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Dental Board of Australia

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Re: Scope of Practice Review

The Australian Dental and Oral Health Therapists' Association (ADOHTA) is the progressive national representative body for dental and oral health therapists, providing leadership, collaboration and advocacy to enhance the profession, and achieve positive oral health outcomes for the community.

ADOHTA welcomes the opportunity to provide comment on the Dental Board of Australia's Scope of Practice Standard Review, and congratulates the Board on its continuing work on this Standard. We support the principles that underpin this review and support a team approach to dental care. ADOHTA believes that the standard should reflect the current practice of dental practitioners within their education, training and competence, and that the Standard should not be prescriptive.

There is some concern, however, regarding ambiguous wording within the Standard, and the consequent misinterpretation by the public, employers and the professions which leads to unnecessary restrictions on practice. The inclusion of terms such as 'clinical team leader', 'supervision' and 'independent practice' are misinterpreted to create confusion about responsibilities. ADOHTA advocates for a Standard which is unambiguous, non-restrictive and allows dental therapists, dental hygienists and oral health therapists to utilise the full range of their skills in order to provide greater accessibility to oral health care for the public and to directly lower costs for care.

ADOHTA therefore welcomes the proposed improvements to the Standard and the efforts made to reflect current practice for our profession, including the process of stakeholder consultations, and particularly the removal of the term 'supervision' from the Standard.

With regard to the questions posed within the consultation document, ADOHTA has responded accordingly:

**Do you agree that the revision to the standard will provide greater clarity and certainty for dental practitioners to work within their scope of practice?**

Whilst the addition of guidelines and the overall review of the standard has resulted in more clarity, ADOHTA does not believe that the revised standard accurately reflects the current practice of dental practitioners practising within their education, training and competence.

There remain issues which will continue to cause misinterpretation and unintended restrictions on practice for dental therapists, oral health therapists and dental hygienists. These issues and ADOHTA's concerns are detailed below.

**ADOHTA believes that all registered dental practitioners should be treated the same under regulation.**

The principle mechanisms of regulation (protection of title, protection of practice, sanctions for unprofessional conduct, ethical behaviour and a requirement to practice within educational preparation, competence and recency of practice, compulsory professional indemnity insurance and CPD requirements) apply to all those registered under the AHPRA framework.

**There is no evidence to support the notion that dental therapists, hygienists and oral health therapists require more levels of regulation of their practice than dentists, dental specialists and dental prosthetists.**

For this reason, ADOHTA takes the view that the inconsistent application of restrictions on independent practice for some practitioners serve only to confuse practitioners, the public and insurers.

**Health Workforce Australia's 2011 review of the Scope of Practice for oral health practitioners recommended '*...within five years to remove the bar of independent practice for Oral Health practitioners...*' ADOHTA believes that this recommendation should now be acted upon.**

In addition, ADOHTA has the view that all standards and policies require review at regular intervals, and we support the stated commitment to review the standards and guidelines every three years.

**Do you agree that the introduction of the guidelines further supports this clarity for dental practitioners and the public?**

The guidelines offer an opportunity to add more detail and to further identify the objectives of the Standard, however as has been witnessed in the past, it is important not to develop prescriptive wording that limits the ability of practitioners to: use their full scope of education and training; incrementally add skills to maintain a contemporary scope of practice; and enable the use of appropriate technological developments. There is also a significant concern about practitioners who are not familiar with the current practice of dental therapists, dental hygienists and oral health therapists imposing limitations based on poor understanding of the scope of practice. There is significant experience and evidence to show that when people read guidelines and supporting documents without appropriate understanding, they will make their own interpretation of any uncertain sections within the standard, and impose inappropriate limits on their employees' practice. Some areas within the guidelines offer further concerns for ADOHTA which are detailed below.

**Are there additional factors which could be included in the guidelines to support the standard?**

The guidelines should include a description of what constitutes Scope of Practice and the differences between Professional Scope and Individual Scope. This would aid understanding of why a prescriptive list of services is no longer appropriate for dental therapists, dental hygienists and oral health therapists.

**Do you agree with the list of skills in the guidelines relating to programs to extend scope? Are there additional skills which the National Board should consider adding to the list? Do you agree that there should be a formal accreditation process where the skills are not a sub-set of an approved program?**

Extension of Scope should refer to additional skills, knowledge and competence to those which new graduates possess at the time of graduation and which are outside of the competencies defined in the Australian Dental Council's framework for newly graduated practitioners. The recognition of an extension of scope and subsequent authorisation upon an individual's registration would need to incorporate formal assessment of learning and skills development and the requirement of the program to be accredited.

The acquisition of skills which currently form part of an undergraduate course should not constitute an extension of scope and should be treated as upgrading an existing skill set to maintain competence and currency. Where these can be provided by an already recognised training

organisation, attendance at and subsequent certificate of attainment should be sufficient to allow practitioners to commence using these skills immediately.

It is important that consistency across all practitioner groups is established in this area. Requirements for extending scope of practice should not be more onerous or demanding for one practitioner group compared to others.

### **Does the preferred proposal balance the need to protect the public with the needs of regulating the profession?**

Registration and its supporting mechanisms are established to protect the public and these are well established across a range of professions including those within dentistry.

The National Law has established that all health practitioner groups should be subject to the same regulation and that different rules are not required to regulate different professions. Registered dental therapists, hygienists and oral health therapists are not inherently less professional, less able to recognise the boundaries of their own competence or less ethical than dentists and should not be treated differently under regulation.

ADOHTA believes that the wording within the revised Scope of Practice Standard remains excessively restrictive without offering any additional protection for the public. Some ambiguous terms have been – and will continue to be – misinterpreted by practitioners, employers and the public. Some terms have failed to prove their relevance in the provision of safe patient care, e.g. the lack of clarity about the reason for naming the dentist as the clinical team leader. There are also components that impede access to oral health care and impose unnecessary impediments to competition. These have been detailed below.

### **What is the impact of the preferred proposal in your jurisdiction?**

ADOHTA predicts further confusion and envisions another raft of queries and concerns from members, employers and the public about the interpretation of some ambiguous statements. The revised Standard does little to clarify the responsibility for patient care when the service is delivered by a dental therapist, dental hygienist or oral health therapist within a structured professional relationship with an off-site dentist who is the clinical team leader yet may never have seen the patient in question.

The revised standard needs to state that all dental practitioners are responsible for the decisions they make and the procedures they perform. They are also responsible for ensuring they will exercise

their best professional judgement and seek consultation and referral in the interests of best outcomes for their patients.

### Preferred option

ADOHTA could support Option 2; *however* there are still a number of points within the suggested revised standard with which we do not agree.

#### 1. Support the team approach to dental care

**Support** – This statement reflects the approach to the provision of care within which dental therapists, dental hygienists and oral health therapists have always practiced.

#### 2. Reflection of practice

##### 2a

**Support** – the removal of the term ‘supervision’

ADOHTA supports the removal of the word ‘supervision’ and its definition from the standard  
ADOHTA also supports the first sentence of the proposed change, although we note that this phrase should apply to all registered dental practitioners, not just dental hygienists, dental therapists and oral health therapists :

*‘Dental hygienists, dental therapists and oral health therapists are members of the dental team. They practice in a range of activities included in the definition of dentistry, in which they have been formally educated and trained.’*

**Reject** – *‘They may only practise within a structured professional relationship with a dentist.’*

The second sentence should be deleted from this clause. The requirement for practise by dental hygienists, dental therapists and oral health therapists within a structured professional relationship adds confusion: all practitioners should seek advice and refer patients when their needs are beyond their expertise and scope of practice- no practitioner should practise in isolation. Dental hygienists, dental therapists and oral health therapists have always practised in a consultative and referral relationship with dentists, dental specialists and other health practitioners and their education prepares them for practise within this context. There is over 40 years of evidence to show that this has been done safely and responsibly by these practitioners. There is no evidence to support a need to impose inconsistent regulation on these practitioners within these guidelines. This sentence imposes additional regulation which adds unnecessary restriction of competition without additional benefit to the public.

We also have a concern that a 'structured professional relationship' might be perceived to represent an employment contract or exclusive arrangement and that dental practitioners would not have the ability to refer to other practitioners dependant on the patient's needs

**Reject** – *'They must not practise as an Independent practitioners'*

The sentence *'they must not practise as independent practitioners'* presents the major issue with this standard. The interpretation of this statement varies between the DBA, professional bodies, employers and practitioners. The restrictive inclusion of this phrase is in direct competition with the ideal of autonomous practice and working within a team relationship. Furthermore this sentence is superfluous as, according to the definition of 'Independent practitioner', it is a repetition of the previous sentence. *They may only practise within a structured professional relationship with a dentist.*

All health practitioners should practise in consultation with other practitioners where patient needs require and this is covered in the AHPRA Health Practitioner Code of Conduct (2.2:pp3, DBA 2010). This raises the question of what this definition means. Does it imply that dentists (who may practise independently under this revised standard) do not need to consult and refer and recognise the boundaries of their own expertise and competent practise? Or is it a definition of a business arrangement, which therefore lies outside the remit of this document and the Board's purpose? It should be noted that currently dental and oral health therapists already own dental practices throughout Australia.

Dental prosthetists also provide care within a range of activities included within the definition of dentistry and, under Clause 3 are able to practise independently. ADOHTA is unclear what informs a decision to treat registered dental hygienists, dental therapists and oral health therapists differently to registered dental prosthetists and dentists. It is clear that such a clause has the capacity to limit access to care by our profession and imposes unnecessary restriction in regulation that is not in the public interest.

The professions of dental therapy, oral health therapy and dental hygiene have identified the problems created by the term 'independent practitioner' as posing the greatest barrier to the full utilisation of their skills. The urgent need to remove this term is reflected in the unanimously passed resolution of the 3<sup>rd</sup> ADOHTA International Conference in Canberra, August 2012 that:

*This conference urges the Minister and the Dental Board of Australia to adjust the Dental Scope of Practice Registration Standard for dental therapists, dental hygienists and oral health therapists to reflect team based practice with autonomous decision making and without supervision requirements with a view to remove the bar on independent practice by the end of 2012.*

ADOHTA contends that the term Independent Practitioner and its definition should be removed from the standard

## 2b

**Reject** – the use of words describing ‘*a structured professional relationship*’

ADOHTA prefers the use of words to describe practice as being a collaborative and referral relationship.

The definition included here is complex and wordy. We suggest an alternative definition:

Consultative and Referral Relationship

This refers to the relationship between practitioners which enables discussion and advice, or the referral of patients between practitioners in the best interests of patient care. It supports a duty of care to patients based on their needs and is a responsibility of all practitioners.

The standard should include the statement that all dental practitioners are accountable for making professional judgements about when an activity is beyond their own capacity or scope of practice and for initiating consultation with, or referral to, other members of the health care team. ADOHTA believes that this premise applies to all the divisions of dental practitioners as well as other registered health practitioners, as the same regulatory standards and guidelines apply to all to ensure quality of care and safe practice.

## 2c

**Reject** – ‘*independent practitioner means a practitioner who may practise without a structured professional relationship*’

As stated previously, the term independent practitioner causes confusion to the standard which is unnecessary and contributes to the restriction of practice. Both the suggested definitions appear circular and offer no real understanding of what is intended by the term independent practitioner thereby adding to the misinterpretation that already exists. We suggest that this is because this is inconsistently applied and is really a business relationship rather than a patient protection mechanism.

ADOHTA contends that the term ‘independent practitioner’ and its definition should be removed from the standard

## 3. Reduce the prescriptive nature of the standard

**Reject** – ‘*Dentists and/or specialist dentists work as independent practitioners who may practise all parts of dentistry included in the definition of dentistry.*’

The first sentence here is problematic; by implication, dentists may practise all parts of dentistry (regardless of their educational preparation, competence and individual scope of practise) and are not required to collaborate with and refer to other practitioners when patients needs fall outside of

the boundaries of their competence. Specialists, by the nature of their specialist registration agree to restrict their practise to their speciality- this means that they cannot practise in all parts of dentistry. This definition is inconsistent with the regulation of the other dental practitioners and the regulatory intent to protect the public.

**Reject** – *‘Where there is a structured professional or referral relationship then the dentist and/or specialist dentist is the clinical team leader’*

ADOHTA rejects the implication that all dentists are capable of being the clinical team leader. Dental therapists, hygienists and oral health therapists have always practised in collaborative team environments and the ADOHTA continue to support this approach. ADOHTA considers it inappropriate to expect a newly graduated dentist to provide clinical team leadership when entering a team of experienced dental therapy, dental hygiene and oral health therapy practitioners. This is clearly not in the best interests of safe, quality patient care and potentially places the dentists in danger of overstepping their own professional boundaries where they do not have the experience necessary to do so.

The current standard does not clarify what is meant by the term ‘clinical team leader’. Public and practitioner confusion arises from misinterpretation of what is meant or intended by this phrase. Many believe that it implies that the dentist is legally responsible for any treatment provided by dental therapists, dental hygienists or oral health therapists with whom they have a collaborative and referral relationship. This interpretation is detrimental to the appropriate utilisation and employment of DT, DH, and OHT’s and their full scope of practice as required in the National Oral Health Plan (AHMC 2004). If the dentist is classified as the ‘team leader’ the responsibilities are blurred as far as clinical responsibility is concerned; this is a legal minefield where dentists could be held responsible for treatments they have not provided. Confusion in this area undermines the public’s confidence in the continued ability of DT, DH & OHT’s to provide safe, high quality and competent oral health care and refer appropriately for care outside of their own scope. These practitioners have consistently demonstrated their ability to provide high quality care, to practise safely and ethically, and effectively recognise the boundaries of their own competence. Members of the public need to be assured that the dental practitioner providing their care is responsible for the care provided and takes responsibility for the quality of that care and for collaborating in the interests of patients’ care and referring appropriately all treatment outside their scope of practice or competence.

Imposing a business model designating a ‘team leader’ imposes inappropriate structural barriers and restricts access to professional services.



ADOHTA supports a team approach between dental practitioners, so that patients are assured of receiving the most appropriate treatment from the dental practitioner who is most appropriate to provide it in the best interests of patient care. This will depend on:

- what is required for the safety and wellbeing of the patient
- the treatment being provided, and
- the type of practice and
- the education, experience and competence of team members.

These are matters for the professional judgement of the practitioners involved and will vary from case to case.

ADOHTA contends that the words 'clinical team leader' should be removed from the standard.

#### *4. Further clarification of the standard*

##### **Definition of dentistry**

ADOHTA believes that there should be no changes to the existing definition of dentistry- the changes proposed in the guidelines are inconsistent with the legislation and are restrictive to access to good quality care and holistic approaches to prevention, identification and referral of oral disease. The additional clauses proposed in this draft should not be included; they impose unnecessary restrictions. Please see Appendix for additional comments.

##### **A description of the dental profession**

ADOHTA believes that the organisation best positioned to describe each of the practitioner divisions is the professional associations. These associations have the expertise to define the professional scope of practice and handle enquiries about utilisation of skills and educational preparation.

As orthodontic procedures have been within the scope of practice for dental therapists, oral health therapists and dental hygienists for many years, ADOHTA believes they should be included in this description.

Please note suggested wording changes in the attached Appendix : Excerpt from the Guidelines

##### **Requirements in order for oral health therapists and dental therapists to provide dental therapy treatment for patients of all ages**

While ADOHTA is comfortable with this list, in contrast with the Scope of Practice Standard and the rest of the guidelines, this section is quite specific and prescriptive. This approach is problematic as it has been demonstrated to be unable to accommodate changes in technologies and variations in educational preparation between education settings. Some points, whilst trying to clarify the parameters of services that may be provided for adults, are in contradiction to those which are currently provided by dental and oral health therapists for those under the age of 26 years.

E.g. *radiographically clear of the dental pulp* would preclude the current practice of provision of direct pulp capping, the management of trauma and if read literally, pulpotomies.

**ADOHTA approves the list but contends that this list should not be included in the guidelines but in a separate document held as accreditation advice.**

**Suggest** – Whilst the need to specify the parameters and description to clarify the minimum standard of modalities expected to be taught and assessed for dental therapists and oral health therapists when practising dental therapy on persons over the age of 25, this function belongs within the accreditation authority's realm and fits better in a separate document and not within the broader guidelines on Scope of Practice document. The Guidelines are intended to inform all aspects of dental practitioners practice, whereas this section is quite specific to the education of a small group of registrants and is unnecessarily prescriptive. This information could be considered for inclusion in a separate document providing advice to educational providers when they are considering developing pathways to this competency. We also believe that assessment against this framework belongs with the accreditation process for education programs for dentistry, and should be incorporated into that role in line with the intent of the NRAS legislation.

**Suggest** –Clarification is also required with regard to the provision of non-restorative, orthodontic and preventive services for patients of all ages by dental therapists as this information focuses on restorative care. There is an interpretation that DT practitioners are currently restricted from utilising their full scope of preventive care in which they are educationally prepared dependent upon the age of the patient; these services are already being provided in many practice contexts.

#### **Education Programs which extend scope of practice**

ADOHTA supports the concept of life-long learning and agrees that dental practitioners should be encouraged and supported to continue to develop their learning and acquire new skills post-graduation. We also support the notion that practitioners should ensure that they are practising at least to the standard of a newly graduating practitioner. ADOHTA supports a consistent approach to adding skills and extending scope of practice across all practitioner groups and raises questions here about why dental therapists, dental hygienists, oral health therapists and prosthetists are treated differently to dentists.

ADOHTA believes that contemporisation of scope of practice, extension of scope and continuing professional development **must be consistently applied to all registered dental practitioners.**

We agree that the only programs that should be considered under this heading are those which extend scope of practice beyond that of the newly graduated practitioner. Education which brings a

practitioners' skill set up to that of a newly graduating practitioner should be an expected undertaking and considered as Continuing Professional Development (CPD).

Requirements for the Board to approve all CPD courses would be prohibitively expensive and detrimental to the provision of quality health care and therefore the public interest.

**Reject** – the extension of Scope of Practice should be for courses which offer additional qualifications to those which new graduates possess. Courses which allow less recent graduates to expand their knowledge, skills and competence in line with that of new graduates should not be considered as an extension of scope.

Orthodontic procedures, intra and extra-oral radiography, stainless steel crowns, local analgesia and tooth whitening are all practices which have been within scope (and educational preparation) for many years and as such, do not constitute an extension of scope. The treatment of adults is simply an extension of patient age group and not an extension of scope into new practice areas. ADOHTA supports the continued use of short courses to enable enhancement of competency as important accessible pathways to maintaining scope of practice at contemporary standards, as required by the Health Practitioner Code of Conduct (DBA 2010).

**Suggest** –The extension of scope should not include tooth whitening, limited orthodontic procedures, periodontal diagnosis, stainless steel crowns and radiography. To include these in the list of extension of scope skills would then require new graduates who have achieved these as part of their undergraduate course to have them authorised or endorsed on their registration as an extended scope for the purposes of consistency with other oral health therapy, dental hygiene and dental therapy registrants.

ADOHTA appreciates the opportunity to contribute to the process of review and refinement of all DBA Standards and looks forward to continued involvement in the process.

Yours Sincerely



Julie Barker

President

Australian Dental and Oral Health Therapists' Association

Please note our **highlighted suggested changes** and additional comments in the footnotes of this Appendix

Dental practitioner divisions

Dentists work as independent practitioners and may practise all parts of dentistry. They provide assessment, diagnosis, treatment, management and preventive services to patients of all ages. The education requirement for a recent graduate dentist to be registered is a minimum four year full time formal education program.

Specialist dentists have undertaken additional specialised training and education. The 13 specialist dentist types are:

- dento-maxillofacial radiology
- endodontics
- oral and maxillofacial surgery
- oral medicine
- oral pathology
- oral surgery
- orthodontics
- paediatric dentistry
- periodontics
- prosthodontics
- public health dentistry (community dentistry)
- special needs dentistry, and
- forensic odontology

The National Board’s List of specialties provides further detail of each specialty. The National Board’s Specialist Registration Standard further outlines the requirements for registration as a specialist dentist.

Dental hygienists provide oral health assessment, diagnosis, treatment, management, and education for the prevention of oral disease to promote healthy oral behaviours to patients of all ages. This includes periodontal/gum treatment, **orthodontic services**, preventive services and other oral care. Dental hygienists may only work within a ~~structured~~ **collaborative and referral** professional relationship with a dentist and/or specialist dentist. The education requirement for a recent graduate dental hygienist to be registered is a minimum two year full time or, **for a dual-qualified practitioner** three **years of** full time formal education program.

Dental prosthetists work as independent practitioners in the assessment, treatment, management and provision of removable dentures; and flexible, removable mouthguards used for sporting activities. The education requirement for a recent graduate dental prosthetist is a three year full time formal education program (including a dental technician course).

Dental prosthetists who are formally educated and trained in a program of study approved by the National Board may provide various types of splints; sleep apnoea/anti snoring devices, immediate dentures and immediate additions to existing dentures. These procedures require written referrals to and from dentists and/or specialist dentists and any appliance or device manufactured under such arrangement must be planned, issued and managed by the treating dentist and/or specialist dentist.

Dental prosthetists formally educated and trained in a program of study approved by the National Board to provide treatment for patients requiring implant retained overdentures must enter into a structured professional relationship with a dentist and/or specialist dentist before providing such treatment. The dentist and/or specialist dentist is the clinical team leader.

Dental therapists provide oral health assessment, diagnosis, treatment, management and preventive services for children, adolescents and young adults and, if formally educated and trained in a program of study approved by the National Board, for adults of all ages. This includes restorative/fillings treatment, tooth removal, **orthodontic procedures**, additional oral care and oral health promotion. Dental therapists may only work within a ~~structured~~ **collaborative and referral** professional relationship with a dentist and/or specialist dentist. The education requirement for a recent graduate dental therapist to be registered is a two year full time or **for** dual-qualified practitioner, **a** three year full time formal education program.

Oral health therapists are dual qualified as a dental therapist and dental hygienist. They provide oral health assessment, diagnosis, treatment, management and preventive services for children and adolescents and, if formally educated and trained in a program of study approved by the National Board, **may provide restorative care** for adults<sup>1</sup> of all ages. This includes restorative/fillings treatment, tooth removal, oral health promotion, **orthodontic**, periodontal/gum treatment, and other oral care to promote healthy oral behaviours. Oral health therapists may only work within a ~~structured~~ **collaborative and referral** professional relationship with a dentist and/or specialist dentist. The education requirement for a recent graduate oral health therapist to be registered is a three year full time ~~bachelor degree~~<sup>2</sup> formal education program.

#### Definition of dentistry

The following range of activities are considered the practice of dentistry and cover the widest range of any procedures that a person educated in dentistry can carry out. Dentistry involves the prevention, diagnosis, advice, and treatment of any diseases, deficiencies, deformities or lesions on or of the human teeth, mouth or jaws or associated structures (including but not limited to):

- a) the correction of malpositions of the human teeth or jaws or associated structures; and
- b) radiographic procedures and interpretation of radiographic images of the human teeth, jaws and associated structures; and<sup>3</sup>
- c) the prescription, administration and possession of drugs and poisons in accordance with relevant State and Territory authorisation; and<sup>4</sup>
- d) the construction or fitting or intra-oral adjustment of artificial teeth or corrective or restorative dental appliances; or provision of advice to any person for the purpose of fitting, inserting, adjusting, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances; and
- e) the prevention of oral disease and the promotion of oral health<sup>5</sup>; and
- f) the performance of any treatment on the human teeth, mouth or jaws or associated structures.

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<sup>1</sup> Oral Health Therapists can already provide care for patients of all ages- they are only restricted to restorative care for those under 26 years of age

<sup>2</sup> This is inconsistent with the rest of the document

<sup>3</sup> Including these words here would prevent radiographers from taking or interpreting x-rays of the dento-facial complex, including OPGs and tomography which would unnecessarily restrict access to care.

<sup>4</sup> This is covered by state and territory legislation and under review for national regulation, it is not necessary to include as part of dentistry- it is unnecessarily restrictive.

<sup>5</sup> This would prevent dental assistants and other health workers from undertaking preventive procedures such as applying fluoride varnishes, providing advice on prevention and identifying and referring dental and oral diseases. This would be a backward step in the collaborative and holistic approaches to preventing dental diseases. This should not be included here.

## 2. Education and training requirements for the treatment of patients of all ages

Dental therapists and oral health therapists<sup>6</sup> require formal education, training and competence in order to treat patients of all ages when practising dental therapy **restorative care**.

Note: Dental therapists **registered prior to the National Scheme in Victoria** with formal education and training and who are competent may treat patients up to the age of 25 years<sup>7</sup>.

The National Board expects the following uniform, minimum standard of modalities to be taught and assessed for dental therapists and oral health therapists when practising dental therapy **for** persons of all ages:

- extension of clinical restorative skills to the provision of simple direct tooth restoration in the adult patient
- development of clinical judgment skills in identifying those teeth which require simple direct restoration and those which must be referred for more complex care
- development of knowledge in management of patients with fixed or removable oral prostheses
- development of knowledge in the identification and the preventive management of root caries
- management of medically compromised patients
- recognition and identification of oral pathological conditions in the clinical situation
- recognition of polypharmacy in the adult population, and
- knowledge and practical skills relating to administration of local anaesthetic to adult patients.

The following assists in determining what constitutes a simple direct tooth restoration as opposed to one which requires the attention of a dentist:

- includes no more than four surfaces
- does not include cusps or require pins or complex retentive features
- does not involve the pulp when assessed radiographically
- is one that is easily accessed and simple to isolate at the gingival margin
- is not placed in an endodontically treated tooth, and
- where the tooth requiring simple restoration is immediately adjacent to a dental prosthesis (fixed or removable) consideration must be given to the complexity of the interface between the restoration and the adjacent fixed or removable prosthesis and referral made when necessary.

Currently, the only formal education programs, which have been supported and/or approved by the Board for dental therapists<sup>8</sup> and oral health therapists to provide dental therapy in various modalities to adults of all ages, are:

- the Dental Health Services Victoria (2007/8) bridging program to facilitate the provision of oral health care to adult patients (only offered prior to the introduction of the National Registration and Accreditation Scheme (the National Scheme); and

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<sup>6</sup> Oral health therapists can already provide care to people of all ages. The only limitation is that some courses do not prepare them for restorative care for those over 25 years of age. Suggest insert Restorative care into this sentence.

<sup>7</sup> It is not only Victorian qualified DTs and OHTs. WA dental therapists can also treat people of all ages. So too can some New Zealand, UK and Netherlands trained dental therapists. This sentence needs re-wording to accommodate all those who have this competence.

<sup>8</sup> This might prove restrictive where an overseas qualified dental therapist demonstrated competency to provide these services. In addition, where new programs are approved, this would need to be adjusted. For this reason it may be better to list these approved programs on the Boards website rather than in this document. Inclusion in this document would require consultation in order to change it- which would be a costly and time consuming process to enable updating.

- Successful graduates of the unit ORH3ACP Advanced clinical practice as part of the Bachelor of oral health science program at La Trobe University from 2010 onwards.

### Extension of scope of practice

The National Board has made a distinction between formal education programs, programs to extend scope, and education activities that are undertaken for continuing professional development (CPD) credit.

- Approved programs (formal education programs) are approved by the National Board and accredited by the Australian Dental Council. The approved programs are those which, upon successful completion, lead to registration as a dental practitioner in the division or specialty in which study was completed.

- Programs to extend scope (formerly known as add-on programs) are programs which can extend a dental practitioner's scope of practice by undertaking educational programs that the National Board has formally approved or transitioned (the National Board transitioned add-on programs which existed in states and territories prior to the introduction of National Scheme).

These programs allow dental practitioners to bring their education and training up to the level of a recent graduate and/or current practice methods within the division in which they are registered. The purpose of these programs are to bridge the gap between the variations in scope of practice between individuals within specific divisions, which have resulted from the different levels of education/training and of regulatory structures which existed prior to the National Scheme and in some areas after the implementation of the National Scheme.<sup>9</sup> The process of approval of these programs by the National Board includes an external audit and accreditation process.

The programs to extend scope cover a range of skills which allow dental practitioners to extend their education, training and competence in certain areas and within the division in which they are registered. The range of skills, as outlined in the table below, are effective from 1 January 2014.

Range of skills covered in programs to extend scope

Local anaesthesia / analgesia - Dental hygienist:

This is not an extension of scope- it is contemporary practice

Periodontal diagnosis and instrumentation skills -Dental therapist

Periodontal diagnosis and scaling is not an extension of scope- it is contemporary practice

External Tooth whitening- Dental hygienist, dental therapist, oral health therapist

This is not an extension of scope- it is contemporary practice

Limited orthodontic treatments- Dental hygienist, dental therapist, oral health therapist

This is not an extension of scope- it is contemporary practice

Direct simple restorations for adults- Dental therapist and oral health therapist

This is contemporary practice in Western Australia and for graduates of the La Trobe University program

<sup>9</sup> This does not represent an extension of scope- it is simply maintaining skills in line with current graduates. This is what occurs through Continuing Professional Development and should be treated in the same way. An Extension of Scope occurs when a practitioner undertakes training in a procedure which is not normally included in current practice i.e. beyond that of a current graduate in their profession.

Stainless steel crowns- Dental therapist, oral health therapist  
**This is not an extension of scope- it is contemporary practice**

Implant retained overdentures- Dental prosthetist

Partial dentures- Dental prosthetist

Occlusal splints- Dental prosthetist

Immediate dentures and immediate additions to existing dentures- Dental prosthetist

Intra-oral appliances to manage sleep apnoea and snoring- Dental prosthetists

Conscious Sedation- Dentist and specialist dentists

\*Note: this requires a specific endorsement from the Dental Board of Australia

Cone Beam Computed Tomography- All

Radiography- All

**This is not an extension of scope- it is contemporary practice**

**CPD programs** are programs that maintain, improve and broaden knowledge, expertise and competence, and develop the personal and professional qualities required throughout a dental practitioner's professional life. The National Board has not specified an approval process for courses or course providers who provide CPD. The National Board's *Continuing professional development registration standard and Guidelines* detail the requirements and expectations of the National Board in relation to CPD.