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ORIGINAL RESEARCH

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Consulting a Victorian Aboriginal community about their oral health

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Abstract

Background: The legacy of colonisation, assimilation, racism and victim blaming has created inequality in health for Aboriginal people, reflected in their oral health status. Despite the existence of community dental services, oral disease levels continue to be of concern. This study, initiated by a rural Victorian ACCHO (Aboriginal Community Controlled Health Organisation), aimed to consult their community about the barriers to and enablers of oral health and understand their lived experiences with dental services.

Methods: Using an Aboriginal knowledge framework and collaborative approach involving an Aboriginal researcher and Community Mentor, this study consulted an ACCHO community about their oral health. Following community engagement, 21 community members participated in digitally recorded yarning circles and semi-structured interviews.

Results: Themes emerging from the data included dental care history and past experiences involving pain and shame, the value of having community-centred services and engagement with patients and the community.

Discussion: Experiences of dental care are often related to pain driving attendance resulting in experiences that multiply fear and anxiety. While community-based care was considered a strength, approaches to individual dental care often resulted in increasing shame and diminishing trust. Increasing cultural safety and participatory approaches to designing and delivering dental care may increase engagement and trust.

Conclusions: Important gaps in cultural and clinical understanding between the community and dental service providers have been identified. These findings will be used to inform the delivery of dental services and to develop oral health promotion programs at the ACCHO, and cultural safety preparation for student dental practitioners.

KEYWORDS

Aboriginal Health, community based service delivery, consumer participation, dental Health, rural health services delivery

1 | INTRODUCTION

Aboriginal knowledge and cultures have strengths that lie in resilience, holistic approaches to health, connectedness and community partnerships.[1] The legacy of colonisation, assimilation policies, racism and victim-blaming approaches has created inequality in health for Aboriginal people, which is reflected in their oral health status.[2,3] Poor oral health is directly linked to poor general health, and substantial evidence for this has been demonstrated in relation to cardiovascular disease, diabetes, kidney disease, dementia and other chronic health conditions.[4] Westernised health care practices have ignored the expertise Aboriginal people have about their own lives and imposed biomedical models of care.[2] To combat this legacy and improve health status, it is crucial to consult Aboriginal people about how they would like their oral health supported and care provided, to build service models and health promotion that is culturally located. Aboriginal people have the greatest understanding of their communities and therefore should be the initiators of change.[3]

A rural Victorian Aboriginal Community Controlled Health Organisation (ACCHO) provides health and community services, including dental services to the Aboriginal and Torres Strait Islander people in their region. Dental staff report that oral disease rates remain high in this ACCHO's community, suggesting that the introduction of the clinical services and oral health promotion programs have been only partially effective. To date, there has been little or no consultation with the community to inform the programs. Without understanding how the community experiences and manages their oral health, the oral disease rates are likely to remain high.[2] To develop successful oral health service models, it is crucial to create models that respond to the needs and incorporate the expertise of the community; this helps ensure that the care is culturally appropriate and supported by the community.[3,5] Thus, this project aimed to use a collaborative approach to consult the ACCHO's community about their oral health. The consultation set out to address the following research questions: How do Aboriginal people from this ACCHO community understand oral health? what are the barriers to and enablers of oral health?; and what are their lived experiences with dental services?

What is already known on this subject:

- There are high rates of dental disease in Aboriginal communities
- Current oral health services often have low participation rates among Aboriginal people
- Barriers such as long travel times, cost of treatment and lack of culturally appropriate care can prevent Aboriginal Australians from accessing dental services

What this paper adds:

- First time, this ACCHO community has been consulted about their oral health
- Increasing community engagement to enhance trust building between patients and dental practitioners is important to reduce shame and judgement
- Further co-design research is required to develop programs and evaluate cultural safety in service provision

2 | METHODS

2.1 | Methodology

In keeping with the ethical and cultural methodologies for research with Aboriginal communities,[6,7] this study included an Aboriginal Lead Researcher (ACCHO LR) in the team, used a collaborative approach with input from and support from the ACCHO and included a local Aboriginal Elder as a Community Mentor (CM) to ensure cultural safety and continuity during the data collection and analysis process. Cultural safety meant creating a respectful, ethically responsible research environment to benefit the community and researchers equally, while cultural continuity was built by maintaining the bonds and relationships between people and between the people and their environment. It also included the responsibility to respect spiritual domains.[7]

The role of the CM was to bring community views to the project, advise on culturally safe approaches, contribute to engagement and champion the project in the community, to help with recruitment and contribute to cultural continuity in the thematic analysis and findings. To allow for participant comfortability, the non-Indigenous Australian researcher conducted a month of community engagement to help the community feel at ease around the researcher before the yarning groups and semi-structured interviews were conducted.

The study design involved qualitative data collection in the form of semi-structured individual interviews and yarning circles. Yarning is a well-known Aboriginal communication method, which enables researchers and participants to work together as equals valuing and trusting each other while allowing robust exploration of a

topic.[8–11] Individual interviews used a similar approach while providing the option of privacy for those who preferred it. Questions were developed collaboratively by the research team, which included the ACCHO Lead Researcher and Community Mentor, and drawing on the work of Krichauff et al (2020). Community engagement was undertaken prior to the data collection to build relationships and trust between the researchers and the community members, which was crucial given data collection was undertaken by a non-Indigenous researcher.

Ethics approval for the study was provided by the University of Melbourne Human Research Ethics Committee (#HREC 2021–20 539–18 209-5).

2.2 | Design, participants and data collection

The study was promoted using the ACCHO's networks and affiliated groups to recruit a variety of participants to ensure multiple views and experiences were collected. The inclusion criteria included the following:

- People older than 18 years who identify as Aboriginal or Torres Strait Islander;
- People who are eligible for health care at the ACCHO;
- A range of people of varied age and genders including people who access the ACCHO health services; people who access the ACCHO dental services, people who do not access the ACCHO health services despite being eligible, elders, young people and parents; and
- Staff at the ACCHO.

Using the networks and settings of the ACCHO, convenience and snowball methods were utilised to recruit participants. Community engagement was conducted by EC, for the month of May 2021, with the guidance and support from the CM and the ACCHO LR, to champion the research in the community prior to recruitment and develop relationships. A flyer with information about the project was placed on notice boards in the ACCHO health clinic and service settings and on associated social media platforms. Staff at the ACCHO were also asked to promote the project in the community via word of mouth. Recruitment was conducted from June to August 2021.

Using a semi-structured interview guide, qualitative semi-structured interviews and yarning circle discussions were used to collect data. Participants had the choice between an individual interview or yarning circle conducted in a private room at the ACCHO or community space, allowing the participants to choose an environment in which they were comfortable, and ensuring a safe space for the discussion.

Interviews/yarning circles were conducted and digitally recorded with the consent of the participants by EC. A $25 Eftpos voucher was given to participants to respect the time given to the study. The ACCHO LR was not involved in data collection to protect confidentiality and to mitigate dependent relationships.

2.3 | Analysis

Analysis was guided by the grounded theory model (GTM), which is a process involving the inductive generation of theory from data using systematic and rigorous approaches considered suitable for use in Aboriginal communities.[12] It encourages researchers and the participants to have an equitable relationship increasing the ability to conduct decolonising research, which accommodates the complexity and recognises the multiple layers of complex historical, social and environmental contexts embedded in Aboriginal peoples' lives.[13] This approach is ideally suited to conducting exploratory and contextually responsive research, especially in areas where a solid evidence base is lacking, which is common in Aboriginal research, and was the case in this study.[13] Based on GTM, a thematic content analysis using an inductive approach was utilised to analyse the data.

The data collected were transcribed by EC, and all transcripts were returned to participants for validation. Following validation, the data were de-identified prior to analysis and entered into the software package NVivo. Initial inductive coding was undertaken by EC, with triangulation from the PR and ACCHO LR. Following triangulation of the coding and initial theme development, discussion with the CM to clarify meaning occurred, facilitating the analysis, and to ensure cultural continuity. Once the data were inductively coded, codes were grouped together to enable axial coding, then the researchers, with guidance from CM, established the themes that emerged from the data and how they were reconstructed to answer the research questions.[14] Once relevant themes were identified, they were finalised for reporting.

3 | RESULTS

Four individual semi-structured interviews and five yarning groups were conducted, with three groups containing two participants, one containing five and another containing six participants, respectively. Of the participants, 11 were female and 10 male, aged between 19 and 87 years with approximately two thirds being younger than 50 years and one third being older than

50 years, and the participants included people who both access and do not access the ACCHO dental service. The duration of the interviews/yarning groups ranged from 17 to 84 min.

Three key themes were identified from the data, which included the following: past dental experiences involving history, pain and shame; the advantages and disadvantages of having a close-knit community; and the engagement occurring between patient and practitioner and in the community. Quotes in the following section are referenced using M or F to refer to male or female participants combined with a letter to refer to the individual to protect anonymity—for example, FK means Female K.

3.1 | Past experiences—history

Participants were asked what their oral hygiene habits and care was like growing up. Most of the participants indicated that some dental care was available to them growing up—they had access to a toothbrush and toothpaste; however, oral hygiene was not routine. Many participants did not have access to a regular dental clinical care while growing up; inconsistent dental care and lengthy travel to Melbourne for dental treatment were discussed, while others attended the mobile dental service at school.

> '...Yeah well I come from a family of nine, single Mother. There was always toothpaste and toothbrushes. But you weren't made to do it, [we] went to Melbourne and went to the Aboriginal dental service in Melbourne...'
>
> -FD

> '...We had the bus come to school. So my first proper memories of the dentist were probably getting fillings in the bus and then getting sent back to class...'
>
> -FK

Not all participants had this experience, one person commenting on the priority their family gave to oral health from a young age.

> '...So we were taught, you know, early on, you know, brush in the morning, night, you know, back then, wasn't much known about flossing....the importance of flossing...'
>
> -MB

3.2 | Past experiences—pain

Tooth pain and pain being experienced in a dental appointment were discussed as a reason both to attend and to not attend a dental appointment. Most participants indicated that they would only attend an appointment if they had significant dental pain and would not attend for regular check-ups.

> '...Yeah see because, and with our mob too, as soon as you mention you got to go and have a dental check up. You won't see them. They're like spirit. And the only time that you actually see them is when they laying up in the chair with big ulcer and the dentist won't touch them...'
>
> -MA

Participants indicated that they avoided dental care/visits unless they were in pain because they have had a previous negative and/or painful experiences in the dental clinic, or they have heard horror stories about dental treatment from other community members.

> '...Yeah, it's like this pain. I know it's going to end, but in there, I don't know how bad it's going to be when I go in...'
>
> -FK

Participants like MC also talked about dental pain as if it is an expected part of life and something that you put up with until it is gone.

> '...In that sometimes the pain does go away.... the next day it feels fine so you... You don't give it another thought...'
>
> -MC

3.3 | Past experiences—shame

The notion of shame around dental appointments was discussed. People felt judged and felt like they were not good enough when dental clinicians 'lectured' patients around dental care.

> '...I don't know if it's sort of related, but I find when you go to a dentist, they'll focus on anything that's not good. Yeah and they don't really tell you any positive stuff.... You get a lecture don't ya...'.
>
> -MC

> '...You know what I really don't like is when they give you lectures. Yeah, I seriously hate that....'
>
> -FH

Some participants said that due to the shame or embarrassment, they feel about the condition of their teeth they are likely to avoid dental visits because they have received or expect judgement from the clinicians.

> '...I think it's that if you go in there like I am, I'm shame when I go in there because of why my teeth look what they're going to judge you. So, yeah, that's my shame...'
>
> -FE

3.4 | Community—advantages

Having a service that is solely for their community and has staff that are community members means that many participants feel safe accessing all the services their ACCHO provides. The community relationships were identified as important;

> '...I think everybody would if they could, go there, yeah cause they would feel at home...'
>
> -FJ

> '...Well just that they're all our people and that's our life there...'
>
> -MI

According to participants, without their ACCHO, the community would be unlikely to access care; they were unlikely to use mainstream public services due to previous negative experiences and would not use private dental clinics, due to the high cost associated with treatment. Dental treatment at the ACCHO is without cost for the community making this community service more accessible.

> '...I don't think I have [been] anywhere else. I wouldn't go mainstream yet and I go to [the ACCHO], where I feel comfortable and they know me and they know how to talk me through the process...'
>
> -FD

> '...I don't use anywhere else. I only use [the ACCHO], I don't use any other service at [the ACCHO] I only use dental and that's because of the relationship I have with xxx. And I use it because it's affordable...'
>
> -FE

3.5 | Community—disadvantages

Participants also indicated that there were some disadvantages with a community-based service. Due to it being a close-knit community, people were worried that their private information would not always be protected.

> '...I would rather go into the dentist and actually tell my dentist, you know, instead of telling the admin who I'm going to see out on Saturday night...'
>
> -FF

> '....some don't come because they think because the community is so tight knit and it talks - that some things might spread out. Yeah, I know that's a real concern from some community members...' Yeah
>
> -MB

The idea of nepotism was also mentioned; due to historic disagreements between different family members and clans, some community members would not access or felt unwelcome at the ACCHO. Participant FE has felt this sense of feeling unwelcome related to clan differences within the community.

> ....it is a common thing that only [xxx clan] people are acknowledged and not [xxx clan].... So I know that plays a big issue with a lot of people not accessing or using it because of the way they are treated when they walk in the door....
>
> -FE

> '...Probably family issues Yeah. or family feuds. I don't wanna go there cause so, and so, works there. That's probably the main one...'
>
> -FH

> '...It's ACCHO funding for Aboriginal. Yeah. You're not particular clan groups or anything.... the nepotism that's developed over the years with just certain families being involved in, you know. Yeah. Just a nepotism side of things...'
>
> -MD

3.6 | Engagement—patient interactions

Participants indicated they want clinicians to stop lecturing and tailor oral health information to the individual. There is a belief that dental practitioners enjoy inflicting

pain making the clinical environment unwelcoming, which according to FK is reinforced by the language and body language practitioners use.

> '...I was gonna say it [lecturing] ignores the reason as to why someone's using drugs or they're drinking a lot of soft drink or, you know, because there's a reason—they didn't just start doing it...'
>
> -MC

> '...it really comes down to how you actually approach them. Yeah. And how you actually say words. Right. because when you're talking to our mob, you got to sort of pick and choose and in particular to read the body language of that person. Right...'
>
> -MA

> '....It's the body language of, 'I just want to get you out of here so I can go home', that sort of thing...'
>
> -FK

Participants such as FB believe that in order to change this experience, clinicians need to get to know their patients on a personal level, to allow time for more conversations regarding an individual's life to occur for a clinician to understand and provide relevant information for the person.

> '... Having those conversations and even if they're not tough, just doing that touching base.... You're going to have more people being honest and yeah, getting that relationship building better...'
>
> -FB

Some community members indicated they feel as if they are just another statistic when attending the ACCHO, because they perceive that the income each patient generates is the most important thing.

> '...Yeah ...a number to get statistics for the funding...'
>
> -MD

> '...Oh and I don't, maybe that's why some people don't wanna come here. Well what I'm Aboriginal so I have to go to the Aboriginal place, yeah but I'm just a stat...'
>
> -MB

3.7 | Engagement—community

A lack of effective community engagement was discussed reflecting the value participants placed on community. To properly engage with community members, participants felt that dental practitioners and dental staff should connect with community groups outside of the clinics.

> '....Over at [the ACCHO], they have all these programs running from there- at the same place they had the elders. Sometimes they have men's groups, they have women's groups. A 2 min walk out the door and you're there. Go and promote that there to them...'
>
> -FD

> '....Make it a social sort of thing and people will come up especially if the weather gets better....'
>
> -FJ

Participants indicated that community members distinguish between workers who have a genuine interest in the community culturally, and those who just see their work as a job.

> '...I think too with non-Indigenous folk, is if you only come in here for a pay check- that's not working in the community, you know, whereas we have a lot of staff that are non-Indigenous, who you see in them at club... You have staff here, at [the ACCHO], who are not Indigenous. They cross that bridge, but they don't actually cross the metaphorical bridge of getting to know community.... It's like, yeah, our staff in dental, they really good, they are really good staff, but they also are just here for the pay check, you know...'. Yeah
>
> -FB

4 | DISCUSSION

This research is significant because it is the first time that the people of this Victorian Aboriginal community have been asked about their experiences with dental services. This study sought to explore how this ACCHO community understands their oral health and their lived experiences with oral health and dental services, and the barriers to and enablers of oral health. By conducting semi-structured interviews and yarning groups, participants

were invited to have a discussion about their oral health. The participants were from a wide range of ages and social backgrounds, which allowed for a range of different views to be captured.

It was generally agreed that participants were aware of how to best care for their teeth but did not always act on this. Despite this knowledge, it was overwhelmingly common for participants to access the dental service only when they were experiencing pain rather than for regular care or preventative services. This was largely due to traumatic dental experiences in their past or from hearing horror stories about dental treatment from other community members. Therefore, in order to prevent any traumatic dental experiences, people in our study commonly avoided dental treatment unless it was the only option to cease the pain. As a result, when an individual finally attends a dental clinic for pain relief it is more common that they may require a more invasive procedure to manage dental pain, for example a root canal or an extraction, potentially accompanied by infection. This increases the risk of painful treatment, thus creating a cycle of pain and traumatic experiences. These types of experiences multiply the fear and anxiety associated with dental care that will then be carried into an individual's next dental appointment. Like the findings of Krichauff and colleagues,[9] most of our participants emphasised the notion that most community members will only go to a dentist when they have a problem, because that is how it has always been. This has become a generational cycle, and despite participants understanding the importance of oral health, no change is occurring.

While community-based care was considered a strength, the approach to individual dental advice and care often resulted in increasing shame and diminishing trust.[9] Berggren's vicious circle of dental anxiety demonstrates that fear and anxiety around dental appointments will lead to avoidance of appointments, which in turn results in deterioration of an individual's dentition; this deterioration leads to the person feeling shame, guilt and inferiority.[15] The impacts of colonisation, racism and generational trauma for Aboriginal people also contribute to entrenched feelings of inferiority multiplying shame, which underpins a reluctance to access services.[2] Our findings indicate that embarrassment about poor oral health is linked to feeling shame and fear of being judged and is commonly experienced within this community, which continues to contribute to the avoidance of dental appointments.

The feeling of being judged was often reinforced when a clinician would 'lecture' the patient about their oral health. These conversations, according to Moore and Colleagues,[15] are likely to establish a social hierarchy between patient and practitioner, in which patients experience social powerlessness in a clinical situation. According to participants, this social hierarchy can also be emphasised by tone of voice and body language. These negatively framed interactions lead to an increase in dental anxiety and diminish the trust felt by a person (the patient) with the dental practitioner.[16] A lack of trust between a person and a practitioner results in dissatisfaction with services, and to an individual being an irregular dental attendee. Our participants indicated that shame and unequal power dynamics felt in a health care setting are expected and fairly common, and this, alongside Aboriginal communities' experiences of being historically disenfranchised, contributes to reluctance around oral health care. This cumulative effect contributes to both the barriers to care and the deficit narrative that is common for such communities.

In order to enhance trust in this ACCHO community, our data suggest that the dental health services would benefit from an increase in participatory approaches to delivering dental care and ensuring that clinical conversations are held in a non-judgemental, culturally inclusive manner. Participants highlighted the importance of community relationships and engaging with community members in a non-clinical environment, to help to break down the perceptions that dental practitioners only inflict pain, to build trust and allow people to establish relationships that are not solely founded on clinical experience. There is a need to understand and contribute to the perception of a more equal power dynamics in the clinical environment. There was also a perceived need for practitioners to have conversations with their patients that involve general life discussions allowing a personal relationship to form and trust to increase.

These findings suggest that in order to have successful dental appointments and preventive conversations, practitioners and dental staff need to have an understanding of the community they are servicing, their history and the powerlessness that can be felt by Aboriginal people in a clinical situation. It is important for non-Aboriginal practitioners to understand the ongoing impact of colonisation and to bridge the cultural gap between westernised models of care and Aboriginal models by building interpersonal relationships and understanding how to enable relationships that build trust. In this community, this includes a sense of humour, the importance of translation of knowledge in ways that do not shame people, considering the types of language used, for example local cultural terms, and recognising the importance of family relationships. Our data show that word of mouth is a powerful influence for this community and the strength of family and community networks and relationships can add to or diminish the standing and acceptance of a service in a community.

This was also highlighted by the metaphor of '*crossing that bridge*'—which recognises the challenge and

expectations for non-Aboriginal people of really working to understand and operate in an Aboriginal paradigm. This emphasises the importance and need for decolonised, culturally safe practices, as defined by Aboriginal people ensuring that their voices are prioritised, and importantly, without which, there is no clinical safety.[17,18] This requires a process of constant self-reflection by oral health professionals and clinic staff to ensure that practices are culturally safe, a process that takes time, commitment and communication with Aboriginal people. Creating trust is crucial in improving the oral health of the community, and an important component of trust is ensuring culturally safe practices that increase the capacity of people to take control of their own oral health.

Creating trust is a process that requires an investment of time in a clinical encounter. Sometimes, due to the structure of the clinical service, often defined by their funding models, the time needed for this approach is not a given in a clinical appointment. For the ACCHO to maintain financial viability, certain performance indicators must be met and the model of funding for dental care is the same as mainstream public dental funding. Mainstream dental clinics, despite having challenges with high-needs clients and funding, do not face the same challenges as an Aboriginal service in regard to building trust. More time for appointments would allow more time for trust between clinician and patient to develop. There is a clear gap between the clinical and biomedical approach that is taken to treat pain and dental disease, and the community or person-centred approach that overwhelmingly seems to be expected by the community of an Aboriginal health service. However, the current funding model does not allow appropriate time, and the need to meet performance indicators results in patients having short appointments, which can lead to them feeling like a statistic, which was raised in our data. This is a challenging concept because if the ACCHO cannot meet their funding requirements, they do not have the clinic, but the way the funding is delivered does not appear to meet the needs of the community.

There is also a need to consider oral health promotion (OHP) from a similar perspective. Our study participants have indicated that they would like to see more OHP provided in community-based settings. They also believe that while oral health information is available to them, and while they generally understand what is needed to achieve optimal oral health, OHP is not well practised and high dental disease rates persist. According to Nutbeam's three levels of health literacy, this community displays functional oral health literacy whereby they are able to obtain relevant oral health information and apply this to limited situations.[19] The continued high rates of dental disease indicate that there is a lack of interactive and critical oral health literacy and structural impediments to this.

Our findings suggest further community consultation and co-design of oral health promotion and a remodelling of service funding to enable approaches to care to meet the needs of this ACCHO community are required. Actively involving the community in designing health services to meet their needs, as a key to building trust and increasing access to care, has been supported elsewhere.[20] Ensuring staff and dental students are culturally safe to work in this Aboriginal community is also crucial. In line with contemporary approaches and respect for autonomy, cultural safety should be determined by the community in which the clinician is working.[18] These results have raised questions that require subsequent research to explore potential funding models and programs that support Aboriginal ways of working and needs around oral health. Ultimately, more understanding is required and this understanding must be informed by the community—those with the expertise in their own culture and health.

5 | LIMITATIONS

As the findings described in this research are from a limited number (n = 21) of community members, it is possible that they do not adequately describe the breadth of understanding within the community. COVID-19 lockdowns in Victoria impacted our recruitment and ability to collect data during 2021 and potentially also our capacity to achieve data saturation. However, commonalities across the data were evident, suggesting that the themes raised are topics of importance to a range of different people in the community and that a degree of saturation was achieved. Another potential limitation is the participation of a non-Indigenous Australian as the primary researcher; this may have impacted on the comfortability of the participants. The impact of the researcher on the data collection process and the questions asked always affects the nature of the data and is acknowledged.[2] Conducting yarning groups was a familiar approach and created a sense of comfort for most participants as they knew the other people participating and had chosen this mechanism. However, the group dynamic may have impacted on individual responses.

6 | CONCLUSION

The results of this study indicate that there are gaps in the cultural and clinical understanding between this ACCHO community and their dental service providers.

Dental service providers need to understand how important both clinical engagement and community engagement are in order to change this cycle. Removing shame and judgement from a clinical relationship and environment is crucial in building trust between patient and practitioner. In addition, understanding the patient's whole self and context to provide holistic care is needed. Although this engagement is necessary, dental staff need to have an appropriate cultural understanding of the community in which they work. This includes understanding how the legacy of colonisation, assimilation policies, racism and victim-blaming approaches to health has created inequality in oral health status for Aboriginal people. It was suggested that more in-depth cultural safety preparation is required not just for dental staff but for all staff when working with Aboriginal communities. To have successful oral health promotion programs, the community must be able to participate in the design of programs, must relate to the information and must be culturally appropriate and delivered in ways that are relevant and by someone the community respects. It is also important to recognise that some issues may be a result of structural problems such as a generalised funding model. The findings from this study have been returned to the ACCHO for their utilisation. These findings will be used to inform the delivery of dental services and to develop oral health promotion programs at the ACCHO and cultural safety preparation for student dental practitioners to increase the capacity of Aboriginal and Torres Strait Islander people to improve control over their oral health.

AUTHOR CONTRIBUTIONS

EMC: conceptualization; data curation; formal analysis; investigation; methodology; writing – original draft; writing – review and editing. TH: conceptualization; formal analysis; investigation; methodology; project administration; resources; supervision; validation; writing – original draft; writing – review and editing. JS: conceptualization; data curation; formal analysis; funding acquisition; investigation; methodology; project administration; resources; supervision; validation; visualization; writing – original draft; writing – review and editing.

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CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest.

ETHICAL APPROVAL

Ethics approval for the study was provided by the University of Melbourne Human Research Ethics Committee (#HREC 2021-20539-18209-5).

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