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Aboriginal Health Practitioners *obtaining, possessing* and *administering* fluoride varnish: self-determination driven regulation amendment for integrated oral health care for Aboriginal children

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ABSTRACT

Self-determination informed policies are key to improved outcomes for Aboriginal health. Aboriginal leadership must be reflected throughout any public health reform process that affects Aboriginal communities. This paper presents a body of oral health policy work, undertaken under Loddon Mallee Aboriginal Reference Group's (LMARG's) leadership, as an exemplar of a self-determination informed change, that led to an amendment of an Australian state (Victoria) regulation – The Drugs, Poisons and Controlled Substances Amendment (Registered Aboriginal and Torres Strait Islander Health Practitioners [AHPs]) Regulations 2022. A summary of activities undertaken by LMARG, from advocacy to leading the submission, to amend the regulation, is provided. The amendment, now in place, authorises registered AHPs to obtain, possess, and administer fluoride varnish (FV) as a part of health services they provide. FV is a concentrated form of fluoride applied to tooth surfaces to prevent tooth decay. The practical implication of this amendment is delivery of a culturally appropriate integrated oral health promotion FV model that addresses mainstream dental access barriers commonly experienced by Aboriginal people. The model aims at upskilling an Aboriginal workforce to facilitate timely FV application to Aboriginal children.

Keywords: Aboriginal Health Practitioners, Aboriginal leadership, AHPs, culturally responsive services, delivery of oral health care, indigenous, integrated primary care, self-determination.

Introduction

'Self-determination is an ongoing process of ensuring that Aboriginal people can make decisions on matters that affect them' (Australian Human Rights Commission, n.d.). Instead of Aboriginal people merely being consulted, Aboriginal people must be authorised to own, direct, and make decisions, and lead on policies and programs that affect their communities (Durey *et al.* 2016*c*).

As highlighted in Victorian State Government Aboriginal focused policy (Department of Health and Human Services 2017), when Aboriginal culture, ownership, and leadership is genuinely reflected in the design and delivery of programs that have an impact on the community, improved health outcomes for Aboriginal populations are achieved. This includes prioritisation of Aboriginal workforce capacity building within policy and program making process.

In Australia, the role of Aboriginal Community Controlled Organisations (ACCOs) is critical in Aboriginal health (Australian Human Rights Commission, n.d.). ACCOs, built on the principle of self-determination, focus on improving health and social outcomes for Aboriginal communities (Australian Human Rights Commission, n.d.). In terms of oral health, despite limited funding, ACCOs have been shown to play a critical role in the planning and implementation of oral health promotion and service delivery for the

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community (Poirier *et al.* 2022). For example, work by Dimitropoulos *et al.* (2019), codesigned with ACCOs in New South Wales, enabled Aboriginal dental assistants to provide fluoride varnish (FV) applications in school settings.

This paper presents on a body of oral health policy work, undertaken under Loddon Mallee Aboriginal Reference Group's (LMARG's) leadership, as an exemplar of a self-determination informed change that led to an amendment of Victoria regulation – The Drugs, Poisons and Controlled Substances Amendment (Registered Aboriginal and Torres Strait Islander Health Practitioners) Regulation 2022 (Victorian Legislation 2022). With Aboriginal leadership being central to policy making, the regulation now authorises registered Aboriginal Health Practitioners (AHPs) to obtain, possess, and administer FV. FV is a concentrated form of fluoride applied to tooth surfaces to prevent tooth decay (Do 2020). Within ACCOs, AHPs are primary healthcare professionals who provide holistic, culturally safe, clinical care services to Aboriginal communities (National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners, n.d.).

LMARG, a consortium of ACCOs in north-west Victoria covers 20–25% of the Aboriginal and Torres Strait Islander population. Its membership comprises Bendigo and District Aboriginal Cooperative, Njernda – Aboriginal Cooperation, Mallee District Aboriginal Services, and Murray Valley Aboriginal Co-operative Ltd.

Aboriginal oral health

In general, tooth decay is the most prevalent disease in Victoria, being the highest cause of potentially preventable hospitalisations in children aged 0–9 years (Department of Health and Human Services 2020). Aboriginal children experience tooth decay 1.5–2.5 times higher than the general population and have a twofold increased risk of being hospitalised due to oral health (Ha *et al.* 2016). Reasons can include limited dental visits, consumption of a high sugar diet, limited oral health literacy among caregivers, and attendance to service for pain relief rather than prevention (Durey *et al.* 2016*b*; Durey *et al.* 2017).

Oral health is a priority for Aboriginal community (Tynan *et al.* 2020), but access is impacted by health issues, family responsibilities, and cost (Durey *et al.* 2016*a*, 2016*c*). Reasons for poor oral health can also contribute to accessibility issues (COAG Health Council 2016; Durey *et al.* 2016*c*). Low levels of cultural responsiveness in dental services and low representation of Aboriginal people in the oral health workforce are significant access barriers. Mainstream policies and organisational practices often marginalise Aboriginal community members from accessing timely oral health care (Durey *et al.* 2016*b*).

As noted within the Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024 (NOHP) (COAG Health Council 2016), improving oral health of Aboriginal people requires focus beyond promotion of oral health behaviours. Oral health policies and programs should reflect Aboriginal people's needs and culture; be led by Aboriginal people; and be centred around understanding of Aboriginal health (Durey *et al.* 2016*c*). Aboriginal health is referred to as the social, emotional, and cultural wellbeing of the whole community (Australian Human Rights Commission, n.d.).

Fluoride varnish and Victoria

In Australia, FV is categorised as a Schedule 4 drug – a prescription only medicine (Parliamentary Counsel of Victoria 2022). Prior to amendment, in Victoria, FV was only administered by the dental workforce – dental practitioners and dental assistants (Do 2020), excluding the Aboriginal non-oral health workforce from FV administration. The practical translation was FV delivery occurred only via dental services. The dependence on dental services for FV applications made access to this service largely culturally inappropriate and less accessible for Aboriginal families. Results of an audit by the Victorian Auditor General's Office (2006) identifies the services have limited capacity to implement preventive dental services. FV, to be effective in tooth decay prevention, should be applied at an interval of at least 6 months (Do 2020).

Consistent with these issues, NOHP recommends extension of FV into non-dental settings to increase access to FV (COAG Health Council 2016) to improve oral health outcomes for Aboriginal people. The strategies include (1) increasing community engagement in the planning and delivery of oral health services and (2) delivery of an integrated oral health model of care that incorporates prevention and screening into other primary care services. The work presented herein, an extension of scope of practice of AHPs to facilitate FV administration within health services they provide, is a direct response to these issues.

Drugs and poisons legislation in Victoria includes two mechanisms to authorise persons to be in possession of poisons and controlled substances (Department of Health, Victoria n.d.). One, the *Drugs Poisons and Controlled Substances Act 1981* (the Act). Two, the Drugs, Poisons and Controlled Substances Regulations 2017 (the Regulations). Section 13(1) of the Act sets out the persons who are authorised to obtain, possess, and use, sell or supply poisons or controlled substances; listed in Schedules 1–9 of the Poisons Standard. Under the Regulations, professions and occupational groups (including AHPs) listed in regulations 7(1), 8, and 99(c) can be authorised to possess and/or administer Schedule 4, 8, or 9 drugs for treating persons in certain circumstances under an approval by the Secretary (to the Department of Health, Victoria (DH)).

Lead role of LMARG in the advocacy of regulation amendment

Table 1 provides a timeline on the work leading to the amendment including the key activities undertaken by LMARG.

Table 1. Timeline and key activities on advocacy and submission process of regulation amendment by LMARG.

2016	Opportunity for a FV pilot program to be developed as part of the oral health priority of an existing primary prevention project in the Loddon Mallee region. LMARG advocated for the need to review a proposed FV pilot project scope informed from discussions with ACCO workers and health managers in the Loddon Mallee region. Included recommendations were: 1. An early mapping exercise of FV activities across the region, with an intention of seeking input from LMARG ACCOs and Aboriginal families on how the community can culturally access FV including any potential avoidance of dependence on the public dental services, 2. Working with LMARG ACCOs on how the FV applications could be integrated with the existing ACCO health services identified (e.g. child health checks), 3. Provision of complementary oral health promotion, and 4. Advocating for including relevant professionals to apply FV.
2017	Commencement of LMARG FV program, funded by DH, with focus on 6-monthly FV applications on children's teeth, oral health screens, and oral health education across ACCOs. The program to be guided by principles of self- determination.
2018–2019	Findings of the mapping exercise show (May 2018 –August 2018): 1. Outreach FV services were offered on an *ad hoc* basis by public dental clinics. The implication of these limitations was that FV benefits to children's teeth would be minimal. 2. Based on Dental Weighted Activity Unit[A] the cost of two applications per annum was estimated at approximately AU$250 per child in an outreach setting in Victoria (Skinner *et al.* 2021) – an exorbitant cost given FV applications are simple and quick (Dimitropoulos *et al.* 2019). The findings were presented by LMARG across several platforms (e.g. LMARG FV governance meetings, via edits to draft program documentation, and FV national consensus workshop (Skinner *et al.* 2021)) that included representatives from DH, Dental Health Services Victoria (i.e. Victorian State lead oral health agency), and regional government advocating for the change in regulation (August 2018–August 2019). This ongoing advocacy to multiple audiences in multiple formats resulted in an opportunity to present the concerns and opportunity via a written letter to then Victoria Health minister (October 2019). The letter presented the mapping exercise findings with LMARG providing recommendation that a regulation amendment is warranted given the existence of a culturally inappropriate, mainstream-focussed, high-cost FV delivery model. LMARG noted the urgent need to address the mainstream FV delivery gaps so that FV applications can be provided to Aboriginal children in a culturally appropriate environment that is inclusive of, and easily accessible to, Aboriginal families. LMARG strongly recommended to the Minister that AHPs obtain, possess, and administer FV at ACCOs.
2019–2021	LMARG invited to make a submission to Secretary for approval of amendment to the Drugs, Poisons and Controlled Substances Regulations 2017 (November 2019). An advisory group with key experts from NT AHP-FV model, dental organisations, and public dental clinics; researchers; policy makers, ACCOs at state and national level was established (December 2019). Consultations, drafting, and submission of brief to HPDAC[B] (December 2019–May 2020). HPDAC endorses the brief to proceed with full submission by LMARG. Presentation of proposal at HPDAC (May 2020). Consultations, drafting, and dubmission of full submission to HPDAC (May 2020–July 2021). Presentation of submission by LMARG and DH at HPDAC and submission approved by HPDAC (July 2021). Minister approval for making of the amendment (August 2021). Public consultation by LMARG and DH with ACCOs, public dental agencies, state and national government agencies, and universities, dental and oral health professional bodies (October 2021). Supportive process implemented by DH – procedural requirements, such as legal input, parliamentary counsel for Minister (October 2021–December 2021).
2022	Ongoing supportive process by DH (January 2021–April 2022). Announcement of amendment by Health Minister (13 April 2022). Regulation gazetted (21 July 2022).

FV, fluoride varnish; LMARG, Loddon Mallee Aboriginal Reference Group; ACCOs, Aboriginal Community Controlled Organisations; DH, Department of Health; AHPs, Aboriginal Health Practitioners; NT, Northern Territory; NAATSIHWP, The National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners; HPDAC, Health Professions Drug Access Committee; NOHP, National Oral Health Plan.
[A]Outputs-based funding model for public dental clinics in Victoria (Victorian Auditor General's Office 2006).
[B]An internal committee of DH, chaired by the Chief Officer, Drugs and Poisons Regulations (Department of Health & Human Services 2011).

In 2016, DH noted the potential for a FV pilot program as part of an existing primary prevention project in the Loddon Mallee region. Based on the discussions with LMARG ACCO staff (including Dallas Widdicombe and Danielle Couch) and funder DH, revisions were made to the program documentation with recommendations (see Table 1) to include opportunity to explore the provision of FV by Aboriginal non-oral health workforce. The result of this was an early mapping FV exercise as highlighted in Table 1.

Overseen by LMARG and guided by the principles of self-determination, in 2017, the program commenced with 6-monthly FV applications on children's teeth, oral health screens, and oral health education across ACCOs, schools, and early childhood centres in collaboration with regional public dental services.

In 2018, following funding of the LMARG FV program, the mapping exercise undertaken by LMARG regional FV coordinator (Rahila Ummer-Christian) identified gaps in the FV delivery model (see Table 1).

A culmination of factors – the FV mainstream access barriers for Aboriginal communities (COAG Health Council 2016; Durey *et al.* 2016c), the mapping exercise findings, coupled with exclusion of AHPs from workforce cohort to administer the FV – rendered the FV delivery model in Victoria culturally inappropriate for Aboriginal children. Additionally, there is a precedence in Australia (e.g. Northern Territory (NT) and Western Australia) for AHPs to apply FV (Dimitropoulos *et al.* 2019; Government of Western Australia Department of Health, n.d.). The amalgamation of factors prompted LMARG to advocate for an amendment to the Victoria state regulation to authorise AHPs to administer FV within their scope of practice. Further personal observations and experiences of co-author (Dallas Widdicombe), a Darug man, who managed an ACCO in Western Australia where FV was part of the service model highlighted the benefits of FV accessibility for Aboriginal children when delivered in a culturally appropriate setting, such as an ACCO. This cemented the grounds for LMARG to advocate for the regulation change.

As noted in Table 1, LMARG (represented by authors Rahila Ummer-Christian, Dallas Widdicombe, and Danielle Couch) raised concerns on the ineffectiveness of the FV model for Aboriginal children across several platforms. A key milestone paving the way for the amendment was LMARG's submission of a written letter to the then Victorian Health Minister highlighting the urgent need to amend regulation.

The subsequent outcome, in 2019, was that LMARG, with DH support (represented by Anil Raichur), was invited to make a submission to the Secretary of the DH for approval of an amendment to the regulation to authorise registered AHPs to obtain, possess, and administer FV.

Once the submission was received by the Secretary, it was directed towards the relevant program area and Health Professions Drug Access Committee (HPDAC) (Department of Health & Human Services 2011) – an internal committee of the DH, chaired by the Chief Officer, Drugs and Poisons Regulations. HPDAC aims to promote safe and effective drug use by advising the Minister/the Secretary of DH on the adequacy of the process undertaken by the profession and the experts consulted, including their input into the submission.

Role of LMARG in leading the submission for the regulation amendment

Table 2 provides an insight into the culturally responsive considerations made by LMARG throughout to ensure the proposed model would meet the community needs. Embedded throughout the process were: (1) Aboriginal community leadership, (2) prioritising of Aboriginal culture and community, and (3) system reform across the health and human services sector; key areas absent in the regulation (Department of Health and Human Services 2017).

LMARG, working with DH (Anil Raichur), expanded the scope of the program to include amendment submission, hence allowing the funded FV coordinator (Rahila Ummer-Christian) to undertake scoping work to review Victorian legislative context and examine the evidence to support submission on FV by AHPs in Victoria.

Establishment of advisory group – December 2019

Crucial to policy making is an advisory group comprising individuals and organisations that have a deep understanding of the issue and can provide expert guidance to address the change to action (David *et al.* 2020). Collaboration between stakeholders not only enriches the credibility but contributes to success of public health advocacy efforts. Hence, under LMARG's leadership (Dallas Widdicombe, Rahila Ummer-Christian) an advisory group of expert representatives from the NT AHP-FV model, dental organisations, and public dental clinics; researchers; policy makers, and ACCOs at state and national level was established. Benefits of the committee, as outlined in Table 2, were manifold.

Submission of brief to HPDAC and endorsement to proceed – May 2020

With guidance from the advisory group, a brief was prepared and submitted to HPDAC for endorsement to proceed. Attention was drawn to AHPs' role being crucial to improving health outcomes of Aboriginal people, including oral health (Dimitropoulos *et al.* 2019; Skinner *et al.* 2020; National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners, n.d.).

HPDAC endorsed the brief, and LMARG was invited to submit a full submission proposal to HPDAC members. Although HPDAC members were receptive to a submission in August 2020, LMARG put a flexible timeframe around the work so every element of the proposed FV model was carefully considered to suit community's cultural needs.

Preparation of full proposal – May 2020–July 2021

Besides ensuring Aboriginal children receive FV applications in culturally appropriate settings, LMARG deliberated on two key factors – a systematic approach to training requirements of AHPs in FV application and workforce sustainability in terms of workload and burnout.

Consultations were held with The National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) – the body for Aboriginal and/or Torres Strait Islander health workers and health practitioners in Australia) (National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners, n.d.), and a submission guided by the NT model (Dimitropoulos *et al.* 2019) and robust discussions with the advisory group members made (see Table 2 for the considerations made). Written

Table 2. Culturally responsive considerations by LMARG and rationale.

Deliberations	Rationale
Extension of scope of the FV program to include amendment submission.	Allowed the funded FV coordinator (Rahila Ummer-Christian) to undertake scoping work to review Victorian legislative context and examine the evidence to support submission on FV by AHPs in Victoria. There was dedicated resource to drive this body of work, while continuing the day-to-day management of FV roll out as per the main program requirements.
Establishment of an advisory group with expert representatives from NT AHP-FV model, dental organisations, and public dental clinics; researchers; policy makers, ACCOs at state and national level.	Individuals/organisations included on the committee had expertise in either Aboriginal health, public health, oral health, and/or policy planning. This provided opportunities for robust discussions and insights into employing holistic, evidence-based approaches within the model to support shift towards a population-based approach from a traditional clinical approach of FV application. This approach addressed FV access barriers for Aboriginal communities in line with an understanding of Aboriginal health and prioritising Aboriginal culture.
A flexible timeframe around the timeline of submission work.	To allow every element of the proposed FV model to be carefully considered to suit community's cultural needs.
Consultation held with NAATSIHWP.[A]	To gain understanding and input on AHP workforce aspects critical to implementing the model.
Written advice from AHPs and general practitioners that was included with the submission.	To gain understanding and input of AHP/ACCO contextual services and pathways to FV implementation.
Scope of practice extended to include FV application as a part of the health services they provide at ACCOs and kept broad (i.e. not limited to any program).	Consistent with the NOHP strategies (COAG Health Council 2016), ACCOs will have the flexibility to plan delivery of the recommended frequency of FV applications by AHPs as per their contextual needs, preferences, and priorities. ACCOs will also have flexibility to develop integrated models of care, where possible, that incorporate oral health education, prevention, and screening with other primary care services.
AHPs not only possess and administer FV but have the authority to obtain FV (i.e. purchase).	Exclusion of AHPs from obtaining FV would mean ACCO reliance on public dental clinics for the purchase. Hence the decision of LMARG to include 'obtain' in the submission would enable development of a culturally competent FV model, independent of mainstream services.
AHPs link with the public dental clinics in case of any referral.	A referral pathway to dental service would increase engagement and strengthen relationships between AHPs/ACCOs and dental clinics.
Extension of scope of practice of AHPs in oral health, in general.	Besides FV, more Aboriginal community members would be encouraged to become registered AHPs and be engaged with oral health. The model also avoids removing dental practitioners from clinics who are already under stress in meeting service demands (Victorian Auditor General's Office 2006).

FV, fluoride varnish; AHPs, Aboriginal Health Practitioners; NT, Northern Territory; ACCOs, Aboriginal Community Controlled Organisations; NAATSIHWP, The National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners; NOHP, National Oral Health Plan.
[A]Peak body for Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners in Australia (National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners, n.d.).

advice was sought from AHPs and general practitioners that was included with the submission.

Submission of full proposal and support of HPDAC – July 2021

Following the submission, authors (Dallas Widdicombe, Rahila Ummer-Christian) with DH (Anil Raichur) presented the proposed model to HPDAC members and received unanimous approval with no further clarification. Committee members' feedback was the submission was well-stated; thereby demonstrating ACCOs' understanding of community issues and ability to self-determine solutions (Australian Human Rights Commission, n.d.).

Minister approval for making of the amendment – August 2022, and public consultation – October 2022

Ministerial approval was received to amend the regulation. Key organisations (i.e. ACCOs across the state, public dental clinics, government agencies, universities, dental and oral health professional bodies), via a public consultation by LMARG (Dallas Widdicombe, Rahila Ummer-Christian) and DH (Anil Raichur), welcomed the proposed model, again noting a well-stated submission.

Secretary approval of the amendment and gazetted – November 2021–April 2022

DH (Anil Raichur) managed the procedural requirements, such as legal input. The amendment to regulation (Victorian Legislation 2022) was announced by the Health Minister on 13 April 2022 and gazetted on 21 July 2022 (Parliamentary Counsel of Victoria 2022).

Key learning and conclusion

This body of oral health policy work is an exemplar of a self-determination informed change. Aboriginal leadership was central to the policy making that gave community input into

the amended regulation. The Drugs, Poisons and Controlled Substances Amendment (Registered Aboriginal and Torres Strait Islander Health Practitioners) Regulation 2022 now authorises registered AHPs to obtain, possess, and administer FV. ACCOs must be at the forefront to influence improvement in Aboriginal health, with governments and policy makers working closely with ACCOs.

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