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HER EXCELLENCY PROFESSOR THE HONOURABLE
KATE WARNER AM
GOVERNOR OF TASMANIA
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Good evening everyone. Thank you for the invitation to open your conference.

I have had an interesting time researching possible topics for my speech to you this evening. My first thought was an historical approach, but whilst this material was intriguing – the tooth worm theory of decay, the pre-dentist days of extractions provided only by surgeons, blacksmiths and enthusiastic amateurs, I thought I should try for something more relevant and more contemporary.

As a criminologist I have always had a keen interest in vulnerable populations including the socio-economic causes of crime and homelessness; Aboriginal disadvantage; family and sexual violence, its causes and responses to it – these have been a particular focus. This led me to think about dentists as frontline service providers.

Family violence is one of the topics I have chosen to focus on in my term as Governor. I was Director of the Tasmanian Law Reform Institute for over ten years before my appointment and prior to that I had considerable involvement with law reform and law reform bodies. As a law reformer, my focus has been on the power of the law to bring about change. In sexual assault law reform I advocated change in the way offences are defined, for example, removing the words which gave a man immunity from prosecution for the rape of his wife; changes to the definition of consent and to meaning of rape; improvements in the way victims are dealt with by the legal system in the hope that victims would be more likely to come forward, offenders more likely to be sanctioned and in the hope that the incidence of such crimes would decline. In the case of family and domestic violence, law reformers have long campaigned for the recognition of domestic assault as a criminal offence and not just ‘a domestic’ in the expectation that this would lead to a reduction in domestic violence by it being denounced and punished rather than condoned.

Since becoming Governor I have shifted my focus from legal change to society's responsibility to address the root causes of family and sexual violence, causes that lie in the persistence of rigid gender roles in our society.

This does not mean that improving our response to family violence through better services for victims and perpetrator programmes, for example, is not important. It is, but we need to reach out beyond the police and victim services to improve the response to it. Sometimes a patient's visit to the dentist will provide an opportunity for intervention in the case of a range of underlying health and social problems, from bulimia and eating disorders, to substance abuse and family violence.

In the case of partner violence, the face is a common target and so patients may present for treatment of chipped, fractured or avulsed (completely displaced from its socket) teeth. Signs of strangulation may even be apparent. Dental effects of domestic violence may not just involve trauma. Decay, decalcification and damage also result from neglect because of emotional abuse which isolates or denies the victim access to dental health care.[1] Think here about kidnapped and imprisoned Ma's toothache in Emma Donoghue's novel*, 'Room'*, although that is of course an extreme example of far more than neglect.

I am not suggesting that dentists give advice to a patient experiencing domestic violence on what direct action they should take, such as leaving the relationship, but rather that they have a role to play in identifying domestic violence and providing referral information. An American journal article I have read suggests that the dental team can create a safe and secure place for victims. Concurrently, dental surgeries can also be equipped to inform patients about local resources, recommend strategies to promote safety, provide supporting messages, and educate patients about the overall effects of abuse on health including dental health. There is a tool, the AVDR tool (asking, validating, documenting and referring) that can guide and assist communication about the issue. The dentist asks the patient about the injury or accident, provides validating messages about the wrongs of domestic violence, reinforces that the victim is not at fault, documents the signs and symptoms as well as anything the patient has said about the incident, and finally refers the patient to a domestic violence service provider. And it adds that it is

[1] Allison M DiMatteo and Terri Rafferty (2013) 'What's hiding behind that smile', *Dentalaegis,* 9(1).

important for the dentist to remember that it is not their responsibility to solve the problem.[2]

An article in the *British Dental Journal* provides similar but more detailed advice to British dentists.[3] For example, in relation to asking about domestic violence, it suggests that where there are signs suggesting domestic violence, the dentist or dental care professional should ask direct and specific questions, noting that vague questions are unhelpful. A list of indicators of domestic violence is given such as frequently missed appointments, injuries inconsistent with the explanation of cause, multiple injuries at different stages of healing and a partner of the patient attending unnecessarily.[4] The article also raises the issue of whether the enquiry to patients about domestic violence should be routine, offers suggestions about how to raise the topic and discusses training for dentists and dental care professionals in relation to identifying and responding to domestic violence.

The issue of what dentists can do to help family violence victims was raised in an interview with a psychiatrist who was involved in preparing a submission to Victoria's Royal Commission on Family Violence, Dr Manjula O'Connor. She explained that she had given talks to dentists advising them that when there was a suggestion that a woman has been hit in the face, she be questioned about it with empathy and referred to an appropriate service.[5]

Oral health and disadvantage

I don't need to tell a group of dentists that poor oral health and dental decay are the cause of pain, poor nutrition and embarrassment. But it is worth pondering the fact that when appearance and speech are impaired by dental disease, this may inhibit opportunities for education, employment and social interactions.[6] As Lesley Russell, an Adjunct Associate Professor of the University of Sydney points out, 'An Aussie

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[2] Di Matteo and Rafferty, note 1.
[3] P Coulthard and AL Warburton (2013) 'The role of the dental team in responding to domestic violence' British *Dental Journal*, 203 (11) 645-648
[4] Coulthard and Warburton, n 3, 647.
[5] The World Today with Eleanor Hall, 'Family violence victims need better-coordinated health: psychiatrists.' http://www.abc.net.au/worldtoday/content/2015/s4188092.htm accessed 23 March 2016.
[6] Lesley Russell, 'How to fill the gaps in Australia's dental health system', *The Conversation*, 15 December 2014.

smile is an instant indicator of socio-economic status, employability and self-esteem.'[7]

It seems that Australia's dental health has not improved in recent years. In fact it seems that the average number of children's baby teeth affected by decay has risen. Russell reports that around 45% of children aged 12 have decay in their adult teeth.[8] This is based on the 2010 Child Dental Health Survey and, according to the Australian Institute of Health and Welfare report on oral health published in January 2016, this is the latest data.[9] This trend of deteriorating child dental health started in the mid-1990s after three decades of improvement.[10] Writing in 2014 Russell reported that over one third of adults have untreated decay. And more than 20% of people aged 65 and over have lost all their teeth. However, more recent data suggests there has been some improvement with respect to the prevalence of untreated decay and tooth loss in adults.[11] However, between 1994 and 2013 there was an increase in the proportion of people who were uncomfortable with their dental appearance, from 20% to nearly 27% and more reported toothache in the previous 12 months in 2013 than in 1994.[12]

The picture is worse for Indigenous Australians, especially in remote communities, where sugar-laden processed foods are now ubiquitous but dental services scarce.[13] The oral health of Indigenous Australians was once better than the oral health of non-Indigenous Australians. Tooth decay and periodontal diseases were uncommon in rural and remote Indigenous communities but all this changed with availability of foods rich in fermentable carbohydrates. Indigenous people lacked the same access to the new preventive measures such as fluoridated water and toothpaste, or easy access to dental care so their oral health deteriorated along with their general health and is now a significant problem.[14]

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[7] Russell, above n 6, p 1.
[8] Russell, above n 6.
[9] Australian Institute of Health and Welfare, *Oral health and dental care in Australia, Key facts and figures 2015*, (2016), p 5.
[10] John Spencer, 'Don't just grin and bear it: act now to improve children's dental health', *The Conversation*, 4 August 2011.
[11] Australian Institute of Health and Welfare, n 9, pp 9, 12.
[12] Australian Institute of Health and Welfare, n 9, p 22.
[13] Russell, above n 6.
[14] A Williams, L Jamieson, A Macrae and C Gray, 'Review of Indigenous oral health', retrieved 23 March 2016 from *www.**health**infonet.ecu.edu.au/uploads/docs/**oral-health**-pl-**review**.pdf*

There is a socio-economic divide at work here. In Professor John Spencer's words, there is chasm between rich and poor in oral health, and policy has widened the gap between the dental 'haves' and the 'have nots'.[15] Unsurprisingly, Australians who can afford regular and routine dental care report low levels of extractions and relatively low levels of fillings. But for far too many Australians going to the dentist is an unaffordable luxury. Many are forced to seek pain relief from general practitioners and emergency departments, which adds to the pressure on these services.[16] In 2013-2014 there were 63,456 potentially preventable hospital admissions for dental conditions.[17]

Improved access to fluoridation, engaging in dental health promotion, preventive dental services for children and more funding for public dental services, and more generally, bridging the dental medical divide have been suggested as solutions.[18]

Would a tax on sugar or sugar-sweetened drinks be a good idea from an oral and dental health perspective?

Tooth decay is the most common non-communicable disease in the world. It affects 60-90% of school-age children and the vast majority of adults. The treatment of dental diseases cost 5-10% of total health expenditure in industrialised countries.[19] As sugars are the cause of tooth decay, it seems sensible to do something about sugar consumption. A tax on sugar is a possible measure and has been advocated by health experts to increase the cost of sugar-rich food and drink. They also advocate curtailing the flow of sugars in the food chain by reducing sugar production drastically and banning it in the EU. They argue if sugar is produced at all it should be converted into alcohol, as in Brazil, to be used in fuel for vehicles.[20]

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[15] John Spencer, *Narrowing the inequality gap in oral health and dental care in Australia, Australian Health Policy Institute*, 2004, p 2/

[16] Russell, above n 6.

[17] Australian Institute of Health and Welfare, *Oral health and dental care in Australia, Key facts and figures 2015*, p 44.

[18] Russell, above n 6, p 2; see also Spencer, above n 15, pp 49-57.

[19] 'Dental nutrition experts call for a radical rethink on free sugar intake' 16 September 2014, UCL news, accessed 30 March 2016 at https://www.ucl.ac.uk/news/news-articles/0914/160914-Experts-call-for-radical-rethink-on-free-sugars-intake.

[20] Above n 19.

Such a tax has recently been announced in the UK, primarily to tackle obesity but it would no doubt have dental health advantages. More than 60 organisations including the National Heart Forum and the Royal Society for Public Health have supported the tax and called for the money raised from it to be spent on programmes to improve children's health and wellbeing.[21] It is likely to lead to a reduction in the sales of sugary drinks if the Mexican example is anything to go buy. Mexico went from a healthy country to one where 71% of the adult population was overweight or obese and sugary drinks were blamed for transforming the Mexican diet. The introduction of a tax on sugary drinks in January 2014 has led to decreased sales particularly in poor communities.[22] Clearly, a tax on sugary drinks is a public health measure that is worth watching. A more modest proposal is for mandatory health warning on sweet drinks which includes the risks to dental health. This was recommended by researchers from the University of Adelaide after a study of 16,800 Australian children they conducted connected sugary drink consumption and tooth decay.[23]

In conclusion, my message to you this evening is that I believe all of us have a duty to do something about family violence to challenge the rigid gender roles that underlie it. But as dentists I also believe you can be part of the frontline services that improve our response to it. I also think that you have a responsibility to continue to advocate for public health measures to improve dental health and to advocate for better access to public dental health services for children and adults to try and address the problem of the dental 'have-nots' in the 'lucky country'.

Thank you.

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[21] C Palmer and M Morgan, 'Study supports calls for soft drink health warning' *The Conversation*, 30 January 2013.

[22] Elisa Pineda, 'What the world can learn from Mexico's tax on sugar-sweetened drinks' T*he Conversation*, 22 March 2016.

[23] Palmer and Morgan, n 21.