Refugee and Asylum Seeker Oral Health Recall Tool Development and Pilot

FINAL REPORT

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JUNE 2017

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First published 2017

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ISBN Printed: ISBN-13: 978-0-9945276-4-6

ISBN electronic: ISBN-13: 978-0-9945276-5-3

Copy editing by Neil Conning
Layout by Mark Carter

Cover photos: © Dental Health Services Victoria

Suggested citation

Tyrrell, L., Mansfield, T., & Casey, S., 2017, *Refugee and Asylum Seeker Oral Health Recall Tool – Development and Pilot: Final Report*, Victorian Refugee Health Network: Melbourne.

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Executive summary

A Refugee and Asylum Seeker Oral Health Recall Tool (see Appendix) has been developed for use in Victorian public dental services. This report details the process and findings of the development and piloting of this tool. The project was funded by Dental Health Services Victoria (DHSV) and conducted over a five-month period from November 2016 to April 2017 by the Victorian Refugee Health Network.

The development of the tool was informed by a literature review, the Project Advisory Group, Foundation House community liaison workers, and dental services who participated in the pilot. The factors associated with poor oral health within refugee and asylum seeker populations are unique and complex, with overall oral health and subsequent access to services impacted by both pre-arrival and resettlement factors. This includes factors such as pre-arrival torture and trauma (including trauma to the mouth/teeth), the health impact of periods of deprivation in transit, and the ongoing systemic and social disadvantages related to resettlement, including language barriers and unfamiliarity with the Australian health system.

In 2010, the Victorian Department of Health implemented two policies in regard to oral health; it identified refugees and asylum seekers as a priority access group and provided a fee exemption at public dental services across Victoria. Subsequently, the 2012 Refugee Oral Health Sector Capacity Building Project (inclusive of Model of Care) aimed to support public dental services in Victoria to implement the priority access and fee exemption policies and work with people from refugee backgrounds. The Model of Care recommends observation and assessment of social and clinical risk factors that impact on oral health care as the basis for continued priority access for individuals from refugee backgrounds.

People from refugee backgrounds present with varying degrees of risk of poor oral health. For this reason oral health practitioners require an approach that differentiates people that require ongoing support to access services from those who may join general waitlists. The development of this evidence-based tool supports oral health practitioners to make these decisions.

Based on the advice provided by the Project Advisory Group and the findings from the pilot, the Victorian Refugee Health Network has made seven recommendations.

RECOMMENDATION 1

DHSV facilitate a trial of the Refugee and Asylum Seeker Oral Health Recall Tool across a larger number of services across the state to assess the validity and inter-rater reliability of the tool. This should include demographic data to understand differences across cohorts.

RECOMMENDATION 2

Dental services participating in the trial consider implementing a six-month recall period for clients identified as higher risk, subject to a DHSV review of the evidence for a six-month recall.

RECOMMENDATION 3

DHSV consider the evidence from the Monash Health Social Risk Assessment research project in the development of a final version of the Refugee and Asylum Seeker Oral Health Recall Tool.

RECOMMENDATION 4

DHSV support agencies to adopt and implement the Refugee and Asylum Seeker Oral Health Recall Tool by facilitating professional development about refugee and asylum seeker experiences (in partnership with Foundation House), the Model of Care, and the tool.

RECOMMENDATION 5

DHSV embed the Refugee and Asylum Seeker Oral Health Recall Tool in Titanium to facilitate its uptake and usability.

RECOMMENDATION 6

Dental services implementing the Refugee and Asylum Seeker Oral Health Recall Tool develop and utilise referral pathways within their community health service to support clients for whom high risks are identified.

RECOMMENDATION 7

DHSV utilise the findings from a broader trial of the Refugee and Asylum Seeker Oral Health Recall Tool to inform further development of the Model of Care for Refugee and Asylum Seeker Oral Health.

Acknowledgements

The Victorian Refugee Health Network would like to thank the members of the Project Advisory Group who provided valuable expert advice and support for this project during the Project Advisory Group meetings and/or stakeholder interviews:

- Dr Colin Riley *Dental Health Services Victoria*
- Jenni Baker *Dental Health Services Victoria*
- Robyn Alexander *Dental Health Services Victoria*
- Sue Casey *Foundation House*
- Dr Ramini Shankumar *Monash Health*
- Dr Parul Marwaha *Monash Health*
- Alana Russo *Monash Health*
- Gemma Kennedy *cohealth*
- Dr Vinitha Soosaipillai *cohealth*
- Dr Michael Smith *Barwon Health*
- Sharon Sharp *Barwon Health*
- Sonya Howard *Barwon Health*
- Dr Sachidanand Raju *Dianella Community Health*
- Angela Black *Dianella Community Health*
- Dr Shibu Mathew *Plenty Valley Community Health*
- Carmel Aliano *Plenty Valley Community Health*
- Dr Martin Hall *North Richmond Community Health and Dental Health Services Victoria*
- Dr Emily Chalmers-Robertson *North Richmond Community Health and Dental Health Services Victoria*
- Dr John Rogers *Department of Health and Human Services*
- Dr Anil Raichur *Department of Health and Human Services*
- Dr Elisha Riggs *Murdoch Children's Research Institute*

Thank you to Gemma Kennedy and the oral health team at cohealth Kensington, and Sonya Howard and the oral health team at Barwon Health Corio for piloting the tool at their services.

Thank you to the community capacity building team at Foundation House for their reflections on how members of their communities may experience the tool: Salam Dankha, Andrew Kalon, Dina Korkees, Muru Murukaverl, Najla Naier, Kifarkis Nissan, Reginald Shwe, Susie Strehlow and Chitlu Wyn.

Thank you to Ella Perlow from the University of Melbourne for her assistance with conducting the literature review.

Introduction

This report documents the process and findings of a project aimed at developing and piloting a Refugee and Asylum Seeker Oral Health Recall Tool for use in Victorian public dental services. The project was funded by Dental Health Services Victoria (DHSV) and conducted over a five-month period from November 2016 to April 2017 by the Victorian Refugee Health Network.

Background

In 2010, the Victorian Department of Health implemented two policies to provide greater access to oral health services for people from refugee and asylum seeker backgrounds. These policies identified refugees and asylum seekers as a priority access group (State Government of Victoria Department of Health, 2014a) and provided a fee exemption at public dental health services across the state (State Government of Victoria Department of Health, 2014b). As a priority access group, people from refugee backgrounds are eligible for the next available appointment for general care and should not be placed on the waitlist.

The 2012 Refugee Oral Health Sector Capacity Building Project was a collaborative project funded by the Victorian Department of Health and undertaken by the Victorian Refugee Health Network in partnership with DHSV, to support Victorian public dental services to implement the priority access and fee exemption policies and to work effectively with clients from refugee backgrounds. Key outcomes of the project included the development of a *Model of Care for Refugee and Asylum Seeker Oral Health*, complementary factsheets on *Identifying clients of refugee & asylum seeker background* and *Working with refugee & asylum seeker clients*, and the development and delivery of a targeted education program for public dental services.

The Model of Care recommends observation and assessment of clinical and social risk factors as the basis for continued priority access for individuals from refugee backgrounds. These recommendations encourage clinical staff to observe and assess clients for clinical and social risks that may impact on the client's oral health care and ability to renegotiate complex appointment systems for follow-up care; and, based on this assessment, to set up adult recall appointments and consider oral health education for high-risk clients. The Model of Care recommends that clients identified as low risk may be placed on the general waitlist. Services participating in the targeted education program identified a need for a tool to support them to assess social and clinical oral health risks for people from refugee backgrounds and implement the Model of Care.

Rationale for the project

The Australian Refugee and Humanitarian Programme resettles 13,750 people annually. It is estimated that around 4,000 new arrivals settle in Victoria each year, with 10–15 per cent of these in rural and regional areas. Another approximately 9,000 people who are seeking asylum are living in the community in Victoria on bridging visas while they wait for the determination of their refugee status (State Government of Victoria Department of Health, 2014c). In 2016–17 the number of people settling in Victoria increased due to an additional 12,000 humanitarian program places made available for people escaping conflicts in Syria and Iraq in 2015 (Australian Government Department of Immigration and Border Protection, 2016b). There are planned increases to the size of the humanitarian program intake by 2018–19 (Australian Government Department of Immigration and Border Protection, 2016a).

People from refugee backgrounds have varied capacity to identify the need and self-advocate for oral health care. For this reason, oral health practitioners require an approach that differentiates people that require ongoing support to access services from those that may be able to negotiate their own care after their initial course of treatment. The development of an evidence-based tool would support oral health practitioners to make these decisions.

Project objectives

To develop and pilot a state-wide, evidence-based tool for use by staff in Victorian public dental services during the first course of care for an adult refugee or asylum seeker client to:

1. Assess social and clinical risks that may impact upon their:
   - oral health status
   - ability to manage their own oral health
   - ability to engage in future treatment.
2. Recommend evidence-based courses of action.
3. Help determine:
   - if the client needs to be recalled to the service for their next appointment, or
   - if they can go on the general waitlist.

Project phases

The project was conducted in three phases:

- **Initial scoping:** included:
  - a review of the academic literature on social and clinical health issues that lead to poor oral health outcomes and decreased access to oral health care for people from refugee backgrounds;
  - consultation with key oral health stakeholders to understand the service context and current practice in public dental services in areas of high refugee settlement across the state, and scope services' views and requirements about the tool; and
  - consultation with community liaison workers at Foundation House for their advice on how refugee-background communities may experience the tool.
- **Development of the tool:** based on what was learned during the review of the literature and the stakeholder interviews. Draft versions of the tool were reviewed and refined based on advice provided by the Project Advisory Group members and pilot participants.
- **Piloting of the tool:** in two public dental services in Victoria (1 metropolitan, 1 regional) over a five-week period, to test user acceptability and congruence with workflow in public dental settings.

This report was prepared for DHSV at the conclusion of these three phases. Several recommendations are made in the report for further work to support the ongoing development of a valid and reliable state-wide Refugee and Asylum Seeker Oral Health Recall Tool.

Literature review

The literature review aimed to identify research that exists on social and clinical health issues that lead to poor oral health outcomes and decreased access to oral health care for people from refugee backgrounds in resettlement contexts. Embase, Medline (Ovid), Pubmed, Informit, Proquest, CINHAL and Google Scholar were searched for relevant scholarly articles published between 2006 and 2016. The search terms used were 'oral' or 'dental' in combination with 'asylum seeker' or 'refugee'. Reference lists were searched and articles or tools recommended by colleagues were also included in the results, and each abstract was screened for relevance.

The review also searched for existing tools that have been developed to assess oral health risk specifically in refugee-background populations, or that assess the impact of social risks on oral health outcomes. No existing tools were identified. Monash Health is currently conducting a project to assess the social risks of refugee and asylum seeker clients attending their dental service in Dandenong. This research is ongoing and will involve statistical analysis to determine correlations between social risks and oral health outcomes (Marwaha et al., 2017). The published findings from this project will significantly contribute to the evidence base on the impact of social risks on oral health outcomes for people from refugee backgrounds.

Refugee oral health and access to dental care

Research indicates that people from refugee backgrounds experience a high burden of oral disease, including dental caries, periodontal diseases, malocclusion, orofacial trauma, missing and fractured teeth, and oral cancer (Davidson et al., 2006; Ghiabi, Matthews, & Brillant, 2014; Johnston, Smith, & Roydhouse, 2012; Keboa, Hiles, & Macdonald, 2016; Riggs et al., 2014). The oral health status of people from refugee backgrounds is often poorer than other vulnerable groups such as Indigenous Australians (Davidson et al., 2006; Ghiabi et al., 2014; Keboa et al., 2016) and other groups of migrants (Riggs et al., 2014). As well as poor oral health outcomes, there is evidence that people from refugee backgrounds access dental care, particularly preventative dental care, at very low rates (Hobbs, 2010; Riggs, Davis, et al., 2012; Riggs et al., 2016; Willis & Bothun, 2011), and that their first dental contact is typically for emergency care (Riggs et al., 2014). One study from the United States found that Sudanese refugee participants were not utilising recommended preventative biannual check-ups and that the majority of participants had not been to a dental facility more than once post arrival (Willis & Bothun, 2011).

Factors associated with poor oral health

There is a strong link between social disadvantage and oral health, with many social issues that are known to have a detrimental impact on oral health status and access to dental care in the general population. These factors include stress (Vasiliou et al., 2016), low levels of income and education (Bernabé et al., 2011; Sabbah et al., 2007), homelessness (Parker et al., 2011), unemployment (Al-Sudani, Vehkalahti, & Suominen, 2016), and living with mental illness, disabilities, or complex medical conditions (COAG Health Council, 2015). Although not all of these factors have been specifically linked to poor oral health in people from refugee backgrounds in the literature, it is known that due to their displacement and resettlement experiences refugees may arrive with chronic and complex health conditions, experience high levels of stress, and are more likely to be unemployed, homeless, or have low incomes and educational levels compared to the general population (State Government of Victoria Department of Health, 2014c; Victorian Foundation for Survivors of Torture Inc., 2012). Since 2012, when humanitarian program entrants were provided access to a waiver to the migration health requirements, the Australian Refugee and Humanitarian Programme has settled increasing numbers of people living with disabilities (Duell-Piening, 2016).

There are a number of social risk factors specific to people from refugee backgrounds that have been found to impact their oral health. These include a range of pre-arrival risk factors, such as periods of deprivation in urban centres or refugee camps with lack of access to clean water, nutritious food, oral health hygiene tools and access to oral healthcare services (Lamb et al., 2009; Nguyen et al., 2013; Willis & Bothun, 2011). Furthermore, people from refugee backgrounds may have experienced torture and trauma, including trauma to the mouth or teeth, and may experience dental effects of periods of prolonged stress, such as bruxism and mucosal lesions (Lamb et al. 2009).

There are also a variety of social factors that impact people from refugee backgrounds' access to dental care and their risk of poor oral health post-resettlement. These include: competing settlement demands, fear and lack of trust in dental practitioners, language barriers, low service literacy and oral health literacy, and changes in diet.

Competing settlement demands

During resettlement in a new country, people from refugee backgrounds are often confronted with a variety of competing demands, such as finding employment and accommodation, that may be prioritised over seeking dental care (Davidson et al., 2007; Hobbs, 2010; Lamb et al., 2009).

Fear and lack of trust

Distress, fear and lack of trust can act as barriers to accessing health care. Undergoing dental care can be distressing for people from refugee backgrounds and people seeking asylum, particularly if they have experienced torture and trauma, including trauma to the mouth (Victorian Foundation for Survivors of Torture Inc., 2012). This distress and trauma can contribute to increased fear in accessing dental care and difficulty in maintaining regular oral hygiene practices (Lamb et al., 2009). Furthermore, even those who have not experienced torture or trauma to the mouth may avoid dental care due to fear of extractions, fear of contracting disease at dental services, or lack of trust in dental care providers (Hobbs, 2010).

Language barriers

Language barriers significantly impact access to oral health care for people from refugee backgrounds (Hobbs, 2010; Riggs et al., 2016; Willis & Bothun, 2011). Limited English proficiency creates barriers at every stage of accessing dental care, including: knowing that a service exists, making and attending an appointment, describing the dental issue, understanding treatment options, and booking new appointments (Hobbs, 2010; Riggs et al., 2016). Research conducted with refugees from the Horn of Africa in Melbourne suggested that reminder calls for appointments made in the client's language would be useful (Hobbs, 2010).

Low oral health service literacy

Lack of familiarity and knowledge of how Australia's oral healthcare system works can create significant barriers to people from refugee backgrounds accessing oral health care (Hobbs, 2010; Willis & Bothun, 2011). Refugees and asylum seekers may be unaware of service availability, eligibility criteria for public dental care, and priority access and fee exemption policies. People from refugee backgrounds have reported that they face financial barriers to accessing dental care in Australia (Hobbs, 2010; Riggs et al., 2016; Willis & Bothun, 2011). As refugees and asylum seekers are entitled to fee exemptions for public dental care in Victoria, these barriers may stem from people's lack of awareness of these policies (Hobbs, 2010; Riggs et al., 2016; Tyrrell et al., 2016; Willis & Bothun, 2011).

People from refugee backgrounds may have difficulties negotiating service access, such as knowing how to make an appointment at a dental service in a busy community health context (Hobbs, 2010; Riggs et al., 2016), or that they can ask for an emergency appointment if they are experiencing pain (Riggs et al., 2014). Limited prior exposure to appointment systems can make adhering to appointment times a challenge for some newly arrived community members (Hobbs 2010; Tyrrell et al., 2016).

Low oral health literacy

Although low oral health literacy is a significant risk factor for poor oral health in the wider Australian population, low oral health literacy may be a particular concern for people from refugee backgrounds (Adams et al., 2009; Hobbs, 2010; Keboa et al., 2016). For many people from refugee backgrounds, accessing preventative care may be an unfamiliar concept (Hobbs 2010; Keboa et al. 2016; Tyrrell et al. 2016), and this may prevent their access to oral health care when not in pain (Hobbs 2010). Furthermore, many people from refugee backgrounds come from countries in which dental care is very inaccessible or exclusively for the wealthy (Hobbs, 2010). As a result, many people believe that you should only visit the dentist if you are in severe pain or your teeth are decaying (Ghiabi et al., 2014; Hobbs, 2010; Keboa et al., 2016; Lamb et al., 2009; Nicol et al., 2014; Riggs et al., 2016). Furthermore, the concept that dental problems may exist even when one is not in pain may not be well understood (Hobbs, 2010).

People may be unfamiliar with Western oral hygiene practices such as tooth brushing before they arrive to a Western resettlement country (Lamb et al., 2009; Riggs et al., 2016). In their home countries, many people practise traditional oral healthcare practices that may differ from Western practices (Adams et al., 2013; Willis & Bothun, 2011). Some examples of traditional oral hygiene practices from various countries include using an index finger to cleanse teeth with an ash mixture, using a stick or branch known as a miswak as a kind of toothbrush, and using reeds or grass between teeth like dental floss (Adams et al., 2013; Geltman et al., 2014; Nicol et al., 2014). The miswak has mixed effectiveness; although it is effective in removal of plaque, it is not effective in preventing dental caries (Adams et al., 2013; Riggs, van Gemert et al., 2012). People from refugee backgrounds may also have limited knowledge about fluoride and its role in preventing dental caries (Riggs et al., 2014).

Despite their varied effectiveness, traditional practices used to improve oral hygiene may have strong cultural and religious significance. For instance, the miswak was advocated for by the prophet Mohammed and may be used by people of Muslim faith as part of cleansing before prayer (Adams et al., 2013; Geltman et al., 2014; Riggs, van Gemert et al., 2012). Due to cultural and religious associations, people may be reluctant to give up these traditional practices in favour of Western oral hygiene methods (Adams et al., 2013; Willis & Bothun, 2011). As these cultural ties are strong, the literature suggests that it is important that they be 'understood, respected and incorporated within oral health care, policies and practices' (Riggs, van Gemert et al., 2012). People from refugee backgrounds may require detailed oral hygiene education and tailored, culturally appropriate oral health promotion messages to address any knowledge gaps, including between traditional and Western oral health practices (Riggs, van Gemert et al., 2012; Willis & Bothun, 2011).

Dietary changes

New arrivals experience dietary changes when migrating to Australia, including increased accessibility of pre-made and packaged food, confectionery and sugary drinks, and some people may be unaware of the impacts of increased sugar consumption on oral health (Riggs et al., 2014; Willis & Buck, 2007). As well as limited nutrition awareness in an Australian context, people from refugee backgrounds may face financial barriers to eating well and purchasing healthy food in Australia (Adams et al. 2013; Riggs et al. 2014; Tyrrell et al. 2016). The oral health of people from refugee backgrounds may deteriorate over time as they consume more sugary food and drinks in their country of resettlement (Geltman et al., 2013).

Project Advisory Group

A Project Advisory Group was convened to provide high-level strategic, content, process and technical advice about the development and piloting of the tool. Project Advisory Group meetings were chaired by Dental Health Services Victoria (DHSV) and secretariat support was provided by a project worker from the Victorian Refugee Health Network. Membership included representatives from the following agencies:

- Dental Health Services Victoria (DHSV)
- Foundation House
- Monash Health
- cohealth
- Barwon Health
- Dianella Community Health
- Plenty Valley Community Health
- North Richmond Community Health
- Department of Health and Human Services
- Murdoch Children's Research Institute

The Project Advisory Group met at two key points in the project. Members were also invited to participate in a stakeholder interview with a project worker from the Victorian Refugee Health Network.

Stakeholder interviews

Ten stakeholder interviews were conducted from December 2016 to February 2017. The aims of the stakeholder consultations were to:

1. Understand the service context, including staffing, workflow, use of other assessment tools, use of recall appointments, application of priority access policies, and referral processes in different service settings across the state;
2. Scope service providers' views and requirements about the purpose, format and administration of the tool; and
3. Identify pilot sites for the tool.

Public dental services are provided in clinics operated by health services and by community health services across the state. Interview responses indicate that staffing configurations and workflow differ in different service settings. This was particularly evident in the area of oral health promotion and education. Some services have dental assistants with a Certificate IV qualification in oral health promotion employed in oral health educator roles, while others do not. As a result, the approach to providing clients with oral health education appears to vary widely.

In many services, information is provided chair-side by the clinician during or at the end of the appointment. In others, clients who are identified as being at higher risk of poor oral health outcomes are referred to an oral health educator for a separate appointment to address oral health literacy and behaviours. Another area of difference was the collection of social health information. Some services collect information on social health issues at intake, on their referral forms, or on paper-based forms in reception, while other services said they do not routinely ask patients any questions about social health risks.

Inconsistent use of risk assessment tools was reported. Most services indicated that they do not use existing caries risk assessment tools, although one service had adapted or borrowed some of the questions for use in its own risk assessment form. Reasons cited for not utilising existing tools are that they are not mandated, the tools are too long and detailed, the tools are not sensitive enough, and that with limited appointment times, clinicians are too busy to use them.

The priority access policy for refugees and asylum seekers is applied differently in different service settings as there is no guidance on how long a refugee or asylum seeker should be granted priority access. Some services provide priority access for clients for the initial course of care only, after which the client goes on the general waitlist. Others provide priority access for the initial appointment, and refer those clients who are assessed as low risk after they have been seen by the service to the general waitlist. At other services, clients from refugee backgrounds have ongoing or indefinite priority access. Most services do not use adult recall appointments.

Referral practices differ across services. Some services say they do not routinely ask people if they need a referral to other services provided by community health services. Others ask on the intake form whether a client would like information about another service at the community health service, and only refer if the client has ticked Yes. Some services ask all patients who indicate on their medical history form that they have a chronic illness whether they have a regular doctor, and if not, link them in with a general practitioner at the community health service. Some services reported that they meet regularly with the refugee health team, the intake team or the counselling team at their service to discuss referral processes.

When discussing what they saw as the purpose of the tool, or what they might want such a tool for, service providers said that they hoped the tool might assist with demand management, and provide clarity and consistency regarding priority access policies and the question of how long someone is considered a refugee. Many providers spoke about public dental services being a finite resource and the need to ensure fairness of service provision. While participants felt that priority access policies are important to ensure refugee and asylum seeker clients can access services early in their settlement, some expressed the belief that once the client has been seen by the service, ongoing service provision and priority of access should be determined by need.

It was felt that it was important to be able to identify those at risk of not coming back to the service due to social risk factors, and support those clients to access the service for a follow-up appointment, until those risk factors can be addressed or overcome. It was also felt that the focus should only be on social risks that impact on oral health status, a person's ability to manage their own oral health care, and ability to access ongoing services. It was also felt that it is important to support dental practitioners to make referrals and identify when a client may need a referral.

In terms of administration of the tool, it was felt that the tool should be administered by a clinical staff member, such as a dentist or dental or oral health therapist. Some felt that the tool could be administered by an oral health educator, if the service has one. We were advised to use higher and lower risk classifications only, rather than high, medium and low, to avoid 'fence sitting' and classifying everyone as medium risk. It was felt that referral is the logical next step if social risks are identified, that it is not the dental services' job to manage people's social risks, and that many patients do not wish to have social risks addressed at the dental service.

With regard to the tool's format, service providers unanimously agreed that the tool would need to be embedded in Titanium for it to be useful – many services are now paperless, with all client data managed through Titanium, and it was advised that the tool would not be used if it was not embedded into Titanium. Many people spoke about dental practitioners being time poor and experiencing high administrative burdens. Therefore, it was recommended that the tool be brief – between 3–10 questions was the recommended length – and a checklist format was preferred over open-ended questions, which were regarded as too time consuming. We were advised to provide prompts and indicators to assist dental staff to ask and assess each of the questions, and to recommend courses of action depending on the situation, including referral, practice tips and promotion of oral health education resources, including links to where they are available. Participants discussed the importance of ensuring that the tool is appropriately selective, so that the outcome for everyone is not higher risk. It was advised that calling the tool a social risk assessment (as it was originally conceived in the Model of Care) may make dental staff less likely to use it if they see social health issues as outside their scope of practice.

Community advice

Community advice was sought during the scoping phase from community liaison workers employed in the Foundation House community capacity building team. Community perspectives were sought to ensure that the questions and practice tips included in the tool would be acceptable to refugee-background communities. This advice highlighted the challenges associated with low service literacy for new arrivals, and the importance of explaining the treatment process and giving client's options, in order to establish trust, provide a sense of control and reduce discomfort or anxiety.

First Project Advisory Group meeting

During the first Project Advisory Group meeting, the group received a briefing on the findings from the literature review and stakeholder interviews, and reviewed and provided feedback on a draft version of the tool. Participants broke into small groups to discuss and develop recommendations about:

- the name of the tool
- its suitability for use in their service setting
- the indicators used to assess various questions
- referral pathways and processes
- the weighting of the questions and threshold for higher risk classification.

Advice provided by the group at this meeting included:

- That, as the tool is designed to assess which clients require a recall appointment versus those who may go on the general waitlist, it should be called a recall tool, and not a social and clinical risk assessment tool as it was originally named in the Model of Care.

- To include ⩾4 visible cavities and ⩾4 active areas of white spot lesions as indicators of high clinical risk. This is as opposed to >1 (as per the DHSV Caries Risk Assessment Tool), as it was felt that this would be overly inclusive and identify too many people as overall higher risk.
- To include periodontal risk questions among the indicators of high clinical risk.
- To include smoking among the indicators of high clinical risk.
- Providing examples of chronic health conditions that if not well managed might lead to poor oral health outcomes.
- That services should identify a single referral point within their community health service, which can then work with the client to identify the type of support they require, rather than requiring oral health practitioners to be aware of the full range of health and social services available in the community. In some community health services the most appropriate referral point might be the refugee health nurse; in others the service intake team, or the counselling or social work team.
- To set the threshold for an overall higher risk rating at requiring a Yes response to three or more of the seven risk factors, including a positive response for either at high clinical risk of poor oral health outcomes, and/or have low oral health literacy in order to be considered at overall higher risk.

Second Project Advisory Group meeting

During the second Project Advisory Group meeting, the group received a briefing on the pilot process and findings, had the opportunity to make final refinements to the tool, discussed recommended recall periods for clients identified as higher risk, and reviewed and provided feedback on draft recommendations for the project.

There was strong support for a six-month recall period for clients identified as higher risk. It was felt that implementing a six-month recall period for new arrivals identified as higher risk would provide people with a sufficient level of care and help to embed oral health promotion messages and behaviours early, whereas waiting 12 months may risk the cycle of disease starting again. It was identified that recalling higher risk patients to reassess identified risk factors after six months presents the opportunity to practise Minimum Intervention Dentistry, which focuses on prevention, early identification and interception of disease (Walsh & Brostek, 2013). The tool would be readministered at the six-month recall appointment to assess whether significant risk factors remain. Clients who remain at higher risk would remain on a six-month recall, while clients for whom risk factors had been reduced could be referred to the general waitlist. This is consistent with the literature that indicates that recall intervals should 'be customised to fit a patient's individual needs, based on a risk assessment' (Gussy et al., 2013).

This approach would create an incentive for services to prioritise oral health education for higher risk clients. While there was consensus support for a six-month recall period, a concern was raised about the ability of services to meet this demand.

DHSV was advised to consider training requirements to support dental services to adopt the tool and embed it in everyday practice. It was advised that training should include information about the refugee experience and working with clients from refugee backgrounds, which could be delivered in partnership with Foundation House, as well as information about the Model of Care and the tool.

Refugee and Asylum Seeker Oral Health Recall Tool

The development of the tool was informed by what was learned during the review of the literature and the advice of the Project Advisory Group, community liaison workers and pilot participants. See the Appendix: Refugee and Asylum Seeker Oral Health Recall Tool.

Based on the advice received, the tool features only seven questions, with associated indicators to assist the oral health practitioner administering the tool to assess the client across each of the seven questions. The tool also includes practice tips and referral advice to support the practitioner to respond where high risks are identified. Respondents are asked to tick the box to indicate a Yes response. A client requires a Yes response to three or more of the seven risk factors to be assessed as overall higher risk. This must include a Yes to Question 1 (high clinical risk) and/or Question 2 (low oral health literacy).

Piloting of the tool

Purpose

The purpose of the pilot was to test user acceptability of the tool and its congruence with workflow in public dental settings.

Pilot sites

During the stakeholder interviews, public dental agencies were invited to self-nominate to pilot the tool in their service. Two agencies volunteered to participate in the pilot. Cohealth, a community health organisation that provides services across Melbourne's CBD, northern and western suburbs volunteered to pilot the tool at its Kensington dental clinic. Barwon Health, a comprehensive regional health service operating in the greater Geelong area and throughout south west Victoria, volunteered to pilot the tool at its Corio dental clinic.

Pilot overview

The implementation of the pilot was informed by the Plan, Do, Study, Act (PDSA) approach, a method for planning and testing changes through small cycles, setting aside time to study the results, and refining the implementation based on what was learned (Institute for Healthcare Improvement, 2017). The PDSA approach was recommended by one of the Project Advisory Group members as a useful framework for introducing new initiatives in health service settings (Yelland et al., 2015).

Training sessions were conducted at each of the pilot sites (*Plan*). The training provided an opportunity for staff participating in the pilot to learn about the background and purpose of the tool, familiarise themselves with the tool, including breaking into pairs or small groups to practise administering the tool, critically reflect on how the tool may be improved, and develop a plan for collecting the pilot data. Some revisions were made to the tool based on the advice provided by pilot participants during the training.

Following the training, the tool was piloted for an initial three-week period (*Do*). It was agreed that the tool would be administered by dentists, dental or oral health therapists, and dental prosthetists at all general or denture appointments with an adult refugee client during the piloting period.

A mid-pilot reflective teleconference was held with staff from both pilot sites (*Study*). During this teleconference, staff participating in the pilot provided feedback about their experience administering the tool, and their client's experience of being asked the questions. Some minor amendments were made to the tool based on the feedback provided.

Following the teleconference, the tool was piloted in each of the services for a further two-week period (*Act*). At the conclusion of the pilot, staff from both services participated in a post-pilot teleconference debrief.

Staff administering the tool were asked to provide responses to some process evaluation questions that were added to the tool for the purpose of the pilot only. The questions included whether the client was comfortable with the questions, whether the indicators were helpful in assisting them to assess the client for each question, whether the clinician came up with any other ways of asking or assessing the question, whether they used the practice tips, and whether they felt the overall rating was appropriate for the client or not. After the mid-pilot teleconference, some demographic questions were added to the back of the tool, including client's country of birth, preferred language, age and length of time in Australia.

Findings and discussion

Over the five-week pilot period, the tool was administered with 70 adult clients from refugee backgrounds (37 at Barwon Health and 33 at cohealth). The breakdown of the professional background of the clinicians administering the tool was:

- Dentist: n = 40
- Dental/oral health therapist: n = 24
- Dental prosthetist: n = 5
- Other (not specified): n = 1

Table 1 shows the number and percentage of clients that were assessed as high risk for each of the seven questions in the tool and for the overall higher risk rating. Of the 70 clients with whom the tool was administered, 37% (n = 26) were identified as overall higher risk – that is the client was assessed as being at high clinical risk of poor oral health outcomes and/or as having low oral health literacy, plus one or two other risk factors.

Table 1: High risk ratings

Risk factor	Number	%
High clinical risk	52	74%
Low oral health literacy	40	57%
Low service literacy	27	39%
Chronic health	2	3%
Disability	2	3%
Homeless	6	9%
Highly distressed	1	1%
Overall high risk	26	37%

Threshold for overall higher risk rating

For the purpose of the pilot, the threshold for an overall higher risk rating was set at three (inclusive of high clinical risk and/or low oral health literacy). This meant that just over a third (37%) of the refugee-background clients participating in the pilot were identified as higher risk. Analysis of the data indicates that if the threshold had been set at two Yes answers, over half (56%) of clients with whom the tool was administered would have been classified as higher risk, and if the threshold had been set at four Yes answers, then only 6% of clients would have been identified as higher risk. In discussing these findings, the Project Advisory Group members agreed that the threshold had been set at the right level, and recommended the threshold remain at three Yes answers throughout further testing and trialling of the tool.

It is interesting to note that 24 of 27 people who had low service literacy also had one of the two essential high risk criteria (poor oral health literacy or high clinical risk).

Table 2: Number of risk factors identified in refugee-background clients during pilot period

Risk factors	Number of people	%
0	9	13%
1+	61	87%
2+	39	56%
3+	26	37%
4+	4	6%

User acceptability and congruence with workflow

> *"I found the tool really easy to use, it wasn't too long, it was easy to understand, I wouldn't change anything."*
> **(clinician participating in the pilot)**

The feedback provided during the PDSA cycle indicates that the clinicians participating in the pilot found the Refugee and Asylum Seeker Oral Health Recall Tool acceptable and useful. Clinicians appreciated the brevity of the tool, given the time pressures they are under. This ensured the tool was feasible to implement in a busy public dental setting.

> *"I like how short it is – just seven questions."*
> **(clinician participating in the pilot)**

Clinicians reported that the tool fits well into their workflow and that the questions were easily and naturally incorporated into the clinical consult.

> *"I found the tool very easy to use in a clinical situation. The questions were easy to ask, it just flowed … it was easily incorporated into general client conversation."*
> **(clinician participating in the pilot)**

Clinicians administering the tool were asked whether they felt the overall rating was appropriate, based on their clinical impressions of the client. All participants felt that the results were appropriate and the tool was acceptable in determining overall higher risk ratings. All agreed that the indicators and questions were helpful in assisting them to assess the client for each of the questions.

> *"The information in the boxes was very helpful."*
> **(clinician participating in the pilot)**

Clinicians also advised that the tool was useful for identifying opportunities for oral health education and provided a useful framework for tailoring oral health promotion messages to the needs of the client.

> *"A few of the indicators uncovered some interesting client perspectives, for example the questions about fluoridation. It was a good conversation starter … The questions were helpful with sparking conversations from an oral health education perspective."*
> **(clinician participating in the pilot)**

The client experience

Clinicians were asked to comment on the client experience of the tool. Everyone indicated that clients they administered the tool with were comfortable with the questions. Furthermore, clinicians reported that clients appreciated being asked about a broader range of issues affecting their health and wellbeing.

> *"The clients were happy with it, because it starts a conversation about things outside of dental, I think it makes them feel important."*
> **(clinician participating in the pilot)**

A low number (n = 12) of tools were administered using the updated version where demographic client information was collected, so meaningful conclusions cannot be made from the data collected. However, within the small sample it was noted that all of the clients who had been in Australia for less than six months were assessed as having low oral health literacy and low service literacy. This indicates that collection of demographic data may assist with better understanding of differences across cohorts.

Recommendations

Based on the advice provided by the Project Advisory Group and the findings from the pilot, the Victorian Refugee Health Network recommends:

RECOMMENDATION 1

DHSV facilitate a trial of the Refugee and Asylum Seeker Oral Health Recall Tool across a larger number of services across the state to assess the validity and inter-rater reliability of the tool. This should include demographic data to understand differences across cohorts.

RECOMMENDATION 2

Dental services participating in the trial consider implementing a six-month recall period for clients identified as higher risk, subject to a DHSV review of the evidence for a six-month recall.

RECOMMENDATION 3

DHSV consider the evidence from the Monash Health Social Risk Assessment research project in the development of a final version of the Refugee and Asylum Seeker Oral Health Recall Tool.

RECOMMENDATION 4

DHSV support agencies to adopt and implement the Refugee and Asylum Seeker Oral Health Recall Tool by facilitating professional development about refugee and asylum seeker experiences (in partnership with Foundation House), the Model of Care, and the tool.

RECOMMENDATION 5

DHSV embed the Refugee and Asylum Seeker Oral Health Recall Tool in Titanium to facilitate its uptake and usability.

RECOMMENDATION 6

Dental services implementing the Refugee and Asylum Seeker Oral Health Recall Tool develop and utilise referral pathways within their community health service to support clients for whom higher risks are identified.

RECOMMENDATION 7

DHSV utilise the findings from a broader trial of the Refugee and Asylum Seeker Oral Health Recall Tool to inform further development of the Model of Care for Refugee and Asylum Seeker Oral Health.

References

Adams, J. H., Laird, L. D., Geltman, P. L., Cochran, J. J., Orlow, M. K. P., Barnes, L. L. (2013). The cultural basis for oral health practices among Somali refugees pre- and post-resettlement in Massachusetts. *Journal of Health Care for the Poor and Underserved*, *24*(4), 1474–1485.

Adams, R. J., Appleton, S. L., Hill, C. L., Dodd, M., Findlay, C., Wilson, D. H. (2009). Risks associated with low functional health literacy in an Australian population. *The Medical Journal of Australia*, *191*(10), 530–4.

Al-Sudani, F. Y. H., Vehkalahti, M. M., Suominen, A. L. (2016). Association of current employment status with oral health-related behaviors: findings from the Finnish Health 2000 Survey. *European Journal of Oral Sciences*, *124*(4), 368–376.

Australian Government Department of Immigration and Border Protection. (2016a). Australia's Humanitarian Programme 2016–17 Discussion paper. Canberra.

Australian Government Department of Immigration and Border Protection. (2016b). Australia's response to the Syrian and Iraqi humanitarian crisis. Accessed 28 April 2017, https://www.border.gov.au/Trav/Refu/response-syrian-humanitarian-crisis

Bernabé, E., Suominen, A. L., Nordblad, A., Vehkalahti, M. M., Hausen, H., Knuuttila, M., Tsakos, G. (2011). Education level and oral health in Finnish adults: evidence from different lifecourse models. *Journal of Clinical Periodontology*, *38*(1), 25–32.

Davidson, N., Skull, S., Calache, H., Chesters, D., Chalmers, J. (2007). Equitable access to dental care for an at-risk group: a review of services for Australian refugees. *Journal of Public Health*, *31*(1), 73–80.

Davidson, N., Skull, S., Calache, H., Murray, S., Chalmers, J. (2006). Holes a plenty: oral health status a major issue for newly arrived refugees in Australia. *Australian Dental Journal*, *51*(4), 306–311.

Duell-Piening, P. (2016) *Response to a discussion paper of the Victorian state disability plan 2017–2020*. Melbourne, Australia. Victoria Refugee Health Network.

Geltman, P. L., Adams, J. H., Cochran, J., Doros, G., Rybin, D., Henshaw, M., Paasche-Orlow, M. (2013). The impact of functional health literacy and acculturation on the oral health status of somali refugees living in Massachusetts. *American Journal of Public Health*, *103*(8), 1516–1523.

Geltman, P. L., Hunter Adams, J., Penrose, K. L., Cochran, J., Rybin, D., Doros, G., Paasche-Orlow, M. (2014). Health literacy, acculturation, and the use of preventive oral health care by Somali refugees living in Massachusetts. *Journal of Immigrant and Minority Health*, *16*(4), 622–630.

Ghiabi, E., Matthews, D. C., Brillant, M. S. (2014). The oral health status of recent immigrants and refugees in Nova Scotia, Canada. *Journal of Immigrant and Minority Health/Center for Minority Public Health*, *16*(1), 95–101.

Gussy, M. G., Bracksley, S. A., Boxall, A. (2013). How often should you have dental visits? *Deeble Institute Evidence Brief*, No. 10, 27/06/2013

Hobbs, C. (2010). *Talking about teeth: exploring the barriers to accessing oral health services for Horn of Africa community members living in inner west Melbourne.* Doutta Galla Community Health, Melbourne.

Institute for Healthcare Improvement (2017) Science of improvement: how to Improve. Accessed 27 April 2017, http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx.

Johnston, V., Smith, L., Roydhouse, H. (2012). The health of newly arrived refugees to the Top End of Australia: results of a clinical audit at the Darwin Refugee Health Service. *Australian Journal of Primary Health*, *18*(3), 242–247.

Keboa, M. T., Hiles, N., Macdonald, M. E. (2016). The oral health of refugees and asylum seekers: a scoping review. *Globalization and Health*, *12*(1), 59.

Lamb, C., Whelan, A. K., Michaels, C. (2009). Refugees and oral health: lessons learned from stories of Hazara refugees. *Australian Health Review*, *33*(4), 618–627.

Marwaha, P., Russo, A., Shankumar, R., McBride, J. (2017). *Responding to the social risks of poor oral health among refugee clients at Monash Health: summary report*. Melbourne, Australia. Monash Health Dental Services and Monash Health Refugee Health Refugee Health and Wellbeing.

Nguyen, T., Casey, S., Maloney, M., Rich, S. (2013). *Oral health: final report of Refugee Oral Health Sector Capacity Building Project*. Melbourne, Victoria.

Nicol, P., Al-Hanbali, A., King, N., Slack-Smith, L., Cherian, S. (2014). Informing a culturally appropriate approach to oral health and dental care for pre-school refugee children: a community participatory study. *BMC Oral Health*, *14*(1), 69. http://doi.org/10.1186/1472-6831-14-69

Parker, E. J., Jamieson, L. M., Steffens, M. A., Cathro, P., Logan, R. M. (2011). Self-reported oral health of a metropolitan homeless population in Australia: comparisons with population-level data. *Australian Dental Journal*, *56*(3), 272–277.

Riggs, E., Davis, E., Gibbs, L., Block, K., Szwarc, J., Casey, S., Waters, E. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *BMC Health Services Research*.

Riggs, E., Gibbs, L., Kilpatrick, N., Gussy, M., van Gemert, C., Ali, S., Waters, E. (2014). Breaking down the barriers: a qualitative study to understand child oral health in refugee and migrant communities in Australia. *Ethnicity and Health*, *20*(3), 37–41.

Riggs, E., Gussy, M., Gibbs, L., Van Gemert, C., Waters, E., Kilpatrick, N. (2014). Hard to reach communities or hard to access services? Migrant mothers' experiences of dental services. *Australian Dental Journal*, *59*(2), 201–207.

Riggs, E., van Gemert, C., Gussy, M., Waters, E., Kilpatrick, N. (2012). Reflections on cultural diversity in oral health promotion and prevention. *Global Health Promotion*, *19*(1), 60–3.

Riggs, E., Yelland, J., Shankumar, R., Kilpatrick, N. (2016). 'We are all scared for the baby': promoting access to dental services for refugee background women during pregnancy. *BMC Pregnancy and Childbirth*, *16*(1), 12.

Sabbah, W., Tsakos, G., Chandola, T., Sheiham, A., Watt, R. G. (2007). Social Gradients in oral and general health. *Journal of Dental Research*, *86*(10), 992–996.

State Government of Victoria Department of Health. (2014a). *Eligibility and priority access for public dental services policy June 2014*.

State Government of Victoria Department of Health. (2014b). *Public dental fees policy, September 2014*.

State Government of Victoria Department of Health. (2014c). *The Victorian refugee and asylum seeker health action plan 2014–2018*.

Tyrrell, L., Duell-Piening, P., Morris, M. Casey, S. (2016). *Talking about health and experiences of using health services with people from refugee backgrounds*. Victorian Refugee Health Network, Melbourne.

Vasiliou, A., Shankardass, K., Nisenbaum, R., Quiñonez, C. (2016). Current stress and poor oral health. *BMC Oral Health*, *16*(1), 88.

Victorian Foundation for Survivors of Torture Inc. (2012). *Promoting refugee health: a guide for doctors, nurses and other health care providers caring for people from refugee backgrounds* (3rd ed.). Melbourne, Australia. Victorian Foundation for Survivors of Torture Inc.

Walsh, L. J., Brostek, A. M. (2013) Minimum intervention dentistry principles and objectives. *Australian Dental Journal*, 58(1), 3–16.

Willis, M. S., Bothun, R. M. (2011). Oral hygiene knowledge and practice among Dinka and Nuer from Sudan to the U.S. *Journal of Dental Hygiene*, *85*(4), 306–15.

Willis, M. S., Buck, J. S. (2007). From Sudan to Nebraska: Dinka and Nuer refugee diet dilemmas. *Journal of Nutrition Education and Behavior*, *39*(5), 273–280.

Yelland, J., Riggs, E., Szwarc, J., Casey, S., Dawson, W., Vanpraag, D., East, C., Wallace, E., Teale, G., Harrison, B., Petschel, P., Furler, J., Goldfeld, S., Mensah, F., Biro, M. A., Willey, S., Cheng, I., Small, R., Brown, S. (2015). Bridging the Gap: using an interrupted time series design to evaluate systems reform addressing refugee maternal and child health inequalities. *Implementation Science, 10*(62), 1–13.

REFUGEE AND ASYLUM SEEKER ORAL HEALTH RECALL TOOL

1. Is the client at high clinical risk for poor oral health outcomes? *If Yes, tick here →* ☐	2. Does the client have low oral health literacy? *If Yes, tick here →* ☐	3. Does the client have low service literacy? *If Yes, tick here →* ☐	4. Does the client have one of the following chronic health conditions that is currently not well managed? *If Yes, tick here →* ☐	5. For clients with a disability, are they unable to manage basic oral health care tasks (either independently or with support)? *If Yes, tick here →* ☐	6. Is the client homeless or at risk of becoming homeless? *If Yes, tick here →* ☐	7. Is the client highly distressed? *If Yes, tick here →* ☐
As indicated by 1 or more of the following: • ≥4 visible cavities • ≥4 active areas of white spot lesions • Radiographic proximal lesions penetrating dentine • Inadequate saliva flow • Hypomineralised enamel[1] • >25% of sites with bleeding on probing • 8 teeth lost from periodontal reasons, excluding third molars • Heavy smoker (>1 pack cigarettes/day, water pipe (shisha/ hookah) >2/week)[2]	May be indicated by: • **Poor knowledge of good oral health practices** - Ask: 'What do you currently do to care for your teeth?'[3] - Can you show me how you brush? • **Unhealthy behaviours** - Brushes teeth <1x/day - Sweetened snacks or drinks >3x/day - Doesn't drink tap water or use fluoridated products[4] • **Poor understanding and use of preventative services**[5] - Ask: How often do you think you should come to the dentist?	Ask: • How did you make the appointment today? • How did you get here today? • Do you know how to make an appointment? • Do you know how to update your details with us if you move or change phone number? • Do you know how to call us for an 'emergency' appointment if you are in pain?	For clients with diabetes, head and neck cancer, osteoporosis treated with bisphosphonates, mental illness, excessive alcohol consumption (>2 drinks/day on most days[6]) Ask: • Do you have a GP or other health care provider you see regularly for this condition?[7] • Do you drink alcohol? How many drinks/day? Do you have any concerns about your drinking?	May be indicated by: • Observed signs of poor oral hygiene • Inadequate oral hygiene practice, and/or inadequate support to manage self-care activities	Ask: • Where are you living at the moment? • How long do you think you will be there?	May be indicated by: • Trembling, jumpy • Pushes you away • Tightly clenched fists • Crying • Doesn't like: - Mirror or drill in the mouth - Chair laying back Ask: • What was your last dental experience? • Do you have any worries or concerns about your visit today?
Consider referral to QUIT program if the client is a heavy smoker	**Practice tips** • It is important that traditional practices used to improve oral hygiene be respected and incorporated within oral health care, alongside western dental practices • Provide clients with information resources in their own language (available from the Health Translations Directory) **Consider referral** to oral health educator (if available)	**Practice tips** • Provide detailed instructions on how and when to contact your service • Send SMS reminders or make calls in clients' own language, rather than posting letters • Provide clients with an appointment reminder card in their own language available from: - Cancer Council Victoria - NSW Refugee Health Service	**Consider referral** • If client does not have a regular GP • If the client has concerns about their drinking	**Consider referral** if the client doesn't have adequate support	**Practice tip** • Consider if recall systems are adequately set up to contact people with no fixed or permanent address • Ensure clients know how and when to contact your service **Consider referral** if the client is not linked with any support services	**Practice tips** To establish trust and control: • Agree to use hand signals as indicators of discomfort • Use 'Tell, Show, Do' technique[8] • Give client options (eg. remaining upright if practical) **Consider referral** • to the Royal Dental Hospital Special Needs Department if client can't be treated • to Foundation House if past experience of torture or trauma is disclosed

[1]Dental Health Services Victoria. Assessment of Caries Risk Factors from Children/Adults Aged 6 Years and Over. Melbourne Australia, DHSV.
[2] Lang, NP. & Tonetti, MS. (2003). Periodontal Risk Assessment for Patients in Supportive Periodontal Therapy. *Oral Health & Preventive Dentistry.*
[3] Marwaha, P., Russo, A., Shankumar, R., & McBride, J. (2017). Responding to the social risks of poor oral health among refugee clients at Monash Health: Summary Report. Melbourne, Australia. Monash Health Dental Services and Monash Health Refugee Health and Wellbeing.
[4]Dental Health Services Victoria. Assessment of Caries Risk Factors from Children/Adults Aged 6 Years and Over. Melbourne Australia, DHSV.
[5] Gibbs, L. et al. (2014) Teeth Tales Final Report. Melbourne, Australia. University of Melbourne
[6] Australian Institute of Health and Welfare (2017) Excessive alcohol consumption. Available at: http://www.aihw.gov.au/risk-factors/alcohol/. Accessed March 2017.
[7] Primary Health Care Advisory Group. (2015). Better Outcomes for People with Chronic and Complex Health Conditions. Commonwealth Department of Health.
[8] Hendrie F. Tell-show-do - It's not just for children! Available at: 'http://www.dentalfearcentral.org/help/psychology/tell-show-do/. Accessed March 2017.

RATING

A client is considered at **higher risk** if they have **3 or more ticks**. This **MUST** include a tick for **Question 1** and/or **Question 2**.

Is the client at higher risk? ☐