

Children with Disability Australia welcomes the opportunity to provide feedback on the consultation regarding the implementation of the new child dental benefits schedule *Grow Up Smiling*. This is a brief response due to the late discovery of the consultation.

Children with Disability Australia (CDA) is the national peak body that represents children and young people with disability, aged 0-25 years. The organisation is primarily funded through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is a not for profit organisation. Additional project funding is also currently received by the Department of Education, Employment and Workplace Relations (DEEWR). CDA has a national membership of 5000 with the majority being families.

CDA's vision is that children and young people with disability living in Australia are afforded every opportunity to thrive, achieve their potential and that their rights and interests as individuals, members of a family and their community are met.

CDA undertakes the following to achieve its purpose:

1. **Education** of national public policy-makers and the broader community about the needs of children and young people with disability.
2. **Advocacy** on behalf of children and young people with disability to ensure the best possible support and services are available from government and the community.
3. **Inform** children and young people with disability, families and care givers about their rights and entitlements to services and support.
4. **Celebrate** the successes and achievements of children and young people with disability.

Comments

1. CDA welcomes the Australian Government's decision to introduce *Grow Up Smiling*.
2. An average of 9.7% of Australian children experience toothache and 12.8% avoid some food because of oral problems. Some 16.7% of children experience at least one of these impacts. Older children (aged 11-17) are more likely than younger children (aged 5-10) to experience any of these impacts.¹
3. Despite the lack of data demonstrating the extent to which disability increases the risk of oral health problems in Australia, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004-2013*, prepared by the National Advisory Committee on Oral Health states

¹ Australian Institute of Health and Welfare 2012, *Families and their Oral Health*, Research Report 57, Canberra, p. 1.

that “(p)eople with special needs experience substantially higher levels of oral disease, with considerably less access to treatment.”²

4. International research has identified that children with disability often do not access dental care and that financial status and degree of disability were predictors of unmet dental needs.³
5. It is the experience of CDA members that dental care is often difficult to access.
6. A cohort of children with disability requires dental work, including basic procedures, to be completed under general anaesthetic. It is very important that these children have the opportunity to have these procedures done with a dentist who they have developed a trusting relationship with and who has knowledge of their individual needs and context. This often occurs through the use of a private dentist and/or through a dentist who provides care and treatment to other family members. For these reasons, dental care needs are not simply met by referrals or access to public dental hospitals where continuity of care from individual dentists who have developed a relationship with a child usually cannot be provided.
7. A significant barrier to having dental work done is cost and it is strongly advocated that those children and families in the circumstances described in comment 6 be able to access financial assistance for vital dental work through *Grow Up Smiling*.

Anthony's experience

Anthony is 11 years old and has an autism spectrum disorder. He has limited verbal communication and requires a high level of support. He commenced treatment with his current dentist around 5 years ago. Prior to this, Anthony had an extremely traumatic dental care experience when he was 12 months old. He broke his tooth and required a cap. He had treatment under general anaesthetic with a medical team who did not know him.

Due to sensory issues, Anthony had severe anxiety about band aids and hospital identification wristbands. Despite significant explanation and advocacy around this issue by his parents, the treating team insisted on him wearing an identification wristband whilst conscious and applying a band aid after administering by injection a pre-operation medication. Anthony subsequently was hysterical and his tortuous experience was compounded by him being forcibly restrained whilst receiving treatment.

Following the treatment, he had bruises on his face from the application of a mask to administer the anaesthetic and further bruising on his arms from being restrained. For a number of years following this, Anthony was very reluctant to see any medical professional, particularly dentists. Usually if he would see any medical equipment, he would become extremely agitated and upset, often exhibiting physical signs of extreme stress such as dry heaving, heart palpitations and sweating.

² National Advisory Committee on Oral Health 2004, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004-2013*, Adelaide, p. 31.

³ See: Charlotte Lewis 2005, 'Unmet dental care needs among children with special health care needs: Implications for the Medical Home,' *Pediatrics*, Vol. 116, No. 3.

Diana Mahoney 2005, 'Special needs children often lack dental care: A large study showed that financial status and degree of disability were predictors of unmet dental needs,' *Family Practice News*, Vol. 35, No. 20, p. 63.

When Anthony was 6 years old, he started seeing a private dental practitioner that was highly regarded for his work with children with disability. The practitioner developed a trusting and respectful relationship with Anthony. His three siblings also commenced as patients of the same dentist. Anthony usually accompanies his siblings to dental check-ups allowing further opportunities to establish rapport and familiarity with the dentist. Anthony is now at ease with having dental reviews at the local practice. Any other more intrusive treatment is simply not possible due to sensory and anxiety issues.

Recently, Anthony chipped his tooth requiring treatment under general anaesthetic. The trust and knowledge the dental practitioner had with the child and family was integral in providing timely treatment which allowed the specific needs of Anthony to be met both through the management by his dentist of the hospital admission and post procedural care.

Conclusion

Some children with disability will require dental treatment and care in a hospital based setting which for children without disability would be provided at local dental practices. Given the increased prevalence and risk of dental problems in children with disability and the importance of continuity of care, it is crucial that these specific treatment needs are taken into account when developing any new dental assistance scheme.

It is envisaged that the financial assistance provided through *Grow Up Smiling* will be able to facilitate access for many children with disability to dental services which would not have been possible otherwise. It is well known that there are significant long term health, social and financial benefits of providing adequate preventative and early dental treatment for children. Whilst it is acknowledged that the scheme will not cover all costs associated with hospital based treatment, eligible families should not be denied financial assistance through this scheme simply because there child has a disability which necessitates the provision of dental treatment or care in a hospital based setting.

Thank you for the opportunity to contribute to this consultation.

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