National Centre of Excellence in Intellectual Disability Health

Department of Health, Disability and Ageing
GPO Box 9848
CANBERRA ACT 2601
Australia

Sent via email: NOHP@healthconsult.com.au

23 May 2025

Dear Australian Government Department of Health, Disability and Ageing,

Development of the next National Oral Health Plan 2025 - 2034

We write on behalf of the National Centre of Excellence in Intellectual Disability Health (the Centre) to provide input on the development of the next National Oral Health Plan 2025 - 2034.

In our submission, we outline the intersections with key actions and work to date in the National Roadmap for Improving the Health of People with Intellectual Disability that relate to oral health. We also include further evidence on the oral health inequities faced by people with intellectual disability to support the Commonwealth in its effort to ensure that the next Plan is grounded in a solid evidence base. We highlight where we align with the findings from the consultation sessions held nationally in this review process. We provide five key recommendations to consider in the development of the next National Oral Health Plan 2025 – 2034 that will improve the health inequities faced by people with intellectual disability.

We trust you will find this information useful in the development of the next National Oral Health Plan 2025 – 2034. We would welcome the opportunity to discuss our comments further and should you require further information about this submission, please do not hesitate to contact me at +61 2 8358 5923 or at sophie@cid.org.au.

National Centre of Excellence in Intellectual Disability Health

Sincerely;

Sophie Howlett
Lead, Driving Change, National Centre of Excellence in Intellectual Disability Health Centre | Senior Manager, Council for Intellectual Disability

Scientia Professor Julian Trollor AM
Director, National Centre of Excellence in Intellectual Disability Health
NHMRC Leadership Fellow
UNSW Medicine and Health, UNSW Sydney

In collaboration with:

Archana Pradhan
Associate Professor of Special Needs Dentistry and Gerodontology
The University of Sydney
Faculty of Medicine and Health, Sydney Dental School
Program Director of the Doctor of Clinical Dentistry
Stream Coordinator of Special Needs Dentistry
Sydney Dental Hospital

About us

The National Centre of Excellence in Intellectual Disability Health ('the Centre') is an important initiative supported by the Australian Government Department of Health and Aged Care. The Centre is a consortium of nine organisations including:

1. UNSW Sydney,
2. Centre for Disability Studies (University of Sydney),
3. Council for Intellectual Disability,
4. Down Syndrome Australia,
5. First Peoples Disability Network,
6. Queensland Centre of Excellence in Autism and Intellectual Disability Health
7. Queenslanders with Disability Network,
8. The Kids Institute and,
9. University of Melbourne.

The Centre also includes another 56 health and disability organisations as partners and collaborators, including the University of Sydney Faculty of Medicine and Health and its School of Dentistry, and the Australian Society of Special Care in Dentistry. The vision of the Centre is to ensure that the roughly 500,000 people with intellectual disability in Australia receive the highest attainable level of healthcare.

Executive Summary

People with intellectual disability continue to experience poorer oral health and access to dental care. People with intellectual disability experience significant oral health inequities compared to the general population, including:

- Higher prevalence and greater severity of gum diseases[1],
- Higher levels of untreated dental decay, with more missing and decayed teeth but less filled teeth[1],
- Less preventative dentistry intervention[1], and
- Significant barriers to accessing quality health care.[1]

A retrospective cohort study that analysed data on people with intellectual disability in NSW in comparison to the overall NSW population, found hospitalisations for dental conditions to be potentially preventable.[2] The relative risk of hospitalisation from

dental conditions for people with intellectual disability was 5.6 for all age ranges, and 11.1 in adults aged 25-44 years, compared to the general population.[2]

The consequences of neglecting oral health are serious and include pain, infection and loss of teeth, leading to functional difficulties with diet, speech and behaviour, as well as severe systemic health issues, including diabetes, respiratory disease and cardiovascular disease.[1, 3] This is of particular concern as these chronic conditions can exacerbate the pre-existing health inequities that people with intellectual disability face.

Work has been done to outline the oral health issues facing people with intellectual disability and the steps needed to resolve them. These can be found in The National Roadmap on Improving the Health of People with Intellectual Disability (the Roadmap), developed by the Australian Government Department of Health and launched in August 2021. One of the measures to improve the health of people with intellectual disability is Oral Health. This work outlined in the Roadmap needs to continue and be tied tightly to the next Oral Health Plan to ensure oral health equity is achieved for people with intellectual disability.

In this submission we outline qualitative and quantitative evidence relevant to the development of the next National Oral Health Plan (NOHP) 2025 – 2034 and consequently make five recommendations for the development of the next National Oral Health Plan (NOHP) 2025 – 2034. They are summarised here:

1. The Australian Government work with states and territories to implement all short and medium term actions relating to oral health from the **National Roadmap for Improving the Health of People with Intellectual Disability**, with immediate attention paid to the priorities identified in the Roadmap Implementation Governance Group Oral Health Priority Actions – Implementation Recommendation.
2. That the **training and design of dental care infrastructure** is done in a manner that fully considers the levers and pulleys available to attracting new dentists to special needs dentistry, and upskills the existing workforce to meet the current need as well as adequately provides for reasonable adjustments to be made for people with intellectual disability.

3. That the **affordability of dental care for people with intellectual disability**, especially when needing emergent care, is considered in the development of the next NOHP.
4. That a **health promotion campaign for disability support staff** is developed to improve oral health literacy, building momentum on the Roadmap Rec D.S.4.
5. That **accessible information, tools and materials regarding oral health and public dentistry options** are developed for people with intellectual disability.

The National Roadmap on Improving the Health of People with Intellectual Disability (the Roadmap)

The National Roadmap on Improving the Health of People with Intellectual Disability (the Roadmap) was developed by the Australian Government Department of Health and was launched in August 2021. It outlines the measures that are required to be taken to improve the health of people with intellectual disability in Australia. One of the seven key measures of the Roadmap is Oral Health.

At present, a Roadmap Implementation Governance Group (RIGG) is overseeing the implementation of the Roadmap. This group includes strong representation from the health and intellectual disability communities. The RIGG has specifically considered action in relation to oral health and prepared a paper *Oral Health Priority Actions – Implementation Recommendations.*[4] This submission includes detailed priority recommendations (denoted in that paper as D.S.4, D.S.1 and D.S.3 respectively). These recommendations need to be accounted for in the next National Oral Health Plan (NOHP). They are:

- **Equal Priority 1: Expanding oral health promotion (D.S.4)[4]**
  The Australian Government to work with the disability sector to identify ways of implementing training in oral health as compulsory for disability support workers (Certificate IV), noting that it currently only contains elective content on this issue.

- **Equal Priority 1: Increasing the volume of services (D.S.1)[4]**
  The Australian Government Department of Health and Aged Care to:
  - work with the Australian Dental Association to promote the Child Dental Benefits Schedule (CDBS) to people with intellectual disability;

- investigate the uptake of the CDBS by particular cohorts, including children with intellectual disability, to help inform the development of appropriate models of care;
- explore the feasibility of financing a dental schedule under the Dental Benefits Act 2008 and other options for people with disability that better support complex and difficult services, such as in hospital services under general anaesthetic;
- lead work with states and territories, peak oral health organisations and PHNs, including in the context of [the proposed] National Centre of Excellence in Intellectual Disability Health, to support the implementation of 'hub and spoke' models of care that facilitate upskilling, communication, and appropriate referral between centralised special needs dentists and community dental clinics.
  - This 'hub and spoke' type of model has existed in South Australia since 2014. As of 2021, this model has enabled 3 specialists in special needs dentistry to provide support to approximately 100 oral health professionals working across a state with the geographical size of France and Germany combined.[5] It suggests that 'hub and spoke' models can support specialists to overcome existing barriers in access to care, in particular barriers associated with clinician willingness and capability to treat the person with disability.[5]

- **Priority 2: Expanding workforce training (D.S.3)[4]**
  The Australian Government Department of Health and Aged Care to:
  - Continue to and expand work with Deans of dental schools on courses for dentists, dental therapists and hygienists to specialise in oral health care for people with disability, using lessons from the University of Sydney and University of Queensland which both offer a Doctor of Clinical Dentistry.
  - work with the Australian Dental Association to develop continuing professional development modules.

We recommend that a review of action to date on these items is completed and where this work has not commenced, that progress is made with urgency to build these priorities into the NOHP 2025-2035.

Evidence to support the development of the next National Oral Health Plan 2025-2034

Around 1.8%, or 490,000 of the Australian population have an intellectual disability[6, 7] and experience substantial health disparities when compared to the general population, including:

- The relative risk of hospitalisation from dental conditions being 11.1 in adults aged 25-44 years[2],
- median age at death of 54 years, some 27 years earlier than the general population[9],
- more than double the rate of potentially avoidable deaths[9],
- 1.6 times the rate of emergency department use, longer wait times and twice the rate of hospital admissions[10],
- higher rates of mental ill-health, including 3-4 times the prevalence of psychiatric disorders among young people[11],
- higher rates of obesity and other potentially modifiable risk factors for chronic disease[12],
- lower use of preventative healthcare services and significant barriers to care in general practice[9].

People with intellectual disability similarly experience significant oral health inequities compared to the general population, including:

- Higher prevalence and greater severity of gum diseases[1],
- Higher levels of untreated dental decay, with more missing and decayed teeth but less filled teeth[1],
- Less preventative dentistry intervention[1], and
- Significant barriers to accessing quality health care.[1]

The contributing factors for these oral health inequities include:

1. Training, resourcing and design of dental care infrastructure
    a) A lack of dentists with confidence in treating people with intellectual disability due to inadequate training and experience, arising from:
        - university training not covering this content,

- a lack of opportunities for training on this in continued professional development, and
- the infrequency of seeing special needs patients.[13, 14]

b) Under-resourcing of public dental health services, in terms of infrastructure, funding, and workforce.[13]

c) Inconsistent special needs dentistry training available in Australian dental schools, with perceived barriers being a lack of faculty expertise and an overloaded curriculum.[15]

2. Cost.[14]

3. Perceived lack of understanding of oral health among carers and the wider disability sector, with clinicians having difficulty in obtaining relevant information to facilitate dental treatment.[13, 16]

4. People with intellectual disability having a lack of understanding about the importance of oral health care.[17]

To look at these contributing factors in more detail, we will detail the research on these four key dental health equity issues for people with intellectual disability here.

1. Training, resourcing and design of dental care infrastructure

a. A lack of confidence in dentists in treating people with intellectual disability.

A 2021 Australian study that interviewed oral health professionals working at primary care clinics in the public dental system found that clinicians lacked confidence in their ability to treat patients with special needs. The study showed that lack of clinician confidence was due to inadequate training and experience. This lack of confidence arises from university training not covering this content, a lack of opportunities for training on this in continued professional development and the infrequency of seeing special needs patients. This is further complicated by clinicians experiencing difficulties in obtaining information about their patients.[13]

b. Under-resourcing of public dental health services

The same 2021 Australian study found that clinicians experienced a second primary barrier; a lack of support provided by the public dental systems. This included inadequate funding, equipment and facilities, and productivity pressures preventing clinicians from being able to provide the care patients

required.[13] Regarding provision of care, the most reported concerns were about clinics being under-resourced, including general anaesthetic facilities, equipment, hoists, wheelchair tilts, and inappropriate infrastructure for: (i) the needs of patients' physical access to the clinic, and (ii) clinicians to provide treatment safely.[13]

Clinicians expressed that they felt frustration around the lack of support and their inability to provide what they felt was an appropriate level of care.[13] They provided examples including long waiting lists, the inability to complete dental recalls or provide ongoing care, time and productivity pressures, and an insufficient workforce.[13] Clinicians cited that while this under-resourcing is not unique to patients with special needs, the consequences of the provided examples were likely more significant for vulnerable groups.[13]

The following quotes are from dentists who were interviewed as part of the study:

- **Waitlists and ongoing care**
  "The public system has some quite firm guidelines which relate to waiting lists. Adults generally do not go on a recall which is a limitation."[13]

- ***Time and productivity pressures***
  "The biggest barrier to treatment for me is time…"[13]

  "We've got productivity goals… That's just never going to come anywhere near those if you're treating special needs patients."[13]

- ***Insufficient workforce***
  "We cannot meet the needs of our client base, never mind even factoring in our disability cohort… we don't have enough dentists and we don't have enough chairs."[13]

Clinicians expressed concerns around the lack of awareness or understanding about patients with special needs by administrative staff that schedule appointments.[13] Clinicians felt that triage and scheduling to meet the needs of

patients was done with minimal consideration.[13] This led to clinicians feeling undermined by lack of information to prepare for a patient's visit and inadequate time to care for complex needs in appointments.[13]

This is highlighted in the following quote from the study:

> "*There's very limited consideration about people with special needs and how some of those people need more time for an appointment.*"[13]

Clinicians felt these issues reflected a lack of priority within the public dental system in meeting the oral health needs of patients with specialised health care needs.[13]

> *"...we've never really focused on special needs as a priority group. There's never been a channel of resources in that area. So it just doesn't seem to be a priority."*[13]

> *"It's a really good question about what are your priorities? I would hope that people with special needs are a priority group... Because of their circumstances. But how do we all do it better? Well, it comes down to training, support, time, education."*[13]

c. Inconsistent special needs dentistry training available

A comparative study involving Australian dental schools found that across eight schools, 87.5% of department heads agreed that special needs dentistry should be taught at the undergraduate level.[15] However, this only translated to 75% of these schools offering a specific module.[15] Overall special needs dentistry education ranged from 2 – 34 hours of content across 4 – 5 yearlong programs, highlighting inconsistencies across Australian qualifications and barriers for implementing an equitable program.[15]

For further example, from 2016, the University of Queensland, and from 2024 the University of Sydney, students have 15 lectures in special needs dentistry and gerodontology, with clinical placement opportunities at residential aged care facilities and disability community settings. Currently, the University of Sydney is

the only university in Australia where postgraduate students are at placements in LHDs and paid 0.8 FTE during their 3 year training.

A lack of faculty expertise and an overloaded curriculum were perceived as main barriers in providing special needs dentistry education by 72% of Australian heads of dental schools.[15] Lack of disability friendly facilities, lack of clinical sites, and lack of patients each accounted for 15%.[15] To make facilities disability friendly consideration needs to be given to reasonable adjustments for people with intellectual and other disabilities to accommodate their treatment.

In 2024, the total number of registered dentists in Australia was 25,454, with 1,956 specialists. Only 29 of these dentists specialised in special needs dentistry.[19] This is 0.1% of Australia's registered dentists and only 1.5% of specialists being able to meet the dental needs of people with intellectual disability in Australia. This is inadequate relative to the need for specialists in special needs dentistry. Therefore, the next National Oral Health Plan needs to consider and address the lack of incentives in place drawing dentists to special needs dentistry.

We recommend that the next National Oral Health Plan considers the levers and pulleys available to attracting new dentists to special needs dentistry to expand the field beyond the 29 currently available to people with intellectual disability in the entire country, and upskills the existing workforce to meet the need and adequately resources dental care infrastructure to provide for reasonable adjustments to be made for people with intellectual disability.

2. Cost

A lack of dentists with adequate skills in treating people with disability is the most frequently reported problem in obtaining dental care, followed by cost.[14] Affordability of dental care is a major issue for many Australians on a low income. For those whose disability or health conditions adds complexity to their oral health care, sourcing this care privately would be prohibitively expensive.

The Council for Intellectual Disability heard from a number of their members about their experiences with dental care, all of whom live within a 2-hour drive of Sydney[1]. From the stories, we heard, cost was the biggest concern:

- Felicity said she cannot afford a private dentist while she waits for public dental care.
- Marcus shared that his debt relating to private dentistry meant he did not access care when needed. Marcus said about private dentists: "*The only thing that goes through my head when booking is the cost.*"
- Kai's complex needs necessitated quick action for a potentially life-threatening issue, so he chose to pay for private dental on that occasion. But it "*cost an arm and a leg*" and is not a cost he can manage for more routine dental care.
- Laura wants to be able to get dental check-ups because she knows that "*dental health is important to stay healthy. I need to be able to go to the dentist but going to a private dentist costs so much money. It is difficult to be able to afford it. It would be really good to have a dentist for myself and my needs. This would really help me and my friends and my community to get access to dental.*"

We recommend that the next NOHP champion the affordability of dental care as a key issue of concern when designing dental system that is able to meet the needs of all Australians, especially those with intellectual disability and complex needs.

The 2023 *Joint submission to the Select Committee into the Provision of and Access to Dental Services in Australia* champions the integration of Dental Care into Medicare (Recommendation 2 Include dental care as part of Medicare for Australians with disability[20]) and on this we agree. This needs to be seriously considered in the next NOHP.

3. Perceived lack of understanding for oral health among carers and the wider disability sector

Disability support workers play a vital role in maintaining the oral health of people with intellectual disability.[21, 22] In a 2021 Australian study, the perceived lack of priority or understanding for oral health among carers and the wider disability sector was

[1] Permission was provided to share their stories.

identified as a barrier for oral health professionals working at primary care clinics in the public dental system, with clinicians having difficulty in obtaining the relevant information to facilitate dental treatment.[13]

Contributing factors to poor oral health among people with intellectual disability include inadequate brushing technique and a lack of carer training. Studies have shown that lower carer education was associated with less preventative dental care[21] and while carers understood the importance of oral care, they self-reported a lack of knowledge, skills and training.[21]

An Australian study aiming to evaluate a pilot training program for carer's providing oral care for people with disability demonstrated significant increases in mean scores in carer knowledge and confidence following 6-month intervention.[23]Research conducted in the United States that provided training to carers to develop self-efficacy and build capacity demonstrated a 50% decrease in plaque index levels and a positive change to carers oral care of people with intellectual disability.[17] Similarly in a French study, carer training resulted in a significant increase in the carer's ability to brush anterior and posterior teeth.[24]

A health promotion initiative targeted to improve oral health literacy among disability workers and support staff would serve to complement Roadmap Equal Priority 1: Expanding oral health promotion (D.S.4)[4] outlined above.

4. People with intellectual disability lacking understanding about the importance of oral health care.[17]

A lack of understanding about why oral care is important and anxiety around oral care has been noted in people with intellectual disability by carers.[25] Suggested solutions to improve oral health included providing specialised dental clinics, training, and using tools to help identify dental pain earlier. [23, 24] Other solutions are to include developing Easy Read and Augmentative and Alternative Communication (AAC) health information, resources and tools. This should include resources on how to make an appointment and what to do if your condition worsens whilst awaiting an appointment. These resources should be made available in print formats, including Easy Read versions.

We recommend that resource materials and tools on dental hygiene and health are developed to improve health literacy for people with intellectual disability and that the

uptake and engagement with these resources is measured. Preventative health measures and programs such as this are sadly far too often ignored as we focus on higher acuity issues for people with intellectual disability.

In support of findings from the consultation sessions held nationally in this review

We agree with the findings from consultation sessions that have been held so far (Nov & Dec, 2024). Specifically, that the need for greater affordability and accessibility of oral health care for all Australians, and particularly marginalised populations, is of vital importance to the next NOHP.[26]

We also agree that the priority populations in the next Plan need to be expanded to include the additional four groups that the participants from the consultations identified. While people living with disability was identified as an additional group[26], we would emphasise the need for people with intellectual disability to be a group requiring particular focus in the next Plan. The grouping of all people living with disability as a priority population can run the risk of not recognising the specific needs of the subsets of disability and addressing their needs.

In addition to the four areas identified in the consultations to mobilise the next Plan including: 1) engage the private sector, 2) strengthen leadership and recognition of shared responsibilities (e.g. appoint a Chief Dental Officer), 3) improve data availability and reporting, and 4) better use of technology, 5) we would also add that the importance of continuity of care across primary, specialist and dental care is necessary to include in the next Plan, as it is in the gaps between care that people with intellectual disability continue to fall.

The ample evidence provided in this submission of the oral health and poorer health status of people with intellectual disability compared to the general population strongly supports the need for concerted effort and action to resolve these inequities. This evidence has been well documented in the Roadmap and in the RIGG work to date and thus needs to be included in the NOHP 2025-2035. The National Roadmap for Improving the Health of People with Intellectual Disability serves as the framework by which the oral health needs of this population can be met.

Recommendations

We make five recommendations to the development of the next NOHP to ensure that the dental inequities faced by people with intellectual disability are addressed. They are:

1. The Australian Government work with states and territories to implement all short and medium term actions relating to oral health from the **National Roadmap for Improving the Health of People with Intellectual Disability**, with immediate attention paid to the priorities identified in the Roadmap Implementation Governance Group Oral Health Priority Actions – Implementation Recommendation.
2. That the **training and design of dental care infrastructure** is done in a manner that fully considers the levers and pulleys available to attracting new dentists to special needs dentistry, and upskills the existing workforce to meet the current need as well as adequately provides for reasonable adjustments to be made for people with intellectual disability.
3. That the **affordability of dental care for people with intellectual disability**, especially when needing emergent care, is considered in the development of the next NOHP.
4. That a **health promotion campaign for disability support staff** is developed to improve oral health literacy, building on Roadmap Rec D.S.4.
5. That **accessible information, tools and materials regarding oral health and public dentistry options** are developed for people with intellectual disability.

We strongly urge the Australian Government to use the evidence we have provided here and that already exists as part of the Roadmap Implementation Governance Group (RIGG) effort to make the next National Oral Health Plan (NOHP) 2025 – 2034 one that meets the needs of all Australians, particularly those with intellectual disability as a matter of priority.

This next NOHP 2025 – 2034 represents a great opportunity to make the continued and necessary improvements to health equity of people with intellectual disability in the Australian health system.

References

1. Wilson NJ, Lin Z, Villarosa A, George A. Oral health status and reported oral health problems in people with intellectual disability: A literature review. Journal of Intellectual & Developmental Disability. 2019 Jul 3;44(3):292-304.
2. Weise JC, Srasuebkul P, Trollor JN. Potentially preventable hospitalisations of people with intellectual disability in New South Wales. Med J Aust. 2021 Jul;215(1):31-36. doi: 10.5694/mja2.51088. Epub 2021 May 24. Erratum in: Med J Aust. 2022 Dec 12;217(11):589-590. doi: 10.5694/mja2.51772. PMID: 34028026.
3. Disability and Oral Health Collaboration, Your Dental Health project team and the Australasian Academy of Paediatric Dentistry. Joint submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. 2019 Aug 30. [Internet] Available from: https://aapd.org.au/wp-content/uploads/2021/01/Royal-Commission-Oral-Health-Disability-YDH-ASSCID-DOHC-20200210.pdf
4. Oral Health Priority Actions – Implementation Recommendations [Internet]. [Place unknown: Australian Government Department of Health and Aged Care]; 2023 May 30 [updated 2025 Feb 21; cited 2025 Mar 14]. Available from: https://www.health.gov.au/resources/publications/oral-health-priority-actions-implementation-recommendations?language=en
5. Lim MA, Liberali SA, Calache H, Parashos P, Borromeo GL. Specialist networks influence clinician willingness to treat individuals with special needs. JDR Clinical & Translational Research. 2022 Jul;7(3):267-76.
6. Trollor J, Small J. Health Inequality and People with Intellectual Disability—Research Summary. Faculty of Medicine, the Department of Developmental Disability Neuropsychiatry, UNSW: Sydney, Australia. 2019.
7. Australia's population was 27,204,809 people at 30 June 2024. Australian Bureau of Statistics (June 2024), National, state and territory population, ABS Website, accessed 15 December 2024.
8. Florio T and Trollor J. Mortality among a Cohort of Persons with an Intellectual Disability in New South Wales, Australia. J Appl Res Intellect Disabil. 2015;28(5):383-93.
9. Trollor J, Srasuebkul P, Xu H, Howlett S. Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data. BMJ Open. 2017 Feb 7;7(2):e013489.
10. Trollor, J.; Reeve, R.; Srasuebkul, P. Utilisation and costs of hospital services for patients with intellectual disabilities. Journal of Intellectual Disability Research, 2016; 60: 753.
11. Young-Southward G, et al. Physical and mental health of young people with and without intellectual disabilities: cross-sectional analysis of a whole country population. Journal of Intellectual Disability Research, 2017. 61(10): 984-993.
12. Yamaki K. Body weight status among adults with intellectual disability in the community. Ment Retard. 2005;43(1):1-10.

13. Lim MA, Liberali SA, Calache H, Parashos P, Borromeo GL. Perceived barriers encountered by oral health professionals in the Australian public dental system providing dental treatment to individuals with special needs. Special Care in Dentistry. 2021 May;41(3):381-90.
14. Pradhan A, Slade GD, Spencer AJ. Access to dental care among adults with physical and intellectual disabilities: residence factors. Australian dental journal. 2009 Sep;54(3):204-11.
15. Ahmad MS, Razak IA, Borromeo GL. Undergraduate education in special needs dentistry in Malaysian and Australian dental schools. Journal of Dental Education. 2014 Aug;78(8):1154-61.
16. Pradhan A. Oral health impact on quality of life among adults with disabilities: carer perceptions. Australian Dental Journal 2013;58(4):526–30.
17. Binkley CJ, Johnson KW, Abadi M, Thompson K, Shamblen SR, Young L, Zaksek B. Improving the oral health of residents with intellectual and developmental disabilities: an oral health strategy and pilot study. Evaluation and Program Planning. 2014 Dec 1;47:54-63.
18. Specialist Dental Practice, Royal Australasian College of Dental Surgeons [Internet]. 2025. Available from: https://racds.org/sdp
19. Registrant data table – 31 December 2024 [Internet]. Dental Board of Australia, 2024 [cited 2025 Mar 21]. Available from: https://www.dentalboard.gov.au/About-the-Board/Statistics.aspx
20. Australian Federation of Disability Organisations, Children and Young People with Disability Australia, Down Syndrome Australia, and Inclusion Australia. Joint submission to the Select Committee into the Provision of and Access to Dental Services in Australia. 2023 Jun 4. [Internet] Available from: https://www.inclusionaustralia.org.au/wp-content/uploads/2023/07/FINAL_Joint-submission_access-to-dental-care.pdf
21. Wilson NJ, Lin Z, Villarosa A, George A. Oral health status and reported oral health problems in people with intellectual disability: A literature review. Journal of Intellectual & Developmental Disability. 2019 Jul 3;44(3):292-304.
22. Pradhan A, Slade GD, Spencer AJ. Factors influencing caries experience among adults with physical and intellectual disabilities; Community Dentistry and Oral Epidemiology 2009; 37(2):143–154.
23. Pradhan A, Keuskamp D, Drennan B. Pre- and post-training evaluation of dental efficacy and activation measures in carers of adults with disabilities in South Australia – a pilot study. Health & Social Care in the Community. 2016;24(6):739-46
24. Faulks D, Hennequin M. Evaluation of a long-term oral health program by carers of children and adults with intellectual disabilities. Special Care in Dentistry. 2000 Sep;20(5):199-208.
25. Wilson NJ, Lin Z, Villarosa A, Lewis P, Philip P, Sumar B, George A. Countering the poor oral health of people with intellectual and developmental disability: a scoping literature review. BMC Public Health. 2019 Dec;19:1-6

26. Building the evidence base for the next National Oral Health Plan [Internet]. [Place unknown: Australian Government Department of Health and Aged Care]; 2024 Dec 13 [cited date – 2025 Mar 12]. Available from: https://www.health.gov.au/sites/default/files/2025-01/building-the-evidence-base-for-the-next-national-oral-health-plan.pdf