

# The use of consent forms in a “call from class” model of dental care for Australian Indigenous children

## Abstract

**Issues addressed:** Dental caries is one of the most prevalent non-communicable diseases in children. Indigenous children reported a disproportionately higher prevalence of dental disease compared to their age-matched counterparts. To improve access to dental care a community-controlled service provides culturally appropriate dental services on the site of an Indigenous primary and secondary school. The dental clinic utilises a “call from class” model of care. Consent forms seeking permission to undertake a dental examination without a parent/guardian present during school hours are sent home. When the forms are returned, the student is located in class and a dental examination is undertaken.

**Methods:** A retrospective audit of dental records from 2019 and 2020 were undertaken. The number of consent forms sent and returned were recorded.

**Results:** In 2019, 87% (n = 220) of the school population were sent consent forms. Of the forms issued, 70% (n = 154) were returned. Almost all students required further treatment (90%, n = 137) and were sent a treatment consent form. Of the total student population, 67% (n = 171) were not seen or had outstanding treatment from unreturned forms. Proportions of incomplete treatment and unseen students were similar in 2020 (64%, n = 173). In this model, barriers are lessened by providing a free dental service on the school site.

**Conclusions:** Consent is an ethical and legal necessity to undertake dental examination and treatment. Using physical forms were effective for gaining consent for most children. However, less than half of the school population's dental treatment was completed. Future

studies should be conducted to explore the acceptability of using consent forms by parents/guardians and different models to gain consent for children from complex social circumstances.

## 1 | INTRODUCTION

Dental caries is one of the most prevalent non-communicable diseases in children globally.<sup>1</sup> Amongst Australian children, Aboriginal and Torres Strait Islander (hereafter respectfully referred to as Indigenous) children reported a disproportionately higher prevalence of dental disease compared to their age-matched counterparts.<sup>2,3</sup> Indigenous children have approximately double caries (dental decay) experience and more untreated carious lesions than non-Indigenous children.<sup>2,3</sup> This health inequity contributes to lower quality of life and life expectancy amongst Indigenous Australians.<sup>4</sup>

Aboriginal and Torres Strait Islander Community Controlled Health Services (ASTICCHS) are an evidence-based model of care which provides subsidised culturally appropriate and accessible health services to the Indigenous community.<sup>5</sup> The multi-disciplinary service provides access to dental care for Indigenous children and utilises a “call from class” model of care. In this model, parents or guardians give written or verbal consent for their child to attend dental services on the site of their school, without the need to be physically present at the appointment. Anecdotal evidence suggests this model provided increased flexibility for parents/guardians and increases appointment attendance and the rate of school aged children accessing dental services. Whilst this model of care is utilised widely in the public dental sector in Australia,<sup>6</sup> there is little evidence to suggest the utilisation of a “call from class” model with consent forms provides an effective pathway to accessing dental care for vulnerable children. This study aimed to investigate the use of consent forms used in a “call from class” model and this tool's ability to provide access to dental care for Indigenous children.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2022 The Authors. *Health Promotion Journal of Australia* published by John Wiley & Sons Australia, Ltd on behalf of Australian Health Promotion Association.

## 2 | METHODS

This study was conducted in an ASTICCHS dental service situated on-site of a school for Indigenous children in Australia. The school has prep to year 12 and all school students are eligible for free dental services. Consent forms seeking permission to undertake a dental examination without the parent or guardian during school hours were sent home. When the forms were returned, the students were located in class and a dental examination was undertaken. Another consent form was sent if further dental treatment was required (such as fillings or extractions). When the form was returned, the students were collected from class to have dental treatment undertaken.

A retrospective audit of dental records at an Indigenous school dental clinical was undertaken. Data collected for analysis spanned the years 2019 and 2020. All school children were recorded if consent forms were sent to their parent/guardian if the forms were returned and if subsequent examination or treatment occurred. A descriptive analysis of the consent audit data was undertaken using frequencies and percentages in Microsoft Excel. Data were presented in a Sankey diagram generated in SankeyMATIC.<sup>7</sup>

This study was reviewed by the University of Queensland Human Research Ethics Office and was exempt from ethical review (2021/HE00184).

## 3 | RESULTS

Figure 1 visualises the pathways of the model of care and rates of consent form return in 2019. In 2019, 87% (n = 220) of the school

population were sent consent forms. Of the forms issued, 70% (n = 154) were returned. Almost all students required further treatment (90%, n = 137) and were sent a treatment consent form. Three-quarters (n = 102) of the treatment consent forms were returned. Of the total student population, 67% (n = 171) were not seen or had outstanding treatment from unreturned forms. Proportions of incomplete treatment and unseen students were similar in 2020 (64%, n = 173) (Figure 2).

## 4 | DISCUSSION

In this model, barriers to accessing dental services are lessened by eliminating barriers of approachability, affordability and acceptability.<sup>8</sup> More than half of the school population accessed a dental examination, which was similar to rates of access for Indigenous children in population studies.<sup>3</sup> Using physical forms were effective for gaining consent for most children. Levesque et al (2013)<sup>8</sup> published a framework explaining the dimensions of patient-centred access to health care and the domains that may understand the facilitators of this “call from class” model. The consent forms provide an avenue for the service to reach parents and guardians of children to enable access. Community controlled dental health services provide an essential tailored and culturally appropriate service for the Indigenous population.

It is evident from this study, there were other barriers to accessing care as less than half of the school population's dental treatment was completed. The “call from class” model of care encompasses numerous dimensions of the patient-centred access to health care

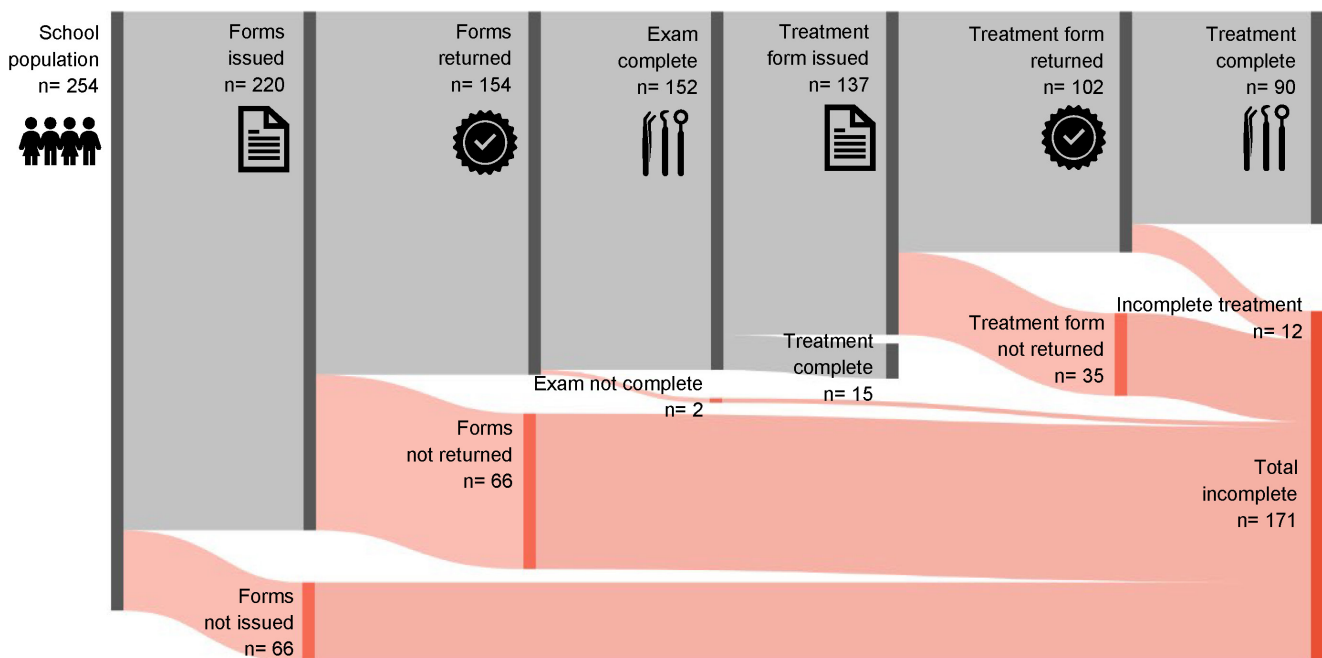


FIGURE 1 Treatment and consent pathways in 2019 in the call from class model of care (n=254)

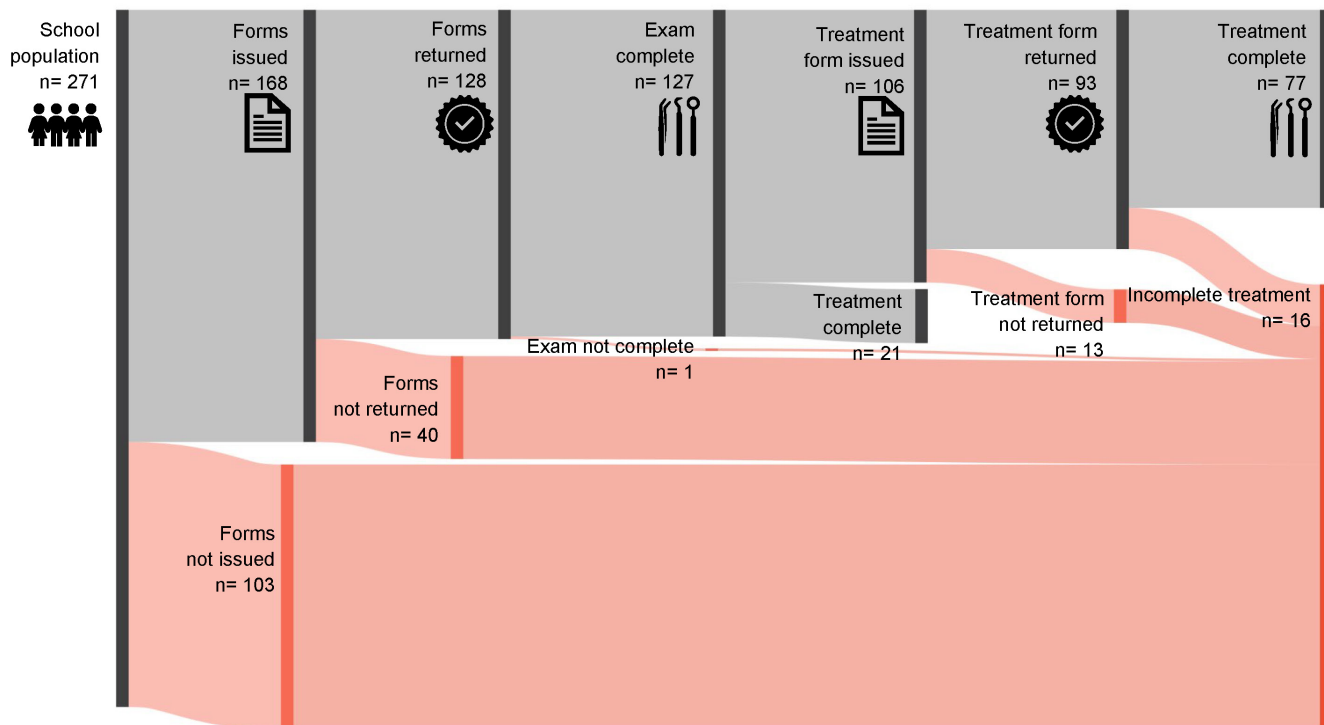


FIGURE 2 Treatment and consent pathways in 2020 in the call from class model of care (n=271)

model; however, the use of consent forms in vulnerable populations may create barriers for those with complex social circumstances and low literacy. Informed consent is an ethical and legal necessity to undertake dental examination and treatment. Future studies are, therefore, required to explore the acceptability of using consent forms by parents/guardians and service innovations are needed for vulnerable children to access dental services and ensure completion of dental care.

#### KEYWORDS

children's health, community health services, Dental public health, health policy

#### ACKNOWLEDGEMENT

Open access publishing facilitated by The University of Queensland, as part of the Wiley - The University of Queensland agreement via the Council of Australian University Librarians.

#### CONFLICT OF INTEREST

The authors have declared no conflicts of interest.

#### ETHICS STATEMENT

This study was reviewed by the University of Queensland Human Research Ethics Office and was exempt from ethical review (2021/HE00184). Permission from the data custodian was obtained prior to data extraction, de-identification and subsequent analysis.

Nicole Stormon<sup>1,2</sup>

<sup>1</sup>School of Dentistry, UQ Oral Health Centre, The University of Queensland, Herston, Queensland, Australia

<sup>2</sup>Aboriginal and Torres Strait, Islander Community Health Service Brisbane, Woolloongabba, Queensland, Australia

#### Correspondence

Nicole Stormon, Oral Health Centre, 288 Herston Road, Herston, Brisbane, 4006, Queensland, Australia.

Email: [n.stormon@uq.edu.au](mailto:n.stormon@uq.edu.au)

#### ORCID

Nicole Stormon <https://orcid.org/0000-0003-0758-1605>

#### REFERENCES

- James SL, Abate D, Abate KH, Abay SM, Abbafati C, Abbasi N, et al. Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *Lancet*. 2018;392(10159):1789–858.
- Jamieson LM, Armfield JM, Roberts-Thomson KF, Sayers SM. A retrospective longitudinal study of caries development in an Australian Aboriginal birth cohort. *Caries Res*. 2010;44(4):415–20.

3. Do LG, Spencer AJ. Oral Health of Australian Children: The National Child Oral Health Study 2012–14. University of Adelaide Press; 2016.
4. Kilpatrick NM, Neumann A, Lucas N, Chapman J, Nicholson JM. Oral health inequalities in a national sample of Australian children aged 2–3 and 6–7 years. *Aust Dent J*. 2012;57(1):38–44.
5. Campbell MA, Hunt J, Scrimgeour DJ, Davey M, Jones V. Contribution of aboriginal community-controlled health services to improving aboriginal health: an evidence review. *Aust Health Rev*. 2017;42(2):218–26.
6. Nguyen T. Is the current model of public dental care promoting the oral health of young children in Australia? 2017.
7. Bogart S. SankeyMATIC. 2021. Available from: <https://sankeymatic.com/>
8. Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013;12(1):18.

**How to cite this article:** Stormon N. The use of consent forms in a "call from class" model of dental care for Australian Indigenous children. *Health Promot J Austral*. 2022;33(S1):134–7. <https://doi.org/10.1002/hpja.575>