QAIHC

Queensland Aboriginal and Islander Health Council

Aboriginal and Torres Strait Islander Oral Health Care in Queensland

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Prepared and presented by

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QAIHC
Queensland Aboriginal and Islander Health Council

Aboriginal and Torres Strait Islander Oral Health Care in Queensland

QAIHC's position

Aboriginal and Torres Strait Islander Community Controlled Health Organisations oral health case studies

Literature scan

Queensland Aboriginal and Islander Health Council

The Queensland Aboriginal and Islander Health Council (QAIHC) was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the community controlled health sector. From our first meeting 30 years ago, we have grown to be a national leader in Aboriginal and Torres Strait Islander health as a voice for our 26 members, the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland, two regional bodies and 14 Affiliate Members.

Like our ATSICCHOs, we embody self-determination; we are governed by an Aboriginal and Torres Strait Islander board that is elected by our Members.

QAIHC Members work tirelessly to provide culturally appropriate, comprehensive, primary health care services to local Aboriginal and Torres Strait Islander communities in Queensland. Collectively they have established more than 60 clinics across the State to service the population. Our two regional bodies – The Institute for Urban Indigenous Health (IUIH) and Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA) also provide support to our Members.

Our Members provide more than just holistic Primary Health Care models, they help the whole community and regional economies by encouraging whole of community wellbeing, creating local jobs and ensuring local design of services.

Nationally, we represent ATSICCHOs through our affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) and are regarded as an expert in our field.

With our Members we have reduced barriers of access and institutional racism, which has led to improved health outcomes for Aboriginal and Torres Strait Islander peoples. We are dedicated to continue our mission to eliminate the disparities in health as faced by Aboriginal and Torres Strait Islander peoples within Queensland.

Acknowledgements

QAIHC has prepared this report on oral health and would specifically like to thank and acknowledge those Members who gave their time and effort to share their stories:

- Aboriginal and Torres Strait Islander Community Controlled Health Service Brisbane Ltd (ATSICHS Brisbane)
- Goolburri Aboriginal Health Advancement Co Ltd (Goolburri)
- Goondir Health Services (Goondir)
- Institute for Urban Indigenous Health (IUIH)
- North Coast Aboriginal Corporation for Community Health (NCACCH)
- Townsville Aboriginal and Islander Health Service (TAIHS)
- Wuchopperen Health Service.

CONTENTS

The Queensland Aboriginal and Islander Health Council (QAIHC) calls for optimal oral health for Aboriginal and Torres Strait Islander peoples in Queensland.

- All Aboriginal and Torres Strait Islander peoples should have access to holistic, culturally safe, timely, affordable oral health services that are close to home and include regular preventative and restorative treatment services.
- All Aboriginal and Torres Strait Islander peoples should have proficient oral health literacy to enable informed and confident decision making for themselves and their family.

The problem

Australia's National Oral Health Plan 2015–2024 states:

"Aboriginal and Torres Strait Islander people experience poor oral health earlier in their lifespan and in greater severity and prevalence than the rest of the population. Aboriginal and Torres Strait Islander people are also less likely to receive treatment to prevent or address poor oral health, resulting in emergency treatment."[1]

Poor oral health is proven to have a significant impact on individual health. Implications include chronic pain, infection, difficulty eating and poor nutrition, mental health and wellbeing issues, sleep disruptions, decreased work productivity, and associations with chronic diseases such as heart health and diabetes.[2]

In 2019, QAIHC spoke with Members, the Queensland Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs), about oral health services provided. This information, along with a review of available literature, found that barriers to accessing oral health services in Queensland include:

Poverty: *"More than two in five Aboriginal and Torres Strait Islander peoples over the age of 15 defer or avoid dental care due to cost."*[3] ATSICCHOs describe a high demand for free dental services, notably by the 'working poor' who are not eligible for public services.

Geographic location: People living in regional or remote Queensland have limited local services and transport options.[4] Rural and remote areas face workforce shortages with high turnover of staff, which affects the continuity and comfort of clients as well as reducing access to equipment and other necessary resources. Food insecurity and issues of not having access to affordable, quality, healthy foods also affect peoples' oral health. These barriers are often also faced by Aboriginal and Torres Strait Islander peoples living in urban areas.

Cultural safety of services: Cultural safety is an essential element of interventions for Aboriginal and Torres Strait Islander peoples.[5] There is limited representation of Aboriginal and Torres Strait Islander peoples in the oral health workforce. Many mainstream clinical services are not culturally safe and do not effectively promote and deliver health promotion programs that improve health literacy.[6]

ATSICCHOs' financial capacity: Although a best practice model of care, oral health services are not integrated consistently into ATSICCHOs across the state. Inconsistent partnerships and inadequate government funding leaves the ATSICCHOs' best practice oral health models and services financially vulnerable with limited or no capacity to meet community demand.

Availability of public health services: Hospital and Health Services (HHS) implement the National Partnership Agreement on public dental service for adults (NPA) and provide public oral health services to eligible people.* Long waiting lists are associated with HHS oral health services where demand exceeds supply. There is no state-wide policy for prioritisation of Aboriginal and Torres Strait Islander peoples although they are evidenced to be of the highest need.

Health literacy: ATSICCHOs support health literacy however there is a need for dedicated, effective, focused oral health literacy activities.[7]

*[1]National Oral Health Plan 2015–2024, page 55. [2]This report, pages 27–40. [3]National Oral Health Plan 2015–2024. [4]National Oral Health Plan 2015–2024. [5]This report, pages 27–40. [6]National Oral Health Plan 2015–2024. [7]This report, pages 4–25. [8]QAIHC Model of Care (2019). [9]ATSICCHOs who have operated dental clinics over a sustained period of time have reported that the nature of treatment is changing from emergency dental treatment to maintenance work. *The Child Dental Benefit Scheme (CDBS) provides funding through Medicare for all eligible children, however there are limitations to its effectiveness relating to sufficiency of funding.*

The solution

To fix this problem the Department of Health, Queensland Health and QAIHC need to ensure that Aboriginal and Torres Strait Islander peoples have the choice to access free, tailored oral health services that reach them where they are. HHS and ATSICCHOs should be supported to co-commission, co-design and co-locate services for Aboriginal and Torres Strait Islander peoples within ATSICCHOs.

The ATSICCHO sector has grown from a need for local, free, holistic, comprehensive and culturally safe healthcare. ATSICCHOs are governed by an Aboriginal and Torres Strait Islander board that is elected by members of the local community and they deliver services that build, strengthen and enable self-determination for Aboriginal and Torres Strait Islander communities and peoples.

In responding to community need, many ATSICCHOs have self-funded oral health services and/or established partnerships with universities, HHS or private providers. Pages 4–25 showcase some of Queensland's ATSICCHOs' current oral health services which are embedded within their Models of Care.

Where oral health services have been embedded within ATSICCHOs, it has proven to have greater community uptake, they have overcome access barriers, increased utilisation and had a direct impact on the level of periodontal disease and dental carries which risk chronic disease.

Embedding oral health services supports the early detection of preventable chronic disease, therefore improving access to early treatment. Good oral health will mean that individuals keep their natural teeth for longer. Healthy mouths mean individuals can maintain healthy eating practices without pain and do not experience shame associated with lost teeth or poor oral hygiene.

The following recommendations will increase preventative and restorative oral health services, increase oral health community outcomes and increase health literacy. Furthermore, the recommendations will provide a return on investment through the early detection of chronic disease, reducing rates of potentially preventable hospitalisations and 'failure to attend' rates, reducing over prescription of medications and reducing the impacts of institutional racism.

Recommendations

1. All HHS have service delivery agreements with the ATSICCHOs in their region to:
   - prioritise Aboriginal and Torres Strait Islander public health dental patients (see North Coast Aboriginal Corporation for Community Health (NCACCH) case study on pages 16–18 demonstrating an effective partnership between the ATSICCHO and Sunshine Coast HHS); and/or
   - sub-contract National Partnership Agreement (NPA) funding to the ATSICCHO. Existing frameworks include the agreements between:

     a) the Institute for Urban Indigenous Health and its members* and Metro North, Metro South and West Moreton HHS (see pages 4–6 and 13–15), and

     b) Goolburri Aboriginal Health Advancement Company Limited and Darling Downs HHS (see pages 7–9).
2. The Department of Health, Queensland Health and QAIHC establish a working group to identify realistic, practical policy and funding solutions, and actionable next steps that will address the evidenced need for oral health improvements for Aboriginal and Torres Strait Islander peoples in Queensland in 2020.

(Aboriginal and Islander Community Health Service (ATSICHS) Brisbane, Yulu-Burri-Ba Aboriginal Corporation for Community Health, Kalwun Health Service and Kambu Aboriginal and Torres Strait Islander Corporation for Health).

Services

Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane delivers a wide range of dental services from three dental sites: Woolloongabba, Logan and the Murri School. ATSICHS Brisbane's focus is on community access to services to improve their oral health.

Available five days a week, 52 weeks a year, the service includes:

- emergency treatment for toothache, trauma and wisdom teeth
- routine dental checkups and screening
- fillings
- extractions
- root canal on anterior teeth
- wisdom teeth extractions
- dentures and crowns
- mouth guards and splints
- specialist referrals.

ATSICHS Brisbane's services are provided by a team of professionals including dentists, oral health therapists, dental assistants, dental technicians and dental prosthetists. ATSICHS Brisbane has an oral maxillary facial surgeon who works pro bono and provides mentoring to dentists.

ATSICHS Brisbane also supports a pathway for young Aboriginal and Torres Strait Islander school leavers with dental assistant traineeships.

ATSICHS Brisbane encourages children to get their health check prior to dental appointments. The dental van at the Murri School specialises in children's dental care. Children can also be seen at ATSICHS Brisbane's two other clinics.

"Healthy smiles, healthy us"

History

The ATSICHS Brisbane dental service was established more than 20 years ago with volunteer dental staff working with one chair. In 2019 it has grown to its current capacity of eight chairs and a full-time working laboratory with almost 30 staff.

Oral health is a core part of the holistic health care that is provided by ATSICHS Brisbane.

Our work in action...

Over the school holidays, while swimming in the pool, accidents are bound to happen! Vernon cracked his tooth. He thought he couldn't smile again! Big shout out to the Woolloongabba Dental Clinic. Now he can't stop smiling.

ATSICHS Brisbane

Eligibility:

- Live in South East Queensland and identify as an Aboriginal or Torres Strait Islander person.
- Be an ongoing patient with an ATSICHS Brisbane medical clinic. If a new patient, ATSICHS Brisbane GPs need to review the patient's medical records.
- A non-Aboriginal and Torres Strait Islander patient with an Aboriginal and Torres Strait Islander spouse may be eligible for care.

Funding model

An agreement with Queensland Health (QH) and the Hospital and Health Services (HHS).

- ATSICHS Brisbane receives funding from the Institute for Urban Indigenous Health (IUIH) as part of the QH initiative for providing services to HHS eligible patients.
- There are no fees for general dental care if the eligibility criteria is met.
- Fees do apply for laboratory work e.g. mouth guards, denture and crown work.
- Treatment is provided to the majority of children via the Child Dental Benefits Scheme (CDBS).
- Aged pensioners are eligible for free acrylic dentures.

Benefits for community

There are many benefits that come from dental health services run by a community controlled organisation:

Improved access: Free, culturally safe services.

A preventative approach: Regular check-ups and preventative dentistry, rather than emergency treatments.

Reduced waiting lists: There is no waiting list for routine care however there can be wait lists for denture work depending on the referrals and demand, which are far shorter than the public health system.

Ongoing care: Recalls are in place for all patients so ongoing care is provided and treatment can be monitored as required.

A holistic approach: All ATSICHS Brisbane and programs can refer into the dental service provided eligibility criteria is met.

Promoting good health: The dental team supports a range of community events to promote oral health with health promotion activities embedded in services. These include visits to kindergartens, new mums groups, schools, youth services, aged care residences and classroom lessons.

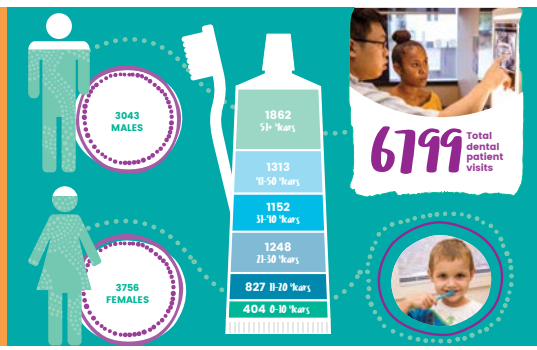
Impact

In the past year there were:

- more than 4,500 patient appointments at Woolloongabba Dental Clinic
- more than 3,100 patient appointments at Logan dental clinic
- more than 690 children appointments at the Murri School
- 2017–18 data shows there has been a 17 per cent decline in access for emergency care (from 1,625 cases in 2016–17 to 1,346 in 2017–18).

Patients are placed on recall and the clinic offers comprehensive check-ups and preventative treatment in terms of fissure sealants as well as restorations. Data supports an increase in check-up and treatment options. In 2016–17, 1,036 patients received check-ups, 319 fissure sealants were placed and 2,386 restorations completed. In 2017–18, 2,103 patients received check-ups, 852 fissure sealants were placed and 2,968 restorations completed.

Over the past three years there has been a steady increase in the number of people in the community accessing dental services. This is due to the introduction of oral health therapists who work with the children and promote preventative appointments, an oral surgeon who assists with complicated surgical extractions and an increase in referrals from IUIH for denture services.



ATSICHS Brisbane offers incentives for children under 18 to access dental services at Woolloongabba and Logan. ATSICHS Brisbane's social media pages inform the community of these incentives and activities and support appointments for children to attend clinics. Staff also offer Lift the Lip sessions to preschool and kindergartens and CDBS funds available through Medicare are claimed.

Oral health support and training is offered to the staff at Jimbelunga Nursing Centre and ATSICHS Brisbane dental continue to integrate services with all departments within the organisation to offer wraparound services to the community.

With the introduction of the QH initiative, ATSICHS Brisbane is now able to provide greater services to all Centrelink health care card holders which reduces the costs especially with expensive laboratory work.

Waiting lists only apply for the dental laboratory referrals for dentures and this can be up to six months at different times of the year.

All chairs are currently utilised five days a week with the only exception being if staff leave. All chairs are serviced by a dentist, prosthetist or Oral Health Therapist and all are registered with Australian Health Practitioner Regulation Agency (AHRPA) to provide quality services to community. Presently there is no room for expansion. ATSICHS Brisbane offers dental assistant traineeship positions to ensure that identified positions are filled with training and support.

Other IUIH member organisation dental teams refer to ATSICHS Brisbane for denture and oral surgery services.

Community feedback

ATSICHS Brisbane values community, whether it's participating in a local event, holding a workshop, having a yarn or giving feedback.

Community engagement is all about building relationships and making sure the voices of community are understood and actively contribute to shaping services, programs and strategies.

ATSICHS Brisbane dental team integrates with other ATSICHS Brisbane services and has participated in NAIDOC celebrations, ongoing visits into Burragah and Gundoo Mirra and Waterford West kindergartens for Lift the Lip initiatives, tooth brushing programs in the Murri School classrooms, after breakfast programs and health promotion activities at the Murri Carnival. ATSICHS Brisbane also holds screening days at Jimbelunga Nursing Centre and continues to facilitate appointments for aged residents to attend clinics for appointments.

In the past year:

- 98 per cent of clients are satisfied overall with dental services
- 98 per cent are satisfied with the variety of services provided
- 95 per cent are satisfied with the wait time for services
- 99 per cent say staff are friendly and warm
- 99 per cent say they feel safe and supported
- 98 per cent of clients would recommend ATSICHS Brisbane's dental services to family and friends.

"Deadly job from a deadly mob." (Logan)

"Overall professional and outstanding services." (Logan)

"The staff were kind and caring and they knew what they were doing." (Logan)

"The dental staff were very professional. I am extremely grateful for the services. I will continue to recommend the clinic to my family, friends and work. Thank you very much. Too deadly." (Gabba)

"I wish everyone experienced the awesome treatment I had today—well done Gabba team."

"Very comprehensive explanations and wide advice given. A pleasurable experience." (Gabba)

Goolburri

Aboriginal Health Advancement Co. Ltd.

"Our Dentists are committed to providing a quality and affordable service to improve your oral hygiene with a focus on prevention and restoration to give you *the Goolburri smile*"

History

Goolburri Aboriginal Health Advancement Company Limited's (Goolburri) dental service was first established in 1994 using Indigenous Australians' Health Programme (IAHP) core funding.

In recent years, Goolburri has expanded its services to provide primary health care and now uses Medicare income to contribute to dental service costs.

Goolburri employ two full time dentists and have a large mobile outreach van. The mobile van spends 20 weeks per year on the road servicing the communities of Charleville, Cunnamulla, Roma and Mitchell. When the dental team are not travelling, they operate from a second dental van in the Goolburri carpark, doubling the number of appointments available in Toowoomba for 20 weeks of the year.

Services

Available five days a week, 50 weeks a year in a single chair surgery in Toowoomba and via a mobile Dental Van which services the South West of Queensland.

Services include:

- oral examinations
- scaling and cleaning teeth
- removal of teeth
- fillings
- basic root canal therapy
- fissure sealant
- dental health advice
- specialist referrals
- preventative and emergency work
- regular recalls and follow up
- transport (for Goolburri clients)
- specialist referrals (e.g. for cosmetic working orthodontics).

Eligibility

Dental services are available to any Aboriginal or Torres Strait Islander person living in South West Queensland who is a regular ongoing patient with one of the region's ATSICCHOs.

The dentistry team also undertake health promotion activities at community events (e.g. National Close the Gap Day and NAIDOC).

Funding model

Agreement with Darling Downs Hospital and Health Service (DDHHS) and IAHP funding.

Goolburri and DDHHS have an agreement where DDHHS provide a fixed payment of $260 per Queensland Health Eligible Patient (QHEPs) seen by Goolburri dental.

Goolburri submit monthly invoices for reimbursement of funds for services provided and report patient data to QH.

The majority of patients seen in the Toowoomba clinic are QHEP patients.

Goolburri are funded $1.17m annually through the IAHP. This funding was originally used to create the dental service for the South West region.

More recently Goolburri have had to use S19(2) Medicare income to fund the service, along with the CDBS Medicare income.

Services are provided at a fee of $10 per appointment for Aboriginal and Torres Strait Islander patients. Non-Aboriginal and Torres Strait Islander patients are charged at a rate of 75 per cent of the minimum Australian Dental Association rate. Cosmetic work, including orthodontics, is not provided.

Benefits

Culturally safe dental services: Provided at minimal individual cost.

Regional approach: Goolburri provides dental services to clients of Carbal Medical Services (Carbal) (Toowoomba and Warwick), Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited (CWAATSICH), and Cunnamulla Aboriginal Corporation for Health (CACH) with informal agreements in place with the ATSICCHOs. All Goolburri, Carbal, CWAATSICH and CACH ATSICCHO teams can refer into the dental service provided eligibility criteria is met. The Goolburri dental van is based at the local ATSICCHO's carpark and each ATSICCHO book their own clients' appointments.

Greater reach: Mobile dental van providing culturally safe outreach services.

Ongoing care: Recalls are in place for all patients so that ongoing care is provided and treatment can be monitored as required.

Health promotion activities embedded in service: Culturally safe promotional resources given to all patients and at events celebrated, including World Oral Health day on 20 March.

Challenges

Multiple funders: Reliant on multiple funding sources (IAHP, CDBS, Medicare S19(2), DDHHS agreement, patient contribution).

High costs: Facility maintenance and upgrade costs are high. Mobile van undertakes valuable work however is costly to operate.

Service costs exceed public funding amounts: DDHHS and CDBS funding frequently inadequate for services required.

Limited space: Only one chair in Toowoomba clinic (and one chair in the van in the carpark).

High demand: Demand exceeds supply and the service has a waiting list.

Gap in service delivery to working poor: The majority of patients accessing the service are QHEPs and CDBS eligible clients due to funding restrictions, leaving a gap in service delivery and access for the working poor.

Communication with DDHHS: Communication regarding school dental van requirements is lacking.

Restricted services: Ability to conduct specialist treatment is limited, referrals are made to QH or private suppliers.

Impact

In 2018 the Goolburri Dental team completed the following patient appointments:

- Toowoomba – 1,320
- Cunnamulla – 101
- Charleville – 87
- Roma – 35
- Mitchell – 34

Procedures in the dental van have transitioned from approximately 80 per cent extractions and 20 per cent treatment in 2008 to 80 per cent treatment and 20 per cent extractions in 2018 due to the cumulative and ongoing presence of the service in community, facilitated by the local ATSICCHO.

Across the service, 65 per cent of patients seen in 2018 were seen in 2017.

The number of regular check-up appointments continue to grow and clients increasingly understand their importance.

Patients' understanding of good oral health practice is increasing. This is demonstrated through:

- The number of eligible families having more check-ups due to no out of pocket costs once CDBS thresholds are met.
- 2017–2018 data indicated that there has been a 55 per cent decline in access for emergency care from 493 cases in 2016/17 to 272 in 2017–18.
- There has been overall growth in dental check-ups rather than extractions and emergency treatments.
- Each year there is an increase in the number of community members accessing dental services—patients are more informed of the benefits of a healthy mouth and teeth due to better culturally safe promotional and educational resources.
- Oral health support and training is offered to the staff at Kulila Kindergarten, Newtown State School, Wilsonton State High School, Harristown State School and Flexi School.
- Goolburri dental continue to integrate services with all programs within the organisation to offer a wraparound service to the community.
- All chairs are utilised five days a week with the only exception being if staff have planned or unplanned leave. All chairs are serviced by a dentist and an oral health assistant who are registered with AHPRA to provide quality services to community.

Goolburri offer full time 12 month Trainee Dental Assistant roles (to complete Certificate III in Dental Assisting) along with school-based traineeships to year 12 students from local schools.

Community feedback

Examples of patient feedback received by Goolburri Dental Clinic:

"The dentists have done a great job with my surgical extractions and I will be letting all my family know about the service" (female patient).

"The mobile van service is a great service."

"Brilliant Service thank you."

goondir health services

"Better health, better living, longer life"

Services

Available four days a week, 40 weeks a year via five chairs in Dalby and four chairs in St George. Services are provided at no cost to the client.

Services include:

- diagnostic and preventive dentistry
- extractions
- dentures (full, partial, repairs and modifications)
- restorations
- root canal therapy
- crowns.

The dentistry team also undertake health promotion activities at community events (e.g. National Close the Gap Day and NAIDOC).

History

Goondir Health Services (Goondir) and University of Queensland School of Dentistry (UQSoD) started developing a partnership in 2010/2011. The Dalby clinic opened when the new building (with five dental rooms) was completed in 2013. Once the model was operational and teething problems had been overcome, an extension was built on the St George clinic and dental operations began in St George in 2017.

Funding model

A good-will and good-intent partnership between the UQSoD and Goondir.

UQSoD provide:

- Fifth year dental students
- dental supervisors
- dental equipment
- clinic support staff
- clinic management
- insurance.

UQSoD fund the program through:

- Australian Government Department of Health, Rural Health Multidisciplinary Training (RHMT) Fund and the Dental Training Expanding Rural Placements (DTERP) program
- UQSoD co-investment
- student's pay for accommodation.

UQ invested $2.5m for infrastructure and fit out.

Goondir provide:

- Facilities: five rooms in Dalby, four rooms in St George and associated facilities costs.
- Referral of clients from the MBS Item 715 Aboriginal and Torres Strait Islander Health Assessment (715 Health Check).
- Cultural safety.
- St George receptionist.
- Transport.
- Onsite pharmacist—medications education.
- Sharing of client health information including medications lists.

Goondir invested $750,000 in one-off set-up costs (IAHP funding for building extension) and for three of the nine dental chairs.

There are no ongoing costs to Goondir to deliver this service.

Benefits to community

Free, culturally safe, dental services: In a model that is affordable to Goondir.

Positive, mutually beneficial, partnership: Partnership between UQSoD and Goondir based on good-will and good-intent.

Integration with ATSICCHO Model of Care: Enabling effective management of chronic diseases (a receptionist is shared with the clinic in St George and the Dalby receptionist has been trained to promote the 715 Health Check).

Quality care: Sharing of health records and medications improves the quality and efficiency of the dental care provided to Goondir clients.

Transport: Is provided and a reminder system is in place.

Health promotion activities embedded in service: Staff focus on promoting regular check-ups and preventative dentistry, rather than emergency treatments.

Culturally safe care: Dental students receive Cultural Safety Training and regularly attend health promotion opportunities e.g. National Close the Gap Day and NAIDOC events. Dental students become part of the Goondir family.

Reduced waiting lists: Waiting times substantially shorter than the HHS list which increases access.

Growing regional workforce: From bush to practice—high quality rural training experience where the University of Queensland (UQ) qualified dental students increasingly opt for remote placements following Goondir experience.

Local workforce development: Aboriginal and Torres Strait Islander Dental Assistant Traineeship now exists in Dalby (funded by UQSoD).

Research opportunities: Current project 'Outcomes of clinical placement: an audit of the economic and social benefits of a dental student clinical outplacement program for an Indigenous population in a rural Queensland community.'

Challenges

Staff turnover: Placements are between nine and 11 weeks long.

Opening hours: Closed during university holiday period.

Appointment lengths: Dental students can take longer to provide dentist services; however, quality is high and patient satisfaction is high.

Fixed locations: No outreach van so clients are required to travel to access the service.

Complex cases: Some patients are not suitable for student learning, requiring referrals to specialists or other services.

Facility establishment costs: The program only exists as a result of planning and investment by Goondir to expand the physical premises and UQSoD to fund the cost of infrastructure and fit out.

Student housing: UQSoD currently subsidise student housing costs in Dalby as remote housing is expensive and elusive.

Impact

In 2018 UQSoD students completed:

- more than 1,500 patient appointments in St George
- more than 1,100 patient appointments in Dalby
- the dental health needs of the St George community are being met through this service
- there is a short waiting list for the Dalby community as demand exceeds service capacity
- throughout 2019, 24 students were placed at Dalby and 16 students were placed at St George.

TO NOTE:

Patients travel from Oakey, Jandowae, Toowoomba, Kingaroy, Roma, Clifton, Millmerran, Pittsworth, Cecil Plains, Chinchilla, Tara and their surrounding areas to Dalby. The St George clinic services patients from towns such as Cunnamulla, Surat, Dirranbandi, Thallon, Roma and further afield.

The Dalby clinic services a larger geographic area than St George and thus the appointments in Dalby tend to include more individual procedures to enable patients to complete their treatment in fewer appointments, reducing the need to travel long distances to attend multiple appointments.

Parents are encouraged to take their children to mainstream dental services to use the CDBS as it frees up Goondir's chairs for older clients, reducing the waiting time for appointments.

Community feedback

Examples of patient feedback received by clinics at Dalby and St George:

"I have been a patient of UQ Dalby Clinic over the past few months. I would like to say thank you to Dr Kelsey for his expert guidance of the students at UQ. A very special thank you to Hannah who has been my dentist. Hannah has always been very professional with an attention to detail. She has an exceptional manner with patients. I am sure she will be a wonderful dentist."

"From the age of 7, I have had some bad experiences at the school dentist, however I can safely say that without a doubt, my fears are long gone. I look forward to my next appointment. This has truly been a life changing experience for me."

"I am so grateful I can get such professional treatment at no cost to me and still be treated with respect by all staff."

"What a fantastic clinic you have here at Dalby. The service you provide for your clients is equal to the best. I have had the best treatment from the students and the Team Leader is just the best. I came to the clinic and was embarrassed to talk as my top dentures would come out. Today as I leave the clinic, I feel like a new person. Thank you."

IUIH

Institute for Urban Indigenous Health (IUIH) Oral Health promotes an integrated model of care which facilitates the delivery of culturally safe oral health services, in conjunction with primary health care services to Aboriginal and Torres Strait Islander families.

History

Prior to IUIH opening a new dental service at Deception Bay in 2014, only three South East Queensland ATSICCHOs offered dental services to their patients—ATSICHS Brisbane at their Woolloongabba and Logan clinics, Kalwun Health Service in Miami, and at Kambu's Ipswich clinic (through a part-time arrangement with QH for QHEPs). As these ATSICCHOs continued to provide high quality dental services, growth in patient numbers resulted in a need for further planning of dental services across the region.

Services

IUIH is the Regional Peak Body for South East Queensland's (SEQ's) ATSICCHOs: ATSICHS Brisbane, Kalwun Health Service (Kalwun), Yulu-Burri-Ba Aboriginal Corporation for Community Health (Yulu-Burri-Ba), Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu), and Moreton ATSICHS.

Kambu, Yulu-Burri-Ba and Moreton ATSICHS dental services are provided through a service delivery partnership with IUIH. ATSICHS Brisbane and Kalwun continue to manage and operate their respective dental services with support from IUIH.

Services include:

- routine dental checkups and screening with an established recall service
- oral hygiene including scale and cleans
- emergency dental treatment
- fillings and extractions
- dentures, mouth guards and splints
- specialist referrals
- oral health promotional activities including at community events.

Speciality services including oral and maxillofacial surgery, paediatric specialist services and treatments requiring a general anesthetic, are referred on to Queensland Health. IUIH continues to build referral pathways with Queensland Health and the private sector.

The opportunity

As part of the implementation of the NPA in 2014, a 'Dental Voucher' scheme was introduced by QH across Queensland HHSs in SEQ (Metro North, Metro South and West Moreton HHSs). This scheme allowed for registered non-government dental clinics, including ATSICCHOS, to be recompensed for dental services provided to QHEPs. Implementing this dental voucher scheme presented an opportunity to increase dental services across the ATSICCHO network. This scheme presented an opportunity for SEQ ATSICCHOs but it also identified some challenges.

The dental voucher system commenced by focusing on QHEPs (Aboriginal and Torres Strait Islander and non-Indigenous) on an extended Queensland Health dental waitlist (>12 months). This initial process did not recognise the high number of Aboriginal and Torres Strait Islander QHEPs who were not on a QH waitlist but who wanted to access the IUIH member dental services under this scheme. In response to this and other challenges, IUIH presented a proposal to Queensland Health, an up-front 'cashing out' of dental vouchers across the SEQ region.

The IUIH funding proposal considered:

- The high number of Aboriginal and Torres Strait Islander patients who meet QH eligibility criteria and who were regular patients of ATSICCHOs across the region.
- The identified community dental need (dental burden of disease).
- The need for improving current and future dental clinic infrastructure.
- The impact that the high demand has on staffing numbers and subsequent service delivery capacity.

The Queensland Health funding agreement, combined with ATSICCHO contributions, has seen over 50 full-time, part-time and/or casual dental professionals employed across ten dental clinic sites including:

- three Senior Dentists/Clinical Supervisors
- 19 Dentists (casual/partime/fulltime)
- five Oral Health Therapists (OHTs) including OHTs with extended scope of practice
- a Dental Prosthetist and Dental Technician (employed at ATSICHS Brisbane, with a clinical referral pathway across the IUIH network providing timely access for patients requiring denture services)
- 29 Dental Nurses/Assistants and Dental Receptionists, including two staff who have commenced a full-time dental assistant traineeship at the ATSICHS Brisbane clinics.

In 2019, IUIH partnered with Yulu-Burri-Ba to open their North Stradbroke Island Clinic. This new service commenced as a two day per week service, quickly moving to three days per week following increased demand.

Funding model

The IUIH-QH dental funding agreement is based on a fee for service arrangement whereby targets are set for dental activity for QHEPs in ATSICCHOS.

Dental activity data is collected by Member ATSICCHOs and submitted to QH for progressive payments. Failure to reach identified targets may result in reduced funding received from QH.

Benefits for community

For patients:

Accessible and culturally safe dental services: for Aboriginal and Torres Strait Islander families that contribute toward improvements in their overall health and wellbeing as well as contributing towards Closing the Gap in health disadvantage.

Changing patients' attitudes towards dental procedures: through positive dental experiences, encouraging regular dental check-ups and good oral health hygiene.

For ATSICCHOs:

Coordinated care: Oral health services delivered seamlessly in conjunction with primary health care services within ATSICCHOs, ensuring Aboriginal and Torres Strait Islander families receive the best available and coordinated care.

Continual Quality Improvement (CQI): Commitment to CQI through the establishment of a Dental Clinical Governance Framework focusing on best practice in Aboriginal and Torres Strait Islander dental care across the region.

Employment opportunities: A range of dental professionals employed across the ATSICCHOs including opportunities for young Aboriginal and Torres Strait Islander people through dental specific traineeships (e.g. dental assistants).

A regional focus: IUIH work with IUIH member services to identify and manage dental infrastructure, asset management and service needs.

Shared procurement opportunities: A regional focus on operational costs and creating opportunities for cost savings through bulk purchasing on behalf of the ATSICCHO network.

Service delivery partnership: between QH and IUIH.

Challenges

Current public dental funding focused on household income: In spite of the high need for dental services amongst all Aboriginal and Torres Strait Islander families, particularly those families who do not meet the eligibility criteria for either CDBS or Queensland Health Dental Services, and cannot afford dental services provided by the private sector, QH services are income-linked.

Facility establishment costs: Capital works costs for new dental services that are required to meet the growing population are not funded.

Uncertainty in the funding environment: Current funding arrangements expire in 2020.

Impact

As at June 2019, dental services are provided from 10 clinics within the IUIH network; an increase in site capacity of 150 per cent since 2014. This increase in dental service capacity has resulted in over 10,000 dental appointments completed in a 12 month period including:

- 3,989 QHEPs
- 4,978 adult non-QHEPs
- 2,238 CDBS eligible children.

ATSICCHO dental services increase access: The Moreton ATSICHS Dental Service was established in 2014 at Deception Bay. A significant number of the clients had never had an interaction with a dentist before coming to the service. The importance of community-run service provision in oral health is highlighted through this gap.

NCACCH

North Coast Aboriginal Corporation for Community Health

"High quality and accessible primary health care"

History

North Coast Aboriginal Corporation for Community Health (NCACCH) is an Aboriginal and Torres Strait Islander Community Controlled Health Service incorporated in 1997 under the CASTI Act 2006.

NCACCH continues to provide quality health services to the Aboriginal and Torres Strait Islander population residing on the Sunshine Coast and Gympie Regions through its unique and innovative "Brokerage Model".

Through this "Brokerage Model" clients are able to access at no cost General Practitioners, Dentists, Podiatrists, Physiotherapists, Diabetes Educators, Dietician/Nutritionists and Psychologists. NCACCH provides services to over 4000 community members.

This innovative approach focuses on cost-effectiveness, efficiency, professionalism, culturally appropriateness and partnerships.

Services

North Coast Aboriginal Corporation for Community Health (NCACCH) has developed and implemented a unique Brokerage Model for providing Aboriginal and Torres Strait Islander community members of the Sunshine Coast and Gympie regions with choice and access to a wide range of oral health care providers.

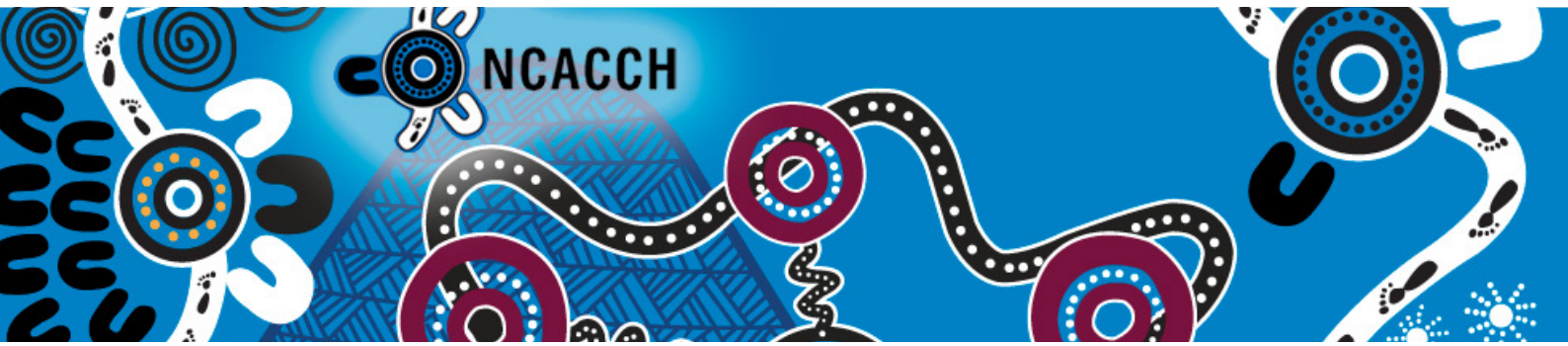
This model provides most of the benefits of private health insurance without the 'upfront' and 'gap' payments and delivers equitable and efficient access to existing health care services. The Brokerage Model was developed to ensure that each NCACCH client would be assured of having individual choice to determine their own definition of cultural appropriateness of the services they choose to attend.

NCACCH organise oral health worker talks for community staff and Aboriginal and Torres Strait Islander Health Workers. This increases knowledge about the benefits of preventative health checks.

Client eligibility

NCACCH clients are eligible for the dental referral scheme where the need is in excess of the CDBS value or where they are not QHEPs Concession Card Holders. NCACCH have a tri-partite partnership with the Sunshine Coast Hospital and Health Service (SCHHS) and provide a Dental Referral Scheme (DRS) for individuals who would otherwise fall through public health gaps.

NCACCH have 22 listed eligible dental clinic providers across the region.



Funding model

Self-funding a brokerage dental service and formal relationship with Sunshine Coast Hospital and Health Service (SCHHS).

- In 2000 NCACCH formalised a partnership with SCHHS.
- SCHHS prioritise eligible public health clients and have an 'Aboriginal and Torres Strait Islander Oral Health Service' of Closing the Gap Dental Clinic sessions.

A majority of the Aboriginal and Torres Strait Islander Health workforce (including other identified SCHHS employees) refer clients to NCACCH to refer either to the SCHHS or through the Dental Referral Scheme.

DENTAL REFERRAL SCHEME:

Additionally, based on need, each financial year, NCACCH identify an allocation amount for oral health services (in 2018–19 NCACCH allocated $120,000 and spent $180,000 — $400 per client).

This enables NCACCH to allocate dental funds to:

- Pre-prep and grade 10 upward (others are expected to use the CDBS).
- Eligible adults (a NCACCH client is an Aboriginal and Torres Strait Islander person who has lived in the area for at least three months). Non-Aboriginal and Torres Strait Islander people who are the biological parent of a child under 18 are also eligible (supporting family unit).

How to access the NCACCH Dental Referral Scheme

An eligible client needs to seek referral from a volunteer community referrer (e.g. Centrelink/Hospital and Health Service/Aboriginal and Torres Strait Islander Health Worker or Liaison Officer). NCACCH receives a referral form and checks the database to see if dental allocation has been used. If approved, the client receives a text message from NCACCH requesting they contact their preferred dental practice, from the list of eligible providers, and make an appointment. NCACCH send the allocated budget to that provider for the client to use in the financial year.

Benefits to community

Positive partnership: Excellent public dental system partnerships.

Waiting times: QHEPs are prioritised for appointments.

Culturally safe dental services: For NCACCH Dental Referral Scheme participants, access to limited but free, culturally safe, dental services (depending on extent of work required).

Diversity of locations: Services close to home.

Health promotion activities embedded in services: Oral health worker talks to community staff and health workers increase knowledge about preventative checks. NCACCH organise workshops to educate referrers on how to disseminate good oral hygiene information to clients.

Challenges

Limited service: Only basic dental services are covered under the Dental Referral Scheme (up to a value of $400 per year).

Transport: No transport is offered.

Funding does not roll over: Some clients have to time-cost treatment (e.g. a crown) so the appointments are split across two financial years.

Geographical gaps in service delivery: For example, NCACCH has had difficulty recruiting practices in Nambour.

Impact

Dental Referral Scheme:

- In 2018, NCACCH supported 491 clients who were not eligible for public dental services to conduct 608 visits to the dentist. All 491 clients spent their $400 allocation in full (indicating greater need).
- No negative feedback received from clients about cultural safety of dental services or clinical service provided.
- Community education is undertaken on an ongoing basis to raise awareness of good oral hygiene practices.

Partnership with Sunshine Coast Hospital and Health Service:

In 2018 NCACCH and SCHHS continued to work constructively to ensure the health needs of Aboriginal and Torres Strait Islander patients were met. This included ongoing support for the prioritisation of Aboriginal and Torres Strait Islander clients for public dental services, along with referrals to NCACCH for non-eligible clients identified with need by the SCHHS.

Community feedback

Each year NCACCH run a community survey in which dental and oral health repeatedly has been raised by community as a high priority, which helps to inform NCACCH's Board when deciding whether to reinvest in the Dental Referral Scheme.

NCACCH has not received any negative feedback about the quality or availability of dental services provided.

TAIHS

TAIHS

Townsville Aboriginal & Islander Health Service

"More than a health service"

History

TAIHS dental facilities were built over 10 years ago and since then a variety of dental models have operated. In 2016 TAIHS sub-contracted the dental service to a private contractor, Project Outback Dental (POD). Prior to that TAIHS employed a dental team directly however the service suffered during periods of leave. Subcontracting services to POD have seen an improvement in service provision for reduced cost.

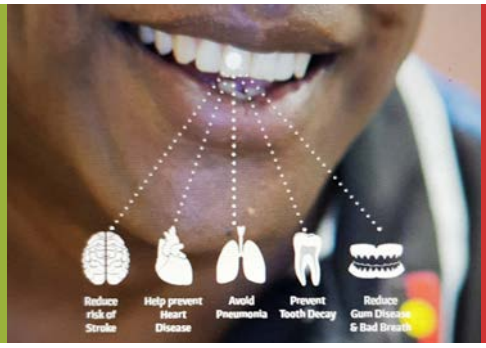
Services

Available five days a week, Townsville Aboriginal and Islander Health Service (TAIHS) Dental services are complementary to existing TAIHS Medical Service clients via appointment and referral through the TAIHS General Practitioner (GP).

Services include:

- dental screening and checks
- dental health education and oral hygiene instruction
- cleaning and scaling
- emergency treatment for toothache and dental trauma
- treatment and the prevention of infections
- fillings and extractions
- wisdom teeth removal
- preventive and restorative dentistry
- a transport service to and from the Medical Centre is available to all clients who need travel assistance within Townsville
- Specialist referrals.

The dentist team also undertake health promotion activities at community events (e.g. National Close the Gap Day and NAIDOC).



Funding model

Self-funding and subcontracting the dental service

TAIHS receives no external dental funding or support to provide the dental service. TAIHS sub-contract to POD at around $450,000 per year, to operate from the Gorden Street TAIHS clinic.

Dental costs are met through Medicare revenue raised and the Practice Incentive Program. Limited income is received via the CDBS.

POD responsibilities:

- employ dental staff (two Dentists and two Dental Assistants)
- business insurance
- professional indemnity insurance
- maintenance (excluding chairs)
- consumables
- software system (Dentrix).

TAIHS responsibilities:

- payment to POD for services
- dental receptionist
- Indigenous trainee position
- transport
- facilities and associated utilities costs.

Medicare revenue (CDBS) from the provision of dental services is allocated 30 per cent to TAIHS and 70 per cent to POD. This goes a very small way to offsetting the cost of funding the service.

Benefits to community

Free, culturally safe, dental services: Available to TAIHS active clients with a 715 Health Check.

Seamless integration with ATSICCHO Model of Care: This supports the management of chronic diseases. Aboriginal and Torres Strait Islander Health Workers conduct oral health screening at the annual health check and GPs refer clients to the dental team.

Quality care: POD contract provides five days a week, 48 weeks a year dental service (POD are responsible for covering periods of absence).

Pro-bono Cosmetic Dentistry: POD assist with cosmetic dentistry at one of their private practices in Townsville, or see TAIHS patients for free at those locations (estimated value of $50,000 to $70,000 in 2018).

Waiting times: Notably shorter waiting time than mainstream Hospital and Health Service (HHS) Dental Service.

Local workforce development: Aboriginal and Torres Strait Islander Trainee position created.

Value for money: Total annual service provision in 2018 estimated to be valued at $604,459 at 2013 government rate (or $725,350 at private practice rate).

Challenges

Cost: TAIHS self-fund the service through income generation.

Restricted services: Team not able to service all dentistry needs—sometimes referrals to specialists or other services required.

Facility establishment: Facility exists as a result of planning and investment by TAIHS—ongoing maintenance and upkeep is not funded.

Partnerships: No relationship with Townsville HHS Dental team.

No show rates: In 2018, on average, there was a 47 per cent no show rate at this service. This has now more than halved, with a new dental reception strategy implemented in August 2019.

Reliant upon POD's considerate pricing levels: TAIHS does not have the ability to afford market value fees.

Impact

In 2018, TAIHS's Dental team:

- booked 5,679 patient appointments
- treated 2,669 dental patients, of whom 1,726 (64 per cent) were new.

Wuchopperen
HEALTH SERVICE LTD

"Keeping our generations growing strong"

History

Wuchopperen's dental facilities were built in 1995. A variety of dental models have operated since, including utilising Close the Gap Dental Volunteers and the Medicare dental billing scheme. In 2013 Wuchopperen allocated Medicare funding to self-fund their dental service.

Dr Rajashekhar joined the Wuchopperen Dental team in 2013. He says that one of the most rewarding aspects of his work since he joined Wuchopperen is turning a practice that was mostly involved in tertiary treatments, such as extractions, into a service that can now focus on restorative (fillings, crowns, root canal treatments etc.) and preventative care. In 2018 Dr Manjunath Rajashekhar was recognised as a member by the Royal Australasian College of Dental Surgeons. Dr Rajashekhar highlights the direct link between diabetes and oral health stating "people with diabetes have a lot of gum infections. When their gums are infected, that raises their blood glucose levels. Good oral health is a vital part of effective diabetes treatment."

Services

Available 5 days a week in the Wuchopperen Allied Health Clinic in Manoora, Cairns. Services are provided at no cost to the majority of patients, however patients who are in employment are charged $20 per visit.

Wuchopperen is in the process of reviewing client contributions to ensure the dental service remains sustainable yet affordable to its clients.

Services include:

- general checkup and cleans
- digital X-rays
- gum treatments/periodonitcs
- crowns and bridges
- root canal treatment
- extractions/wisdom teeth
- tooth ache/emergency care
- management of sensitive teeth
- aesthetic restorations
- inlay/ceramic fillings
- mouthguards
- children's dentistry
- snore appliances and night guards
- full and partial dentures.

The dental team also undertake health promotion activities at community events (e.g. National Close the Gap Day and NAIDOC).

Funding model

Wuchopperen receives no external dental funding or support to provide the dental service. Dental costs are met through Medicare revenue and a minimal client fee.

The program costs approximately $800,000 per annum to run. This covers the cost of:

- two dentists
- two dental assistants
- transport
- facilities and associated utilities costs
- Laboratory costs for dentures and crowns (clients over 65 with a pension card get free dentures and concession card holders pay 50 per cent of the cost).

Not included is any ongoing maintenance costs for equipment (Wuchopperen has recently purchased two new dental chairs which are under warranty. They also maintain other equipment such as the eHD Dental X-Ray sensor machine).

Wuchopperen have a positive relationship with JCU Dental School and are able to refer clients to the school if required (Wuchopperen provide transport).

Benefits to community

Accessible and culturally safe dental services: Aboriginal and Torres Strait Islander families can access culturally safe dental services with long term staff employed directly by Wuchopperen.

Integration with ATSICCHO Model of Care: Seamless integration with ATSICCHO Model of Care and management of chronic diseases. Integrated dental service provides a positive impact on general health.

Quality care: With reduced waiting times, continuity of care is greater as clients can now come back more regularly—supporting a shift in focus to preventative dentistry.

Health promotion activities embedded in services: Dental team provide education to community staff, health workers and community to increase knowledge about preventative checks and good oral hygiene, including a focus on early childhood. The dental team also work closely with other internal service providers e.g. Nutritionist, Dietitian, Deadly Choices Team, Paediatric Specialist (for Rheumatic Heart Disease) to promote and educate on oral health.

Waiting times: Patients only have to wait two weeks for a general appointment compared with Cairns and Hinterland Hospital and Health Service (CHHHS) Dental Service who meet their waiting time target of seeing general care patients within two years.

Reduced pressure on public health system: This service is in addition to the public dental system.

Effective reminders: Reminder system supports attendance.

Transport: Transport is provided free of charge to patients.

Partnerships: Wuchopperen have a good relationship with James Cook University (JCU) Dental School.

Outreach: There is a mobile van service offered at Edmonton for two days a week.



Challenges

Cost: Wuchopperen fund the service through Medicare income generation and client fees, diverting funds from other essential primary health care services.

High demand: Ongoing demand from community for service.

Maintenance: Chairs and equipment have to be maintained.

Restricted services: The team are not able to service all dentistry needs—sometimes referrals to specialists or other services are required.

HHS relationships: No meaningful relationship with CHHHS Dental team, however Wuchopperen have made contact with the HHS to work on establishing better relationships with the HHS.

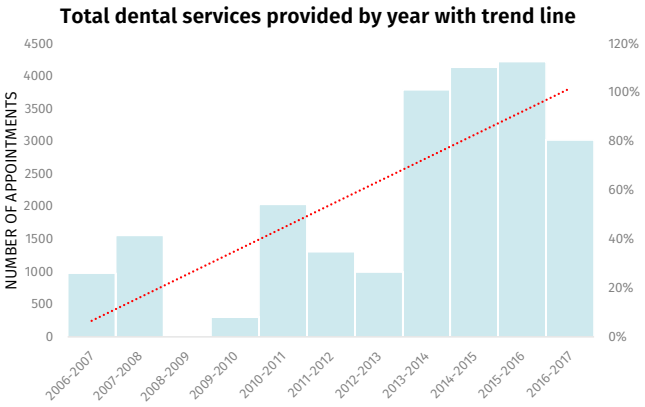
Community awareness: Community awareness of the amount of sugar in sports drinks, the impact of dental infections on heart health, and the importance of flossing for good oral health could be improved.

Oral health promotion: is undertaken however it could be strengthened with greater investment in health promotion resources and capacity development.

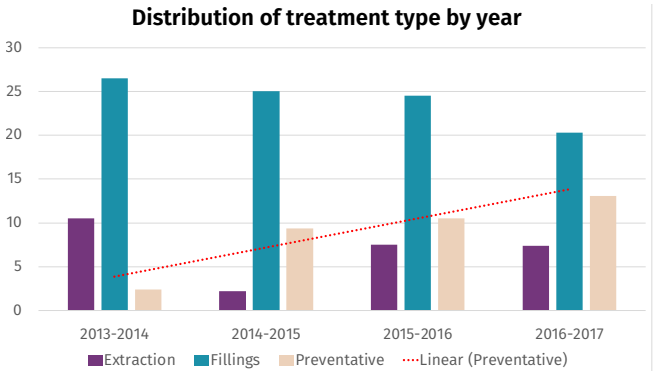
Impact

Aboriginal and Torres Strait Islander Health Workers conduct oral health screening at the annual health check and GPs refer clients to the dental team. Wuchopperen is actively working to strengthen their Aboriginal and Torres Strait Islander Health Worker Model of Care in practice. The dental team also attend chronic disease Doctor meetings and work closely alongside the clinical team to ensure referrals and holistic health care needs of patients are met. The integration of teams ensures that clients experience a seamless process for disease management.

Wuchopperen has increased its service provision through internal prioritisation and investment in dental service since 2006.



The graph below shows the shift from reactive treatment to preventative treatment:



Community Feedback

In 2017 Wuchopperen Dental won the QAIHC Patient Satisfaction and Service Excellence Award for their outstanding results through initiatives that demonstrate leadership and a commitment to excellence in customer service. The service continues to receive positive feedback from community.

What's in your lunchbox?

Wuchopperen have developed a hand's on, interactive 'What's in your lunchbox' game for children to play. The game allows children to 'build' their own healthy lunchboxes.

School aged children demonstrate good knowledge of what they should be eating. In Cairns there is good preventative teaching with Wuchopperen, JCU Dental Students and QH visiting schools to provide education.

Students say that, despite this knowledge, their parents or guardians still put sugary foods and drinks into their lunchboxes.

References	Annotated bibliography
Disparities in oral health outcomes for Aboriginal and Torres Strait Islander peoples	
(Australian Institute of Health and Welfare, 2007)	**Oral health of Aboriginal and Torres Strait Islander children** The report provides a summary of Aboriginal and Torres Strait Islander child oral health using information collected from three data sources: the Child Dental Health Survey; the Aboriginal and Torres Strait Islander Children and Receipt of Hospital Dental Care Investigation; and the Study of Aboriginal and Torres Strait Islander Child Oral Health in Remote Communities. • At each age of childhood, a higher percentage of Aboriginal and Torres Strait Islander children had clinical caries (decay) experience in the deciduous dentition than non-Indigenous children. At age 6 years, nearly double the percentage of Aboriginal and Torres Strait Islander children had clonical deciduous caries experience (72 per cent) than non-Indigenous children (37.7 per cent). • Four year old Aboriginal and Torres Strait Islander children had the highest levels of decay in the deciduous dentition, being 3.2 times that of non-Indigenous four year old children • A higher percentage of Aboriginal and Torres Strait Islander children had experienced dental caries when compared with other Australian children at all ages between 4 years and 14 years. • Throughout the states and territories observed, Aboriginal and Torres Strait Islander children had consistently higher levels of dental caries in the deciduous and permanent dentition than their non-Indigenous counterparts. • Aboriginal and Torres Strait Islander children most affected were those in socially disadvantaged groups and those living in rural/remote areas. Trends in Aboriginal and Torres Strait Islander child dental caries prevalence indicate that dental caries levels are rising, particularly in the deciduous dentition. • Aboriginal and Torres Strait Islander children aged less than five years had almost one and a half times the rate of hospitalisation for dental care compared with other Australian children. • The rate of Aboriginal and Torres Strait Islander children receiving hospital dental care increased with greater geographic remoteness. • Less than 5 per cent of remote Aboriginal and Torres Strait Islander pre-school children are reported to have brushed their teeth on a regular basis. • Many young remote Aboriginal and Torres Strait Islander children experienced extensive destruction of their deciduous teeth.

References	Annotated bibliography
(Butten K., 2019)	**Risk factors for oral health in young, urban Aboriginal and Torres Strait Islander children** • Demographic and risk factor indicator data were collected in a cohort study of children attending a health clinic in North Brisbane. Dentulous children received a basic oral examination to explore the presence of decayed, missing and filled teeth. A total of 180 children enrolled, with 11 children receiving the examination. • Within Australia, dental caries is the most common chronic disease of childhood and Aboriginal and Torres Strait Islander children experience a disproportionate amount of this disease burden. • Despite being acknowledged as a priority population by the Australian Government's National Oral Health Plan since 2004, data on the oral health of Aboriginal and Torres Strait Islander peoples is lacking, particularly for those living in urban areas and related to young children. Overwhelmingly, there is a lack of data nationally on the oral health of children aged less than five years. • It is important to address this gap as recent research suggests that a cariogenic environment may be established early in life and preventative measures should take place in the first year of life before deciduous dentition commences. • Dental caries is associated with a number of different risk factors and risk indicators. Individual factors attributed to the increased risk of early childhood dental caries include: going to sleep with a bottle; regular exposure to sugar through consumption of food or fluids; not visiting a dentist; and a lack of preventative care i.e. brushing and fluoride exposure. Socio-demographic factors including low-income, being a single-parent, and low levels of parental education are also well-established risk indicators for dental caries. • Historical factors such as the impact of colonisation and the transgenerational experience of dispossession may also be associated with dental caries risk within Aboriginal and Torres Strait Islander populations. The oral health of Indigenous peoples is reported to have been considered of a 'good' standard, if not superior to non-Indigenous peoples. However, it is well known that colonization and transgenerational inequities have negatively impacted the overall health of Indigenous people. Cultural factors such as family history (e.g. Stolen Generation), community involvement, connection to Country and partaking in traditional cultural practises have not been studied in relation to oral health.
(Caffery, Bradford, & Smith, 2017)	**Association between patient age, geographical location, Indigenous status and hospitalisation for oral and dental conditions in Queensland, Australia** The aim of this study was to identify the rate and cost of hospitalisation and to examine the association between hospitalisation and age, geographical location, and Indigenous status. An analysis of data related to hospitalisations due to oral and dental conditions was performed for patients in Queensland. • Aboriginal and Torres Strait Islander infants and primary school children were found to be significantly more likely to be hospitalised than their non-Indigenous counterparts. • The rate of hospitalisations due to oral and dental conditions for patients aged 0–4 years of age for Aboriginal and Torres Strait Islander patients was 203 per 100,000 compared with 590 per 100,000 for non-Indigenous patients. • The rate of hospitalisation due to oral and dental conditions for patients aged 5–12 years of age for Aboriginal and Torres Strait Islander patients was 873 per 100,000, compared with 778 per 100,000 for non-Indigenous patients.

References	Annotated bibliography
(Carlisle, Larkins, & Croker, 2017)	**Disparities in dental health of rural Australians: hospitalisation rates and utilisation of public dental services in three communities in North Queensland** The purpose of this study was to examine hospitalisations for dental conditions and utilisation of public dental services in three rural communities in Queensland, compared with the whole of Queensland. All admitted patient episodes of care in Queensland during the calendar year 2013 for dental principal procedures were collected. • Hospitalisation data shows the disparity in oral health of Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians living in Queensland. Further preventative and oral health promotion interventions targeting Aboriginal and Torres Strait Islander populations in Queensland were identified are necessary to achieve an improvement in outcomes. Populations under study were three rural communities in Queensland. • Aboriginal and Torres Strait Islander children continued to experience higher levels of dental caries than their non-Indigenous peers • Aboriginal and Torres Strait Islander peoples living in rural communities experienced a higher rate of hospitalisation for dental conditions (hospitalisation rate 3.3 per 1000) compared with the non-Indigenous community (hospitalisation rate 1.76 per 1000). • Aboriginal and Torres Strait Islander peoples living in rural communities experienced a higher rate of hospitalisation for dental conditions (hospitalisation rate 3.3 per 1000).
(Christian & Blinkhorn, 2012)	**A review of dental caries in Australian Aboriginal Children: the health inequalities perspective** The purpose of this study was to describe dental caries prevalence and experience amongst Aboriginal and Torres Strait Islander children and to investigate the disparity in dental caries between Aboriginal and Torres Strait Islander children and non-Indigenous children. • Dental caries was found to be a widespread disease amongst Aboriginal communities, resulting in a severe impact on children and their wellbeing. • The global decline in dental caries rates since the 1960s has not yet reached the Aboriginal community, resulting in dental health inequalities. The magnitude of disparity (relative difference) in 6 year old's dental caries experience between Aboriginal and non-Aboriginal children was relatively consistent over the period 1983-2007, with Aboriginal children having an approximately two-fold higher dental caries experience score. • No single factor could be identified as the reason for this. Rather, it is more likely to be explained by a complex interaction of factors such as: as social isolation; cultural perceptions of oral health; misguided policy; lack of access to health services; inadequate education; remote location; inadequate housing and living conditions; no access to fluoride; and exposure to a westernised diet. • Decayed and painful teeth greatly inhibit an ability to eat healthy foods, directly influencing nutrition and ultimately systemic health. A nationwide study has found Queensland and the Northern Territory had the highest levels of dental caries. Ninety percent of 5 year old Aboriginal children in rural Queensland had dental caries. Potential reasons for urban Aboriginal children having better dental caries rates than their rural counterparts include: access to fluoridated water; access to and timely dental visits; supportive school dental services; better education systems and social support networks; and better environmental conditions.

References	Annotated bibliography
(de Silva, Martin-Kerry, Geale, & Cole, 2016)	**Caries and periodontal disease in Indigenous adults in Australia: a case of limited and non- contemporary data** The aim of this study was to identify published evidence about oral health in Aboriginal and Torres Strait Islander children in Australia and to determine trends in Aboriginal and Torres Strait Islander oral health over time. • PubMed was searched for published peer-reviewed articles that reported dental caries prevalence rates and/or dental caries experience (based on caries indices) in Indigenous children. Studies included in the analysis needed to report clinical oral health data (not self-reported dental experiences). Articles were excluded if they reported dental caries in only a select, specific or targeted sample (e.g. only children undergoing hospital admissions for dental conditions). • The review identified 32 studies that met the inclusion criteria. These studies reported data from the Northern Territory (n=14), Western Australia (n=7), South Australia (n=7), Queensland (n=7), New South Wales (n=1), Australian Capital Territory (n=1) and Tasmania (n=1). Of the studies, 47 per cent were in rural locations, 9 per cent were in urban locations and 44 per cent were in both rural and urban locations • The study documented the prevalence and severity of dental caries in Aboriginal and Torres Strait children and highlights that limited oral health data are available for this priority population. Data is limited, and predominantly relates to Aboriginal and Torres Strait children living in rural locations. There were no published studies on dental caries in Aboriginal and Torres Strait children living in Victoria. Although risk factors for oral disease are well known, most of the studies did not analyse the link between these factors and oral disease present. There was also inconsistency in how dental caries was reported in terms of age and dental caries criteria used. Available data cannot reliably inform the development of policies and programs to address the oral health differences in Aboriginal and Torres Strait populations living contemporary lives in metropolitan areas.
(Hopcraft & Chow, 2007)	**Dental Caries Experience in Aboriginal and Torres Strait Islander in the Northern Peninsula** The study relates to a survey conducted between May and September 2004, involving 486 children aged 4–15 years. • Aboriginal and Torres Strait Islander children from the Northern Peninsula Area of Queensland had more than four times the dental caries experience when compared with similar aged children from Queensland and Australia for both 6 year old and 12 year old children. • The third of children with the highest dental caries experience were more than 7-8 times the national average with the highest caries experience had a mean Decayed, Missing and Filled Permanent Teeth (DMFT) score more than 10 times that of the rest of Australia.
(Lalloo, Jamieson, Ha, & Luzzi, 2016)	**Inequalities in Tooth Decay in Australian Children by Neighbourhood Characteristics** Data sourced from an Australia wide, Child Dental Health Survey conducted in 2010 (N=103,387) found: • Across all ages and neighbourhood categories, Aboriginal and Torres Strait Islander children had more decay compared with their non-Indigenous counterparts. • The greatest differences were observed among older adolescents. Aboriginal and Torres Strait Islander children living in poor areas were reported as having two to three times the DMFT score compared with non-Indigenous children in the same neighbourhood category.

References	Annotated bibliography
(Lalloo R. T., 2019)	**Salivary characteristics and dental caries experience in remote Indigenous children in Australia: A cross sectional study** While associations between salivary characteristics and dental caries have been well studied, assessment of this in a remote Aboriginal and Torres Strait Islander child population, where lifestyles may be different from urban children is lacking. Children attending schools in an Indigenous community in remote north Queensland, Australia were invited to an oral examination by qualified and calibrated examiners. Salivary flow rate, pH, buffering capacity and loads of mutans streptococci (MS), lactobacilli (LB) and yeasts were determined. Questionnaires were used to obtain information on children's brushing frequency and soft drink consumption. • As with studies in other populations, childhood salivary counts of MS and LB were significantly associated with greater dental caries experience in this remote community. To address the serious burden of oral disease, ways to promote a healthy oral environment by encouraging good dietary habits, and emphasising the importance of daily tooth brushing with a fluoridated toothpaste was identified as a significant need.
(Oral Health Monitoring Group, 2016)	**Healthy Mouths, Healthy Lives- Australia's National Oral Health Plan 2015–2024** Aboriginal and Torres Strait Islander people experience poor oral health earlier in their lifespan and in greater severity and prevalence than the rest of the population. Aboriginal and Torres Strait Islander people are also less likely to receive treatment to prevent or address poor oral health, resulting in emergency treatment. • Many Aboriginal and Torres Strait Islander children experience extensive destruction of their deciduous (baby) teeth. • Trends indicate that high-level dental decay in deciduous teeth is rising • Aboriginal and Torres Strait Islander people aged 15 years and over, attending public dental services, experience tooth decay at three times the rate of non-Indigenous counterparts and are more than twice as likely to have advanced periodontal (gum) disease. • Aboriginal and Torres Strait Islander people experience complete tooth loss at almost five times the rate of the non-Indigenous population. • Aboriginal and Torres Strait Islander people are 1.8 times more likely to experience toothache, twice as likely to avoid certain foods due to oral health problems, and 1.5 times more likely to report their oral health as 'fair' or 'poor'. • The rate of potentially preventable dental hospitalisations for Aboriginal and Torres Strait Islander people is higher than other Australians. • Aboriginal and Torres Strait Islander 15 year olds have 50% more tooth decay than the rest of the population. • Aboriginal and Torres Strait Islander people who are socially disadvantaged or on low incomes have more than double the rate of poor oral health than their counterparts.

References	Annotated bibliography
(Schluter, Askew, Spurling, Lee, & Hayman, 2017)	**Aboriginal and Torres Strait Islander oral health and its impact among adults: A cross sectional study** Interview participants were Aboriginal and Torres Strait Islander adults aged 20 years and over attending the Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Island Primary Health Care, Brisbane (N=945). • 28.8 per cent visited a dentist within 12 months, mostly due to problems (84.3 per cent) • 93.7 per cent owned a toothbrush • 56.2 per cent brushed two or more times/day • 28.4 per cent reported dental appearance dissatisfaction • 55.5 per cent reported dental problems • 32.7 per cent reported pain or discomfort in teeth/mouth in the last 6 months • 31.1 per cent reported 'uncomfortable to eat' because of problems with teeth/mouth i n the last 6 months.
Access and barriers for oral and dental health services for Aboriginal and Torres Strait Islander people	
(Campbell, Hunt, Walker, & Williams, 2015)	**The oral health care experiences of NSW Aboriginal Community Controlled Health Services** This study explored the oral health care experiences and activities of Aboriginal Community Controlled Health Services (ACCHS) to inform policy and program decision making. A mixed methods study using an online survey and semi-structured interviews was undertaken with ACCHS staff. Case studies to illustrate aspects of ACCHS models of oral health service delivery were recorded as part of the interviews. In NSW, ACCHS are reported to be the most appropriate service to provide oral health care to Aboriginal communities. However, barriers to access exist. ACCHS offer several advantages in delivering oral health care over other service providers in NSW, including being integrated with other health activities as part of comprehensive primary health care and having the expertise to provide culturally appropriate support. **Barriers for ACCHS in delivering oral health care** ***Funding*** • Funding was identified as a key barrier to ACCHSs providing oral health care and services. • ACCHSs without an oral health service reported lack of funding to be the primary reason they were unable to provide an oral health service. • ACCHSs with oral health services reported insufficient funding to be the main barrier to providing the level of service they felt was needed in the community. • The ACCHS funding models were described as being an impediment to developing sustainable and effective health care models, including oral health care. • Interviewed ACCHSs reported being unaware of why some ACCHSs received specific oral health funding and expressed concern about whether funding decisions were 'needs based'.

References	Annotated bibliography
(Campbell, Hunt, Walker, & Williams, 2015) continued	***Staffing*** • Workforce was another identified key barrier to ACCHSs providing oral health care and services. • Eight of the 15 ACCHS interviewed with oral health services reported difficulties with staff recruitment and retention, this included urban, rural and remote regions. Inadequate funding prevented ACCHSs from offering competitive salaries. • For rural and remote regions, location was a further barrier to recruiting and retaining oral health staff. • Workforce challenges meant that oral health was provided only intermittently and were dependent on fly-in/fly-out oral health staff or visiting teams from nearby clinics or hospitals. Where staff are unable to attend the service becomes vulnerable to closure and significant time and financial resources to negotiate visit dates, transport and accommodation. Employing fly-in/fly-out staff and local staff presents a challenge as there is less time to develop ways of working together. • These approaches where ACCHSs had little control over the arrangements of the visit could be disempowering for ACCHSs, and could be considered inconsistent with community control. ***High burden of oral disease in Aboriginal communities*** • Of the ACCHS surveyed 79 per cent (23) stated the community need for oral health care was far from being met. Fourteen per cent said community need was only moderately being met, and no ACCHS said community need was being met. • The high burden of oral disease presents a particular challenge for new ACCHS oral health services and also where ACCHS oral health services are limited. Having to 'catch up' on the high level of acute oral health issues before being able to address prevention and provide maintenance oral health care. ***Barriers for community members accessing private and public oral health services*** • distance to the private or public oral health service • waiting times: variable public oral health service waiting time ranging from less than three months to more than three years, viewing the services as 'inaccessible' • cost: private oral health care was described as relatively inaccessible due to cost • concern that the public oral health care in their area was fragmented • reports that community members received only minimal care before being returned to the waiting list • opportunities for oral health promotion are missed because of a focus on acute problems. • racism was also reported by an ACCHS to be a barrier for Aboriginal people to access local public oral health services.

References	Annotated bibliography
(Irving, Gwynne, Angell, Tennant, & Blinkhorn, 2017)	**Client perspectives on an Aboriginal community led oral health service in rural Australia** An oral health service was implemented, using a unique community development approach, for Northern NSW Aboriginal communities in 2013–14. This study examined the views of children (and parents) who accessed the service, including: the extent of reported dental problems, oral health knowledge, attitudes and behaviour, accessibility of oral health services, satisfaction and cultural sensitivity of the service. A survey of Aboriginal children aged 4–14 years (or parents of) who accessed the service (n=49) found: • All agreed that healthy teeth were important (100 per cent), but many thought oral disease leading to extraction was normal (68 per cent) • The reasons given for 'not seeing a dentist regularly in the past' varied, but many (54 per cent) did not attend the dentist as they were 'not in pain', 15 per cent did not know where to go to obtain services and 13 per cent indicated that waiting lists at other oral health services were too long • A sizeable proportion (29 per cent) of the children interviewed did not have ready access to toothbrushes and fluoride toothpaste. To address ongoing community concerns regarding access barriers to culturally competent dental care an oral health service model was developed in collaboration with the local community, local health service providers, The Poche Centre for Indigenous Health (University of Sydney) and the Centre for Oral Health Strategy (NSW Health). Oral health services were established in 2013–14 and provided to each local community within remote Northern Central Tablelands of NSW on a rotational basis (approximately 1 week per month in each community) and utilise space in the local Aboriginal Medical Service, community centre or school. Children aged up to 14 years, or parents of, (n=49) who accessed the service reported: • Access to the new dental health service was reported as 'easy' (92 per cent), with 90 per cent taking <30 min to get to where the service was located • 30 per cent indicated they would have found it difficult to travel to see a dentist in the next town • 42 per cent were not aware of where they could access dental services outside of the new service • 30 per cent of the children accessing the service reported never having been to the dentist before coming to the new collaborative oral health service and of those who had been to the dentist before over 50% had not seen on in more than three years • All respondents were happy with their dental treatment, and that their Aboriginal heritage was respected by the oral health team (100 per cent). The implementation of a new collaborative model oral health service was designed to overcome barriers to access. Cost as a barrier was largely overcome with philanthropic and Government funding ensuring that all Aboriginal patients using this service did not incur a charge from their treatment.

References	Annotated bibliography
(Oral Health Monitoring Group, 2016)	**Healthy Mouths, Healthy Lives- Australia's National Oral Health Plan 2015–2024** Accessibility of services is a key factor contributing to the current gap between the oral health of Aboriginal and Torres Strait Islander people and the rest of the population. • Over 43 per cent of Aboriginal and Torres Strait Islander peoples live in inner or outer regional Australia and 21 per cent live in remote areas with limited local services and transport options. • More than two in five Aboriginal and Torres Strait Islander peoples over the age of 15 defer or avoid dental care due to cost. • There is limited representation of Aboriginal and Torres Strait Islander peoples in the oral health workforce and many dental services are not culturally sensitive. For example, strict appointment times and inflexibility regarding 'failure to attend' may result in a fee to the consumer. Many Aboriginal and Torres Strait Islander people also prefer to visit a dentist with family members and friends, a practice that is generally not accommodated.
Dental services within Aboriginal and Torres Strait Islander Community Controlled Health Organisations	
(Parker, Misan, & Russell, 2005)	**Planning and implementing the first stage of an oral health program for the Pika Wiya Health Service Incorporated Aboriginal Community in Port Augusta, South Australia** The purpose of this article is to describe the coming together of interested parties, the formation of partnerships, and the planning and implementing the first stage of the program that was to be a dental clinic and dental service for Indigenous adults. The under-utilisation of mainstream services in Port Augusta in South Australia by the Aboriginal and Torres Strait Islander community are purported to be due, in part to existing services being 'dentist-centred' and failing to meet cultural and holistic health needs along with transport barriers and communication barriers. In recognition of this, the local Aboriginal and Torres Strait Islander community resolved to establish a culturally safe dental service within the Aboriginal Health Service already operating. The dental clinic was officially opened in 2001 in Pika Wiya Aboriginal Health Service, initially consisting of an adult clinical service 2 days per week. • Community acceptance of the planning and implementation better than anticipated. High demand for services was evident almost immediately, necessitating booking of appointments well in advance. Acceptance was further exemplified by the observation that clients who did not use the Pika Wiya's Medical Service were making appointments at the service's dental clinic Factors believed to have contributed to the success of the service included, but not limited to: • location of the clinic within the main health centre premises, promoting dental care as an integral part of general health care • resident dentist employed by the health service • employment of local staff living in the community • allocation of an aboriginal health worker in program team.

References	Annotated bibliography
(Parker, et al., 2012)	**Planning, implementing and evaluating a program to address the oral health needs of Aboriginal children in Port Augusta, Australia** In recognition of the demonstrated success and community acceptance of the adult clinical service and growing community concerns regarding Aboriginal child oral health the Aboriginal Children's Dental Program (ACDP) was established in 2002 within the Pika Wiya Aboriginal Health Service. Early outcomes indicated: • increased overall participation of Aboriginal children in dental services in Port Augusta • a shift in the distribution of enrolment from the mainstream School Dental Service (SDS) to the ACDP offered in the Pika Wiya Aboriginal Health Service • after 3.5 years utilisation of dental services among Aboriginal children increased from 53 to 70 per cent.
(Pulver, Fitzpatrick, Ritchie, & Norrie, 2010)	**Filling the gap: An evaluation of a Voluntary Dental Program Within the an Aboriginal and Torres Strait Islander Community Controlled Primary Health Service** To address the maldistribution of dentists in regional areas in Far North Queensland, a volunteer dental program 'Filling the Gap' was established in 2006 in partnership with the local Aboriginal and Torres Strait Islander community controlled primary health service, Wuchopperen Health Service, Queensland. • Evaluation of the program's operation over a two-year period revealed that 79 weeks of dental care were provided by 68 volunteer visitors addressing patient needs satisfactorily and eliminating waiting lists. • Stakeholders believed that the program met a pressing need, enhanced workforce development, provided a quality service with continuity of care, and enabled cross-cultural relationships to thrive, with the familiarity and trust felt by patients towards the wider health service and its Aboriginal and Torres Strait Islander dental staff extending to the short-stay volunteers. • Whilst at the same time highlighting the critical importance of dental care within the community controlled primary health care service setting, the evaluation of 'Filling the Gap' found the program to be both effective and appropriate. Its success, however, should not take the place of sustainable, accessible oral health care services in regional and remote Australia.

References	Annotated bibliography
Improving oral health outcomes for Aboriginal and Torres Strait Islander peoples	
(Jamieson, 2018)	**Dental Disease Outcomes Following a 2-Year Oral Health Promotion Program for Australian Aboriginal Children and Their Families: A 2-Arm Parallel, Single-blind, Randomised Control trial** A single-blind, parallel-arm, randomised controlled trial of a multifaceted oral health promotion initiative was developed to reduce children's experience of dental disease at age 2 years. The intervention comprised: (1) provision of dental care to mothers during pregnancy; (2) application of fluoride varnish to teeth of children at ages 6, 12 and 18 months; (3) motivational interviewing delivered in conjunction with; and (4) anticipatory guidance. Women pregnant with an Aboriginal child (N=448) were recruited from February 2011 to May 2012, resulting in 223 children in the treatment group and 225 in the control. • Findings suggested that a highly structured, standardised, carefully implemented and culturally-sensitive multifaceted early childhood caries intervention was effective in reducing carious lesions in this Aboriginal child population in an epidemiological sense, but the translation to dental public health settings (where there are usually not the same resources available or rigour applied) may not yield such results. • The intervention was especially efficacious among non-metropolitan dwelling children, suggesting that, if resources are scarce, this might be one group that benefits from tailored and targeted oral health promotion initiatives. • Due to the multi-faceted nature of the intervention, it is not possible to determine whether any single component had greater efficacy in reducing children's early childhood caries than another.

References	Annotated bibliography
(Oral Health Monitoring Group, 2016)	**Healthy Mouths, Healthy Lives- Australia's National Oral Health Plan 2015-2024** The Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015-2024 highlights the need to strengthen the focus on oral health as an integral part of general health and education policies and plans. Aboriginal and Torres Strait Islander people are an identified priority population under the plan in recognition of the significant barriers to accessing oral health care and the greatest burden of oral disease experienced by this community. The defined goal is to improve oral health outcomes and reduce the impact of poor oral health for Aboriginal and Torres Strait Islander people. Defined indicators include: • increase community engagement in the planning and delivery of oral health services • promote the incorporation of cultural competency across training, education and assessment, clinical management protocols and guidelines • develop integrated models of care that incorporate oral health education, prevention and screening with other primary care services • increase the representation and engagement of Aboriginal and Torres Strait Islander people in the oral health workforce • expand existing primary health practice incentives and funding adjustments for oral health services for Aboriginal and Torres Strait Islander people • more broadly, the inclusion of oral health in national, state and territory, and local government policy documents and strategies is important to achieve prevention outcomes. Examples of policy documents, relevant to Aboriginal and Torres Strait Islander include the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.
(Villarosa, Villarosa, Salamonson, Ramjan, & Sousa, 2018)	**The role of indigenous health workers in promoting oral health during pregnancy: a scoping review** A systematic search was undertaken to identify the role of Indigenous health workers in promoting maternal oral health globally. • Twenty-two papers met the inclusion criteria, focussing on the role of Indigenous health workers in maternal oral healthcare, types of oral health training programs and screening tools to evaluate program effectiveness. • There was a paucity of peer-reviewed evidence on the role of Indigenous health workers in promoting maternal oral health, with most studies focusing on other non-dental health professionals. • Nevertheless, there were reports of Indigenous health workers supporting oral health in early childhood. Although some oral health screening tools and training programs were identified for non-dental health professionals during the antenatal period, no specific screening tool has been developed for use by Indigenous health workers. • While the role of health workers from Indigenous communities in promoting maternal oral health is yet to be clearly defined, they have the potential to play a crucial role in 'driving' screening and education of maternal oral health especially when there is adequate organisational support, warranting further research. • Globally, Indigenous health workers are in a unique position to deliver culturally competent oral healthcare because they have a contextual understanding of the needs of the community.

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