ Likewise, the GDC requires registrants to raise concerns where patients may be at risk and expects graduates to recognise and act on abuse and safeguarding concerns.^{11,12} Despite this, many dental professionals report feeling insufficiently prepared to identify and respond to DA. Tailored education and training can improve knowledge, confidence and intended clinical action.^{13–16}

Previous reviews have examined IPV interventions in dental settings and dental professionals' knowledge, attitudes and education relating to DV.^{17,18} However, evidence remains fragmented. Compared with Lewer et al.,¹⁷ this review focuses on empirical studies and grey literature, includes dental education and undergraduate curricula, broadens the scope from IPV to domestic abuse and family violence, and considers interventions through a trauma-informed care (TIC) lens.¹⁹ Whereas Lewer et al. largely mapped guidance documents, reviews and commentaries, the present review focused specifically on empirical evidence and evaluated interventions across both dental education and clinical practice. Searches were also updated to November 2025, capturing more recent evidence. This review therefore aims to map and synthesise interventions in dental education and practice that improve the identification, support, referral and care of individuals experiencing DA, and to identify evidence gaps for future research, policy and practice.

Methods

Review design

This scoping review was conducted in accordance with the Arksey and O'Malley framework and Joanna Briggs Institute (JBI) guidance for scoping reviews.^{20,21} Reporting followed the PRISMA-ScR checklist.²²

Eligibility criteria

Eligibility criteria were developed using the Population, Concept and Context (PCC) framework (Appendix 1). The population included dental professionals (dentists, dental therapists, dental hygienists, dental nurses and

reception staff), dental students, and adults experiencing or with a history of DA. The concept was interventions intended to improve the identification, management, referral or care of individuals experiencing DA, or professional knowledge relating to DA; the context was dental education and clinical dental settings.

Studies focused solely on other healthcare professions or non-DA-related trauma were excluded unless dentistry-specific findings could be identified, as were studies reporting knowledge, attitudes or injury prevalence without evaluating, describing or recommending approaches to improve education, care or responses to DA. Only studies involving adults aged 18 years and over were included, to avoid overlap with child abuse; non-English language publications were excluded because translation resources were unavailable, and no date restrictions were applied. Primary research studies and relevant grey literature were both eligible for inclusion.

Search strategy

An initial MEDLINE search identified relevant keywords and subject headings, informing the final search strategy (Appendix 2), which was adapted for each database (Appendix 3) and executed in MEDLINE, Scopus, CINAHL (EBSCO) and Web of Science in November 2025. Controlled vocabulary and free-text terms relating to domestic abuse (domestic violence, spouse abuse, intimate partner violence) and dentistry (oral health, dental care, dentists, dentistry; truncated as "Dent*" to capture variants) were combined using Boolean operators, with no date or study design limits applied. Citation searching of included studies and relevant reviews identified additional records, and supplementary searches were conducted in Google Scholar, Google and grey literature sources.

Study selection

All records were exported to EndNote and duplicates removed. As this study formed part of an undergraduate research project, screening was conducted by a single reviewer (LG), with the eligibility criteria piloted on a random sample of 50 titles and abstracts beforehand to enhance consistency and reduce selection bias. The remaining titles and abstracts were then screened against the predefined criteria, followed by full-text assessment of potentially eligible studies for final inclusion.

Data charting and synthesis

A standardised data-charting form was developed and piloted on a sample of three included studies before use, then applied by the single primary reviewer (LG). To enhance reliability in the absence of a second reviewer, all charted data were subsequently cross-checked against the original source publications on a separate date to identify and resolve any extraction errors. Extracted data included study location, design, participant group, intervention characteristics, educational content, care-related interventions, and reported outcomes.

Results

Selection of sources of evidence

A total of 1,608 records were identified. After 653 duplicates were removed, 955 records remained for title and abstract screening; 817 were excluded, leaving 138 for full-text screening, of which 17 met the inclusion criteria. The study selection process is presented in Figure 1.

-= Figure 1 about here =-

Characteristics of evidence sources

Table 1 summarises the characteristics of the 17 included studies, including country, population and design. Studies were published between 2003 and 2026, predominantly in the United States (n = 9), with others from the United Kingdom, Canada, the Netherlands, France and Australia. Most studies involved dental professionals (n = 9) or dental students (n = 6); one involved both, and one involved dental school education leads.

-= Table 1 about here =-

Results of individual sources of evidence

-= Table 2 about here =-

Synthesis of results

Fourteen studies included an educational intervention,²³⁻³⁶ delivered via presentations, tutorials, role-play and other interactive methods; practical, experiential approaches, particularly role-play, were consistently most valued,^{29,30,36} supporting DA education across undergraduate and continuing professional development, given students' likely clinical encounters with affected patients. Educational interventions were associated with improvements in knowledge, confidence, preparedness, recognition of abuse and referral-related skills (Table 2), although recommendations on screening varied between targeted enquiry when abuse signs were present,^{24,25,29,34} routine enquiry,^{28,33,36} and an unspecified approach;^{27,30-32,35} common frameworks included "Ask, Validate, Document, Refer" (AVDR)^{24,25,27} and "Routinely screen, Ask direct questions, Document findings, Assess patient safety, Review options and refer" (RADAR).²⁸

Two studies engaged directly with survivors: Abel et al. delivered shelter-based dental care using portable equipment,²⁷ and Chadambuka et al. explored barriers and facilitators to oral healthcare access among racialised women with IPV experience.³⁷ Clinical interventions included a modified IRIS (Identification and Referral to Improve Safety) programme incorporating training, identification software and referral pathways,^{31,34} behavioural techniques such as tell-show-do and stop signals,²⁹ and practice resources including posters, leaflets and discreet support contact details.³³ Common themes included participant and staff support, interprofessional collaboration, and trauma-informed care (TIC): emotional and peer support addressed the sensitive nature of DV education,^{30,32,33} and collaboration with healthcare professionals,^{23,29,32} shelter providers^{27,37} and social workers³⁶ informed clinical management, programme development and teaching, with high patient satisfaction reported where dental residents cross-trained with shelter staff.²⁷ Six studies referred explicitly to TIC, five incorporating it into educational content,^{29,30,32,35,36} including SAMHSA's six TIC principles,³⁰

and Chadambuka et al. identified TIC as an important facilitator of dental care access,³⁷ though evidence of its effectiveness remained limited.

Study designs varied: nine used pre-post designs,^{23,27-30,32,33,35,36} four were qualitative studies,^{31,34,36,37} two were randomised controlled trials,^{24,25} two were cross-sectional,^{38,39} and one was post-test-only,²⁶ with outcomes spanning knowledge, attitudes, confidence, intention and practice change, acceptability and feasibility.

Knowledge, attitudes and confidence

Eight studies assessed knowledge outcomes;^{23-26,28,29,32,33} six reported statistically significant improvements,^{24-26,28,29,32} with gains seen even from brief interventions of 15 minutes to one hour,^{24,28} and an interactive online tutorial outperforming a control,²⁵ suggesting online learning may help address commonly reported time constraints.^{31,33} Seven studies assessed attitudes towards DA,^{23-26,28,32,36} which generally improved, particularly regarding recognising DA as part of the dentist's professional role,^{24,25,32} and 65% of women reported feeling less anxious or less likely to avoid dental attendance after treatment.²⁷ Five studies assessed confidence or comfort in responding to DA,^{26,29,30,34,35} which generally improved, including students' confidence with sensitive communication²⁹ and comfort managing IPV disclosures,^{30,35} sustained at five months in one study,³⁰ dental nurses reported less anxiety than dentists,³⁴ and improvements were greatest among third-year students.³⁶

Practice change, acceptability and feasibility

Five studies reported intention to apply learning in practice,^{24-26,32,35} but intention did not necessarily translate into behaviour change: only 73% of participants in one study self-reported changes within five months,³⁰ and only 30% reported increased awareness of abuse following a UK reporting programme,³⁹ although Coulthard et al. found DA was discussed with 11 adults presenting with suggestive injuries, all referred to advocacy services.³¹ The modified IRIS intervention was generally acceptable when supported by staff training,³¹ and uptake of Doughty et al.'s programme improved with CPD certification and a domestic violence and abuse (DVA) champion, despite initial time pressures and uncertainty about relevance,³³ in a Dutch reporting programme, 82% of dentists were aware reporting was mandatory, and 68% of those with negative views felt insufficiently equipped,³⁹ while patient acceptability was high in Abel et al.'s shelter-based programme.²⁷ Feasibility was constrained by a lack of unified information technology systems for data collection,^{31,33} though staff training, direct referral pathways, and Dutch dentists' interest in further e-learning suggested such approaches could be implemented.^{34,39} Financial sustainability was also a concern, with pro bono care considered unsustainable long-term³⁷ and ongoing funding highlighted as a barrier,³³ and limited staff capacity, external speakers and curriculum time were reported as barriers to education,³⁸ with a proposed train-the-trainer model not formally evaluated.²⁶

Barriers to accessing dental care

Reported barriers to dental care for women experiencing IPV included race and gender bias, prioritising children's needs over personal healthcare, financial pressures, unaccommodating services, and language barriers, alongside limited dentist awareness of how race influences access to oral healthcare and a lack of relevant

training.³⁷ Facilitators included trauma-informed care (TIC), financial autonomy, translation services, longer appointments, and direct support from domestic violence shelters.³⁷

Discussion

This modified scoping review mapped interventions to improve the identification, support and care of individuals experiencing domestic abuse (DA) within dental settings. Educational interventions dominated the evidence base, with fewer studies evaluating interventions implemented directly in clinical practice. Education was generally associated with improved knowledge, confidence and preparedness to respond to DA, but evidence of sustained changes in clinical practice or patient benefit was limited, so while educational approaches appear promising, their impact on patient outcomes and routine practice remains unclear.

Several studies reported intentions to apply learning clinically, yet few measured actual behavioural change, an important distinction since increased confidence does not necessarily translate into increased identification, referral or support. Models such as the COM-B system, which frames capability, opportunity and motivation as necessary for behaviour change,⁴⁰ may help explain this: this review suggests educational interventions build professionals' capability and opportunity to respond, with referral pathways, resources and specialist links viewed positively,^{31,33,34} and although guidance exists for healthcare and dental teams,^{7,41} uncertainty about initiating conversations persisted, suggesting guidance is most effective alongside practical training and organisational support. Greater support for learners and practising professionals is also needed, as organisations are increasingly encouraged to support those affected by trauma or abuse,⁴² though implementation appears inconsistent across dental settings,⁴³ which ties into the psychological capacity needed to engage with behaviour change.⁴⁰

Dental professionals' motivation to respond was not explored in this review, which may explain why change is not being seen in practice: motivation has been found to be significantly associated with reporting suspected abuse among dentists, independent of previous training or awareness of victim support agencies, although awareness itself was low.⁴⁴ Motivation may therefore be a missing factor in previous interventions; future studies should determine whether education alone creates motivation, and how it can be increased and sustained, since confidence can increase whilst willingness to respond may not.³⁰ Viewed through a COM-B lens, effective domestic abuse responses in dentistry may require interventions that address capability, opportunity and motivation simultaneously, rather than relying on education alone.

It remains unclear whether routine enquiry or targeted questioning based on clinical indicators is the more appropriate approach in dentistry. A recent pilot study conducted outside the review period found substantial increases in IPV identification following implementation of routine screening in a public dental setting,⁴⁵ but further research is needed to evaluate the acceptability, feasibility and effectiveness of such approaches across diverse dental settings.

Variation in content, duration, delivery and outcome measures made it difficult to determine the most effective educational approach, though interactive, experiential methods, including role-play and interprofessional activities, were consistently well received,^{29,30,36} aligning with broader dental education literature on active learning.⁴⁶ Interprofessional collaboration between dental professionals, social workers, domestic abuse advocates and shelter providers recurred throughout the literature as beneficial for both care and

education,^{23,29,32,36} echoing multidisciplinary responses to sexual and family violence elsewhere,⁴⁷ though professional responsibilities and referral processes need clearer definition throughout dental education, not only after qualification. Patient-centred communication appeared fundamental to improving access to care and facilitating disclosure: women experiencing IPV reported that feeling unsupported, judged or intimidated could deter engagement with dental services,³⁷ whereas positive interactions with dental professionals promoted trust and improved experiences of care,²⁷ echoing similar barriers to disclosure reported in wider healthcare settings.⁴⁸ The emphasis placed on communication, trust, patient choice and avoidance of re-traumatisation across the included studies suggests that TIC may provide a useful framework for supporting individuals experiencing DA, though few studies directly evaluated its effectiveness,³⁷ reflecting the broader dental literature, where trauma-informed frameworks have been proposed but rarely assessed in practice.⁴⁹

Limitations

Most included studies employed pre-post designs without control groups, limiting confidence in intervention effectiveness and based on GRADE principles, generally indicating low-certainty evidence. Many also relied on convenience or self-selected samples, and screening and data extraction were conducted by a single reviewer (LG) as an undergraduate project; piloting and temporal self-verification mitigated but did not eliminate the risk of selection bias and missed nuance.

Although critical appraisal is not a required component of JBI scoping review methodology, relevant JBI critical appraisal tools were consulted to support interpretation of the evidence. Overall, methodological quality varied considerably, and the predominance of self-reported outcomes limits confidence in the reported effectiveness of interventions.

Follow-up was generally limited and patient-centred outcome measures scarce, with most studies assessing knowledge, attitudes or confidence only immediately following interventions, and overlap existed between some publications reporting different aspects of the same intervention, such as the modified IRIS programme,^{31,34} so the number of unique interventions may be smaller than the number of included studies suggests. This review was also restricted to studies published in English, and all included studies were conducted in high-income countries, so relevant evidence may have been missed and the transferability of findings to other contexts may be limited; most studies also focused on women experiencing DA, highlighting the need for future research exploring the experiences of men and other underrepresented groups.

Future research should move beyond educational outcomes to evaluate clinically meaningful measures, including identification rates, referral activity, patient experiences and oral health outcomes, designed with behaviour change models in mind; motivation, in particular, may warrant inclusion as an outcome measure, alongside the wider barriers dentists face, such as limited time, competing priorities and fear of getting it wrong. Sustainable change is likely to require integrating training with safeguarding procedures, referral pathways and practice-level policies, supported by robust implementation studies and controlled trials.

Conclusions

This scoping review identified a developing but limited evidence base on interventions addressing domestic abuse within dental education and clinical practice. Most interventions were educational and were associated

with improvements in knowledge, confidence and preparedness among dental professionals and students, but evidence of sustained changes in practice, successful implementation and patient benefit remains limited.

The findings support including domestic abuse education throughout undergraduate and continuing professional development, particularly using interactive, experiential learning. Clear referral pathways, interprofessional collaboration and trauma-informed principles appear to be important components of effective responses to DA, although further evaluation is required.

Future research should prioritise robust assessment of practice-based interventions, implementation strategies and patient-centred outcomes, to define the role of the dental profession in responding to domestic abuse and support effective guidance, education and clinical practice.

Declarations

Ethics approval and consent to participate:

Not applicable (Scoping Review).

Competing interests

The authors declare no competing interests.

Consent to publish

Not applicable. This scoping review did not include identifiable individual patient data.

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Author contributions

LG led the review: conducted the literature searches, screening, data extraction and synthesis, and drafted the manuscript. AS contributed to the conception and design of the review, provided methodological supervision, and critically revised the manuscript. SCM conceived and supervised the study, provided critical revision of the manuscript, and is the corresponding author. All authors approved the final manuscript.

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Data availability

All data generated or analysed during this study are included in this published article and its supplementary information files.

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Tables

Table 1 – Characteristics of the 17 included studies evaluating domestic abuse interventions within dental education and clinical practice.

Author, year, location	Type of Publication	Aims	Population	Intervention	Summary of key findings and conclusions
Abel S et al., 2013, USA	• Quasi-Experimental study • Pre-post test design	Evaluate the impact of an oral health program on Oral Health Related Quality of Life (OHRQoL) for female victims of domestic violence in community shelters.	• 37 women living at domestic violence shelters • Self-selected sample of women, 65% were white • 20 dental residents	Educational program delivered to dental residents who then provided dental care to women at the shelters who completed a pre and post test as well as a patient satisfaction survey.	Positive increase in OHRQoL from after completion of dental treatment. Education of dental residents on DV contributed to patient satisfaction and reduced dental anxiety. Overall, a mutually rewarding collaboration between DV shelter staff members and dentists.
Aved B.M et al., 2007, USA	• Quasi-Experimental study • Post test design	Determine the impact of the training course on awareness, knowledge, ability and confidence reporting in relation to family violence.	• 1,213 dental professionals. • Convenience sample, mostly female.	Educational training course	Educational training course increased knowledge on domestic violence and participants had positive reviews of the course. The authors believe this should be a fundamental part of dental schools education.
Banava S et al., 2026, USA	• Quasi-Experimental study • Pre-post test design	Increase understanding of IPV definitions, prevalence, clinical indicators, management strategies and available resources.	• 14 dental professionals, with 11 completing the surveys. • Convenience sample.	Educational workshop	The results demonstrated the workshop increased dental professionals' preparedness and willingness to manage intimate partner violence cases in the dental setting.
Berthin M et al., 2025, France	Descriptive cross sectional study	Identify the current overview of domestic violence education in undergraduate dental education in France and	• All 15 French dental schools heads of education contacted, 11 responded. • Those who responded may	Questionnaire	Reports opinions that undergraduate dental education could be improved through workshops,

the barriers to its implementation and strategies for improvement.

be more likely to be involved in DV education.

directed teaching, role-play and external speakers. Suggested that future efforts should be aimed towards a nationwide standardised DV curriculum.

Brown T et al., 2021, USA	• Quasi-Experimental study • Pre-post test design with a 5 month follow up	To Introduce students to the principles of Trauma informed care and how to apply them to patient care.	164 first year medical and dental students	Educational Intervention	Students comfort addressing trauma and using TIC principles increased after the teaching session which was maintained over 5 months. This supports training beginning early when dental students as exposure to patients experiencing trauma can happen early and the importance of standardised training. Authors now developing OSCEs to assess this within clinical skills.
Carrington A et al., 2023, Australia	• Mixed method study • Pre-post test • Focus groups	To develop and implement an effective interprofessional domestic violence curriculum for students to improve care for patients	• 3rd, 4th and 5th year dental students • 82 third year students 2016 • 72 4th year students 2016 • Unclear how many students in 2019	Educational Intervention	Highlights the importance of interprofessional collaboration (in particular social work), practical training and a scaffolded training approach beginning early in dental school. There is limited presentation of the results and no statistical analysis however, the program went through a

Chadambuka C et al., 2026, Canada	Qualitative study involving interviews and focus groups.	To identify barriers and facilitators to accessing oral healthcare for racialised women who experience intimate partner violence (IPV) to help inform care.	• 14 Racialised women who have experienced IPV, 9 dentists and 8 shelter providers . • There was an over-representation of black women. • These women also had to be part of the RS program so may have reported more positive experiences being part of this.	Interviews of racialised women who have experienced IPV and focus groups with dentists and shelter providers.	Highlights the factors affecting access to oral healthcare for racialised women with experiences of intimate partner violence. To improve access policy and practice changes are required and competent, culturally appropriate and trauma-informed oral healthcare. This research would be more generalisable with a larger, more diverse population.
Coulthard P et al., 2022, UK	• Feasibility study for a cluster randomised control trial. • Also involving interviews and focus groups.	To assess the feasibility of using a modified IRIS intervention in a General Dental practice.	6 General dental practices in Greater Manchester, of which 3 were placed in the intervention group and 3 were controls. 16 dentists and 23 dental care professionals including dental nurses, practice managers, hygienists, safeguarding leads and reception staff attended the training.	IRIS intervention involving practice-based DVA training sessions, installation of software to prompt enquiring and of DVA and a referral pathway to a named DVA advocate who delivered the training. However, as there are no unified IT systems in dental practices they had to use paper forms to capture data.	They were not able to determine the feasibility of undertaking a definitive cluster randomised control trial however, the research has started a process which may inform practice change. It was feasible to implement the domestic violence training and establish a referral pathway in the dental setting however, there was not the IT software. It was suggested for future development CPD rewards may increase attendance.
Danley D et al., 2004, USA	Randomised control trial	To determine the impact of a tutorial on recognising and	• 13 dentists and 161 dental students. • Convenience	• Educational intervention. • Control group that	The tutorial resulted in significant improvements in

responding to domestic violence for dentists and whether completion of a pre-test has an effect on the results.

sample.
• No difference in demographics between control and intervention groups.

completes the pre-test and post test without doing the tutorial.
• One experimental group that completes the pre-test, completes the tutorial and then does the post-test.
• One experimental group which only completes the post-test after the tutorial.

knowledge and attitudes about domestic violence screening and intervention. In future research, it will be important to determine if education leads to actual changes in practice.

Doughty J.L
et al., 2023,
UK

• Quasi-
Experimental
study
• Pre-post
test design

To raise awareness and increase knowledge on domestic violence and abuse among dentists and teaching them how to ask about DVA and support disclosures through implementing a safe space. To identify the challenges faced in doing so.

• 153 Dental professionals consisting of dentists, dental hygienists, dental therapists, dental nurses and managerial and administrative staff from 26 dental practices.
• Mostly female.

Educational intervention and campaign tailored to the needs of dental professionals.

The training improved knowledge however limited evidence of this and no statistical analysis. Many suggestions of how practice can be changed and resources available however, unsure on their clinical impact and benefits for patients. It was noted further formal evaluation of the intervention is required.

Femi-Ajao O et al., 2023, UK	Feasibility study for a cluster randomised control trial focusing on the qualitative data collection involving interviews and focus groups.	To fulfil the evaluative component of the Dentistry Responding in Domestic violence and Abuse (DRiDVA) feasibility study through understanding dental professionals experiences of the training program and implementation in practice.	• 30 participants in total, 9 dentists and practice principals/owners who took part in one-to-one interviews and 21 auxillary staff split across two focus groups. • Mostly female.	Modified IRIS intervention (see Coulthard et al., 2022). It was ensured there were separate focus groups for dental nurses and receptionists so there was no hierarchal atmosphere effecting responses.	Most dental professionals felt the intervention could benefit patients. Through DVA training and a referral pathway to a named DVA advocate increased knowledge and awareness of DVA and confidence making referrals. Further research was needed to determine how to increase dental professionals willingness to ask about DVA as this did not necessarily increase following training.
Hsieh N.K et al., 2006, USA	Randomised control trial	To determine the effectiveness of the tutorial in educating dentists to identify and respond to domestic violence. As well as see if dentists' empathy has an effect on addressing domestic violence in patients.	• 174 dentists • Convenience sample. • 48% white. • No statistical difference between control and intervention groups.	• Educational intervention. • Pre and post tests completed. • The control group completed the tutorial after completing the tests. • Use of an adapted Jefferson scale to assess empathy.	The results demonstrated after the tutorial dentists intentions to use AVDR in practice increased, as well as knowledge, However, it was less effective at changing attitude regarding DV but there was still some improvement. The effectiveness of the tutorial is not dependent on dentists' empathy as this is a stable trait.
Johnson L.A et al., 2022, USA	• Quasi-Experimental study • Pre-post test design	Develop, evaluate and implement interprofessional modules to increase knowledge on intimate partner	• 672 Health science students, of which 15% were dental students. • Convenience sample.	Educational intervention	This highlights the importance of interprofessional learning for students and learning in this way means

violence and other types of interpersonal violence and understand their role in relation to other professions.

students are likely to use these skills in clinics.

Johnston G.M et al., 2003, Canada	• Quasi-Experimental study • Pre-post test design • Collecting qualitative results in years 1 and 2 and quantitative in the year 3 post-test.	To enhance the ability of healthcare students to work together to address domestic violence now and in the future.	• Healthcare students including dental hygiene and dentistry students • 43 students in year 1. • 119 students in year 2 (19 dental hygiene and 20 dentistry students). • 468 students in year 3.	Educational intervention	The results show the workshop increased students knowledge on theirs and other healthcare professions roles in family violence and they successfully taught and simulated interprofessional collaboration. However, there was no statistical analysis. The study describes the importance of interprofessional learning in student education so this follows through in future practice.
Mc Andrew M et al., 2014, USA	• Quasi-experimental pilot study • Pre-post study design	To assess the effectiveness of the online tutorial on improving knowledge, attitudes, beliefs and behaviours of dental students on domestic violence.	• 25 dental students (8 in the control group and 17 in the intervention group) • Convenience sample.	Educational intervention	The online tutorial was effective at increasing the perceived preparation, perceived and actual knowledge and self-efficacy of dental students regarding managing intimate partner violence. Use of the PREMIS tool which is an validated tool. It was attempted to conduct a randomised control trial however, the sample size was

too small so new participants all had to be placed into the intervention group.

Raja S et al.,
2015, USA

- Quasi-experimental
- Pre-post study design

To develop and assess a trauma informed care interactive educational module for dental students.

- Cohort 1 (n=92) and Cohort 2 (n=102) of second-year dental students.

Educational intervention

The module was successful in teaching trauma-informed care for patients who have experienced trauma as students felt well trained to treat these patients in practice and were able to identify statements not consistent with trauma-informed care. The more interactive second module was more effective in meeting objectives and the authors found collecting student feedback helpful to refine educational modules.

Van Dam B.A.F.M et al., 2015, Netherlands	Cross sectional study	To determine if Dutch General Dental practitioners are aware of the reporting code for dental professionals (RCD) and if and how they implement this to deal with suspicions of abuse.	• 264 General Dental practitioners responded of the 1038 the survey was sent to. • There was a low response rate and between dentists who did and did not respond there was statistical significance.	Questionnaire	GDPs aware of the RCD who have implemented it and have engaged with the guidance resources are more likely to feel positively about it and respond to signs of domestic violence. Authors stated further critical evaluation of the results is needed. An updated version was being worked on at the time for publication in 2015.
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Table 2 - Components and outcomes of interventions designed to improve the identification, support, and referral of domestic abuse in dental settings. This table summarises the intervention components and headline outcomes for each study; the full study-level data extraction is provided in the Supplementary Information (Appendix 4).

Author, year, location	Intervention components	Key outcome(s)
Abel et al., 2013, USA	One-day educational programme (AVDR) plus dental care delivered to women at DV shelters via portable equipment and shelter cross-training.	Oral health-related quality of life improved in 36/37 women, alongside high patient satisfaction and more positive attitudes towards dentists.
Aved et al., 2007, USA	4-hour seminar or online training on child abuse, elder abuse and IPV (reporting, recognising signs, legal responsibilities).	Perceived knowledge increased significantly; comfort and attitude changes were smaller and largely non-significant.
Banava et al., 2026, USA	Workshop with presentations and case-based scenarios covering IPV definitions, indicators, trauma-informed communication, safety planning and referral protocols.	Confidence managing IPV disclosure increased significantly; 82% were very likely to incorporate IPV screening into practice.
Berthin et al., 2025, France	National survey of dental schools' current IPV/DV teaching, delivery methods and barriers to strengthening education.	Only 6 of 11 responding schools taught DV, mostly on child abuse; lack of trained staff and time were the main barriers.
Brown et al., 2021, USA	3.5-hour trauma-informed care training (live interview demonstrations, role-play, reflection) on trauma screening and responding to disclosure.	Comfort screening and responding to disclosure increased significantly; 73% of 5-month follow-up respondents reported a change in clinical practice.
Carrington et al., 2023, Australia	Interprofessional DV curriculum (lectures, case studies, role-play) evaluated over repeated cycles, covering communication, risk assessment and referral.	Attitude and preparedness to recognise, respond to and refer DV rose to near 100% across year groups; over half of final-year students had seen a patient with DV indicators.
Chadambuka et al., 2026, Canada	Qualitative interviews with IPV survivors and focus groups with shelter/dental providers, linked to the Restoring Smiles dental access programme.	Identified affordability, waiting times, unaccommodating environments and power imbalances as barriers, and shelter referral links and trauma-informed, culturally competent care as facilitators of access.
Coulthard et al., 2022, UK	IRIS-model implementation trial: dentist/advocate-educator training on asking, responding to and recording DVA, with referral to a named DVA advocate.	Training and the referral pathway were feasible and generated real disclosures and referrals, but quantitative referral/disclosure rates could not be reliably captured due to IT limitations.
Danley et al., 2004, USA	15-minute multimedia AVDR tutorial (asking, validating, documenting and referring), tested against a control group.	Knowledge of asking, validating, documenting and referring increased significantly versus control; attitude change was more limited.
Doughty et al., 2023, UK	3.5-hour DVA training with ongoing peer support, plus a practice-level campaign (champion, posters, leaflets, referral pathway, policy).	Perceived knowledge improved from a low baseline; embedding screening into routine workflow was the main ongoing challenge, though posters prompted at least one patient self-referral.
Femi-Ajao et al., 2023, UK	Companion IRIS-model trial: training on identifying and responding to DVA, with referral to a named Women's Aid advocate-educator.	Confidence to ask about and respond to DVA increased with a structured pathway and named advocate-educator, though some anxiety about initiating conversations persisted.

Hsieh et al., 2006, USA	15-minute interactive computer AVDR tutorial, tested against a control group.	Knowledge of AVDR and DV signs increased significantly versus control; intention to ask, validate and refer also increased.
Johnson et al., 2022, USA	Interprofessional online modules on IPV, human trafficking and child abuse (prevalence, warning signs, screening tools).	Familiarity with IPV signs and symptoms increased significantly; most valued the interprofessional format and intended to apply the learning.
Johnston et al., 2003, Canada	Interprofessional workshop on family violence (preparatory material, small-group discussion, case studies, expert panel).	Qualitative reports of improved understanding of professional roles, legal obligations and the value of interprofessional collaboration.
McAndrew et al., 2014, USA	Online RADAR-framework module (screening, documentation, safety assessment, referral) with cultural competency content.	Perceived knowledge, preparedness and self-efficacy increased significantly, though several actual-knowledge items were still answered correctly by fewer than half of participants.
Raja et al., 2015, USA	Trauma-informed care training, expanded from lecture to interactive sessions with patient videos and role-play.	Trauma-related knowledge and confidence communicating with traumatised patients increased significantly; uncertainty about when and how to report persisted.
Van Dam et al., 2015, Netherlands	National survey on dentists' awareness and use of the Dutch mandatory reporting code (RCD) for suspected DV/child abuse.	Awareness of the mandatory reporting code was high, but only 51% of dentists had implemented it in practice, mainly due to inexperience or insecurity.

Figures

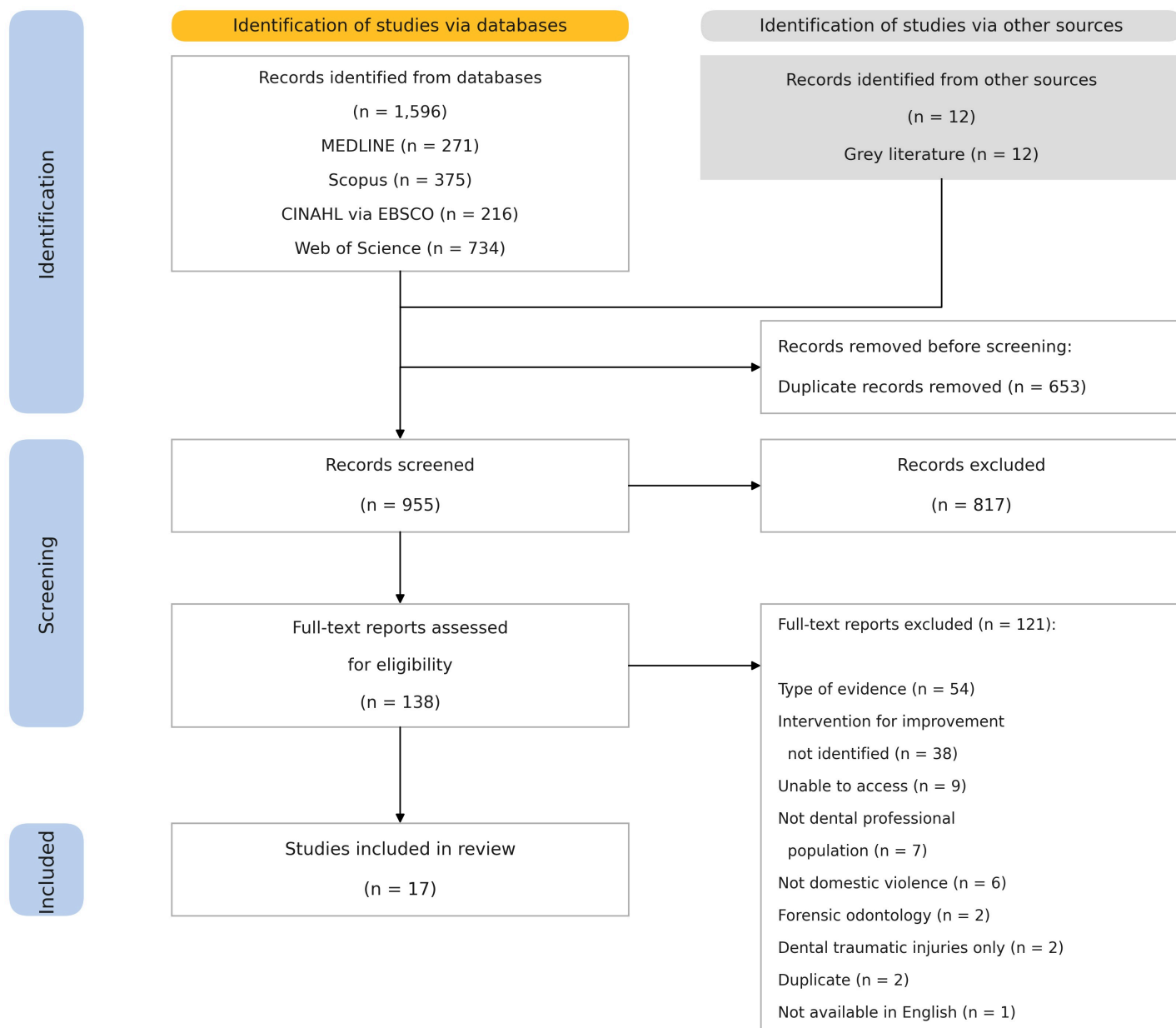


Figure 1

PRISMA flow diagram illustrating the study selection process for literature relating to domestic abuse interventions in dental education and clinical practice.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [2026GladdisSupplementaryInformationv1.05.docx](#)