ADOHTA

AUSTRALIAN DENTAL and ORAL HEALTH THERAPISTS' ASSOC Inc.

26 May 2016

Dental Council of New Zealand
consultations@dcnz.org.nz

RE: **Follow-up consultation on a proposed oral health therapy scope of practice**

The Australian Dental and Oral Health Therapists' Association Inc is pleased to provide the following responses to the questions raised in the DCNZ follow up consultation.

**Q1: Do you agree with the proposed changes to the oral health therapy scope of practice? If not, please explain.**

ADOHTA supports the need for an oral health therapy scope of practice, which is consistent with the education and training of this profession both locally and internationally, such as in Australia and Singapore. This is particularly important given the Trans-Tasman Mutual Recognition Act which enables portability of qualification across the Tasman and the historic and professional parities that exist within these professions. This relationship is recognised in the formal accreditation relationships between Australian Dental Council and the Dental Council of New Zealand around program accreditation. We also support the protection of the title 'oral health therapist' (OHT) as a stand-alone category of registration. Additional registration titles will add confusion for the general public and make data collection around the practice of OHT for workforce planning purposes difficult.

ADOHTA disagrees with the proposed wording that restricts dental caries diagnosis and restorative procedures to people less than 18 years old. Whilst the educational preparation and training in oral health therapy varies slightly between universities across Australia and New Zealand, dental caries diagnosis for all ages is part of the scope of practice for dental hygiene and therefore oral health therapy. In addition, there would be unnecessary restrictions on practice for oral health therapists who have obtained formal qualifications to treat all ages under the jurisdiction of the Dental Board of Australia. There is evidence to show that dental hygienists, including those who are not university prepared can reliably diagnose and treatment plan care for people with complex needs (Hopcraft et al 2007-10). There is also evidence to show that dental therapists are demonstrably capable in this area for people up to age 26 years and this scope of practice has been in place in Australia since 2006. The extension of practice for patients aged beyond 25 years for dental therapists is not focused on examination, diagnosis or restorative skills, which they can do reliably, but about planning care for older age groups. It is the responsibility of the accreditation body and the training institution for the approved programs to determine whether that program enables practice in restorative

procedures for people above 18 years old, however, legislation should not restrict the practice of appropriately trained dental practitioners. This scope of practice (comprehensive examination, diagnosis and treatment planning for people of all ages) is recognised as being part of an OHTs' scope of practice in Australia.

There are currently no age limits in regulation in Australia and this has not seen any adverse outcomes since it was established in 2009 in Victoria and in 2010 nationally. Graduates' ability and scope of practice should rest on their educational preparation and competency for practice and not on artificially imposed age limits without evidence. There is good evidence to show that oral health therapists can reliably determine the boundaries of their own practice and act accordingly. Sanctions for unprofessional practice are in place to manage deviations from expected standards.

New Zealand was among world leaders when it removed age limits on dental therapy practice in 1988 and despite the current lack of educational opportunities, this was a positive move. ADOHTA suggests New Zealand regulation should not impose age limits on practice but enable practice to match educational preparation and competence: regulation should not contain wording that limits patient age and dental caries diagnosis and restorative procedures for oral health therapists. Professional boundaries regarding scope of practice are mandatory for all the dental practitioner divisions. Therefore, ADOHTA argues that the wording should be consistent with the Dental Board of Australia's Scope of Practice Standard:

> *2. Dental practitioners must only perform dental treatment:*
> *a) for which they have been educated and trained in programs of study approved by the National Board, and*
> *b) in which they are competent.*

**Q2: Do you agree with the proposed consultative professional relationship between an oral health therapist and one, or more, dentists/dental specialists, without the need for a signed agreement? If not, please explain.**

ADOHTA supports the suggestion to remove the unnecessary need for a written signed agreement for the proposed consultative professional agreement. ADOHTA believes that whilst a written agreement should not be compulsory it is desirable to clarify that an agreement exists and the parties involved. A signed contract should not be mandatory- however this does not preclude practitioners from creating one.

OHTs can reliably determine when they require consultation with a dentist or specialist and when patient referral should occur and have been practising this way for almost 100 years; there is evidence to support their ability to do so reliably.

The Australian experience has been that a signed contract is not required, merely that an established relationship in which a dentist has to agree to act in that role exists, whether or not the OHT is employed by them. In a public sector environment, a requirement for a signed contract agreement creates impediments to practice if a single dentist has to sign an agreement to act as the 'consultant' in an organisational setting where dentists may be deployed across wider region or several work part time; in this situation it is enough that the

organisation undertakes to employ a dentist to provide that consultative service and it is a recognised part of their role.

Equally in a private practice where there are several dentists and the 'consulting & referral dentist' works only part time, is on leave or at a conference etc., it can leave the OHT in a position where they can't work.

It is the position of ADOHTA that all dental practitioners are required to practice in a manner that is in the best interest of the patient. Thus, general dentists and dental specialists are also obliged to consult and refer with other health practitioners for dental and general health care beyond their own scope of practice. This is consistent with the statement of the Dental Board of Australia Scope of Practice Standard:

> 1. *All dental practitioners are members of the dental team who exercise autonomous decision making within their particular areas of education, training and competence, to provide the best possible care for their patients.*

**Q3: Do you agree that the following orthodontic activities from the oral health therapy scope of practice be moved from direct clinical supervision to being performed within the consultative professional relationship?**
**a. tracing cephalometric radiographs**
**b. fabricating retainers and undertaking simple laboratory procedures of an orthodontic nature**
**If not, please explain.**

As per the above comments, orthodontic procedures performed by an oral health therapist within their scope of practice should be defined by their formal training and competence. Direct clinical supervision should be removed from the scope of practice standard.

**Q4. Do you agree with the proposal to end-date the two oral health programmes as prescribed qualifications for the orthodontic auxiliary scope of practice? Consequently, oral health graduates that register as an oral health therapist will be removed from the orthodontic auxiliary scope of practice – if registered in the orthodontic auxiliary scope of practice. If you do not agree with the proposal, please explain.**

ADOHTA supports the proposal that orthodontic procedures become part of dental therapy, dental hygiene and oral health therapy scope of practice. Therefore we support the proposal to end-date the two oral health programmes as prescribed qualifications for the orthodontic auxiliary scope of practice.

**Q5: Do you agree with the proposed competency standards for oral health therapists? If not, please explain.**

In principle, ADOHTA supports the proposed competency standards for oral health therapists except for the need for restriction to dental caries diagnosis and restorative care to be limited to people less than 18 years old. It would be beneficial to align these competencies to the approved professional competencies and attributes of the newly graduated oral health therapist recently published by the Australian Dental Council to ensure consistency across both jurisdictions.

**Q6: Do you agree with the proposed registration transition for oral health graduates? If not, please explain.**

ADOHTA supports the proposed registration transition for oral health graduates.

ADOHTA appreciates the opportunity to comment on the proposed Oral Health Therapy Scope of Practice.

Warm regards,

**Hellene Platell**
**President**
Australian Dental and Oral Health Therapists' Association Inc.
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