National Indigenous Oral Health Workshop
Adelaide, 13 – 14 September 2012

Workshop Report

Cover photo: Simon Wooley

Workshop sponsors:
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**Abbreviations**

ACCHO  Aboriginal Community Controlled Health Organisation  
ACCHS  Aboriginal Community Controlled Health Service(s) 
ADA  Australian Dental Association  
ADOHTA  Australian Dental and Oral Health Therapists’ Association  
AFL  Australian Football League  
AHCSA  Aboriginal Health Council of South Australia  
AHMRC  Aboriginal Health & Medical Research Council of NSW  
AHWs  Aboriginal Health Workers  
AIHW  Australian Institute of Health and Welfare  
ALO  Aboriginal Liaison Officer  
ALP  Aboriginal Liaison Program  
AMS  Aboriginal Medical Service  
ARCPOH  Australian Research Centre for Population Oral Health  
COAG  Council of Australia Governments  
CPD  Continuing Professional Development  
CSU  Charles Sturt University  
DHSV  Dental Health Services Victoria  
DMFT  Decayed/Missing/Filled Teeth  
DPERU  Dental Practice Education Research Unit  
ECC  Early childhood caries  
EPAS  Enterprise Patient Administration System  
GA  General anaesthetic  
GP  General Practitioner  
GST  Goods and Services Tax  
HCC  Health care card  
IOHU  Indigenous Oral Health Unit  
IPTAAS  Isolated Patients Travel Accommodation Assistance Scheme  
ITAS  Indigenous Tutorial Assistance Scheme  
LIME  Leaders in Indigenous Medical Education  
MI  Motivational interviewing (A client-centred style of counselling aimed at eliciting  
MOU  Memorandum of Understanding  
NHMRC  National Health and Medical Research Council  
NPA  National Partnership Agreement  
OATSIH  Office for Aboriginal and Torres Strait Islander Health  
PHC  Primary Health Care  
RDHM  Royal Dental Hospital of Melbourne  
RFDS  Royal Flying Doctor Service  
SDS  School Dental Service  
SADS  South Australian Dental Service  
VACCHO  Victorian Aboriginal Community Controlled Health Organisation  
VACKH  Victorian Advisory Council on Koori Health  
VAHS  Victorian Aboriginal Health Service
Acknowledgements

Many people contributed to the workshop and to the preparation of this publication. Their contributions are acknowledged with gratitude. We thank the Advisory Committee of the University of Adelaide’s Indigenous Oral Health Unit (www.arcpoh.adelaide.edu.au/iohu/governance/) for its commitment to continue addressing the oral health issues of Aboriginal and Torres Strait Islander people through a workshop and report format.

Our generous workshop and publication sponsors:

Colgate Palmolive
South Australian Dental Service
Northern Territory Oral Health Services
Dental Health Services Western Australia
Centre for Oral Health Strategy New South Wales
Australian Dental Association

Kaurna introduction and welcome to country - Michael O’Brien

The workshop working party that comprised members of key stakeholder groups:

Katherine O’Donoghue – Indigenous Dentists’ Association of Australia
Angie Perry-Mansell – Danila Dilba Health Services, Northern Territory (oral health presentation)
Alwin Chong – Aboriginal Health Council of South Australia (oral health presentation)
Eleanor Parker – University of Adelaide Indigenous Oral Health Unit (oral health presentation)
Kaye Roberts-Thomson – University of Adelaide Indigenous Oral Health Unit (oral health presentation)
Colin Endean – Tullawon Health Service & Kakarrara Willurrara Health Alliance (oral health presentation)
Sandra Meihubers –Dental Public Health Consultant (oral health presentation)
Chris Handbury – Northern Territory Oral Health Services
Chris Morris – South Australian Dental Service
Foreword

In 2002, the National Aboriginal and Torres Strait Islander Oral Health Workshop Report and Action Plan was endorsed by the National Aboriginal and Torres Strait Islander Health Council and the Standing Committee of Aboriginal and Torres Strait Islander Health. The 2002 Workshop provided for the first time a forum for health professionals, community representatives, service providers and policy makers to meet and discuss Aboriginal and Torres Strait Islander oral health issues, covering the areas of access to services, workforce needs, health promotion, data and information, and integration of oral health within health systems and services.

Ten years later, in 2012, the University of Adelaide’s Indigenous Oral Health Unit (a Unit of the Australian Research Centre for Population Oral Health, which is in turn a research centre of the School of Dentistry) hosted a follow-up workshop with a wide range of key stakeholder groups, again including oral health service providers, academics, Aboriginal health workers, peak body representatives and policymakers. Similar issues were canvassed in regards to access to services and service provision, with additional themes including culturally-appropriate oral health policies and labour force, prevention, treatment, research and monitoring, and advocacy.

Although a decade has passed, the current report highlights the continuing need for action to work collaboratively towards comprehensive initiatives to reduce disparities in Indigenous and non-Indigenous oral health. Although there have been some gains in regards to increased recognition of the importance of oral health in general Aboriginal and Torres Strait health and well-being, unacceptable levels of dental disease persist. Furthermore, challenges in ensuring services are appropriate and accessible remain. We are committed to ensuring the next decade sees some improvements in this.

OATSIH
**Executive summary**

Oral health is increasingly recognised in Australian Aboriginal and Torres Strait Islander communities as playing an important role in general health and well-being, as well as having deteriorated in recent times (Roberts-Thomson et al., 2008). While proximal factors such as access to timely dental services; co-morbidities with diabetes, cardiovascular disease and other chronic, systemic conditions; high sugar diets and barriers to optimal oral self care behaviours all play a role. So too do more distal factors such as institutional racism and discrimination, past policies of assimilation and acculturation, and the all-consuming social determinants including low socio-economic status and psychosocial dysfunction (Marmot, 2011; Ziersch et al., 2011).


In this climate, and following from the 2002 National Aboriginal and Torres Strait Islander Oral Health Workshop Report and Action Plan (DOHA, 2003), the 2012 Indigenous Oral Health Workshop was hosted by the University of Adelaide’s Indigenous Oral Health Unit. The aim of the 2012 workshop was to create an opportunity for health professionals, community representatives, service providers and policy makers to discuss Indigenous oral health issue. Key areas to discuss, as advised by the Workshop’s Advisory Group, included:

- generation of funding for comprehensive oral health programs through Indigenous community-controlled health services
- an increase in water fluoridation in Indigenous communities
- encouragement of community ownership of dental programs
- incorporation of cultural awareness as a mandatory part of all oral health professional training
- integration of oral health into medical and other health training
- expansion of dental therapists’ roles to meet demand
- adoption of incentives to attract oral health professionals to rural and remote areas
- increase in training and support for the Indigenous oral health workforce
- accreditation of University courses for Indigenous health workers
- encouragement of partnerships with other health care providers (oral health checks being a part of general health checks)
- establishment of regular and standardised collection of oral health data
- linkage of oral health data to general health data
- consolidation and evaluation of existing data sets
- formal assessment of prevention and promotion activities

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1 Note: While this report favours the term ‘Aboriginal and Torres Strait Islander’ people, we also use the word ‘Indigenous’ in places for ease of expression.
collection of oral health data from Indigenous-controlled health services in a manner consistent with national standards

The workshop was held at the National Wine Centre in Adelaide on September 13 and 14, 2012, with over 90 delegates present. Although many of the key points raised in the 2002 workshop report were highlighted, additional points included the recognition for national-level leadership in Indigenous oral health and for regular meetings of interested Indigenous oral health stakeholders.

A brief summary of each workshop session, including key areas for action, stakeholders and first steps, follows:

### Workshop Session 1: Culturally-appropriate oral health policies and labour force

<table>
<thead>
<tr>
<th>Action area</th>
<th>Stakeholders</th>
<th>First steps</th>
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</table>
| 1. Aboriginal Cultural Awareness incorporated into all dental/oral health courses (assisting, oral hygiene, oral health therapy, dentistry, post-graduate specialist training) which includes social determinants of health and barriers to care | • All Universities and TAFEs offering dental profession training  
• Australian Council of Deans of Dental Schools (ACODS)  
• Australian Dental Association (ADA) | IOHU to work with ACODS to document current curriculum components in dental and oral health degrees and identify good models and opportunities for collaboration. |
| 2. Cultural Awareness training to be undertaken by oral health providers in the workforce | • State oral health service providers  
• ACCHOs with oral health services  
• Private dental practices  
• ADA  
• Providers of Continuing Professional Development | a) IOHU to write to state oral health providers and encourage them to ensure Aboriginal Cultural Awareness training is mandatory for all staff.  
b) IOHU to write to the federal and state ADA branches re: promoting cultural awareness training for private practices |
| 3. Increase the proportion of Aboriginal and Torres Strait Islander people employed in the oral health workforce (dentists, therapists, hygienists, assistants, receptionists). | • All Universities and TAFEs offering dental profession training  
• ACODS  
• ADA  
• Indigenous Dentists’ Association of Australia | IOHU to work with ACODS to document the number of Aboriginal and Torres Strait Islander students  
1. graduated from dental degrees in the last two years,  
2. entering dental degrees in 2014  
3. number of students enrolled in dental degrees in 2014 |
| 4. Increase opportunities and support for Indigenous students to enter and complete dental/oral health degrees | • All Universities and TAFEs offering dental profession training  
• ACODS | IOHU to work with ACODS to document existing special entry and support pathways for Indigenous students |
5. Increase opportunities for promoting benefits of working in Indigenous oral health services to dentists and oral health therapists
- Indigenous Health InfoNet
- ADA
- NACCHO

IOHU to contact key stakeholders to identify an appropriate leader to gather, collate and distribute positive stories of working in Indigenous Health

6. Establish a network of support for people working in Indigenous oral health services
- Indigenous oral health workshop 2012 attendees

IOHU to establish an on-line network of practitioners involved and interested in Indigenous oral health

### Workshop session 2: Access to services and service provision

<table>
<thead>
<tr>
<th>Action area</th>
<th>Stakeholders</th>
<th>First steps</th>
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<tbody>
<tr>
<td>1. Documentation of successful models of service delivery, including how they have been achieved and tips for other services and organisations.</td>
<td>All service providers</td>
<td>IOHU to contact key stakeholders to identify an appropriate leader to gather, collate and distribute successful examples of different models of service delivery and how this has been achieved in each instance.</td>
</tr>
</tbody>
</table>

- State Governments
- NACCHO
- Volunteer groups

<table>
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<tr>
<th>2. Work towards comprehensive oral health care programs targeting early childhood caries.</th>
<th>All service providers</th>
<th>IOHU to write to and organise to meet with:</th>
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<tr>
<td></td>
<td>State Governments</td>
<td>- Federal ministers (health and Indigenous affairs)</td>
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<tr>
<td></td>
<td>NACCHO</td>
<td>- Member from the Greens</td>
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<tr>
<td></td>
<td>Volunteer groups</td>
<td>- OATSIH</td>
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<td></td>
<td></td>
<td>- NACCHO</td>
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To discuss outcomes of the workshop and recommendations.

| 3. Address the gap in adult dental services, requiring general dental care and denture services rather than emergency only. | All service providers | As above |
|----------------------------------------------------------------------------------------------------------------------------------|
| State Governments | NACCHO | Volunteer groups |

| 4. Encourage state-funded dental services to partner with ACCHSs for delivery of oral health services | State Governments | IOHU to write to each state-funded dental service and ACCHS peak body to discuss delivery of oral health services |
|-------------------------------------------------------------------------------------------------|-------------------|
| NACCHO                                                                                                                                              |
### Workshop session 3: Prevention

<table>
<thead>
<tr>
<th>Action area</th>
<th>Stakeholders</th>
<th>First steps</th>
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| 1. Reduce the price of toothbrushes and toothpastes, particularly in remote Indigenous communities. | • Federal government (GST)  
• Colgate-Palmolive                     | 1. IOHU to write to government highlighting the need for removal of GST from toothpaste.  
2. IOHU to write to Colgate-Palmolive to ask for active participation and support for reducing cost of basic oral health items in remote communities. |
| 2. Focus on spreading the message of the benefits of fluoride to patients, communities and other health providers (in water, toothpaste, fluoride varnish) nb: this is important at all levels – ongoing action on the ground as well as in the media and health policy | All service providers  
• State Governments  
• NACCHO  
• Volunteer groups | 1. Through the establishment of an on-line support network (workshop session action area 6) provide an avenue for sharing of strategies and resources for work at the ground-level  
2. Oral health promotion clearing house role  
3. IOHU to write to the professional bodies of other health providers (medical practitioners, dieticians, child and youth health, physiotherapists) to highlight the importance of collaboration and support from all health providers in reinforcement of these simple messages – perhaps place notices/articles in their professional newsletters/journals |
| 3. Seek clarification on the approaches for the recently announced government dental schemes (child dental benefits schedule and the National Partnership Agreement for adult dental services) and provide input for use for Indigenous oral health | • Federal government                      | IOHU to write to and organise to meet with Federal ministers (health and Indigenous affairs) and member from the Greens (as per session 2 action areas 2 and 3) |
**Workshop Session 4: Treatment**

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<th>Action area</th>
<th>Stakeholders</th>
<th>First steps</th>
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<tr>
<td>1. Encourage appropriate programs for children with ECC while on the waiting list (eg regular visits, duraphat varnish, supportive dietary and hygiene counselling)</td>
<td>All service providers</td>
<td>IOHU to write to each State’s child dental program leader to ascertain current treatment for those awaiting care under a dental general anaesthetic</td>
</tr>
</tbody>
</table>
| 2. Encourage flexible service delivery options for communities, through partnering of mainstream and community controlled health services (as per workshop session 2 action area 4) | - State Governments  
- NACCHO                                                                 | IOHU to write to each state-funded dental service and ACCHS peak body to discuss flexibility of oral health services                                                      |
| 3. Share ideas and successful approaches with other practitioners and services | - State Governments  
- NACCHO                                                                 | a) Through the establishment of an on-line support network (workshop session 1 action area 6) provide an avenue for sharing of strategies and resources for work at the ground-level  

b) Through the documentation of successful examples of different models of service delivery and how this has been achieved in each instance, share ideas and resources for practitioners and services (session 2 action area 1). |
### Workshop Session 5: Research and monitoring

<table>
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<th>Stakeholders</th>
<th>First steps ..........</th>
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| 1. Add some simple self-report items related to oral health to the National Aboriginal and Torres Strait Islander Health Survey | • Federal Government  
• NACCHO  
• Australian Bureau of Statistics | IOHU to write to the Australian Bureau of Statistics to ask for inclusion of specific items in the next survey. |
| 2. Ensure communities are driving research and that research is based around the future, interventions, improving health rather than documenting poor health | • Aboriginal community groups  
• NACCHO  
• Universities involved in Indigenous oral health research  
• Indigenous Health InfoNet | 1) Through establishing an online Indigenous oral health research network  
2) Regular engagement with Aboriginal communities involved in research |
| 3. Work towards funding and support for ACCHSs in collecting and analysing their own data to review service delivery and outcomes of local health interventions | • Aboriginal community groups  
• NACCHO  
• Universities involved in Indigenous oral health research | IOHU to collaborate with NACCHO and other University groups, including seeking funding for basic research infrastructure support for ACCHS |

### Workshop Session 6: Advocacy

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<th>Stakeholders</th>
<th>First steps ..........</th>
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| 1. Ensure oral health is on the agenda for the National Aboriginal and Torres Strait Islander Health Plan | • Federal Government (OATSIH)         | a) IOHU representatives to attend community consultation meetings  
 b) IOHU to distribute information throughout networks to encourage participation and attendance from other interested parties to ensure oral health is on the agenda |
Background
In 2012, the Australian Institute of Health and Welfare released the *Aboriginal and Torres Strait Islander Health Performance Framework* (AHMAC, 2012). The report highlighted the many persisting disparities between Indigenous and non-Indigenous Australian populations in terms of health status and outcomes. Around half of Indigenous and 16 percent of non-Indigenous women smoked during pregnancy. Although incidences of lung and cervical cancers were 1.7 and 3.4 times higher, respectively, in the Indigenous compared with non-Indigenous population, the rates of cancer-related hospital admissions were lower for Indigenous people. Amongst the Indigenous population the incidence of end-stage renal disease was 14 times higher, and mortality rates from chronic illnesses (including cancer, diabetes, and circulatory, respiratory, and kidney diseases) were all around eight times higher than for non-Indigenous people. Approximately 50 percent of the Indigenous population were in the most disadvantaged quintile of socioeconomic status compared with less than 20 percent of their non-Indigenous counterparts. On a more positive note, the rate of avoidable deaths decreased by one-third in the Indigenous population between 2001 and 2010, and the infant mortality rate decreased by approximately 40 percent, with a concomitant 70 percent reduction in the discrepancy between the Indigenous and non-Indigenous populations.

However, the gap between Indigenous and non-Indigenous Australians in oral health remains wide. Indigenous people suffer from more caries, periodontal diseases and tooth loss than non-Indigenous people (Roberts-Thomson et al., 2008). Tooth decay among the Indigenous population more commonly goes untreated, eventually leading to more extractions. These inequalities may be partly attributable to a lack of access to culturally appropriate and timely dental care, especially in rural and remote areas.

Fluoride
The success of fluoride in the prevention of dental caries has been substantiated by over 60 years of research (Clarkson et al 2000). Fluoride has two main modes of application, systemic and topical. Systemic delivery can involve fluoride being incorporated into the tooth structure of an infant in utero whilst teeth are developing (Hellwig et al 2004), but the main systemic delivery of fluoride is through water fluoridation (Wong et al 2010). Topical application of fluoride occurs post-eruption where fluoride enters the oral cavity by a variety of means and is applied directly to the tooth (Hellwig et al 2004), with fluoridated toothpastes being the most common method (Wong et al 2010). When a person is at low risk of developing dental caries, brushing with fluoride toothpaste is effective. When people are at high risk, fluoride therapies or shorter dental recall periods are essential to prevent disease (Collins 2008).

Water fluoridation
Early evidence from the 1900s suggested that high fluoride content in the water supply provided a protective effect against dental caries (Paeza et al 2001). The addition of fluoride to water supplies is found to be safe, effective (Clarkson et al 2000) and socially equitable (Spencer et al 2010), as access bears no relation to income. Although the majority of Australians have benefitted from water fluoridation over the last 40 years, one in five Australians still do not have access (Spencer et al 2010). Rural and remote communities are the most likely to miss out on water fluoridation, and are increasingly comprised of low-income, low-educated families that are at higher risk of developing dental disease (Spencer et al 2010).
The national Australian guidelines for effective levels of fluoride in the water supply range from a low level of 0.6mg/L, to a high of 1.1mg/L (Bailie et al 2009, Spencer et al 2010). In the Northern Territory, over 80 percent of rural and remote Indigenous communities have less than the minimum recommended fluoride level occurring naturally in the water supply (Spencer et al 2010). Recent technological developments have made it feasible to provide water fluoridation plants to high risk remote communities with less than 1000 people (Ehsani et al 2007), and the Australian Oral Health Plan supports the implementation of such plants (Ehsani et al 2007).

**Toothpastes**
Adult toothpaste typically contains 1000 parts per million fluoride, whereas children’s toothpaste contains around 3-400 parts per million. The efficacy and safety of brushing with fluoridated toothpaste is well established (Curnow 2002). Evidence suggests that “children who establish brushing at an early age are likely to retain this behaviour throughout life and to be of lower risk of developing dental caries” (Curnow, 2002). However, cost is a documented barrier to tooth brushing and use of toothpaste among children of low-income families (Mouradian et al., 2000).

**Fluoride varnish**
Fluoride varnish was developed to help prolong the contact time and uptake of fluoride to the tooth structure (Collin 2011). It is a sticky substance that contains 22,600 parts per million fluoride. Its application is quick, simple and not technique sensitive (Jahn, 2010). Six-monthly applications of fluoride have proven to be safe and effective in both primary and permanent dentition to reduce dental caries (Jahn 2010). For example, Berg (2006) demonstrated that children receiving fluoride varnish applications experienced less decay than those that received no fluoride varnish. When children received an increased number of applications, they experienced less decay.

**Fluoride gels/foams**
Fluoride gels or foams are another form of topical fluoride application. They are not recommended for use in young children (under the age of 10 years) as the risk of ingestion is high (Rugg-Gunn 1990, Jahn 2010).

**Silver fluoride**
Craig and colleagues (1981) reported on a treatment to arrest dental caries in primary molars which utilised silver fluoride solution and stannous fluoride paste. This treatment has been used in some dental practices in Sydney and remote areas in New South Wales, the Northern Territory and South Australia for many years. The Nganampa Health Council Dental Program has utilised the 40 percent silver fluoride technique extensively, with reported clinical success and broad community acceptance. A randomised controlled trial is currently underway to determine its efficacy in preventing dental caries among Aboriginal children.

**DENTAL HEALTH SERVICE PROVISION**
The majority of oral health services in Australia are provided privately, with some public dental services (NACOH, 2004). Many Indigenous Australians are able to access dental care through Aboriginal Controlled Community Health Services (ACCHSs), although these services, and copayment requirements, differ markedly across regions and jurisdictions.
Private oral health services
Treatment at a private practice generally requires the patient to pay the full treatment cost, or, if they have dental insurance, the amount their insurer does not cover (NACOH, 2004). Many disadvantaged people who are ineligible for public dental services have difficulty accessing private oral health services due to cost (Slade et al., 2007). Until its disbandment in December 2013, people were able to seek treatment from a private dentist or an ACCHS under Medicare's chronic disease dental scheme. The scheme was designed so that patients suffering from chronic illness who were managed by their General Practitioner (GP) under an Enhanced Primary Care plan could access dental services through Medicare. Eligible patients were entitled to $4250 worth of dental care over the referral period up to a 24 month maximum period. However, dentists were not obligated to charge a set schedule of fees for service and so treatment costs varied. Dentists were also not required to bulk bill, meaning some patients still incurred an out-of-pocket cost.

Public oral health services
Although the Federal Government has the same powers to fund oral health services as it does other medical services, oral health services receive relatively little state or federal funding (Harford and Spencer, 2007). To be eligible for state-funded public dental treatment, adults must hold a Centrelink concession card (NACOH, 2004). Patients on the public roster are often subject to long waiting lists and, depending on jurisdiction and the treatment required, may have a co-payment obligation. Under certain arrangements in some States, this fee is waived for Indigenous people. It is also possible to seek emergency care through the hospital system; often this does not result in direct treatment, but rather the provision of pain and/or antibiotic medications. The latter is temporary in nature as it alleviates symptoms only; the care requirements remain unmet.

Most children are eligible to receive public oral health treatment through the School Dental Service (SDS) (NACOH, 2004) or equivalent, although these services vary greatly between states/jurisdictions. In jurisdictions where SDSs require co-payments, which are substantially cheaper than the equivalent service from a private practitioner, they can present an economic barrier for some. There is evidence that the SDS scheme is under-utilised by some Indigenous communities due to population mobility, low school attendance, the short duration of dental visits to the community, limited awareness of the importance of preventive oral health checks and failure to obtain consent forms from carers (Parker et al., 2012).

Mobile dental clinics operate in certain areas of Australia and are usually used to provide oral health checks and services for children through the SDS. These clinics are equipped with basic dental equipment needed to provide treatment, and are used to great effect in Indigenous communities such as Ballarat and the District Aboriginal Cooperative in Victoria (Cartledge, 2008). The mobile clinics are used both in the public system and as part of the ACCHS.

Aboriginal community-controlled health services
Aboriginal community controlled health services (ACCHSs) are primary health care services that provide culturally appropriate, holistic health care to Indigenous communities across Australia (Dwyer et al., 2009). These services are often initiated by the communities themselves and have complex funding arrangements involving various grants, government and non-government sources, and support from Aboriginal agencies and other community services (NACOH, 2004). The first ACCHSs were established in the early 1970s as a response to the barriers of mainstream health care.
The services are built on the principle of self-determination; the community selects the board of management and is involved in the planning and ongoing development of the services. There are now over 150 ACCHSs across Australia, with their workforces typically including Aboriginal Health Workers, nurses, doctors and specialists. Only some provide oral health programs (Dwyer et al., 2009), and of those that do, each has different eligibility requirements that may or may not require a concession card and co-payment (NACOH, 2004).

NATIONAL ORAL HEALTH POLICIES AND STRATEGIES
There are a number of current policies that aim to improve the oral health of Indigenous Australians. These include:

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013
The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) builds on the National Aboriginal Health Strategy (1989) and provides a plan for guiding changes in Indigenous health policy (NABTSIH, 2004) through direct government action using a coordinated, collaborative and multi-sectoral approach that is agreed upon by all the states and territories and involves Indigenous health organisations. Oral health was identified as a priority because of its close links with chronic disease among adults. The strategies specific to oral health in the NSFATSIH were largely adopted in the National Oral Health Plan (NACOH, 2004).

Healthy mouths healthy lives was prepared by the National Advisory Committee on Oral Health (NACOH) and builds on the work of the 2001 framework, Oral Health of Australians: National Planning for Oral Health Improvement (NACOH, 2004). It also draws on the National Aboriginal and Torres Strait Islander Oral Health Workshop Report and Action Plan, released in 2003. Healthy Mouths Healthy Lives details the most pressing issues for oral health in Australia and provides a framework for addressing these issues. The plan is focused around the integration of oral health into general health, focusing on health promotion and disease prevention, and providing affordable and appropriate services to all Australians through a skilled and educated workforce. It is composed of seven 'action areas' that give detailed benchmarks for achieving good oral health for the total Australian population. Indigenous people are addressed in action area six.

Action area six: Aboriginal and Torres Strait Islander peoples, specifically addresses the oral health deficit experienced by the Indigenous population (NACOH, 2004). The main actions are as follows:

- support the proposal to include a biennial health assessment for Indigenous adults covered under Medicare that would include an oral exam
- provide oral health services that are culturally appropriate for Indigenous people by:
  - creating partnerships between Indigenous specific and mainstream services
  - creating patient transport schemes
  - increasing the proportion of mainstream services that are culturally appropriate
- provide water fluoridation for communities with more than 1,000 residents
- improve recruitment and retention of oral health staff in rural and remote locations
- create programs to increase the number of Indigenous oral health care students
- increase oral health care promotion for Indigenous people by:
  - developing strategies which target Indigenous oral health, focusing both on oral health exclusively and promoting oral health in related health
promotion activities (e.g. diabetes, cardiovascular diseases, tobacco, alcohol, nutrition)
- increasing access to oral hygiene supplies (toothbrushes, toothpaste, floss)
- increasing access to nutritious foods

• promote integration of oral health within the wider health care systems and services by:
  - including oral health in health checks both for people who experience general good health and for those with chronic illnesses
  - including oral health in relevant Indigenous health policy

• improve Indigenous data quality with respect to oral health by:
  - creating a national Indigenous oral health data set
  - consolidating current data on oral health
  - the regular collection and dissemination of Indigenous oral health data

• increase the Indigenous oral health workforce, specifically:
  - increase the number of Indigenous people working in oral health professions, including providing scholarships for Indigenous students
  - clarify roles and recognise the key role played by Aboriginal Health Workers in the oral health workforce
  - address the role and development needs of the oral health workforce in relation to Indigenous health
  - improve training, recruitment and retention for oral health staff working in Indigenous primary health care settings
  - expand the role of dental therapists, dental hygienists and oral health therapists
Workshop sessions
The following section of the report focuses on the content and outcomes of the 2012 National Indigenous Oral Health Workshop and the six sessions it comprised. Each session commenced with an oral presentation, followed by a small group discussion around the session’s questions, and closed with a discussion of the points/ideas/comments raised in the small group discussions. Data that contributed to the workshop report was thus collated from the oral presentations, written feedback from small group discussions, and transcribed notes from large group discussions.

SESSION 1 - CULTURALLY-APPROPRIATE ORAL HEALTH POLICIES AND LABOUR FORCE
The session was introduced by Dr Eleanor Parker of the University of Adelaide’s Indigenous Oral Health Unit. Dr Parker is a Senior Lecturer at the University of Adelaide’s School of Dentistry and is closely involved with two National Health and Medical Research Council (NHMRC)-funded Indigenous oral health randomised controlled trials. Eleanor established the oral health program at the Port Augusta Aboriginal community-controlled Pika Wiya health service in 2001, where she worked and managed the program for five years. She is actively involved with the student body in encouraging appropriate participation in Indigenous oral health-related research and clinical practice, has published widely in this field and been an invited presenter to oral health conferences regarding her expertise in Indigenous Australian oral health.
Executive Summary
The issue of cultural appropriateness featured in the 2002 workshop, with goal one of the action plan being to “provide culturally appropriate oral health services to all Aboriginal and Torres Strait Islander people”. Dr Parker asked what it is that we understand “culturally appropriate” to mean in 2012. She also raised the issues of Aboriginal and Torres Strait Islander providers, difficulties in understanding the workforce, the distances between dental services, the involvement of non-dental staff in oral health, how to best utilise the skills of Aboriginal Health Workers, dental volunteering, community ownership, consistency in providers and prevention and treatment philosophy, as well as the overarching issue of sustainability. Other issues included the very different context in relation to the previous workshop which was driven by OATSIH (no OATSIH representative attended the 2012 workshop) and the need to focus on driving the agenda for Indigenous oral health at a national-level given the recent Government announcement of dental funding.

The discussion revolved around the following questions:

1. In the context of this workshop and the subsequent recommendations, will we use the term “culturally appropriate” as an overarching understanding for all recommendations? And, how do we define what it means?
2. What will it take to build a workforce that is capable of and appropriate for addressing the oral health needs of Aboriginal and Torres Strait Islander people in urban as well as rural and remote Australia? What is the best workforce model? How can it be achieved?
3. What approaches or models can be built to utilise the workforce to its fullest capacity (drawing on the full scope of practice of health professionals)? Does this include training for non-dental personnel?
4. What support / incentives / professional development / inter-professional collaborations would provide the best opportunity for recruiting and retaining oral health professionals for Aboriginal and Torres Strait Islander Oral Health services?

Culturally-Appropriate Policy
The vision statement resulting from the 2002 National Aboriginal and Torres Strait Islander Oral Health Workshop was to:

improve the oral health status of Aboriginal and Torres Strait Islander people in culturally supportive ways that induce overall health benefits

Today many organisations provide cultural awareness training for staff, and increasingly universities are incorporating this into the curriculum. Workshop participants expressed a strong belief that this should be a core component of all dental and oral health courses. However, there is a need to address the issue of how exposing providers to cultural awareness training actually translates into improved practice by individuals and organisations - this can be done through broader policies and programs, requiring cycles of reflection, analysis and action.
Culturally appropriate approaches to health care should incorporate the definition of Aboriginal health:

“Aboriginal health” means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.

Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and this bring about the total well-being of their community.”

National Aboriginal Health Strategy, 1989
transitional, and contemporary lifestyles, ownership of land and of services – history of engaging with the health system. This is inclusive of spiritual, social and emotional wellbeing. It needs to be a two-way street – from communities and to communities.

- **Local/regional appropriateness** - needs to be tailored towards the community, taking into account a knowledge of local history rather than just cultural elements in isolation.

- **Continuity** of services

- **Engagement** – it must be responsive to the needs of the particular community, using cultural information and knowledge to apply to contemporary life. Stakeholder engagement and consultation, and the incorporation of Aboriginal and Torres Strait Islander perspectives are essential.

- **Flexibility** for an adaptable service that meets people’s needs.

Campinha-Bacote’s model “requires health care providers to see themselves as becoming culturally competent rather than already being culturally competent. This process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.”

http://tcn.sagepub.com/content/13/3/181.full.pdf+html

The Workforce
In terms of the workforce, there are several key areas requiring attention. These include increasing the numbers of Aboriginal and Torres Strait Islander personnel employed in oral health, altering the roles played within the workforce by both dental and non-dental staff, the involvement of non-dental personnel, and the recruitment and retention of staff.

Increasing the Numbers of Aboriginal and Torres Strait Islander Personnel Employed in Oral Health
Progress in this area is slow. The Indigenous Dentists’ Association is active and now has seven members, an increase from 2002. There are more Aboriginal and Torres Strait Islander dentists registered, but accurate data is difficult to obtain. There are anecdotal reports that the number of Aboriginal and Torres Strait Islander students commencing dental or oral health studies has increased, but actual numbers have not been collected or collated. Some Schools have reportedly developed special entry and support pathways for Indigenous students, however concerns remain about the number of students who continue through to graduation of their respective degrees.

Roles within the Workforce

*Dental staff*
There was considerable support for a different approach to the organisation of the workforce, incorporating multi-level teams centred around oral health therapists/allied oral health staff, requiring fewer dentists, and expanding the role of dental therapists. “Community workers” could

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2 IOHU are currently in the process of working with the Australian Council of Deans of Dental Schools to collate information about Indigenous student numbers, recent graduate numbers in addition to information related to cultural competency/awareness training and Indigenous oral health experience for dental students.
be involved in screening, prevention and early identification of dental diseases across the life course. It will be essential to provide clarity on the roles and recognition of health workers and address the role and development needs of the oral health workforce.

**Non-dental staff**

Workshop participants agreed overwhelmingly that an optimum workforce will include the involvement of non-dental personnel. There is a strong belief that dentists are not capable of closing the gap in oral health alone – it will depend on strong partnerships with nurses, general practitioners, diabetes educators, early childhood nurses, Aboriginal Health Workers, nutritionists, teachers, maternal health workers, etc. This is fitting with the holistic definition of Aboriginal health. Particularly given health professionals may have limited access to patients (especially in rural and remote areas), the idea of a “one stop shop”, a ‘community and opportunistic’ approach for primary health care was popular. Often doctors are more likely to see patients (and more specifically children) more regularly than dentists. Child and adult health checks conducted by non-dental personnel can incorporate checking for dental disease for early detection and referral.

However, concerns were raised regarding the involvement of non-dental personnel, in particular Aboriginal health workers, as this could potentially overload already busy staff and create difficulties for staff in juggling health and work priorities for their communities. The spasmodic nature of the work to support oral health services, in remote communities in particular, means oral health roles need to be incorporated into other positions to make them sustainable. This further complicates the juggling of roles and ongoing need to prioritise time and resources, when other health areas are also needing attention. This could, however, work to the advantage of oral health programs, encouraging their integration with other health and community services. Involvement of non-dental staff in oral health programs has been shown to be effective in preventive programs. For example, screening and referrals has occurred in a number of ways, including lift the lip and fluoride varnish programs, incorporation of oral health into comprehensive care planning for people with chronic disease (although this program was discontinued) and support or coordination of service delivery.

**Support to Improve Recruitment and Retention of Staff**

This includes support for students as well as professionals, and in particular the implementation of incentives to attract oral health professionals to rural and remote areas. At the same time, staff retention will benefit from increased funding allowing staff to also work on program management, reporting, administration, coordination etc. It was reported, for example, that Aboriginal Medical Services need extra resources to keep on ancillary staff such as receptionists.

“*Our receptionists are for medical, not dental, and need training*” – quote from workshop participant

**At the Educational Level:**

Increasingly, students are being trained in regional or rural areas, and participating in rural placement programs, often incorporating services and programs for Aboriginal communities. Scholarships and recruitment programs, including priority access pathways for rural students, have been occurring in various ways for some years, with varied reports of success in terms of work choices post-graduation. There is hope that the planned intern year for graduates may facilitate recruitment.
Financial and other support has increased for Indigenous students in some areas, however, the number that continue until graduation is markedly reduced from the numbers who enrol. This needs attention. Some ideas around how to encourage more students to become involved in Indigenous oral health include:

- Beginning at school - school-based apprenticeships for Aboriginal and Torres Strait Islander students, and/or the promotion of oral health careers through career advisor
- Continued student placements in Aboriginal Medical Services, and more promotion of the opportunities provided
- Expansion of scholarship opportunities for dental students, including bonded scholarships for Aboriginal people and a support line for scholarship holders
- Different delivery modes – flexible learning programs, tutoring, training programs/placements in rural and remote areas. Increased access to oral health work experience
- Liaison people more readily available, particularly for students from regional/remote areas
- Introduction of LIME (Leaders in Indigenous Medical Education) for dental and all of the initiatives that support Aboriginal and Torres Strait Islander students
- Additional training in rural ways, cultural awareness, National Aboriginal and Torres Strait Islander Dental Training program.
- Articulation/accreditation from other dental courses
- Training within the community – educator comes to you
- Promote to students and graduates the benefits of working in rural Australia
- Take lessons from medical education program because it is effective. Utilizing the existing training modules. Develop the opportunity for a specialist in oral health.
- Public health mentors for clinicians in training
- It is unrealistic to expect people from remote areas to work in their communities after graduating - they should have equal choice of where to use their skills
- Oral health as a “core competency” in education
- Orientation programs in the communities
- Partnerships between organisations and universities
- Include oral health competencies in all health professionals’ training, given the strong connections between these areas – utilise a holistic model of primary health care (for example in diabetes checks, nutrition)

"Make programs more flexible. Longer initiation processes, opportunities to decide if it is right before committing. Training programs in rural areas. There has been an increase and that is important. It is difficult for young Aboriginal and Torres Strait Islander students to move away from home. Support from urban areas for remote areas. More scholarships and career planning assistance in schools to get people interested. No articulation between assisting, therapy, and dentistry. You don’t get any credit for the work that you’ve done. Should be employment available. NSW has allied health cadetships - they get jobs. Getting people through to completion".

Quote from workshop participant

Recruitment
Recruitment of oral health professionals into Aboriginal and Torres Strait Islander services most commonly occurs through the Koori Mail, word of mouth and radio. However there is no central place to look for jobs – it was suggested that a web resource focussed on this should be created and promoted to facilitate the search. (Note: since the workshop was held, it has come to our attention...
That the Australian Indigenous Health InfoNet has a page dedicated to advertising jobs in Indigenous health. The Indigenous Oral Health Unit has made an effort to promote this as a resource amongst the Indigenous Oral Health network, both for those offering and seeking employment.

**Transition from Study to Employment**

It is difficult to ascertain work patterns and preferences given that graduates’ contact with support organisations does not always continue. There are anecdotal reports from undergraduates as well as graduates of either experiencing or anticipating challenges working in their own or other Aboriginal and Torres Strait Islander communities, although this is not necessarily felt across the board. For those Aboriginal and Torres Strait Islander students graduating there needs to be a mentor program (mentors from Aboriginal Medical Services, dental services, community members), facilitated pathways into dental assistant/oral health professional placements.

New graduates need support, assistance with career pathways, opportunities throughout and immediately after study to work in rural and remote areas and in the public sector, and opportunities for employment beyond traineeships. Partnerships between Aboriginal Medical Services and mainstream services could facilitate the provision of support to graduates.

There was some discussion surrounding a voluntary versus compulsory dental graduate year, and comments that one year is not sufficient – in the past cadetships and bursaries bonded students for 3 years in rural areas, and many of these graduates have remained.

“We run a hub-and-spoke model in NSW. We don’t really promote to students or graduates the benefits of working in places like rural Australia. It would be good to do a “road show,” promoting to students the idea of working in rural or remote communities, especially with Aboriginal communities. A small team who could go around to final year dental or therapy student groups to promote this, might get a good response. Also promoting oral health careers to Aboriginal high school kids would be great”

QUOTE FROM WORKSHOP PARTICIPANT

**Retention**

The issue of retention revolves around more than just money and location - professional isolation, the challenging clinical and non-clinical work environments, and a lack of relief staff may all have an impact. Professionals working in remote locations need substantial support. The isolation can be difficult to deal with and so plans need to be implemented to facilitate social interaction and the maintenance of a healthy professional and social life.
Retention of oral health staff could be improved by:

- **Accommodation support** for professionals working in rural/remote areas - shared inter-professional/interdisciplinary accommodation could help reduce the isolation and contribute to social support. The support for oral health workers in this regard needs to be at the same level as that offered to other health practitioners. This could also have a positive influence in breaking down barriers between dental and medicine, and also for people from both groups to share their stories and learn more about other professions.
- **Ensure cultural safety** for workers.
- **Pay incentives** – salary parity for the oral health workforce.
- **Professional support**, partnering with local services in addition to Aboriginal Medical Services. Inclusion of services in AMS models to improve professional collaboration and support for practitioner.
- Reduced “red tape” – reporting/targets set by funding bodies.
- Access to affordable locums, and better training for locums.
- Professional development opportunities – suggested five days per year set aside for professional development.
- **Sustainability** - long term employment contracts, sustainable funding models, partnership approach to ensure continued care. Community contact/building connection to different services, increased leave allowance per year.
- Opportunities for **networking** need to be facilitated. Peer review, quality control to ensure quality of work, support in remote areas. Forums for Aboriginal and Torres Strait Islander oral health more regularly.

Remote dental practice in common with clinical practice in general, may have its own intensity and clinical challenges.

It can also have the benefit of being located in spectacular surroundings of outback Australia, in rugged country where nature’s events are unavoidable, and where chance encounters with natural landscape and its animals can be enlightening and inspiring.

They are not places to be taken for granted, with weather extremes, lack of water and threat of bushfire being ever-present issues, particularly in summer months.

But when spending time in country, whether going for bush tucker with traditional owners, or simply exploring country for its own sake, there can be some unexpected sights and rewards, like a redgum glowing in the twilight, days after a bush fire has passed. - *Simon Wooley*
SESSION 2 – ACCESS TO SERVICES AND SERVICE PROVISION
Session 2 was presented by Dr Sandra Meihubers. Sandra is a public health dentist and consultant working mostly in rural and remote Aboriginal communities in Australia. Her experiences include the establishment of new partnership dental programs in remote areas, developing and implementing community based dental programs, training local staff, developing resources to support dental professionals in remote clinical practice, and providing policy advice to both State and Commonwealth governments. Her involvement in general health and overseas volunteer dental programs has now extended to the development and coordination of a village sanitation project in rural Nepal.

Executive Summary
Oral health is on the radar, receiving more attention than in the past – however the situation for Indigenous Australians continues to worsen, and cannot be improved until other things improve such as living and environmental health conditions, economic security. Services for adults are the biggest problem at present. There is a need to focus on sustainability and maintaining on-the-ground core staff as the role of volunteer dental groups continues to expand. As always, it is essential to continue working towards convincing medical providers that oral health forms part of comprehensive primary health care. We must recognise that many Aboriginal groups are ‘working poor’- ineligible for health care cards and therefore not eligible for dental care under many public dental sectors and Aboriginal-controlled health services. When adopting new models it is important to take time on the process – a lack of continuity in the past makes it particularly challenging to foster trust. While acknowledging that the Chronic Dental Disease Scheme was a rort in some areas,
it did also fill a gap that now remains empty. Today the Medicare Locals are interested in oral health; this presents a big opportunity.

The discussion for session 2 revolved around the following questions:

**Consider 2002 recommendations - Action Plan Goals 1, 3 and 5:**

**Goal 1:** Provide culturally appropriate oral health services to all Aboriginal and Torres Strait Islander people

**Goal 3:** Increase oral health promotion activity for Aboriginal and Torres Strait Islander people

**Goal 5:** Foster the integration of oral health within health systems and services, particularly with respect to primary health care and Aboriginal and Torres Strait Islander people

1. Have the objectives been achieved? If not, why not?
2. If so, what are some examples of best practice?
3. Identify three strategic priority areas in each of:
   (a) Access
   (b) Service Delivery
4. How can we ensure these priority areas are actually implemented?
   Considering implementation, monitoring and evaluation issues at the level of
   (a) Local
   (b) Regional
   (c) National

**Where are we at now?**

The 2002 objectives are still relevant today, but the context has changed. Progress has been made in various areas, but there remains a great deal to be done.

Oral health has been integrated into adult and child health checks, and in some instances also into Aboriginal and Torres Strait Islander health policy, although this does not necessarily follow through to practice. Overall, fluoridation programs have largely increased. There has been an increase in oral health promotion, a lot of work done with ACCHSs, organisational change/structural support, and some local initiatives such as taxi vouchers in metro areas and ACCHS transport. Access in community centres is an issue – in some places exclusive Aboriginal clinics have been introduced.

Partnership elements have been working, and these are essential in order to meet the objectives. Issues include funding, and the formalising of these partnerships - eg auditing, quality control, policy and procedures, cross-cultural programs. There were calls for overall leadership at the national level - a national body Aboriginal community controlled service in oral health that is able to advocate, guide and form partnerships.
Some of the obstacles identified included transport schemes, as NSW’s Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), amongst others, does not cover general dental. Data system incompatibility, the negative impact that the end of Medicare rebates will have on integration, and the inability of government clinics to offer culturally appropriate services were also identified as barriers.

**South Australia**
There are more partnerships with mainstream ACCHSs, more clinics, and more commitment from organisations allowing priority access for Aboriginal people. More work is still needed to be able to provide respectful dental care for Aboriginal and Torres Strait Islander people.

The “no questions asked” policy was raised, in relation to providing proof of Aboriginality and there was some concern that this could be abused by people wanting priority access – however the South Australian Dental Service (SADS) reported that this has not been a problem.

**Northern Territory**
The NT continues to rely heavily on the Commonwealth for access to remote areas, and there are many informal arrangements in place.

**Western Australia**
Anecdotal reports of the introduction of a new leadership role for Aboriginal and Torres Strait Islander oral health, with a recently completed job description. No further information available.

**New South Wales**
Particularly in rural and regional areas there is a range of partnerships – some very strong, some emerging. In central NSW training providers are key, and partnerships have been implemented with Charles Sturt University. Action has been taken on fluoridation. In 2002 many AMSs lost funding; today approximately 20 Aboriginal Medical Services have dental facilities. There is still a need to push oral health to the forefront and commit formally in order to address objectives.

“In NSW, if we don’t have partnerships, we can’t do it” - quote from workshop participant

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**Victoria**

There is now better transition between services. The oral health sub-committee of VACKH (the Victorian Advisory Council on Koori Health) is meeting regularly.

Access has improved, service delivery has not. There have been difficulties bringing people into the Royal Dental Hospital, travel is an issue. As an exclusive Aboriginal and Torres Strait Islander service, usage has increased 200%. There is a breakfast club on Saturday mornings, with all specialists present and available to clients. Patients can be picked up from home.

**Queensland**

Very little liaison

**Tasmania**

No information available.

**Examples of best practice**

- Strong partnerships in NSW built in last 10 years (between AMS and public services) – eg. Bila Muuji and Western NSW Health, Charles Sturt University partnerships
- Oral health being embedded into general health and wellbeing, for example in adult checks (in primary healthcare there is greater recognition of the importance of integrating oral health, however there are still serious barriers to practical implementation).
- Two-day fluoride/Duraphat varnish course for Aboriginal Health Workers and Registered Nurses in the Northern Territory
- Taxi vouchers for clients at Royal Dental Hospital of Melbourne
- Queensland fluoridation scheme, with New South Wales and Victoria also working well to increase fluoridation
- Bila Muuji established scholarships and placements for oral health therapy students at Charles Sturt University to encourage a career in Aboriginal oral health in rural communities
- School screening in remote areas
- Renal Diseases Health Network waived services for non card holding Aboriginal clients, this could be a good example for oral health.
- Dedicated Aboriginal Dental Clinics within the mainstream system, such as at Sydney Dental Hospital and through the South Australian Dental Service
- Rumbalara’s Aboriginal dental assistant trainee program

“We’ve had a general clinic in Alice Springs which has an emergency service 5 days a week and Aboriginal people can come without being questioned—if they come late, they’re still seen, and there’s no co-payment. People are guaranteed to be seen that day, and it’s proven popular. We did a project at Utopia where we visited communities, through negotiation we agreed people would come along for a check-up. It was a service that had been delivered for a long time so there was trust. It was well accepted but may not be universal. People were grateful so they participated.”

Quote from workshop participant
What we should be working towards

- Abolition of co-payments
- Aboriginal staff working in reception areas
- Workforce for extended stays in all areas, but particularly remote areas, so as to build trust
- Targeting early childhood caries, pre-school kids, going out to where people are, and continuing that through to a comprehensive school dental program
- The gap surrounding adult care - working on an adult program that meets the demand
- Oral health-general health integration
- Access for non-card holder Aboriginal clients
- Compatible data systems and data management to allow for the integration of oral health care
- More requirements at state/national level for mainstream services to partner with ACCHSs
- Increasing scope of practice for therapists, incorporating an understanding of what the profession can offer for promotion and prevention, and rethinking models of care
- A national fluoride policy, bottled water containing fluoride.

A workshop participant from Dental Health Services Victoria asked one of The Royal Dental Hospital of Melbourne’s Aboriginal patients what having access to dental treatment has meant to them.

“To be able to have maintenance done to my teeth in an environment where staff have been supportive and patient with me is invaluable. I have suffered from anxiety, panic attacks and just overall fear from dentists because of one bad experience with a dentist.

The dentists at The Royal Dental Hospital of Melbourne have enabled me to trust again. One in particular would take me through step-by-step, as he would perform any dental work. For example, I’d ask how long each step in my treatment would take, he’d say one minute, and I would focus on counting down that minute. Before the next step – in one of my very anxious moments, he actually sang for me to keep my mind occupied!”

SESSION 3 - PREVENTION

Dr Colin Endean spoke of the importance of prevention within a framework that recognises the social determinants of health (social & economic disadvantage, inequity, unemployment, housing, education & access to healthy food influence the context for prevention in Aboriginal and Torres Strait Islander oral health).

Colin is a dentist working in private dental practice, in the public dental sector and in remote Aboriginal communities in SA & WA. He began his journey to remote Indigenous communities and practice in remote primary oral care in 1985 and has remained engaged and committed to improving oral health for all. He has worked as a dentist for Aboriginal Community Controlled Health Services (ACCHS) for over 28 years, firstly for the Nganampa Health Council on the APY Lands of SA, thence for the Ngaanyatjarra Health Council on the Ngaanyatjarra Lands of WA and for the last 7 years for the Tullawon Health Service (THS) in Yalata SA. Since 2010 Colin has been involved with establishing an outreach dental programme for the Kakarrara Willurrara Health Alliance (KWHA - “East-West” Health Alliance), an alliance connecting the small ACCHS of Oak Valley (SA) & Tjuntjuntjara (WA) and extending services & developing programs with the THS.
Through this work with the KWHA and the extensive years of dental service delivery in much of the remote regions of SA & WA, Colin has developed an understanding of what “Closing the Gap” might really mean for oral health in the context of these remote Aboriginal communities.

Colin has also worked with Adelaide University and the Menzies School of Health Research on the “Strong Teeth for Little Kids” project that has provided insights & opportunities for early intervention and prevention of Early Childhood Caries (ECC).

Executive Summary
There are many steps that can be taken to ensure prevention becomes more of a focus in Aboriginal and Torres Strait Islander oral health. Fluoride (through both fluoridated water and topical applications) needs to be promoted and marketed - perhaps with the help of Colgate or other bodies. Collaborating with sports stars to spread the message is also seen as an effective tool, for example marketing with AFL players on oral health prevention (fluoride, drinking water) in the Northern Territory. We need to lobby to remove GST from toothpaste and also to reduce the price of toothbrushes - in some communities they cost as much as $10. It is important to recognise that the hardest step is to get patients into the chair; once they are in it’s possible to move from acute to general care.

Other issues covered included ECC (early assessment and intervention, toothbrushing, and maximising tooth protection), the integration of oral health and general health, the School Dental Program, adult dental care and acute care priorities.
See pages 7-8 for a background on fluoride in its different forms

These were the questions that guided discussion for this session:

1. **Telling the Fluoride Story**
   How oral health professionals can best tell the story about the efficacy of fluoride in prevention & treatment of dental caries? To our health professional colleagues, teachers, schools & communities as well as to families & individuals?

2. **CDBS – Child Dental Benefits Schedule**
   “will provide a Commonwealth funded capped benefit entitlement for basic dental services for children”. Replacing Teen Dental Plan in 2014 with $1000 per child over 2 years.
   How will this fee for service model prevent (&/or treat) ECC in preschool children?
   And for School Aged Children, is this an opportunity for School Dental Care for All?

3. **Naming the Enemy**
   After the anti tobacco campaign, a national campaign to reduce access & consumption of soft drinks & sweetened beverages?

4. **Collaborations in Promoting Oral Health**
   Shared risk factors & shared opportunities for disease prevention & health promotion:
   “Lift the Lip”, incorporating oral health checks & prevention
   “Toothbrushing with Fluoride Toothpaste”, creating opportunities to develop good habits & skills in child care centres, preschool, ‘mothers & babies’, school & other
   “Diabetes & Adult Chronic Disease”, diet, exercise & reducing weight
   “Smoking – Quitting for oral health too”

5. **NPA – National Partnership Agreement for adult dental services**
   How does this fund the oral health needs of Aboriginal and Torres Strait Islander Australian adults? And the ACCHS’s Dental Programmes? And the need for dentures by Aboriginal and Torres Strait Islander adults with chronic disease?
Telling the Fluoride Story

How best to tell what we know as oral health professionals about the efficacy of fluoride in prevention and treatment of dental caries? To our health professional colleagues, teachers, schools and communities as well as to families and individuals?

There was a lot of promotion of fluoride in tap water, but the focus now has moved to plaque, diabetes and gingival health. We can certainly talk more about fluoride again.

Change the story to prevention is better than cure! Fluoride is important here.

It’s important to ensure we promote a clear, simple message – no contradictions, plain language, to target groups. We must keep in mind that there are many competing health messages, and we should take care not to assume prior knowledge. We work with many groups and therefore need to consider how to make resources context-specific, but always with consistent key messaging about fluoride to health professionals, across health services etc. Everybody knows about the links between sugar and diabetes, or a high-fat diet and obesity, but fewer people know about fluoride strengthening the teeth. That should be the message: the right amount is not a risk to your health.

Price control for toothbrushes - they are $10 in some communities, and many people expressed the view that we should be lobbying the government to remove the GST from toothpaste in the context of social determinants.
Alert via e-health, using consistent messaging through social media – a lot of people now own phones.

**Have a yarn – engagement.** Involve and consult with the community, the board, Elders, tell the fluoride story. In certain communities word of mouth is the most effective way of increasing access and promoting services, you just need the right people to spread the message.

**Promotion of children’s toothpaste,** early childhood caries screening and Duraphat (fluoride varnish) applications for children. It is about promotion at the ground level – with the community and clients having a yarn, involving early child health workers and nutritionists.

**Partnerships** - work with industry to promote the uptake of fluoride toothpaste, encourage doctors to advocate its safety.

**Drinking water** – good water quality. Issues with taste of water. Need to understand why people aren’t drinking water. People report that water is horrible-tasting and expensive in many areas. Need to understand why that is.

**Health promotion**

- national oral health messages, such as brush teeth twice daily, use fluoride toothpaste, spit but don’t rinse.
- school tooth brushing programs, particularly in areas with no fluoride in the water - need to provide access to toothbrushes and paste. Have health promotion workers visiting schools, need to involve teachers and families.
- Target communities without fluoride.

**Celebrity endorsement** - the idea of using role models as part of a professional marketing campaign garnered support, following the NT example of working with AFL players - but the story isn’t just fluoride, it’s also about oral hygiene, brushing teeth, eating well, drinking water. Another idea raised was using talking posters with little chips through which the message is spoken in language. This would require appropriate marketing to both Indigenous and non-Indigenous Australians, utilising appropriate language.

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**'Indigie Grins' Indigenous Youth Dental Health Project**

'Indigie Grins' is a 12 month research project funded by Dental Health Services Victoria (DHSV). It aims to improve the oral health of Indigenous youth aged 5 - 12 years in rural Western Victoria.

'Indigie Grins' is led by Western District Health Service in partnership with the Melbourne Dental School, University of Melbourne and Winda Mara Aboriginal Cooperative.

This project hypothesises that the oral health of Indigenous children can be improved by making linkages between Indigenous health care workers and non-Indigenous oral health services.

Participants are provided with specific Indigenous-friendly oral health care products, information and education and have contact with Indigenous health care workers and dental therapists. The project includes research on Indigenous cultural values, beliefs and meanings regarding oral health.

The research is near completion. It has already:

- provided critical information about the state of oral health in Indigenous children in western Victoria.
- led to an increase in access to men's health services by children's families.

School Dental Services could be expanded to family dental services, so the whole family can go together.

Will the Child Dental Benefits Schedule prevent (&/or treat) ECC in preschool children? And for School Aged Children, is this an opportunity for School Dental Care for All?
Theoretically there can be care for all, however access inequities must be addressed. There were many concerns raised about this model:

- Fee-for-service schemes are at risk of fraud – they must be widely used and audited so as to avoid being abused like the Chronic Disease Dental Scheme.
- Oral health therapists need provider numbers in order to be able to utilise this money. There is no cap, meaning it is possible for dentists to charge excessive fees.
- Geographic access to a dentist, as well as affordability, can still be issues.
- There is the risk services may not provide preventive information and services but rather clinical interventions only.
- The Schedule is not targeted to those most in need, and therefore may not reach the groups who most require the services.
- In efforts to avoid ECC, most prevention efforts actually need to target parents – how can we link the consultation with prevention?
- “In states like NSW, where infrastructure is lacking (e.g. clinics and staff), the majority of people take kids to private dentists to use vouchers. I guess private practices have a different mentality when treating these kids. How are we going to regulate that? Or encourage them to have a public health ‘hat’?” – workshop participant.
- Accreditation is concerning – who ensures people are held accountable for money? $1000 for a filling or a lot of toothbrushes? How to evaluate and where is the sustainability?
- “First, if every eligible child presents for this care, there’s not enough money. It doesn’t cover everybody. It’s supplementary at best though it’s still good. Medicare-based payment supports regulation better than a voucher system because it has more detailed data. Medicare scrutinizes service patterns. There is an opportunity to get it right, unlike the teen dental program which was rushed in.” – workshop participant.
- ACCHS funding models can be problematic.
- Different strategies for AMS, private practice, SDS.
- Media promotional information focused on private practice – the gap changes privately.

How to prevent/treat ECC

- Parents need to be targeted, and mothers during pregnancy – the message can be promoted even before the baby is born.
- Anticipatory guidance rather than just clinical interventions.
- Money could be utilised for more preventive activities.
- Family-based dental care.
- Some funding quarantined for preschool and pre-natal programs.
- Minimal bureaucratic red tape for bona fide public health programs.
- Funding public health services – more chairs, more services.
- Free up funding for services from school dental service/public system.
- Benefit children not eligible for concession cards.
• Encourage local production of healthy, natural foods – this can allow not just oral health benefits but also employment opportunities, engagement with country and the opportunity to teach children about these benefits
• “There was information from the APY lands that 50% by weight of produce coming into stores was drinks, and half of it was soft drink. Healthy stores policies had a range of healthy food, and controlled the store. “Food democracy.” They substituted with diet soft drink, successfully.” – workshop participant

Naming the Enemy; After the anti tobacco campaign, a national campaign to reduce access & consumption of soft drinks & sweetened beverages?

Tax – The GST could be added to sugar products and soft drink – healthy choices need to be made easier, and unhealthy foods more difficult. The cost of healthy foods in rural and remote areas could be subsidised to promote their consumption.

Banning advertising of junk food to children. There is an evidence base for this and a significant amount of support. Link into the Coalition on Food Advertising to Children (http://www.cfac.net.au/).

In schools - promotion and prevention, healthy canteen policies.

Partnerships with other health professionals, the Heart Foundation, Diabetes Australia, Nutrition Australia, to target consumption of soft drinks. Government support, particularly in the form of Government services messaging, would be beneficial.

Labelling – clearer labelling of sugar in drinks

Education, at the ground level, on the negative impacts of soft drink

• Educate that soft drink is not a thing to have all the time
• Marketing around drinking water

Water supply – local water supplies need to be palatable, or people will drink other things. Promote the ‘choose water first’ as opposed to campaigning big brands. Bottles water providers could be lobbied to include fluoride in water for distribution in small communities.

National media campaign promoting moderation and linking in to other health messages – sugar as an addiction, diet, smoking, alcohol consumption

Collaborations in Promoting Oral Health

- Bring back (and fund) oral health promotional programs such as “Indigie grins*”
- Community gardens
- Correlation of data sets ie diabetic, smoker, visited a podiatrist, heart specialist etc
- Shake a leg - a health promotion program aimed at both primary and secondary school children in various NSW schools. The goal is to reduce preventable health conditions in Indigenous children through education, which empowers the children to have some responsibility for their own health. Topics covered in class include oral health and cultural awareness, amongst many others
The Jimmy Little Foundation, which travels around to deliver healthy lifestyle messages to more than 30 communities around Australia (http://thumbsup.org.au/about/)

The Mai Wiru regional stores policy aims to improve the health and wellbeing of all Aboriginal people living on the APY Lands by ensuring continuous access to safe, nutritious and affordable food as well as essential health items through community stores. Mai Wiru translates as 'good food' in Pitjantjatjara. As well as providing access to healthy, affordable food and adequate refrigeration, the Mai Wiru policy ensures stores support health promotion and nutrition programs and the employment and training of Anangu workers under appropriate wages.

Photo courtesy of Maddy Shearer

NPA – National Partnership Agreement for adult dental services.
How does this fund the oral health needs of Aboriginal and Torres Strait Islander Australian adults? And the ACCHS’s Dental Programmes? And the need for dentures by Aboriginal and Torres Strait Islander adults with chronic disease?

This varies across states in terms of access and cost.

In terms of dentures, this is probably an opportunity to use prosthetists with technical skills – this would make for better utilisation of all dental practitioners, as well as employment of prosthetists

“In Qld they closed down the dental tech room because there was no tech. For somebody to get teeth, they have to go to Cairns. There are no cheap airfares and it takes four visits.”

Quote from Workshop participant

“We know that funding is available for Aboriginal people, but we want to see a percentage of this funding going to community controlled organizations”

Quote from Workshop participant
SESSION 4 – TREATMENT

Angie Perry-Mansell is Dental Services Co-ordinator at Danila Dilba Health Services in Darwin. She has a Diploma in Oral Health Therapy from the University of Melbourne and has worked with Dental Health Services Victoria in regional Victoria before moving to the Northern Territory.

Executive Summary

Angie discussed the issues of flexibility in the delivery of services, patient and community trust, partnerships, and the importance of resources that match demand so as to avoid the implementation of bandaid solutions. She expressed concern over the strong focus on general health at the expense of oral health. Angie discussed treatment from an Aboriginal and Torres Strait Islander perspective, this perspective being shaped by lived experience and shared through generations. Aboriginal and Torres Strait Islander health services view oral health within a social disease framework, but lack resources. It is important to make the most of first visits both for examination and treating immediate needs as well as building relationships. It is also necessary to acknowledge the autonomy of children and work together with their families to make dental care as enjoyable as possible. There needs to be more preventive efforts and support and training for dentists so as to avoid, wherever possible, using general anaesthesia.

These were the questions guiding conversation for this session:

1. How do we ensure Aboriginal patients’ preferences about oral health outcomes are a priority in contrast to the traditional practitioner-driven treatment planning model?
2. Much oral health training requires multiple visits for extensive disease treatment. In many Aboriginal oral health settings multiple visits do not eventuate or are unavailable. How do we best manage this?
3. Are there ways in which dental clinical settings can be adjusted to better suit Aboriginal family-oriented visiting?
4. When specialist oral health services are required (such as oral surgery, general anaesthesia for children) there can sometimes be different approaches to meeting the needs of Aboriginal patients. Are there ways in which these partnerships can be strengthened?
5. Traditional approaches to monitoring and evaluating services (eg. visit patterns and treatment output) are not always comparable between different service settings. What are the best models for evaluating Aboriginal oral health services?

How do we ensure Aboriginal patients’ preferences about oral health outcomes are a priority in contrast to the traditional practitioner-driven treatment planning model?

There are concerns around the fact patients are not necessarily provided with options for saving teeth, but rather extractions are undertaken on a regular basis. A minimal intervention approach to dentistry could go a long way in terms of incorporating the preferences of Aboriginal and Torres Strait Islander patients. Often clinical expectations are different to the patients’ expectations, and dentists must respect this. Tension between these expectations, however, is a huge barrier.

Participatory Action Research could be applied to AMSs to determine which is the best model of practice.
Community involvement/engagement - The planning stage needs to incorporate both community and patient involvement and consultation. It is important to recognise the importance of family members attending with a patient, and to understand what is happening within that community and the relevant priorities. There may be role models within the community who could take a leading role in spreading the word.

“What is it that we know about Aboriginal and Torres Strait Islander patients’ preference? In the US, they are developing cultural assessments. It’s about giving respect. If we aren’t aware of cultural things that impact on children’s treatment, how do we ensure there are parents there to be part of that process and keep us informed? In pilot studies in WA on 0-4 year olds, we’ve found Aboriginal and Torres Strait Islander students are under-represented in childcare. Why aren’t Aboriginal and Torres Strait Islander kids at childcare? Cultural responsibility is within the family. So putting children in childcare takes away family obligations. There’s also the issue of removal of Aboriginal and Torres Strait Islander children historically. What other strategies engage representation? Culture is important”
Quote from workshop participant

“Go out to Aboriginal and Torres Strait Islander services and do modelling and action research on patient-driven treatment. Put patients in control and allow them to decide what’s most important for them and what to do with treatment. If they have more important worries, they won’t see a dentist. Address major concerns so they can then think about the rest of their health care. Stop the downward approach: go to, listen to, act with, and work together (slogan from Pika Wiya)”
Quote from workshop participant

Education of patients – refer to an Aboriginal Health Worker to discuss health issues and client perspectives

Communication - provide information and ask patients how they would like to go about their treatment planning, including family members in discussions. AHWs have an important role in communicating treatment options, and where the practitioner is not Aboriginal it is beneficial to have Aboriginal support people, such as dental assistants. Language is important – Aboriginal English. Empowering patients to have a say in their own treatment, for example through motivational interviewing, can lead to improved patient engagement and better self-management.

Trust - In many cases, the initial contact is for pain relief. Through treatment, it is important to gain trust. Every clinical relationship is based on trust and informed consent, and cultural respect is obviously essential – this includes an understanding of social determinants so that patients feel safe being treated.

Partnerships and agreements - what is achievable, what is realistic? Address the needs within Aboriginal-run health services by creating appropriate partnerships.

Part of an integrated primary health team – looking at the environment, social structure, and holistic health. Integrate oral health treatment options with existing health information and work with other health professionals to look at options for treatment plans – this consultation will take time.
Staffing – We need continuity - regular staff on the ground and locums. The staffing system acknowledges the role of health workers in identifying dental needs within the health service, giving an opportunity to discuss any concerns and providing health information before appointments, recognising that some patients will be more comfortable chatting with an AHW than a dentist. Oral health professionals should make an effort to give patients options and listen to their preferences, offer follow up treatments, spend time with the client, include family members, utilise available referral pathways. Continuing professional development opportunities should be maximised.

Children - Champion the work done in silver fluoride – while this is not the only strategy it is critical in middle intervention, avoiding the burden of a general anaesthetic.

Much oral health training requires multiple visits for extensive disease treatment. In many Aboriginal oral health settings multiple visits do not eventuate or are unavailable. How do we best manage this?

Firstly, through commitment to a National Aboriginal Oral Health Plan which addresses the needs of urban, regional, rural and remote populations. There are two issues at play – the availability of practitioners, and the patient returning.

Funding to do these needs to be written into policies/strategic and operational plans, developing policies that facilitate access to comprehensive care. This could involve examining barriers for attendance (such as travel, dental fear) and implementing strategies to decrease these barriers, always linking to the social determinants of health. In the meantime, practitioners need to address the immediate problem then set out a plan for the client in the interim. Plan for the dentist to return, with a focus on prioritised care.

Transport is a major problem. Providing more transport options for patients to attend appointments can make a huge difference. Utilise all transport options, such as more travelling vans. Vehicles must be sturdy.

Patient safety/trust are essential to ensure that patients return. As previously outlined, this involves taking the time to talk through the situation and develop relationships before clinical treatment, the involvement of Aboriginal health workers, and the upskilling of local people who may not be involved directly in dental practice (for example training Aboriginal Health Workers in fluoride
varnish application). Aboriginal and Torres Strait Islander administrators are also pivotal in establishing relationships and trust with the patients.

**Flexibility** - set appointment times do not work. More efforts should be made to trial drop-in clinics, perhaps for one day per week, where Aboriginal and Torres Strait Islander patients can come at whichever time is convenient to them, possibly even after hours.

Do block checks, set sessions, whereby clients who live in remote communities can travel to see the dentist and other health professionals at the same time. These can be blocked out in the calendar over several months.

**Silver fluoride** – while essentially a bandaid response, this can become necessary where only short dentist visits occur. At present there are no dental schools teaching silver fluoride application, perhaps this should change.

**Are there ways in which dental clinical settings can be adjusted to better suit Aboriginal family-oriented visiting?**

Oral health services that sit within ACCHSs are the ‘gold standard’, and mainstream services should be modelled on that. Heterogeneity is an ideal, Aboriginal control is critical. A close relationship with organisations is very important.

As for children, autonomy of kids is important. If the dentist is a fun place, children are more likely to attend - it needs to be framed in a way that is relevant to their lives.

The divided public system, with a separate school dental service and adult service, does not facilitate this. How can we overcome this?

**Big picture health centre** – allowing for a one-stop shop for all family members rather than one clinic for adults and another for children. This could incorporate opportunistic screenings (for example blood sugar, blood pressure, diet, etc) and allow cooperation with other providers and AHWs.

**Clinics** could be made much more welcoming (and less clinical) with the Aboriginal flag, Aboriginal paintings, specifically targeted brochures and posters, local artwork (including children’s artwork), and options for childcare while adults have treatment. Ideas were presented such as offering patients a drink on arrival, providing toys, storybooks or educational oral health-based activities to keep children entertained in the waiting room, and employing more Aboriginal staff (including dedicated client liaison officers to support Aboriginal and Torres Strait Islander patients in accessing mainstream services).

**Collaboration** – employing a model that suits the community, and where the provider is part of the model. This includes being flexible to allow the model to develop over time.

**Messages** – promote the messages that:

- dentists can help with prevention, they are not only there to extract teeth
- oral health is an integral part of general health

Family events such as AFL carnivals can be an excellent forum for health promotion.
Again, allowing **flexibility with appointments** is crucial – the standard appointment system does not work. Other possibilities could include using a locally developed appointment model, booking family times rather than individual appointments so as to accommodate families as a whole, having recalls for check-ups on patient data systems, where possible aiming to make the first appointment a check rather than initiate treatment, providing advocacy and support during visits, or possibly even offering a healthy meal before or after the appointment.

Potentially offering night services could facilitate family visiting – be open when the services are most likely to be accessed. Longer appointment times would be helpful, alternatively clinics could schedule non-appointment times each day or each week, providing a drop-in service.

**Building partnerships**

An oral surgeon from DHSV visits the Victorian Aboriginal Health Service regularly. The Memorandum of Understanding between the two organisations has been in place for almost three years now and has facilitated an invaluable service for the community and the service’s patients.

“The relationship we have with DHSV has been beneficial and very welcoming. It ensures that our community and patients are accessing services either through the Royal Dental Hospital of Melbourne (RDHM) or a rural service and that they are treated and made welcome in a culturally appropriate manner. This has seen both DHSV and RDHM staff undergo training and changes to their policies and procedures and has been a great success for our patients.”

- Christine Ingram, Oral Health Manager

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When specialist oral health services are required (such as oral surgery, general anaesthesia for children) there can sometimes be different approaches to meeting the needs of Aboriginal patients. Are there ways in which these partnerships can be strengthened?

**Specialist teams** - periodontal specialists and hygienists are needed, and we need to take these services out to regional areas

**Hospital** - Admit the night before or provide local accommodation to facilitate getting there as well as managing NBM (nil by mouth, before general anaesthetic). Allocate specific day/half day surgery at hospital so all stakeholders can plan around it and commit, and day stays should involve a partnership between the dentist and the hospital, with hospitals ensuring there’s space for the patient’s family.

**Aboriginal oral health liaison programs**, with more staff in all services including hospitals and dental surgeries.

**Elder engagement** - recognise the kinship systems amongst Aboriginal cultures and work with them
- Develop skills/ train dentists in ‘rural’ dentistry
- Aboriginal Health & Medical Research Council of New South Wales (AHMRC) & OATSIH – clinical governance to guide board decision-making and obligations to follow through
- Serious and considered Memoranda of Understanding connecting services than can support families through difficult aspects, with a high level of understanding between the services.
- Partner with AMSs for dedicated coordination – planning of accommodation, transport, surgery/procedures. Coordinate other interventions for family in same trip.
Specifically regarding General Anaesthesia

- “Our GA waitlist is given Duraphat - sometimes it stabilises so they don’t need a GA” – quote from workshop participant
- Efforts to smooth the journey and provide support should be system-wide
- Could regional anaesthesia or sedation be used in some cases as an alternative?
- In South Australia there are efforts to set up GA sessions in rural communities and train general dentists to administer dental care under GA
- It must always be explained to parents that GA is the last resort – it cannot be repeated and so such oral health problems need to be avoided in future.
- Specialist teams’ intervention in NT problematic. GA not an option because of lack of facilities. Kids are in pain, and there is a problem of non-compliance and priority.

Traditional approaches to monitoring and evaluating services (eg. visit patterns and treatment output) are not always comparable between different service settings. What are the best models for evaluating Aboriginal oral health services?

As discussed at many points throughout the workshop, there needs to be a way to capture and then analyse all data from all service providers, as well as transparent communication of the findings. There needs to be additional funding for data evaluation positions.

Feedback from both staff and patients could be incorporated into the evaluation process, making sure the community is really given the opportunity to voice their views.

Oral health services could also be evaluated by looking at:

- Whether Aboriginal people are included in the dissemination of care plans and treatment and prevention, or if there is a community and service provider action plan in place
- Whether staff are trained in Aboriginal and Torres Strait Islander culture - is there some form of ‘culturally appropriate’ checklist, or a Reconciliation Action Plan developed?
- Free resources provided and what is actually used
- How general care patient management systems are used
- Data on repeat checkups
SESSION 5 – RESEARCH AND MONITORING

Professor Roberts-Thomson is Co-Director of the Australian Research Centre for Population Oral Health (ARCPOH) at the University of Adelaide and Director of the Dental Practice Education Research Unit (DPERU). She also manages the National Oral Health Promotion Clearing House. Her research interests are in epidemiology and dental public health, particularly in inequality in oral health and access to dental care. Her current work is in Indigenous health, oral health surveys and health promotion for oral health. She has been a leader in national oral health surveys in Vietnam, East Timor, and Australia and has trained and calibrated examiners for national surveys in New Zealand. She has authored over 60 scientific papers, several books, book chapters and reports.

EXECUTIVE SUMMARY

There are many questions that need to be asked regarding how data is recorded and used – there needs to be a universal system to support analysis, and all evaluations and outcomes should be shared, even if not done in the traditional research ways. Data collection needs to be simple, and clinicians should be encouraged to value data. Where service provision bodies do not have a strong evaluation/research skill set there is potential to collaborate with Universities. There is also potential to be opportunistic with data collection policies, and to inform local services and benefit communities through data ownership. Action research methodology and qualitative approaches are valuable, as well as traditional, quantitative-focused work. It is also important to consider the value of marketing research to the community, clinicians and ethics boards.

The following questions guided discussion for this session:

1. If we want to advocate for and implement strategies to close the oral health gap we need good quality data. This is particularly relevant for clinical oral health data. What is the best approach for obtaining good clinical oral health data across Australia for Aboriginal people?
2. The national-level oral health data (including non-clinical oral health measures) available for Aboriginal Australians is inadequate. Again, to best inform policy, we need nationally representative good quality data. There are a number of barriers to achieving this. How can these barriers be overcome?
3. Traditionally research has not been received well in Aboriginal communities, for a variety of well-founded reasons. The current political climate is such that funding for Aboriginal oral health-related initiatives relies on the availability of evidence indicating probable success. This evidence is mainly formed through research. How do we facilitate good quality oral health research to be conducted in partnership with Aboriginal communities?
4. Research often allows us to be creative with solutions for addressing the oral health concerns of Aboriginal people. Partnerships are strengthened when these ideas come from communities themselves. In what specific ways do you see research projects benefiting Aboriginal communities, including specific research ideas?

If we want to advocate for and implement strategies to close the oral health gap we need good quality data. This is particularly relevant for clinical oral health data. What is the best approach for obtaining good clinical oral health data across Australia for Aboriginal people?

We need broader representation of Aboriginal people in national surveys. Research will be most beneficial to Aboriginal communities when it meets the needs and desires of the community in question, and so community consultation is essential. The benefits for research must inform and improve specific problems. It could be beneficial to develop partnerships between researchers and delivery organisations, and also to build capacity to conduct research in delivery organisations.
Programs must be evaluated, basic data collected during examinations, and there should be a project register.

**Some specific approaches:**

**Standardised data collection** – a universal, national system, consistent minimum data set. It is crucial for service providers to be able to share information, and there needs to be funding for common software to facilitate this. At present AMSs and mainstream services are collecting data (through different methods in each state), but this needs to be collated before it becomes useful. ‘Aboriginality’ status field is mandatory in the Northern Territory, for example, but not South Australia. An improved data network could also link dental and medical records.

- linking nationally – web-based to link ehealth Enterprise Patient Administration System (EPAS)
- Factor in mobility as an issue for data collection – ie well integrated system
- **Concern** - National Child Oral Health Survey – employing local people to conduct in Kimberly areas – doesn’t enable good quality data, consent issues

**Ethical standards** – research should be driven by the community, and Aboriginal and Torres Strait Islander clients should feel comfortable with data collection.

For **clinicians**, data collection methods need to be simple and user-friendly. For all patients presenting, there needs to be a full oral health examination, adding approximately 5-10 minutes to the appointment time.

**Funding**

- A circular problem with funds and data: we need one to get the other
- Use of data questionable in relation to influencing government decisions

**Specific things to include:**

- Index for gum disease
- Collection from adult and child health checks
- DMFT (Decayed/Missing/Filled Teeth)/CPITN (Community Periodontal Index of Treatment Needs)
- Qualitative data
- The story of clients’ journeys through the services, to better understand access and participation – how many patients follow on from check-ups with a completed course of care?

The national-level oral health data (including non-clinical oral health measures) available for Aboriginal Australians is inadequate. Again, to best inform policy, we need nationally representative good quality data. There are a number of barriers to achieving this. How can these barriers be overcome?

**What are the barriers?**

Data may not be collected, or may be collected but not used. Data quality can be an issue, as can confidentiality and ownership. Other barriers include the lack of uniformity at the national level, the division between oral health and general health, over-collection of data and resulting concerns amongst the community about why data is collected. Collecting data in addition to providing services requires an extra investment of time, money, and resources, when staff are often overworked already.
Overcoming the barriers
At the community level, it would be helpful to market the concept of data collection and explain to patients why data is collected. Individual communities could volunteer to be ‘model’ communities to start the data collection from. Bottom-up research was favoured, involving local health workers and respectful, appropriate consultation with community representatives. It was also mentioned that benefits would come from more health workers undertaking advanced degrees. Data collection should become a normal part of business.

The next barrier is the lack of a central, national software system coordinating all the data. This must be rectified. It is also important to disseminate results in a timely fashion to relevant stakeholders.

Partnerships and joint funding applications could also be powerful tools in overcoming these barriers.

Concerns
Participants expressed concerns around excessive reliance on one-off research projects for data, the need for further research in rural-regional areas, the useability of data at a local level and the fact systems often do not capture all services provided to clients.

Traditionally research has not been received well in Aboriginal communities, for a variety of well-founded reasons. The current political climate is such that funding for Aboriginal oral health-related initiatives relies on the availability of evidence indicating probable success. This evidence is mainly formed through research. How do we facilitate good quality oral health research to be conducted in partnership with Aboriginal communities?

Firstly, the need must be identified by the community itself. We need clear articulation of the research, and also to put a positive spin on research celebrating the ‘wins’.

By evaluating programs - continuous monitoring and evaluation. This could be facilitated through partnerships, for example partnering with a University and involving students in the evaluation. There were reports that a lot of evaluation is conducted but not written down and published, so there is a need to further disseminate this information.

Share the findings
It is important to properly discuss research with the community, talk about how it can be of benefit to the community, and share findings with them.

“There is always an assumption that the Aboriginal community needs to be researched. In fact, the problem might lie in the system instead of with Aboriginal people”
Quote from workshop participant

Involve the community – active involvement in supporting community representatives, looking into previous research conducted in the community, the provision of feedback and capacity building of organisations (this could include training community members to collect data to be less intrusive). Community involvement also means allowing time to consider proposals, joint ownership of data,
and introducing the relevant information to ACCHS board members and elders, inviting their feedback.

**Data collection**
Data could be collected by non-dental workers, and stories from small groups could also be useful in providing deep insight, not necessarily to extrapolate to wider populations.

**Chronic disease**
- “When we got money for chronic disease, I didn’t get a dollar. All went to community control. Can we keep this at least with Aboriginal people? I don’t get any advantages from the program” – workshop participant
- Periodontitis is a chronic disease, but it isn’t listed
- “Question about chronic disease not being a well-targeted program. What is the impact of that early closure? It creates a gap suddenly” – workshop participant

**Specific research ideas:**
- Diabetes and oral health
- Why are clients not accessing care even when it is free and transport is provided?
- Why is my child better off with no teeth, compared to teeth with decay?

*Photo courtesy of Maddy Shearer*
SESSION 6 – ADVOCACY
The final session was presented by Mr Alwin Chong. Alwin is a Wakamin descendant from Far North Queensland and is currently the Transition Manager with the Aboriginal Health Council of South Australia Inc (AHCSA). The Transition Manager is responsible for guiding the establishment of a new Aboriginal Community Controlled Health Services (ACCHS) in the Hills Mallee Southern Region of South Australia. He has worked closely with the Australian Research Centre for Population Oral Health (ARCPOH) on several NHMRC funded oral health projects and is a strong advocate for Aboriginal communities in regards to oral health. He believes an important element of advocacy is supporting Aboriginal people to better understand information being delivered in their communities, so that they can take ownership of their own oral health practices.

EXECUTIVE SUMMARY
There is a need for national-level leadership in order to transmit coordinated, clear and consistent messages. Effective advocacy must be driven by partnerships; this could involve working with the medical profession (for example incorporating oral health advocacy into broader health messages) and other national-level bodies.

More specifically, major issues requiring advocacy include pay parity, water fluoridation, and the increased scope of practice for oral health therapists and those who can apply fluoride varnish.

These were the questions asked:

1. There have been many good ideas raised in the workshop regarding improving Aboriginal and Torres Strait Islander oral health in Australia. The key question of how to translate these ideas and suggestions largely revolves around advocacy. Please give us your views on how advocacy for the five workshop themes (Culturally-appropriate oral health policies and labour force, Access to services and service provision, Prevention, Treatment and Research and monitoring) could occur.

2. In regards to Aboriginal and Torres Strait Islander oral health, key advocacy questions include increasing awareness among Aboriginal communities. Much of the policy rhetoric is around better delivery of oral health services. Please describe other areas critical for Aboriginal and Torres Strait Islander oral health advocacy.

3. There are some very good examples in Australia of co-ordinated approaches to primary health care, including oral health primary care among Aboriginal populations. Please describe some of your experiences of these.

4. Aboriginal oral health training is an area requiring strong advocacy. Please describe the training for Aboriginal oral health in your respective jurisdictions, including what oral health components are included

5. Good evidence is critical in informing Aboriginal oral health service delivery and policy making. Equally important is working with Aboriginal community-controlled organisations. Please describe benefits of the latter, particularly in regards to understanding local contexts.

6. There is much we can do as a collective in regards to removing barriers with Aboriginal oral health advocacy, particularly regarding Aboriginal oral health training. We would love to hear your suggestions of how we might best do this.
What should our approach to advocacy be?
Our approach to advocacy needs to be united, leaving no room for misinterpretation - it is important to keep in mind that there are many different health messages and campaigns and that sending too many messages is likely to cause confusion.

The best way forward is involving medical colleagues, advocating with other Aboriginal and Torres Strait Islander professional bodies in health, education, employment, and housing, and overall employing a holistic approach. It is important to incorporate a strong understanding of the social determinants of health into advocacy work, emphasising the importance of the first few years of life and being mindful that improved health is dependent on better living conditions. We need to progress in partnership with peak bodies such as such as the Australian Dental Association (ADA), Indigenous Allied Health, National Health and Medical Research Council (NHMRC), Aboriginal Health and Medical Research Council (AHMRC), Office of Aboriginal and Torres Strait Islander Health (OATSIH), National Aboriginal Community Controlled Health Organisation (NACCHO), Cancer Council, National Oral Health Alliance, National Preventive Health, and Rural Health Collective. It is also important for oral health to be included in both the National Aboriginal and Torres Strait Islander Health Strategy and Plan, and the National Aboriginal and Torres Strait Islander Health Survey. Further benefits could come from increased engagement with politicians and making the most of technological methods to spread our message. More work could be done in capacity building, including efforts to develop skills such as writing funding proposals for organisations.

There were calls for the formation of a new non-governmental lobby group to influence change.

Photo courtesy of Maddy Shearer
What should we be advocating for?

- ACCHSs need to lobby state oral health services to financially support their service delivery models
- Promoting ACCHSs services/oral health services
- Supporting oral health workers (dentists, therapists etc) with scholarships
- Resources/support to help those most disadvantaged amongst the community in requesting services, filling in forms, etc.
- Remove the GST on toothpaste
- Form a group to lobby government for measures to reduce sugar in food and encourage awareness of sugar quantities in products
- Make healthy food more accessible
- Universal access for all Aboriginal people regardless of Health Care Card status
- Funding for community control for oral health and Aboriginal Liaison Officers
- Incorporating oral health and prevention in all areas of service delivery
- Access to affordable treatment for those with high needs and low access
- 5 As – acceptable, appropriate, available, affordable, and accessible treatment
- resources to allow availability in the workforce for Aboriginal professionals, for example a register that students can access that shows career pathways and available jobs
- More efforts to identify, mentor and encourage young Aboriginal people to aspire to oral health careers
- access and equity in Aboriginal education in oral health
- advocating for clear clinical guidelines in relation to fluoride and dentures
- more research for ATSI communities, ATSI oral health specific statistics
- Monitoring. Negotiating with ACCHSs around the collection of data
- Assist ACCHSs to advocate for the research they wish to conduct, and further develop their research capacity
- The Australian Dental and Oral Health Therapists’ Association (ADOHTA) can advocate for changes in the scope of practice for therapists
- Funding for more than one chair within ACCHSs
- Changing expectations and aspirations of being able to have healthy and attractive teeth – building a vision for a caries free future
- Palatable drinking water, including cold water in schools
- Move from emergency to maintenance and general health
- Avoiding general anaesthetics for children
- Quarantined funding for prevention
- Improve health literacy
- Nutrition - Lobbying outback stores, community gardens/market gardens (water wise bush foods, fruit), liaising with community stores around food policy.
- Improved communication networks amongst oral health professionals around Australia
- Accountability of schemes so they are not rorted
- Translational research rather than numerical research
- 1978 Declaration of Alma-Ata states – the people have the right and duty to participate individually and collectively in the planning and implementation of their health care
- Include oral health on the agenda of the National Preventative Health Taskforce

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4 Translational research can be defined as 'comprehensive applied research that strives to translate the available knowledge and render it operational in clinical and public health practice' (Venkat et al, 2000, p.1794 quoted in Thomson 2012)
Other critical areas for Aboriginal and Torres Strait Islander oral health advocacy

A broad range of partnerships with other general health services (AMS, ACCHSs, public dental services, hospitals, etc) could help to break down the practitioner silo and isolation experienced by those working in Indigenous communities. Oral health advocacy needs to be involved in the campaigns regarding whole body issues such as diabetes, smoking, chronic disease, and aged care.

Sustainable, generational funding is needed, as opposed to the year-by-year scheme.

Improved access to education - scholarships and support services allowing more opportunities for Aboriginal oral health and dentistry students. Collaborate with universities to provide culturally appropriate training, and train ATSI health workers in oral health with the AHW scheme.

Examples of best practice - co-ordinated approaches to primary health care, including oral health primary care among Aboriginal population

Throughout the workshop it was repeatedly stated that the most effective approaches focus on social determinants and employ a whole-body approach to health – oral health cannot be isolated.

- Cross-sector leadership
- Australian Indigenous Health InfoNet ‘yarning places’
- Community days, such as those held by the Victorian Aboriginal Health Service – they have an information/prevention program bus (screening van) that travels to local football games, community barbecues, etc.
- Child health checks are coordinated with primary healthcare (eg oral)
- Strong teeth for little kids and subsequent fluoride varnish program
- SADS’ Lift the Lip program - not just screening, dialogue is very important
- The Royal Flying Doctor Service has a very well-coordinated primary health care approach, incorporating preventive health teams, retrieval services, and medical supplies
- States giving funding to ACCHSs to support their own dental service, as has happened in NSW
- Aboriginal Liaison Program – full primary healthcare screening, then referral to the public system for priority access
- Gulf of Carpentaria – mining and health working together. One day a week dental services are available to the mining community, as well as the local Aboriginal community
- Daycare menus
  - Childcare accreditation
  - Bottle feeding times

Good evidence is critical in informing Aboriginal oral health service delivery and policy making. Equally important is working with Aboriginal community-controlled organisations. Please describe benefits of the latter, particularly in regards to understanding local contexts.

Aboriginal communities are so diverse, it is imperative to gain ACCHS support, knowledge and advice when working and researching - they can give advice on the best way to work within the community, and also help in fostering broader community acceptance and support of the work you’re doing.
There is much we can do as a collective in regards to removing barriers with Aboriginal oral health advocacy, particularly regarding Aboriginal oral health training. We would love to hear your suggestions of how we might best do this.

- Develop a National Aboriginal Oral Health Plan
- Mentors, role models, leaders, and more support for staff and students (such as scholarships and career planning opportunities)
- Remove the barriers to proven, safe, effective interventions (fluoride varnish application)
- Standardised national training for all Aboriginal and non-Aboriginal health workers, making oral health a core competency in tertiary education and training

Photo courtesy of Sandra Meihubers
References


Cartledge F. Dental van has huge success. The Courier 19 Dec 2008.


Collins F. The role of fluoride in caries control. RDH, Dec 2008.

Collins F. The development and utilisation of fluoride varnish. RDH, May 2011.


Jahn C. Fluoride varnish: One size fits all. RDH, January 2010.


Appendix 1: 2012 Indigenous Oral Health Workshop agenda

Thurs Sept 13 & Fri Sept 14
National Wine Centre, Corner Botanic and Hackney Roads, Adelaide

Day 1
8:30 – 9:00am Registration

9:00 – 9:15am Introduction and Welcome – Lisa Jamieson
   Traditional (Kaurna) Welcome – Mickey O’Brien
   Workshop overview: purpose, program and process
   Facilitator: Lisa Jamieson

9:15 – 10:15am Panel Session: Indigenous oral health issues from each jurisdiction
   Session chair: Kaye Roberts-Thomson
   NT representative; Chris Handbury (7 minutes)
   QLD representative; Katherine O’Donoghue-Scarce (7 minutes)
   WA representative; Lesley Nelson (7 minutes)
   NSW representative; Sandra Meihubers (7 minutes)
   SA representative; Christine Morris (7 minutes)
   VIC representative; Jacqueline Watkins (7 minutes)
   TAS representative; Lisa Jamieson on behalf of Oral Health Services
   Tasmania (7 minutes)

10:15 – 10:30am Morning Tea

SESSION 1 - CULTURALLY-APPROPRIATE ORAL HEALTH POLICIES AND LABOUR FORCE
10:30 – 10:45am Presenter: Eleanor Parker

10:45 – 11:30am Workshop discussions (break into small group sessions)

11:30 – 12:15pm Plenary discussion: (workshop feedback and discussion)
   Facilitator: Lisa Jamieson

12:15 – 1:00pm Lunch

SESSION 2 - ACCESS TO SERVICES AND SERVICE PROVISION
1:00 – 1:15pm Presentation: Sandra Meihubers

1:15 – 2:00pm Workshop discussions (break into small group sessions)

2:00 – 2:45pm Plenary discussion: (Workshop feedback and discussion)
   Facilitator: Lisa Jamieson

2:45 – 3:00pm Afternoon tea
SESSION 3 - PREVENTION
3:00 – 3:15pm  Presentation: Colin Endea
3:15 – 4:00pm  Workshop discussions (break into small group sessions)
4:00 – 4:45pm  Plenary discussion: (Workshop feedback and discussion)
Facilitator: Lisa Jamieson
4:45 – 5:00pm  Summary Day 1: Lisa Jamieson
6:30 for 7:00pm Dinner – Fig Tree Function Centre, Adelaide Zoo

Day 2
8.15 – 8.30am  Coffee
8:30 – 9:00am  Introduction and Welcome to Day 2 of Workshop; Lisa Jamieson

SESSION 4 - TREATMENT
9:00 – 9:15am  Presenter: Angie Perry-Mansell
9:15 – 10:00am Workshop discussions (break into small group sessions)
10:00 – 10:45am Plenary discussion: (Workshop feedback and discussion)
Facilitator: Lisa Jamieson
10:45 – 11:00pm Morning Tea

SESSION 5 – RESEARCH AND MONITORING
11:00 – 11:15pm Presentation: Kaye Roberts-Thomson
11:15 – 12:00pm Workshop discussions (break into small group session)
12:00 – 12:45pm Plenary Discussion: (Workshop feedback and discussions)
Facilitator: Lisa Jamieson
12:45 – 1:30pm Lunch

SESSION 6 - ADVOCACY
1:30 – 1:45pm  Presentation: Alwin Chong
1:45 – 2:30pm  Workshop discussions (break into small group sessions)
2:30 – 3:15pm  Plenary discussion: (Workshop feedback and discussion)
Facilitator: Lisa Jamieson
3:15 – 3:30pm  Afternoon tea
3:30 – 4:00pm  Summary Day 2 & Moving forward: Lisa Jamieson
Appendix 2: Workshop participants and organisations represented

Aboriginal Health and Medical Research Council
Aboriginal Oral Health Program, SADS
Aboriginal Health Council of South Australia
Aboriginal Medical Service Western Sydney
Apunipima Cape York Health Council
Australian Dental and Oral Health Therapists’ Association
Australian Dental Association
Australian Healthcare and Hospitals Association
Australian Research Centre for Population Oral Health
Biripi Aboriginal Corporation Medical Centre
Bulgarr Ngaru Medical Aboriginal Corporation
Central Australian Oral Health Service
Centre for Oral Health Strategy
Colgate
Danila Dilba Health Service
Dental Health Services Victoria
Dental Outlook
Department of Health and Ageing
Filling the Gap
Gippsland and East Gippsland Aboriginal Cooperative
Griffith University
Indigenous Dentists’ Association of Australia
Indigenous Eye Health Unit, University of Melbourne
Indigenous Unit, University of South Australia
Indigenous Oral Health Unit, University of Adelaide
James Cook University
Katungul Aboriginal Corporation Community & Medical Services
Kimberley Aboriginal Medical Service

Megan Campbell
Kellie Graves, Lisa Pigliafiori, Jenny Smith
Michael Larkin, David Scrimgeour
Kim Mafi
Jo Garton
Kylie Innes, Julie Barker
Linda Bingham, Eithne Irving
Andrew McAuliffe
Jessica Merrick, Helen Mills, Kaye Roberts-Thomson
Ian Blanch, Eardley Rozario
Chris Possingham
Vanessa Holm
Peter Hill, Boe Rambaldini, Carolyn Walsh
Susan Cartwright, Lenore Tuckerman
Angie Perry-Mansell
Jacqueline Watkins
Graham Craig
Vanessa Sheehan
Ivor Epstein, Jennifer Symonds
Stephanie Thow-Tapp, Shellee Clay
Ratilal Lalloo, David Baker
Katherine O’Donoghue
Andrea Boudville
Kym Thomas
Lisa Jamieson, Eleanor Parker, Madeline Shearer
Robyn Boase
Laurel Nalder, Val Ofati
Joanne Cox
Kakarrara Wilurrara Health Alliance and Tullawon Health Service
Maari Ma Health
Mid North Coast Local Health District
Nganampa Health Council
North Metropolitan Public Health and Ambulatory Care
North Richmond Community Health
New South Wales Ministry of Health
Oral Health Services Northern Territory
Nunkuwarrin Yunti
Office of the Chief Dental Officer, Queensland Health
Orange Aboriginal Medical Service
Port Lincoln Aboriginal Health Service
Portland District Health
Royal Flying Doctor Service
South Australian Dental Service
Tweed Dental
Aboriginal Oral Health Clinic, Sydney Dental Hospital
Sydney Local Health District
Tasmanian Aboriginal Centre
Thubbo Aboriginal Medical Cooperative
Tooth Mob
University of Newcastle
University of Queensland
University of Sydney
Victorian Aboriginal Community Controlled Health Organisation
Victorian Aboriginal Health Service
WA Health
Walgett Aboriginal Medical Service
Western District Health Service
Western NSW Local Health District

Colin Endean
Erin Commins
Janelle Hurley
Simon Wooley
Lesley Nelson
Martin Hall
Alexis Zander
Chris Handbury
Pieter Herbold
Julie Glass
Lynda Smith
Brett Abbott, Mary-Jane Honner
Christine Morris, Jo Kennedy, Martin Dooland, Mohini Narayan
Andrew Brenac
Keira Green
Kim Horneman
Sandra Wilcox
Cecil See
Fiona Belcher
Linda Wallace
Pauline Ford
Cathryn Forsyth
Wendy Bissinger, Dana Pyne
Alex Thomas, Christine Ingram, Jazmyn Fuller
Renee Elphick
Suman Kavooru
Abbie Lawrence
Jennifer Floyd
Appendix 3: Scholarships and support for Aboriginal and Torres Strait Islander students

At the national level, access schemes are designed to assist students from disadvantaged backgrounds – such as financial disadvantage or disability, or those moving from a country/rural area in order to commence their studies. Commonwealth Education Costs Scholarships are also available to help full-time Commonwealth supported Aboriginal or Torres Strait Islander students “in an area of National Priority” who can also demonstrate financial hardship.

The Indigenous Tutorial Assistance Scheme (ITAS) is a specialised tutorial program established as part of a Commonwealth government initiative to enhance the educational outcomes for Indigenous people. The Department of Education, Education Employment and Workplace Relations (DEEWR) provides bulk funding to Australian tertiary institutions for administering the program locally, to meet the tutoring needs of its Indigenous students. ITAS provides funding for supplementary tuition to Indigenous students studying university award level courses, and some specified Australian Qualifications Framework accredited vocational education training courses at ITAS funded institutions. Tuition is available only for subjects in a student’s formal education program and is not usually available for basic literacy, numeracy, enabling and bridging courses.

Australia-wide scholarships

There are many scholarships available to Aboriginal and Torres Strait Islander students, such as the Indigenous Commonwealth Education Costs Scholarships, Indigenous Commonwealth Accommodation Scholarships and Indigenous Access Scholarships. There are however only a handful across the country focussing specifically on the Health Sciences. These are listed below:

The Puggy Hunter Memorial Scholarship, funded by Australian Government Department of Health and Ageing, provides financial assistance to Aboriginal and Torres Strait Islander people who are intending to enrol or are enrolled in an entry level course (including graduate entry level) in an eligible health related discipline at an Australian educational institution, including dentistry/oral health (but excluding dental assistants). The aim of the scheme is to help address the under-representation of Aboriginal and Torres Strait Islander people in health professions and assist in increasing the number of Aboriginal and Torres Strait Islander people with professional health qualifications. Dentistry was included in the eligible qualifications in 2008.


The Rotary Indigenous Health Scholarship is a co-operative program between Australian Rotary Health, Rotary clubs, some State or Territory Governments and the Commonwealth Government. The scholarship is paid in addition to the Government Abstudy allowance and assists Indigenous students with their day-to-day expenses while they undertake a course in a wide range of health related professions.


http://www.acu.edu.au/study_at_acu/courses/scholarships_and_financial_support/Scholarships_and_Bursaries_Browser/commonwealth_education_costs_scholarship

The Australian Dental Association offers two study grant programs for dental students:

**ADA Study Grants for Indigenous Dental Students**

**ADA Study Grants for Rural and Remote Dental Students**

The **R.N. Hammon Scholarship** invites applications from Australian Aboriginal and/or Torres Strait Islander students who have successfully completed at least one year of a post-secondary program at one of five Queensland universities, and are enrolling on a full-time basis for a subsequent year of that program, or for a further program at that or another participating institution. Preference will be given to applicants enrolling for programs in the fields of Science, Engineering, Medicine, Dentistry, Architecture, Agriculture and Veterinary Science. Of these five universities, The University of Queensland and Central Queensland University have dental schools.

Aboriginal students are encouraged to apply for the following programs:

**The Rowan Nicks Russell Drysdale Fellowship** is designed to support the development of workers and future leaders in Australian Indigenous Health and Welfare.

Services for Australian Rural and Remote Allied Health (SARRAH) manages five allied health scholarship streams under the **Nursing and Allied Health Scholarship and Support Scheme**. These include assistance for undergraduates, postgraduates, and clinical placement, particularly in rural, remote and regional areas, with Aboriginal and Torres Strait Islander health professionals strongly encouraged to apply.

**Bachelor of Oral Health/Science scholarships** offered by the Victorian Department of Health to support final year students in Oral Health Therapy at either La Trobe University or Melbourne University.
Below is a summary of the support services and any scholarships available to Indigenous students at each of the Australian universities with a dental school:

<table>
<thead>
<tr>
<th>UNIVERSITY</th>
<th>ATSI STUDENT SUPPORT</th>
<th>SCHOLARSHIPS AND OTHER SERVICES</th>
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<tbody>
<tr>
<td>Central Queensland University</td>
<td>Nuloo Yumbah</td>
<td>See note above regarding the R.N. Hammon Scholarship</td>
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<td></td>
<td></td>
<td>The Darrambal skills assessment program gives Aboriginal and Torres Strait Islander students the opportunity to attend University-style classes, to learn skills needed for success at University, and to meet lecturers and other staff in a supportive environment.</td>
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<tr>
<td>Griffith University</td>
<td>GUMURRII</td>
<td>Griffith University has a GUMURRII Student Support Unit on all 5 campuses.</td>
</tr>
<tr>
<td>James Cook University</td>
<td>JCU employs Indigenous Student Support Officers in each faculty. The Indigenous Health Unit works on Indigenous student recruitment and retention, development of relevant and appropriate Indigenous health curriculum, promotion of health careers to the Indigenous community, engagement with Indigenous community in health, and building the faculty’s capacity to engage in Indigenous health research. This includes support (such as workshop sessions targeting better study skills and organisational practices, as well as exam preparation) for all Aboriginal and Torres Strait Islander students enrolled in courses offered by the Faculty of Medicine, Health &amp; Molecular Sciences.</td>
<td>The Wood Scholarship, applications open to Aboriginal and Torres Strait Islander students enrolling full-time (undergraduate or postgraduate) in the Faculty of Medicine, Health and Molecular Sciences. <a href="http://www-public.jcu.edu.au/scholarships/studenttype/indigenous/JCUPRD1_055330">http://www-public.jcu.edu.au/scholarships/studenttype/indigenous/JCUPRD1_055330</a></td>
</tr>
<tr>
<td>La Trobe University</td>
<td>Indigenous Student Service Units</td>
<td>The La Trobe University Indigenous Students Scholarship is available for up to ten Indigenous students commencing full-time or part-time studies at any campus of La Trobe University (this does not have a specific health focus). <a href="http://www.latrobe.edu.au/scholarships/uni-wide/la-trobe-university-indigenous-students-scholarship-liss">http://www.latrobe.edu.au/scholarships/uni-wide/la-trobe-university-indigenous-students-scholarship-liss</a></td>
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<td></td>
<td>See note above regarding the Bachelor of Oral Health/Science Scholarships</td>
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<tr>
<td>University</td>
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<td>Additional Info</td>
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<tr>
<td><strong>The University of Adelaide</strong></td>
<td>Wilto Yerlo is responsible for recruiting Aboriginal and Torres Strait Islander students, administering the Special Entry Access Scheme and providing support services to Aboriginal and Torres Strait Islander students and staff in the University. Yaitya Purruna specifically supports Aboriginal and Torres Strait Islander students within the Faculty of Health Sciences.</td>
<td>The Resek Scholarship is offered to an Indigenous student who is undertaking a Bachelors degree in Agriculture or Health Sciences (Medicine, Nursing, Dental Surgery or Oral Health) at the University of Adelaide. <a href="http://www.adelaide.edu.au/scholarships/undergrad/resek.html">http://www.adelaide.edu.au/scholarships/undergrad/resek.html</a></td>
</tr>
<tr>
<td><strong>The University of Melbourne</strong></td>
<td>Murrup Barak, Melbourne Institute for Indigenous Development provides support to all Indigenous Australian students enrolled at as well as those wishing to apply for a place at the University of Melbourne. The Institute offers information, advice and support on a wide range of academic, cultural and personal matters to help make the transition to University studies easier.</td>
<td>See note above regarding the Bachelor of Oral Health/Science Scholarships</td>
</tr>
<tr>
<td><strong>The University of Newcastle</strong></td>
<td>Wollotuka provides officers to look after students in each faculty, provide advice and re-direct them to the appropriate services that the university offers within Wollotuka or within the wider university. These services include ITAS, scholarships, financial assistance, counselling, student groups, mentor programs, cadetships, the university’s Peer Assisted Study Program.</td>
<td>The Koiki Eddie Mabo Scholarship is provided to assist Aboriginal and Torres Strait Islander students studying in the Faculty of Health at the University of Newcastle. The Aboriginal and Torres Strait Islander Cultural Competency Workshop aims to increase participants’ knowledge and understanding about Aboriginal and Torres Strait Islander peoples and cultures and help them develop skills, values, and critical reflection to enable positive changes in professional practice. The program also aims to build capacity for staff and students in working effectively within inter-cultural contexts.</td>
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<td><strong>The University of Queensland</strong></td>
<td>The Aboriginal and Torres Strait Islander Studies Unit (ATSIS). The ATSIS Unit facilitates a case management approach to student retention, progression and graduation. Staff in the ATSIS Unit work with the UQ community to provide a range of professional services and academic support for Aboriginal and Torres Strait Islander Students from pre-enrolment through to graduation, including: • assistance with admission to the University, including information on the range of tertiary programs available, tertiary</td>
<td>See note above regarding the R.N. Hammon Scholarship</td>
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</tbody>
</table>
- Preparation programs and alternative entry pathways.
  - Orientation programs for new students to assist with the transition to University life and study.
  - Advice and support for students experiencing personal and academic difficulties.
  - Advice on scholarships, prizes, cadetships and student support payments.
  - Learning support and advice, including workshops, group sessions, tutorial programs, workshops and individual consultations.

In addition, the ATSIS Unit hosts a number of events and activities throughout the academic year to introduce potential students to the University experience and assist current students with University life and study.

The ATSIS Unit has offices on the St Lucia, Ipswich and Gatton campuses and remote assistance is provided to students at other UQ campuses or locations.

<table>
<thead>
<tr>
<th>University of Sydney</th>
<th>Koori Centre/Yooranganang</th>
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<td>The Chancellor’s Committee Indigenous Australian Bursaries are awarded on a needs and merit basis (but not specifically for health sciences students)</td>
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<td></td>
<td>The Cadigal Program - an admission and support scheme for Aboriginal and Torres Strait Islander Australians who wish to study at the University of Sydney.</td>
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<tr>
<th>University of Western Australia</th>
<th>The School of Indigenous Studies</th>
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<td></td>
<td>The Centre for Aboriginal Medical and Dental Health provides a range of services related to recruitment, retention and student support as well as a substantial role in teaching and learning in Aboriginal health across the health professional courses offered at UWA. CAMDH has received several state and international awards for its work in this area.</td>
</tr>
<tr>
<td></td>
<td>Aboriginal Orientation Course</td>
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Appendix 4: Links

The Lowitja Institute: http://www.lowitja.org.au/
Office for Aboriginal and Torres Strait Islander Health (OATSIH): http://www.health.gov.au/oatsih
Australian Institute of Aboriginal and Torres Strait Islander Studies: http://www.aiatsis.gov.au/