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**Dental professionals' perspectives working with Aboriginal children in Western Australia:
A qualitative study**

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Abstract

Background: The disproportionate burden of oral disease in Aboriginal children and the issues in accessing mainstream dental services are well documented. Yet little is known about dental professionals' perspectives in providing oral care for Aboriginal children. This paper presents findings from a study exploring such perspectives.

Methods: Semi-structured interviews were conducted in Western Australia following purposive sampling of non-Aboriginal dentists, dental clinic assistants (dental nurses) and oral health therapists/dental hygienists. Interviews were recorded, transcribed and analysed guided by grounded theory for key themes related to the topic.

Results: Findings included a service delivery model sometimes unresponsive to Aboriginal families' needs; dental professionals' limited education and training to work with confidence and cultural sensitivity with Aboriginal patients and socioeconomic influences on Aboriginal children's poor oral health considered outside dental professionals' remit of care.

Discussion: Findings suggest oral health policies and practices and dental professionals' education and training need reviewing for how well such policies support dental professionals in an Aboriginal context. This includes engaging with Aboriginal stakeholders, working effectively with Aboriginal families, and developing shared understandings about what is needed to increase access to care and improve oral health outcomes for Aboriginal children.

Key words: Aboriginal health, oral health, social determinants, barriers

Introduction

The higher burden of oral disease among Australian Aboriginal compared with non-Aboriginal children is widely reported in the literature, along with underlying issues that contribute to these poor oral health outcomes.^{1,2} Despite research and interventions to address the problem, oral disease in Aboriginal children persists.

Evidence demonstrates the positive influence on Aboriginal clients of Aboriginal health staff delivering oral health care.^{3,4} Supporting non-Aboriginal dental professionals with the skills, capacity and opportunity to improve oral health in Aboriginal children is also important, including strengthening partnerships with Aboriginal communities.⁵⁻⁷ Evidence of the extent to which this has occurred in dental education or post-graduate professional development, or whether it has improved oral health outcomes in this population group is scant at best. A review of international literature demonstrated the benefits of tailored, culturally safe family- and community-based initiatives that addressed the multidimensional issues confronting Aboriginal communities.⁸ However, implementing these recommendations has proved challenging due to limited resources and difficulties recruiting and retaining dental staff to work in Aboriginal Community Controlled Health Services.^{3,9}

Western Australia (WA) is a geographically large state with a population of nearly 2.5 million people. Aboriginal Australians make up 3.1% of whom 22% live in inner or outer regions with 40% living in remote or very remote areas with few local services and transport options.¹⁰ The WA government provides a Schools Dental Service offering free dental care to students aged 5-16 years. Services are delivered via 100 dental therapy centres (DTCs) located in schools and 40 mobile DTCs to 150 schools with no onsite clinics.¹¹

There has been some research on Aboriginal perspectives on dental services.^{12,13} Research on how dental professionals view Aboriginal children's oral health and available dental services is scarce.^{9,14} Early international studies focused on the general population and suggested a link between the dentist-patient relationship and the nature of care provided.¹⁵⁻¹⁷ Clients' age, ethnicity, socio-economic status, compliance and level of anxiety influenced how dental professionals communicated with and responded to patients.¹⁶⁻¹⁸ Barriers to communication were also affected by location and intensity of treatment provided.^{3,7,9,15}

This paper presents research findings from non-Aboriginal dental professionals' perceptions and experiences of providing dental care for Aboriginal children in Western Australia.

Methods

Grounded theory was chosen as an inductive approach to guide this research,^{19,20} given the lack of previous investigations and the need to further explore the perspectives of dental professionals who have worked with Aboriginal children. Semi-structured interviews were conducted with 12 dental professionals purposively selected for their experience delivering oral care in regional and metropolitan areas of Western Australia with high populations of Aboriginal children. Consistent

with grounded theory, this purposive sampling ensured participant selection involving dentists, oral health therapists/dental hygienists and dental clinic assistants/dental nurses, contributed to enriching our understanding based on their experiences.²¹

Following participants' informed written consent, semi-structured interviews were conducted using a broad range of questions allowing participants to freely express their perspectives and concerns including current barriers, how these could be overcome, and potential roles dental professionals could play in this process. The interviews were conducted one-to-one by a researcher experienced in conducting qualitative interviews. There was no pre-existing relationship between the interviewer and interviewees. Interview topics included participants' perspectives and experiences working with Aboriginal children within the dental system, engaging and communicating with Aboriginal families, education and training to work in this context, consent issues, factors impacting on Aboriginal children's access to services and any challenges.

All interviews were audio-recorded and transcribed verbatim and imported into NVivo software (www.qsrinternational.com) to organise and manage the data. In line with grounded theory methods, data were open coded and categorised into topics and issues as they emerged, and then a selective coding process was used to clarify and redefine our understanding of emerging themes.^{19,21,22} The initial open coding was conducted freely across all interview notes and then consolidated into broader categories or nodes in NVivo. The data were broken down into individual elements (characteristics of participants and their attitudes to barriers and enablers) and then selectively regrouped to expose deeper meaning.^{19,22}

Rigour was ensured through the initial analysis being reviewed by two authors. All authors then reviewed and discussed initial analysis and emergence of predominant topics.²³ Ethics approval for the overall study was obtained from the University of Western Australia and Western Australian Aboriginal Health Ethics Committee.

Results

Twelve dental professionals were recruited, five dentists, five oral health therapists/dental hygienists and two dental clinic assistants (dental nurses) (Table 1). As no new information was emerging, we determined we had reached data saturation with these numbers. Participants worked in a variety of regional and metropolitan settings: hospitals, public oral health services, Aboriginal community health services, school dental services, and private dental clinics. Ten of the interview participants were female and professional experience ranged from five to 35 years with a mean of almost 23 years.

Six key themes emerged from the interviews: lack of control over social determinants influencing poor oral health of Aboriginal children; frustration with the clinical dental environment; discomfort working with Aboriginal children and their families; lack of influence to reduce high sugar diets; oral care through community-based centres and relevance of experiential learning.

Lack of control over social determinants influencing poor oral health of Aboriginal children

Participants perceived the underlying determinants of Aboriginal children's oral health as complex, citing social, physical and health behaviour issues that contributed to the current disparities between Aboriginal and non-Aboriginal children. Yet, while many acknowledged that dental diseases are often preventable, participants felt limited in their ability to address these complex issues, suggesting many were outside their control:

The periodontal problems, decay problems, they're all preventable oral medicine issues that are usually because of alcohol, smoking issues. ... But depending on their [Aboriginal parents'] level of education it's very difficult. Because we can provide restorative care, we can provide cleaning, we can provide toothbrushes, we can provide all that, but if the drive is not from within themselves it makes it very difficult, so I don't know what we can do (D2).

While this comment implies that the problem and solution lies with Aboriginal people, several participants recognised the impact of external environmental barriers on their lived experience that limited Aboriginal people's capacity to make optimum decisions around their children's oral health.

I think that a lot of them are under pressure; there may be violence in the home or a drug problem or alcohol problem or just commitments to relatives that is more immediate to them. They might have other children that they have to feed so "how am I going to go and sit at the hospital all day. I have to be there for these children" (OHT1)

The families are having all sorts of difficulties so you sort of get it, because if you've got all these other health issues and social issues and unemployment, well, teeth are going to be at the bottom of the ladder unfortunately as far as priorities go (OHT4)

Responses suggested that these issues were often compounded in challenging family environments where family members move between houses, or where grandparents or other relatives look after the children. Such factors may compromise Aboriginal children's oral health behaviours including their engagement with the school or community dentist.

Many participants further identified socioeconomic and geographic determinants of oral health where school dental services in rural and remote areas were often unable to reach Aboriginal children:

I don't know why they don't come.... again we've tried, the school has tried busing the kids over once they get there, but again it's lack of resources and then from the school's point of view they're running out of time to do their stuff as well (DNI)

Dental professionals also raised the issue of trauma to their teeth from fighting and sports, especially among Aboriginal boys:

One of the other things that pop up especially with young Aboriginal boys is trauma to their teeth.... I suppose Aboriginal kids they're probably be quite a high percentage of that, trauma to the front teeth.....So it's quite a big deal and that's often a rude awakening for people because they just think it's teeth, they don't realise the mouth is part of your whole body. (OHT4)

Thus, while all participants described their understanding of these external barriers at the family, school and community levels and the impact they had on Aboriginal children's oral health, the problem was considered too hard for dental professionals to deal with:

I know in the Aboriginal area it's not going too good.....But changing the system is a very hard thing to do. There is an issue of have you got the willpower to solve the problems across the whole board or are you just going to pay band aid lip service to it? (D1).

This comment implies a level of frustration and hopelessness when the expectations of the dental system seem not to account for the needs of the Aboriginal community, inhibiting access to care, yet beyond the control of dental professionals to resolve.

Frustration with the clinical dental environment

Almost all participants expressed frustration with the clinical dental environment and its lack of flexibility, limiting their capacity to provide support for preventive education regarding Aboriginal children's oral health. Numerous comments related to onerous legal requirements, parent consent forms, bookings and time allocations, as well as their role delineations and high workloads:

Our whole dental system is very regimented. They set up fifteen minute allotments, depending on where you're working if someone turns up ten minutes late, lots of areas will say no that's your appointment time but you know that's not, they don't live quite as

regimented as a dental clinic is usually operated at Filling out forms is getting more and more onerous, we need to have all this documentation (DN1)

Moreover, many acknowledged that the mainstream system focused on treatment, often emergency, making participants uncomfortable talking to Aboriginal children about prevention and healthy lifestyles. Others felt the clinical dental policy and procedures, including the negative attitudes of some administrative staff, had alienated Aboriginal parents. These tensions between policy and practice were further complicated by broader funding and workforce issues, constraining equal access to oral health care for Aboriginal families:

I think the way government dental services are provided now is like everyone's on budget constraint. I just think it's a little bit disconcerting... It is because the school dental service at the moment, we're very understaffed. They've increased our patient workload.....so it's just a matter of you really don't have the time to do the prevention education that you would like to. (OHT5)

In addition to current organisational and procedural barriers, most dental professionals discussed the system's lack of flexibility to adapt to the needs of Aboriginal families. While some participants explained economic and social difficulties faced by some Aboriginal families, including access to transport, and outlined how their clinical team tried to accommodate these challenges, most once again saw this as beyond their remit of care. Instead, interview participants reported that responsibility was often placed on Aboriginal parents for their children not attending appointments on time, not signing consent forms, coming only for emergency treatment and not following up on appointments.,

They have an Aboriginal liaison lady here who comes and asks us can you do something for this child. She will then chase up some things with the parent; that quite often is a long process. The parent may not be amenable to her coming at that particular time. There is one family particularly like that; the children have got abscesses and toothaches. It is very difficult to get hold of the mother. (OHT1)

This comment highlights the challenges facing health providers, their frustration and implied judgements when clients fail to turn up for appointments, and sense of helplessness in knowing how best to respond.

Discomfort working with Aboriginal children and their families

While most participants discussed the importance of cultural sensitivity, they described their communication with Aboriginal children and their families as “difficult”. Some participants attributed this to Aboriginal families feeling uncomfortable in the dental environment leading to their own reluctance to discuss oral care with these families. While one participant mentioned

her uneasiness was due to “a lot of resentment to the white man” (OHT1), others suggested the mainstream approach focused more on the needs of the dominant Anglo-Australian population leaving Aboriginal children and their families feeling uncomfortable:

I don't know if the whole set up is too... it's very, you know, our English set up is foreign but I don't know if that's one of the reasons why they don't feel comfortable. (DNI)

This suggests more sensitivity is needed to create an environment where Aboriginal families felt welcome.

When you would come to a place you'd be doing fillings and extractions and things like that so it wasn't a particularly happy visit as you were just there to get people out of trouble. And that's the problem; the level of disease is so high so your focus is on getting people out of pain (DI)

Nearly all participants noted that their lack of training in cultural awareness limited their capacity to work well with Aboriginal families which compounded the already complex process of reaching children in rural and remote communities. This also reflected the tension between dental system expectations and the lived experience of community members:

Well, we'd go to this one community [outback community 1] and all the kids would be at [outback community 2] so you'd go to [outback community 2] and all those kids would have moved to [outback community 1]. So you get the class list a week or two before and by the time you get there they've moved.... And then you have to fill out all these forms. I think the most was five records for one child because they changed their surname or they were named after someone who'd passed away so they couldn't use that name anymore. (DNI)

Lack of influence to reduce high sugar diets

The high sugar diet of many Aboriginal children was viewed as another key issue influencing oral health. Yet most dental professionals believed this problem was not limited to Aboriginal children, suggesting instead it was common among those from lower socio-economic groups, and particularly migrants. Nearly all participants thought hidden sugars or acid exposure in the diet was a major problem. However, they felt mitigating it was outside their control with many suggesting the problem was being fuelled by industry that made it ‘cool’ to drink high energy sports drinks and ‘healthy’ fruit juices:

Energy drinks are a big culprit because once they go into the teenage years and they start playing sport or they think drinking soft drinks is not ‘cool’ enough then they start picking up the energy drinks which are very very high in sugar. (DH1)

Several participants suggested that Aboriginal parents often gave their children money to buy lollies or ready-made, instant food rather than providing them with consistently healthy diets. Yet, as one participant emphasised, this was not generally due to lack of knowledge but rather the reality in which many Aboriginal families lived:

There is a lot of education in connection with nutrition and stuff like that. It is not as if they don't know. It is very presumptive of me to say that good nutrition is to help with their oral health or just their general health. Maybe they are like the rest of us, they get tired or lazy or the budget doesn't stretch. It is much easier to go down and get the heavily processed foods which are relatively cheap and quick to prepare and you have a big hoard of kids to feed in a hurry. (OHT2)

Others raised the issue of sugary drinks in early childhood with dental problems arising during their preschool years. While these quotes also illustrate the power of the sugar industry in successfully marketing sugar products that damage oral health, much emphasis was placed on the lack of government support for dental care for children from 0-4 years of age:

The damage is done before they get to us. They have the juice in the bottle and going to bed with the milk in the bottle or they are having coke in the bottle. They go to the sleep with bottle so the sugar is circulating all night. They are not brushing when they first come through or even wiping the teeth (OHT1)

All participants acknowledged their limited role in influencing Aboriginal children's diet, partly due to the inflexible clinical environment offering little time and support to promote oral health.

Oral care through community-based centres

One way to address this problem was to be more responsive to Aboriginal people's lived experience. Most participants stressed the need to provide community-based dental care through local support groups and Aboriginal health centres to offer a more holistic approach to oral health and health generally, as opposed to stand alone dental clinics. Integral to this process was non-Aboriginal health professionals engaging with the Aboriginal community:

If we don't touch base with their community they're unseen..... It's a different system so you've got to work within a different system. There's a cultural clash between those two systems, when you actually understand it then you can get in and solve the problem. (D1)

I think going into their environment in which they are comfortable rather than them coming to you has better value and better outcomes. (OHT3)

Participants thought community centres could support greater collaboration between the community, dentists, general practitioners and allied health professionals. Unlike dental clinics and school dental visits, which some criticised as siloed treatment that was “*too little, too late*”, nearly all emphasised the importance of community health centres as “*one-stop shops*” with continuity of care focused on local needs. This approach responded more to the expectations of the community rather than the dental system. Starting from birth, and working with the individual, family and community leaders over time, participants believed they could build trust, motivation and education, and improve their own capacity to communicate about how smoking, drinking and other issues negatively influence overall health:

If you don't motivate the carer or anyone else who's brushing their teeth, or the mum or dad who is responsible for your kids' teeth, you are not going to have success. So if we can tackle that at three levels of education, motivation and social determinants that prevent you from being motivated or from brushing or cleaning your teeth then we'll have a much better outcome.... So we've got to get in there, work out the social determinants of these kids and things, work through the dental determinants for the dental scenario and get it fixed.... Without putting the individual into their social context you will fail as a dentist (D1).

While several participants noted that close connections within the community fostered resilience and offered support for those attending dental clinics for treatment, opportunities were also available for prevention. Many participants considered that working through Aboriginal community health centres could strengthen the role of community nurses and playgroups in promoting children's oral health from preschool, suggesting a more inter-professional approach to oral health care. In particular, they felt playgroup coordinators had a powerful influence over parents of babies and toddlers, and, with support from dental professionals such workers could capture the importance of oral health, nutrition and dental care during their regular meetings:

We should be networking with people who are already seeing parents who have the 0-4s and try to zoom in on them like a captured audience, because the 0-4s, that's where we have to reach the little Aboriginal kids. (OHT4)

Yet, while all participants stressed the importance of developing positive community-centred environments, and engaging with local stakeholders and members of community health centres, most acknowledged their limitations: “*...to be truthful I haven't done a lot of group things, it's all on the individual level*”. (OHT4)

Relevance of experiential learning

Although most participants emphasised that more Aboriginal dental professionals and liaison

officers were needed, several also recognised the importance of educating non-Aboriginal dental staff about cultural sensitivity. Most acknowledged that current dental education provided a foundation for risk factors influencing Aboriginal health, and the sensitivity they needed to show when working with Aboriginal people, yet were concerned that lectures alone were not enough:

I probably think as a dentist yes I know everything but I don't. I don't know a lot about their traditional methods of keeping their health under control, I'm most likely unaware of certain cultural issues that may be preventing them from seeking help or.... I think in that sense I feel that I don't have as many tools to be able to help. But there's no point getting the education and being a bit more culturally aware unless I'm practicing it. If I'm not seeing it and practicing in it I probably won't retain it as much.... so exposure is probably the main thing, the more exposed you are the more you learn about the culture and behaviours and outcomes.... (D2)

The need for engagement and experiential learning were raised frequently, with several stressing the importance of clinical placements in their third or final year. Nevertheless, some indicated that although being allocated to rural areas or working with Aboriginal community centres was important:

...training of personnel when they're going out to specific groups has to be good, they have to be informed, but that person has to be engaged with the community as well. (OHT5)

Emphasis was again placed on cultural sensitivity, engaging with the community and seeking to understand the lived experience of local Aboriginal people in different contexts to be more aware of how social determinants influence optimum oral health choices.

Discussion

This paper investigated perceptions and experiences of dental professionals regarding oral health of Aboriginal children. Our findings highlight the concerns many participants raised about shortfalls in the dental health system when treating Aboriginal children. These include a 'one-size-fits-all' that may meet the needs of many Australians yet fail to create a welcoming environment for Aboriginal families or to understand or respond sensitively to the sociocultural context in which they live. While Aboriginal families often feel blamed for their poor oral health, participants also noted how the system itself can be a barrier to dental attendance. Findings also illustrated how the successful marketing of sugary products damaging to young children's oral health was not offset by enough culturally sensitive dental services accessible to Aboriginal children to prevent and treat dental caries and promote oral health. These findings suggest that part of the problem lies with the system itself that often seems indifferent and unresponsive to supporting Aboriginal families in preventing disease and promoting their children's oral health.

Participants offer suggestions of how to better respond to such needs including more education and training for dental professionals in Aboriginal oral health, understanding the importance of engaging with the local Aboriginal community, and including inter-professional oral health care as a strategy to promote oral health young children.

All participants had worked in public dental services and were committed to providing equitable services and meeting the needs of Aboriginal children. They wanted to deliver high quality appropriate oral care to Aboriginal children yet were governed by the structure of their work environment, education and personal experiences that often constrained this choice.^{9,24,25} As reported elsewhere,²⁶ participants attributed their lack of influence in making changes to organisational restrictions in mainstream oral health services and limited resources to deliver appropriate oral health support for Aboriginal children. They often felt unable to address complex social issues influencing lifestyle and poor oral health, considering it beyond their remit of dental care.

Participants' frustration with broader structural issues impacting on caring for Aboriginal children was also due to legal requirements, parent consent forms, bookings and time allocations, and high workloads. They felt overburdened and understaffed, which hindered their ability to build personal relationships necessary to discuss issues confronting Aboriginal children and families. In line with other studies some criticised the current emphasis on individual treatment rather than on oral health promotion, social integration and universal coverage.^{27,28} Several participants only saw Aboriginal children when they were in crisis or pain where dental work focused on procedures that invaded their personal space,²⁹ making it awkward to raise issues of oral health promotion.

Consistent with other studies, the attitudes of most Aboriginal families to oral health and lifestyle were perceived as 'different'.^{9,27,30} This created a tension that influenced dental professionals' provision of care where negative stereotypes about Aboriginal people were juxtaposed with a professional commitment to provide equitable care in a clinical environment.²⁴ Most were sensitive to socio-economic and cultural issues influencing Aboriginal health, including alcohol, drug abuse, unemployment, smoking and family violence. Some participants felt uncomfortable and lacked confidence communicating with Aboriginal children and their families to reduce the growing disparity in Aboriginal children's oral health, highlighting long-standing evidence of the need for better education and training.¹⁶⁻¹⁸

Participants' frustration with the system was compounded by competing demands from high workloads and short fragmented dental visits without continuity of care especially for those Aboriginal children most in need. Participants acknowledged the limited guidance, education or in-service training they receive on caring for Aboriginal children. While most began their discussions in a non-judgemental way on risk factors for oral health disparities in Aboriginal

communities, Aboriginal parents were often blamed for not bringing their children to appointments, coming only for emergency treatment and not following up on appointments despite the efforts the dental team used to accommodate their needs. While participants identified how individual and family behaviours compromise Aboriginal children's oral health, they also noted broader structural or socioeconomic issues that negatively impact on parents/carers making optimum oral health choices.^{9,24,31}

While some participants wanted more education on Aboriginal culture, traditions, customs and values others emphasised the importance of working with Aboriginal communities in more compassionate, respectful and patient-centred ways and the need for training in this area. More studies are recognising the need to acknowledge power imbalances involving clinician/patient in health care settings and indicate the importance of education and training in this area and in how to respond respectfully to cultural differences. This includes health providers critically reflecting on and questioning their own assumptions about Aboriginal people and whether such assumptions promote or undermine health outcomes of Aboriginal children and their families.^{32,33} Participants considered that working respectfully with Aboriginal people required effectively engaging with Aboriginal communities and offering flexible, respectful and sensitive oral health services for Aboriginal children. This reflected findings from other studies highlighting the importance of establishing relationships with local community groups to build trust, motivation and education, while at the same time improving their own capacity to work towards shared goals.^{3,25} Participants also considered how local community or Aboriginal health centres could offer a more holistic approach to oral health and health generally, as opposed to stand alone dental clinics. In particular, some participants noted that by working in a context where Aboriginal communities felt more comfortable, dental professionals could build relationships and gain greater knowledge and understanding of their lived experience. Moreover, through collaborating with primary health professionals in these local community centres, participants felt they could jointly provide a range of oral health promotion and clinical services, beginning from the early years of life.

Limitations included the self-selection of participants that was predominantly female reflecting a gender imbalance (as in some dental professions) where the views of male dental professionals or those with different views and experiences were not represented in the findings. While findings are contextual and cannot be generalised beyond this study, we anticipate they may be applicable to mainstream dental health settings in other Australian jurisdictions.

To conclude, current oral health care in Western Australia does not adequately reduce disparities between Aboriginal and non-Aboriginal children. Given the government's national mandate to 'close the gap' in health disparities between Aboriginal and non-Aboriginal Australians,³⁴ this is unacceptable. Our findings offer policy makers and oral health practitioners an opportunity to

reflect on current oral health policies and practices for their effectiveness in creating dental environments where Aboriginal families feel welcome and where dental professionals feel supported to work confidently with Aboriginal families. A first step might be to engage key stakeholders in Aboriginal communities in a collaborative approach with policy makers and practitioners across sectors to reduce this gap and consider effective strategies to improve oral health outcomes for Aboriginal children.

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