CDRAF
Canadian Dental Regulatory Authorities Federation

FCORD
Fédération canadienne des organismes de réglementation dentaire

Canadian Dental Regulatory Authorities Federation
Fédération canadienne des organismes de réglementation dentaire

Fairmont Château Laurier Hotel, 1 Rideau Street, Ottawa, ON,

Renaissance Room

BOARD MEETING

Saturday, April 22, 2017

8:30 a.m.

CDRAF
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A G E N D A

Canadian Dental Regulatory Authorities Federation
Fédération canadienne des organismes de réglementation dentaire

CDRAF Board Meeting

Fairmont Chateau Laurier Hotel, Renaissance Room
1 Rideau Street, Ottawa, ON

Saturday, April 22, 2017 – 8:30 a.m.
(Light breakfast available: 7:30 a.m.)

1.	Call to Order		
2.	Approval of Agenda		
3.	Approval of October 14, 2016 Meeting Minutes	**APPENDIX A**	(5 minutes)
4.	President's Remarks		(5 minutes)
5.	Executive Director's Remarks		(5 minutes)
6.	CDRAF Financials and Operations: 6.1 Approval of 2016 Audited Financial Statements **(*Management Group Recommendation*)** 6.2 Reappointment of 2017 Auditors **(*Management Group Recommendation*)** 6.3 Fund Balance vs. Budget Report 6.4 Fund Balance, Balance Sheet & Bank Reconciliation 6.5 Renewal of liability insurance	**APPENDIX B**	(30 minutes)
7.	CDRAF Strategic Planning *(Brenda Fair, Fairwinds Training & Development to attend)* 7.1 Report of the Steering Committee ***(Management Group Recommendation)***	**APPENDIX C**	(45 minutes)

8.	CDRAF Governance	**APPENDIX D**	(60 minutes)
	8.1 CDRAF Governance Review Plan 2017		
	(Management Group Recommendation)		
9.	Wellness Conference v2.0 – April 2018	**APPENDIX E**	(10 minutes)
	(Management Group Recommendation)		
10.	English Proficiency Assessment	**APPENDIX F**	(20 minutes)
	(Management Group Recommendation)		
11.	Opioids Crisis: CDRAF Public Commitment	**APPENDIX G**	(20 minutes)
	(Management Group Recommendation)		
12.	PGY1: Update		(10 minutes)
13.	Specialty Recognition – Update		(5 minutes)
14.	Smile Direct Club	**APPENDIX H**	(10 minutes)
15.	CETA/EU Commission: Moving Forward		(10 minutes)
16.	Royal College of Dentists of Canada		(10 minutes)
	16.1 Bi-Lateral Agreement Update		
	16.2 Appointment of CDRAF Representative to RCDC		
17.	CEO/Registrars' 2016 Conference – Verbal Report		(10 minutes)
18.	Topics for Discussion at the Request of Provinces		(30 minutes)
	18.1 Collaboration on Central Repository Agreement – Dr. Marcel Van Woensel		
19.	Invitations to attend:	**APPENDIX I**	
	19.1 ACFD, Quebec City, June 2017		
	19.2 CCSA Substance Abuse Convention, Calgary, Nov 2017		
	19.3 FCDSA Annual Meeting, Quebec City, June 2017		
	19.4 CDA Future of the Profession, Nov 2017		
	19.5 RCDC, Toronto, June 2017		

20. For Information: **APPENDIX J**
    - 20.1 RCDSO Correspondence
    - 20.2 NDEB Annual Report
    - 20.3 CCSA Report to Canadian Youth Perception On Cannabis
    - 20.4 Manitoba Dental Assistants' Association
    - 20.5 Minutes, Management Group, January 6, 2017
    - 20.6 Notes of Board Teleconference Meeting, November 24, 2016
    - 20.7 Notes of Board Teleconference Meeting, March 2, 2017

21. Other Business

22. Adjournment

AMS:718911

APPENDIX A

CANADIAN DENTAL REGULATORY AUTHORITIES FEDERATION

MINUTES OF MEETING
BOARD OF DIRECTORS

Friday, October 14, 2016
Westin Bayshore Hotel, Vancouver, BC

The 26th meeting of the Canadian Dental Regulatory Authorities Federation took place on Friday, October 14, 2016.

PARTICIPANTS:

Dr. Don Anderson, President, College of Dental Surgeons of British Columbia
Dr. Nancy Auyeung, Treasurer, CDRAF/Past-President, Manitoba Dental Association
Dr. Chris Baker, Chair, Provincial Dental Board of Nova Scotia
Dr. Mintoo Basahti, President-Elect, Alberta Dental Association and College
Dr. Susan Chow, Board member, College of Dental Surgeons of British Columbia
Ms. Caroline Daoust, Registrar, L'Ordre des dentistes du Québec
Dr. Barry Dolman, President, L'Ordre des dentistes du Québec
Dr. Véronique Gagnon, Board member, L'Ordre des dentistes du Québec
Dr. Martin Gillis, Registrar, Provincial Dental Board of Nova Scotia
Dr. Allan Graas, President, Alberta Dental Association and College
Dr. Patricia Hunter, Board member, College of Dental Surgeons of British Columbia
Dr. Louie Kriel, President, College of Dental Surgeons of Saskatchewan
Dr. Guy Lafrance, Vice-President, L'Ordre des dentistes du Québec
Mr. Dan Leger, Registrar, New Brunswick Dental Society
Dr. Elizabeth MacSween, Council member, Royal College of Dental Surgeons of Ontario
Mr. Jerome Marburg, Registrar, College of Dental Surgeons of British Columbia
Dr. Paul O'Brien, Registrar, Newfoundland and Labrador Dental Board
Dr. Mike Prestie, Delegate, College of Dental Surgeons of Saskatchewan
Dr. Brian Rinehart, President, CDRAF/Delegate, New Brunswick Dental Society
Dr. David Segal, Vice-President, Royal College of Dental Surgeons of Ontario
Dr. Cliff Swanlund, Vice-President, CDRAF/Delegate, Alberta Dental Association & College
Dr. Gordon Thompson, Delegate, Alberta Dental Association & College
Dr. David Tobias, Past-President, College of Dental Surgeons of British Columbia
Dr. Ray Wenn, Registrar, Dental Council of Prince Edward Island
Dr. Marcel Van Woensel, Registrar, Manitoba Dental Association
Dr. Ronald Yarascavitch, President, Royal College of Dental Surgeons of Ontario

STAFF:
Dr. Diane Legault, CDRAF Executive Director
Ms. Angie Sherban, CDRAF Executive Assistant
Ms. Kelly Tripp, CDRAF Controller

REGRETS:
Dr. Carla Cohn, President, Manitoba Dental Association
Mr. Irwin Fefergrad, Registrar, Royal College of Dental Surgeons of Ontario
Dr. Bernie White, Registrar, College of Dental Surgeons of Saskatchewan

1. CALL TO ORDER

Dr. Rinehart called the meeting to order 8:35 a.m. and welcomed CDRAF Board members to the meeting. He explained that the first hour of the meeting would deal with *in-camera* items and those guests and observers would attend the meeting at 9:30 a.m.

2. APPROVAL OF AGENDA

Dr. Yarascavitch reminded the CDRAF Board that in September, the RCDSO sent a letter in support of having a strategic planning exercise and asked that consideration be given to changing the current governance structure of CDRAF, representation of the Management Group, number of meetings, etc. Given the importance of these issues, he asked why the strategic planning session was not taking place before the Board meeting when the election and the draft budget will be approved. He advised that the Ontario delegation would not be running a candidate for the Management Group or participating in the budget conversation because of this.

Dr. Yarascavitch also asked that Dr. Peter Trainor, Chair of the CDRAF Commission, be permitted to make his submission first, given that labour mobility and trade agreements are important topics.

MOTION: Tobias/Thompson

THAT the CDRAF Board approves the agenda of the October 14, 2016 meeting, as circulated.

CARRIED
(Unanimously)

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3. APPROVAL OF MEETING MINUTES

There were no revisions made to the draft minutes of the CDRAF Board meeting of April 15, 2016, and they were approved as circulated.

MOTION: Rinehart/MacSween

THAT the CDRAF Board approves the minutes of the meeting of April 15, 2016, as circulated.

CARRIED
(Unanimously)

4. PRESIDENT'S REMARKS

Dr. Rinehart welcomed CDRAF Board members to the meeting and asked everyone to introduce themselves.

He thanked Mr. Jerome Marburg and the College of Dental Surgeons of British Columbia for hosting the meeting and as well for arranging the dinner on the previous evening.

Dr. Rinehart remarked that the CDRAF Management Group had worked well together and he thanked Dr. Legault for her first year in the role as Executive Director.

5. EXECUTIVE DIRECTOR'S REMARKS

Dr. Legault acknowledged Ms. Nancy Crosby at the College of Dental Surgeons of British Columbia for her assistance with the meeting and dinner arrangements.

She reported that since the April CDRAF Board meeting, she had been handling daily activities, such as responding to internationally-trained candidates enquiries, organizing and participating in Management Group meetings in June and August, as well as two Registrars' meetings held in July and October. She also spent significant time connecting with external stakeholders of CDRAF to better understand the challenges that those organizations are facing.

Dr. Legault also reported on the installation dinner of the President of the Canadian Dental Association that she attended with Dr. Rinehart; the installation

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dinner of Colonel Dwayne Lemon of the Royal Canadian Dental Corps, where she addressed the audience about CDRAF. She was also invited to speak to the Royal College of Dentists of Canada in September about the work of CDRAF.

She looked forward to a productive meeting and hoped the strategic planning session on the following day would prove to be an important step forward for CDRAF.

6. MANAGEMENT GROUP MEETINGS

The CDRAF Board was provided with copies of the minutes from the CDRAF Management Group meetings of June 13, 2016 (approved) and August 29, 2016 (draft) for information.

7. FINANCIAL REPORT

The following documents were provided to the CDRAF Board for its review:

(a) Balance Sheet
(b) Bank Reconciliation
(c) Fund Balance vs Budget Report
(d) Draft 2017 Budget

The bank reconciliation as at September 30, 2016 was $212,998.43. The total amount of assets at September 30, 2016 was $219,955. Ms. Tripp reported that 53% of the total expected expenditures for the year have been spent. She added that expenditures for the Board meeting, expenses for Management Group and the Executive Director will need to be included as well.

In response to a question from a Board member, Ms. Tripp stated that she anticipated approximately $84,000 in additional expenses by the end of the year.

Dr. Auyeung thanked Ms. Tripp for her assistance as Controller. She reviewed the budget process with CDRAF Board members: Dr. Auyeung and Ms. Tripp prepare the draft budget, with the assistance of Dr. Legault, and it is presented to the CDRAF Management Group for review and recommendation to the CDRAF Board. The 2017 budget was designed to include more breakdown details and Dr. Auyeung highlighted the following items:

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- Administration fees have been increased for the provision of electronic banking.
- Equipment fees have decreased, as in 2016 the needs of the Executive Director were not known.
- $20,000 has been allocated for projects in 2017.
- The costs for attending the International Society of Dental Regulators (ISDR) have been budgeted at $13,400, but this will be dependent on the location of the conference, fluctuation in exchange rates, etc.
- There is a budget line for the Executive Director to attend a CEO/Registrars' meeting in 2017. Dr. Dolman and Dr. MacSween stated that Quebec and Ontario was not in favour of the CEO/Registrars' meeting being held outside of Canada and that they did not think the Executive Director should be attending. However, some others were of the opinion that it was a national dental meeting with external stakeholders and it was a good opportunity for the Executive Director to attend to network and share information. The budget line for this item was retained.
- The amount allocated for severance has been removed from the 2017 budget.

Dr. Legault advised that the recommended operating fee for 2017 is $17.64 per member per province. In discussion with the Management Group, it was felt that it should be rounded up to $18.00 per member per province to cover any extraordinary expenses that may arise. For example, should the CDRAF Commission briefing document be adopted, expenditures for meetings with government, public relations and communications will be required.

There were no further questions on the draft budget and it was adopted, as presented. Dr. Yarascavitch stated that Ontario would abstain from voting on the budget pending the outcome of the strategic planning session. They felt that the strategic planning should have been held prior to the Board meeting.

MOTION: Tobias/Wenn

THAT the CDRAF Board adopts the 2017 budget, as presented.

CARRIED

(Abstention: Ontario)

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It was suggested and agreed to that the budget be revisited following the strategic planning session by the Management Group, if necessary.

Dr. Legault reported that the strategic plan would not be finalized in one meeting. A Steering Committee will be struck to continue the work over the next few months. When a final document is ready to be adopted, a teleconference meeting for the CDRAF Board can be arranged.

AMENDED MOTION: Marburg/Gillis

THAT the CDRAF Board adopts the 2017 budget, as presented, and it can be amended by the CDRAF Management Group if necessary by the end of the year.

CARRIED
(Abstention: Ontario)

At 9:30 a.m. the meeting resumed to open session and guests and observers attended for the remainder of the meeting. They were invited to introduce themselves.

8. ELECTION FOR CDRAF MANAGEMENT GROUP

Dr. Legault, under the By-Laws as Elections Administrator, conducted the election for the CDRAF Management Group. She sent a Call for Nominations to CDRAF Board members on August 31, 2016 and the deadline was October 9, 2016. As a result, she announced the following results by acclamation for 2016-2017:

President:	Dr. Cliff Swanlund
Vice-President	Dr. Barry Dolman
Treasurer:	Dr. Nancy Auyeung

Dr. Swanlund, Dr. Dolman and Dr. Auyeung were congratulated and each gave a short address to the CDRAF Board.

9. CDRAF COMMISSION REPORT

Dr. Peter Trainor, Chair of the CDRAF Commission was introduced. He thanked members of the Commission, Dr. Brian Rinehart, Dr. Cliff Swanlund, Dr. David Tobias and Dr. Barry Dolman, as well as the Registrars that had participated in discussions with the Commission – Jerome Marburg, Irwin Fefergrad, Dr. Gordon

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Thompson and Caroline Daoust. He also acknowledged the work of Robert Lees and the communications staff from the RCDSO for their assistance in preparing the briefing document.

Dr. Trainor reminded the CDRAF Board of its direction for the Commission to prepare a briefing document for Government outlining the achievements of dentistry in being responsible to fulfilling the legislated mandate of dental regulators, but yet fairly addressing the issue of increased demand for licensure by internationally trained candidates due to the labour mobility brought about by globalization. He presented the draft document for the CDRAF Board's review.

He emphasized the importance of sharing this document with government. The document has been revised several times and input has been sought from Commission members, regulators and those external stakeholders mentioned in the brief for accuracy. Most of the comments received were included in the brief.

The CDRAF Board adopted the document that was presented.

MOTION #1: Swanlund/Yarascavitch

THAT the CDRAF Board adopts the Brief, as presented by the CDRAF Canada-EU Free Trade Commission.

CARRIED
(Unanimously)

Dr. Trainor reported that the document will be translated into French and posted on the CDRAF website in both languages. He encouraged the dental regulators in each province to provide a copy of the document to each of their respective provincial governments.

MOTION #2(a):

THAT the CDRAF Board adopts the Brief as a public document to post on the CDRAF website and distribute the document to government representatives.

CARRIED
(Unanimously)

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There was a discussion on which federal ministry officials the CDRAF should meet with to present the briefing document. The Minister of International Trade, the Honourable Chrysta Freeland, is responsible for the CETA and trade agreement file and would therefore be the foremost Ministry to meet with. There would also be other ministries that would benefit from the information.

The CDRAF Board had discussion on which members of the CDRAF should be delegated to meet with the federal government. The CDRAF Commission recommended a delegation of three to include the CDRAF President, the CDRAF Executive Director and the Chair of the CDRAF Commission, Dr. Peter Trainor. It also recommended that a resource person attend, if required for a specific meeting.

MOTION #2(b): Swanlund/Yarascavitch

THAT a delegation of three, consisting of the CDRAF President, CDRAF Executive Director, Dr. Peter Trainor, plus one other resource person who would be beneficial to a specific meeting, present the Brief to government representatives.

Some members did not think that it was necessary to name people personally in the motion and suggested that the Management Group should make the determination. It was felt that by naming individuals, it might hinder scheduling meetings if not everyone in the motion was available. Some were adamant that Dr. Trainor should be named in the motion and attend all the meetings given his knowledge and commitment to this file.

Dr. Segal made the following amendment to the motion that would allow some flexibility to the individuals named in the motion:

AMENDMENT TO MOTION #2(b): Segal/Yarascavitch

THAT a delegation of three, when possible, consisting of the CDRAF President, CDRAF Executive Director, Dr. Peter Trainor, plus one other resource person who would be beneficial to a specific meeting, present the Brief to government representatives.

CARRIED
(Unanimously)

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MOTION #2(b) (AMENDED): Swanlund/Yarascavitch

THAT a delegation of three, when possible, consisting of the CDRAF President, CDRAF Executive Director, Dr. Peter Trainor, plus one other resource person who would be beneficial to a specific meeting, present the Brief to government representatives.

CARRIED
(Unanimously)

Dr. Trainor was thanked for his fulsome report and for all his work as Chair of the Commission.

10. STRATEGIC PLANNING

Dr. Legault reported that the Registrars were invited to provide names of potential consultants that could facilitate developing a strategic plan for CDRAF. Several suggested names were received and at the suggestions of Dr. Martin Gillis, Ms. Brenda Fair of Fairwinds Training and Development was engaged. Dr. Gillis stated that the Provincial Dental Board of Nova Scotia undertook a similar exercise with Ms. Fair and it was a productive experience.

Dr. Legault stated that Board members will be attending the workshop on Saturday, October 15, 2016 and it will be an ongoing process to develop the strategic plan. Ms. Fair sent a survey to CDRAF Board members, Registrars and stakeholders and Dr. Legault thanked them for their valuable feedback.

11. REGISTRARS' MEETINGS

Dr. Legault thanked the Registrars for inviting her to attend the Registrars' meetings, held in Montreal on July 7, 2016 and in Toronto on October 6, 2016. Copies of the agendas for those meetings were provided to the CDRAF Board for its information.

12. CEO/REGISTRARS' MEETING

A copy of the agenda for the CEO/Registrars' meeting on November 29 to December 1, 2016 was provided to the CDRAF Board for its information. Dr. Legault reported that she would attend on behalf of the CDRAF.

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13. HEALTH CANADA

13.1 Sugar Sweetened Beverage Reduction

Dr. Legault reported that she received an invitation from Health Canada to obtain stakeholders' interest in participating in an initiative for promoting good oral hygiene to parents and children (teenagers) and striving for the reduction of sugar sweetened beverages. The CDRAF Management Group felt this is a membership initiative rather than regulatory and, therefore, not within CDRAF's mandate.

13.2 Anti-microbial Stewardship

The CDRAF Board reviewed information received from the Centre for Communicable Diseases and Infection Control Infectious Disease and Prevention Control Branch, Government of Canada (Health Canada). CDRAF was invited to collaborate in an initiative towards antimicrobial stewardship.

Recent studies have shown that the number of physicians prescribing antibiotics has decreased, but there is a significant increase in dental prescribing. The CDRAF Board was of the view that there is a need for patients to better understand more about antibiotics and the patient's responsibility when they receive a prescription. Dr. Legault reported that Health Canada would like CDRAF to work with their brainstorming group to create a strategy. Any final decisions would have to be made by the CDRAF Board. It directed Dr. Legault to advise Health Canada of CDRAF's willingness and interest in working together on antimicrobial stewardship.

MOTION: Prestie/Dolman

THAT CDRAF agrees to collaborate with Health Canada for the Antimicrobial Stewardship initiative to further education for public use.

CARRIED
(Unanimously)

It was noted that the Canadian Dental Association is also involved in discussing the dissemination of current guidelines and advice for prophylaxis before undergoing invasive dental procedures for patients with total joint replacements.

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13.3 Opioid Conference and Summit

Dr. Legault reported that as Executive Director of CDRAF, she was invited to participate in a teleconference with Health Canada that provided information on an upcoming Conference and Summit in November for discussion on the opioid crisis in Canada. Stakeholders will be given the opportunity to commit to a specific action that would address the opioid crisis. On the second day of discussions, a joint action plan will be finalized. The CDRAF Board was asked if it wished to commit to an action at this time.

Dr. Legault reminded the CDRAF Board and Dr. David Mock has done a lot of work on this issue and he and Dr. David Segal have represented CDRAF on this topic at past meetings. It was noted that Dr. Mock will attend the conference and summit on behalf of the Royal College of Dental Surgeons of Ontario.

Although the CDRAF Board did agree this is an important issue, it did not wish to commit to an action at this time, but felt it was a topic that should be addressed provincially.

Dr. Allison stated that the Association of Canadian Faculties of Dentistry (ACFD) has also been invited and he will be representing ACFD the conference and summit. ACFD would be committing to ensure that all under-graduates has information on opioid misuse.

CDRAF agreed that Dr. Legault and Dr. David Segal should attend the conference on Friday, November 18, 2015 on behalf of CDRAF. They undertook to provide a written report to the CDRAF Board following the conference.

13.4 Call for Proposals

Dr. Legault reported that the Office of the Chief Dental Officer (through the Public Health Agency of Canada) has launched a Call for Proposals for a project that would launch a stand-alone website to increase the access to oral health care in remote areas.

The Public Health Agency of Canada has invited stakeholders to submit applications to launch this “pan-Canadian oral health provider website” and offered up to $100,000 of funding for two years towards the project.

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The CDRAF Board agreed this would be a worthwhile initiative, but did not feel that it was not part of the CDRAF mandate nor does it have resources to support it.

13.5 Position Statement of Dental Amalgam

The CDRAF Board was provided with information on the Final Act of the Conference of Plenipotentiaries on the Minamata Convention on Mercury. The Chief Dental Officer, Dr. James Taylor, contacted CDRAF to advise that the Public Health Agency of Canada is preparing a Statement on Mercury waste management related to the Minamata Convention and it asked CDRAF to validate the last sentence of the following paragraph:

> *"In September 2001, the Canadian Council of Ministers of the Environment (CCME) signed a Canada-wide Standard (CWS) on Mercury for Dental Amalgam Waste. In May 2010, Environment Canada published a "Notice Regarding Pollution Prevention Planning in Respect of Mercury Releases from Dental Amalgam Waste (P2 Notice)". This Notice serves to help achieve the 95% CWS target, and requires all those subject to it (dental facilities) to prepare and implement a pollution prevention plan for dental amalgam waste. This has been adopted - and is enforced- by Canada's thirteen Provincial and Territorial dental regulatory authorities."*

Dr. Legault canvassed the Registrars and asked for confirmation that this notice was enforced in the provinces. There were different actions taken in each province with regard to this issue of best practices of waste management of dental amalgam, but dental regulatory authorities are ensuring that dentists are complying with waste management in the most appropriate way.

14. TOPICS FOR DISCUSSION BY PROVINCES

14.1 Denturists' Scope of Practice

This item was raised for discussion by Québec. It was reported that the debate of expanding the scope of practice for denturists to carry out non-invasive intervention on implants is ongoing. It was reported that denturists in other provinces are also requesting greater scope of practice, but there is concern over the lack of training to carry out expanded procedures. The CDRAF Board agreed that the public is not being informed about what acts can be performed by denturists and understand the risks of treatment.

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14.2 RCDC Agreement Initiative

This item was raised for discussion by Québec. Ms. Daoust reported that there have been two recent meetings of the Registrars; one in July and one in October. Following the July meeting, an invitation was sent to the RCDC to discuss the future with dental regulators and a meeting was arranged for the two organizations to have representatives meet in Edmonton on September 8, 2016.

It was a very productive meeting and a list of topics that would be the core of a written agreement for Registrars with RCDC was collated. The next meeting is scheduled for November 20, 2016 in Ottawa to discuss a written agreement with RCDC and any province that wishes to sign the agreement.

15. STAKEHOLDER REPORTS

15.1 Association of Canadian Faculties of Dentistry (ACFD)

A written report from ACFD was provided in the CDRAF Board meeting materials.

Dr. Paul Allison, President of ACFD, presented the report. He reported on the ACFD competency document. Concerns were expressed to the International Society of Dental Regulators (ISDR) on using the document for its own purposes without acknowledgement to ACFD.

Dr. Allison discussed the need for hiring program directors at the universities.

15.2 Canadian Dental Association (CDA)

A written report was provided by the CDA for information.

15.3 Canadian Dental Specialties Association (CDSA)

A written report was provided by the CDSA for information.

15.4 Commission on Dental Accreditation of Canada (CDAC)

A written report from CDAC was provided in the CDRAF Board meeting materials.

Dr. Amarjit Rihal, President, and Mr. Frédéric Duguay, Director of CDAC, presented the report. They gave an overview of the structure and composition of CDAC, as well as reporting on its short and mid-term projects.

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There were questions raised about international accreditation and the challenges with lack of human and financial resources to fulfill these initiatives. CDAC was pleased with the success of the reciprocal agreements that have been finalized with the United States, Australia, New Zealand and Ireland.

Dr. Rihal reported that stakeholders will be consulted for CDAC's strategic planning in 2018.

It was reported that the fee for dentistry in 2017 will be $20.53 per member.

15.5 National Dental Examining Board of Canada (NDEB)

A written report from NDEB was provided in the CDRAF Board meeting materials.

Dr. Jack Gerrow, Registrar/Executive Director of NDEB, presented the report. He provided an overview of NDEB, including:

- mandate, mission and vision;
- the various pathways for NDEB certification;
- reporting on the equivalency process applicants and results.

It was reported that since 2010 and up until September 30, 2016, there have been 7,991 paid applicants.

Dr. Gerrow stated that as a third-party provider, NDEB works collaboratively with each dental regulatory authority (DRA). Each DRA has one representative on the NDEB Board. DRAs are also requested to recommend dentists for appointment as NDEB examiners (usually 20 from each province), as well as being invited to attend workshops and meetings and to observe examinations.

NDEB is pleased to assist DRAs in providing information to Fairness Commissioners, responding to complaints from participants and administering examinations and/or assessments on their behalf. It was noted that this is very helpful for members who have been out of practice for several years.

Dr. Gerrow asked CDRAF is give consideration to the following:

1. Do DRAs want NDEB to implement a language proficiency requirement?

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It was noted that in 2010 CDRAF did not wish to have this, but given the new Citizenship and Immigration Canada express entry requirements for both English and French, this may require reconsideration. Dr. Gerrow reported that NDEB will be bringing options to CDRAF for its review.

2. Do the DRAs want to direct NDEB to consider rejecting applicants from identified countries based on: minimum number of years of education; requirement for clinical experience in the program; and known corruption in universities in country?
   Dr. Gerrow stated that there is no change to the minimum number of years of education and the clinical experience and corruption are difficult to monitor. However, NDEB requires direction from CDRAF in this regard.
3. Does CDRAF want NDEB to continue to accept different required documents for graduates of Canadian programs? CDRAF was asked to confirm that NDEB continue with the current requirements.
4. Does CDRAF want to lead the process in producing a revised competency document? NDEB requested that CDRAF take the lead in this initiative.
5. Does CDRAF want the NDEB to create a central electronic document repository for all international graduates?

Dr. Legault advised that the CDRAF Management Group would review and discuss the requests from NDEB and report back.

It was reported that NDEB has a budget deficit. NDEB has started to do assessments twice a year which has proved to be costly. In addition, NDEB has been served with a judicial review for an applicant who failed the clinical skills examination three times at a cost of $100,000 in fees. Dr. Gerrow advised that it is likely that NDEB fees will have to be increased to help cover these costs.

Dr. Rinehart thanked Dr. Gerrow for his comprehensive presentation.

15.6 Royal College of Dentists of Canada (RCDC)

A written report from RCDC was provided to the CDRAF Board in its meeting materials.

Dr. Chris Robinson, President of RCDC, made a presentation to the CDRAF Board. He reported on the collaboration between RCDC and DRAs to fulfill the mandate of serving the interest of public protection. He reviewed the nine dental specialty

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examination results for Canadian, U.S. and international candidates from 2012 to 2016.

Dr. Robinson added that the RCDC Strategic Plan for 2015-2018 was developed and circulated to stakeholders in June 2016. Valuable feedback was received and RCDC will try to implement the suggestions offered.

He reported that transparency, accountability and collaboration are key topics that RCDC is trying to communicate both internally and externally.

He added that RCDC appreciates the active stakeholder engagement on governance, for example, changing the Examinations Committee to an Education Committee. Dr. Robinson reviewed the revised RCDC governance structure. As reported earlier in the meeting, there have been recent meetings between RCDC and CDRAF to discuss governance concerns and the next meeting scheduled for November 20, 2016 in Ottawa will be held to draft a written third-party agreement for DRAs and RCDC.

Some of the initiatives that RCDC will undertake in the near future will be to review and refine its documentation.

15.7 Royal Canadian Dental Corps (RCDC)

At his request, Colonel Dwayne Lemon addressed the CDRAF Board on activities and responsibility in the Royal Canadian Dental Corps. He has replaced Colonel Kevin Goheen as the Chief Dental Officer of RCDC, responsible for the strategic future and implementation of operations, policies and procedures at RCDC.

16. ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY (ACFD) – PGY1

Dr. Allison made a PowerPoint presentation to provide further information on the proposed PGY-1 program. It was reported that CDRAF was invited to work collaboratively with ACFD and form a working group to prepare a literature review of the subject, develop and evaluate a pilot PGY1 project and investigate resources necessary to develop a PGY1 project, such as staffing and financial resources and physical facilities. It was suggested that the working group be funded 50/50 by both organizations.

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The CDRAF Board suggested that CDAC and NDEB also be included in the working group and that the costs be shared amongst the four organizations and Dr. Allison was agreeable to this.

Dr. Prestie reported on the research done in Saskatchewan on a PGY1 program. It was agreed that it might be beneficial to ask Dr. Bernie White to be the CDRAF representative on the working group for this initiative. Dr. Legault advised that the CDRAF Management Group will add this to its agenda for the next meeting. In the meantime, she would contact Dr. White to find out his availability and interest in this appointment.

17. CDRAF BOARD – NEXT MEETINGS

Dr. Legault reminded the CDRAF Board that the Spring meeting will be held in Ottawa on Saturday, April 22, 2017. The Fall meeting will be held on Friday, October 13 and Saturday, October 14, 2017 and there was a discussion on location for the meeting.

There were mixed suggestions. Although it was agreed that Toronto or Montreal were convenient cities for most people across the country to access, some also liked having the meetings held in different provinces each year.

It was agreed that the CDRAF Management Group will discuss and determine the location at its next meeting and inform the CDRAF Board of its decision.

18. CORRESPONDENCE FOR INFORMATION

There was no discussion on the correspondence provided for information.

19. OTHER BUSINESS

19.1 Electronic Health Records

Dr. Thompson raised this issue for discussion.

20. ADJOURNMENT

Dr. Legault reported that this meeting was the last meeting for Dr. Rinehart in his role as President. The CDRAF Board thanked him for his leadership and contributions during his term as President.

DRAFT

Dr. Rinehart concluded the meeting by thanking the College of Dental Surgeons of British Columbia for its hospitality. He also thanked Dr. Legault, support staff, the New Brunswick Dental Society and the CDRAF Management Group for its support over the past two years.

There being no further business, the meeting was adjourned at 3:15 p.m.

MOTION: Tobias/Segal

THAT the CDRAF Board meeting of October 14, 2016 be adjourned.

CARRIED
(Unanimously)

AMS:688586

DRAFT

APPENDIX B

6. CDRAF FINANCIALS AND OPERATIONS

6.1 Approval of 2016 Audited Financial Statements

THAT the CDRAF Board approves the draft audited financial statements, as at December 31, 2016, as presented at Appendix B of the Board materials.

Financial statements of

Canadian Dental Regulatory Authorities Federation

December 31, 2016

D R A F T

FOR DISCUSSION PURPOSES ONLY

Canadian Dental Regulatory Authorities Federation

December 31, 2016

Table of contents

Independent Auditor's Report 1-2

Balance sheet 3

Statement of operations and change in fund balance 4

Statement of cash flows 5

Notes to the financial statements 6

DRAFT

Deloitte LLP
400 Applewood Crescent, Suite 500
Vaughan, ON L4K 0C3
Canada

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www.deloitte.ca

Independent Auditor's Report

To the Board of Directors of
Canadian Dental Regulatory Authorities Federation

We have audited the accompanying financial statements of the Canadian Dental Regulatory Authorities Federation, which comprise the balance sheet as at December 31, 2016, the statements of operations and change in fund balance, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for Not-For-Profit Organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

DRAFT

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the Canadian Dental Regulatory Authorities Federation as at December 31, 2016 and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for Not-For-Profit Organizations.

Chartered Professional Accountants
Licensed Public Accountants
_____, 2016

D R A F T

FOR DISCUSSION PURPOSES ONLY

Canadian Dental Regulatory Authorities Federation

Balance sheet
as at December 31, 2016

	2016	2015
	$	$
Assets		
Current		
Cash	**124,057**	16,817
Prepaid expenses	**1,734**	2,750
Capital assets (Note 4)	**980**	1,470
	126,771	21,037
Liability		
Current		
Accounts payable and accrued liabilities	**1,550**	4,485
Fund balance		
Unrestricted	**125,221**	16,552
	126,771	21,037

Approved by the Board

_____ Director

_____ Director

DRAFT

The accompanying notes to the financial statements are an integral part of this financial statement.

FOR DISCUSSION PURPOSES ONLY

Canadian Dental Regulatory Authorities Federation

Statement of operations and change in fund balance
year ended December 31, 2016

	2016	2015
	$	$
Revenue		
Fees	**395,946**	107,695
Other income	**118**	353
	396,064	108,048
Expenses		
Bank charges	**681**	160
Executive search (Note 3)	**-**	64,364
ISDR membership	**2,750**	5,000
Meetings	**52,116**	28,199
Operating	**227,651**	48,430
Oral Surgery MOU	**-**	10,000
Translation services	**4,197**	3,695
	287,395	159,848
Excess (deficit) of revenue over expenses	**108,669**	(51,800)
Fund balance, beginning of year	**16,552**	68,352
Fund balance, end of year	**125,221**	16,552

DRAFT

The accompanying notes to the financial statements are an integral part of this financial statement.

FOR DISCUSSION PURPOSES ONLY

Canadian Dental Regulatory Authorities Federation

Statement of cash flows
year ended December 31, 2016

	2016	2015
	$	$
Operating		
Excess of expenses over revenue	**108,669**	(51,800)
Items not affecting cash		
Amortization of capital assets	**490**	-
	109,159	(51,800)
Changes in non-cash operating items		
Prepaid expenses	**1,016**	(2,750)
Accounts payable and accrued liabilities	**(2,935)**	(19,341)
	107,240	(73,891)
Investing		
Additions to capital assets	**-**	(1,470)
Net cash inflow (outflow)	**107,240**	(75,361)
Cash, beginning of year	**16,817**	92,178
Cash, end of year	**124,057**	16,817

DRAFT

The accompanying notes to the financial statements are an integral part of this financial statement.

FOR DISCUSSION PURPOSES ONLY

Canadian Dental Regulatory Authorities Federation

Notes to the financial statements
December 31, 2016

1. General

Canadian Dental Regulatory Authorities Federation ("CDRAF") was incorporated under the Canada Corporation Act and was established by Letters Patent issued on March 3, 2004 under the Seal of the Federal Ministry of Industry. It is a corporation without share capital and a Not-For-Profit Organization.

CDRAF is the national forum and collective voice of Provincial and Territorial dental regulatory authorities regarding inter-provincial/territorial, national and global regulatory matters for the dental profession.

2. Significant accounting policies

The financial statements have been prepared in accordance with Canadian Accounting Standards for Not-For-Profit Organizations published by the Chartered Professional Accountants Canada, using the deferral method of reporting restricted contributions.

Revenue recognition

Income from CDRAF fees are recorded when the amounts are due and collection is reasonably assured. Investment income is recognized when earned.

Financial instruments

CDRAF initially recognizes financial instruments at fair value and subsequently measures them at each reporting date as follows:

Asset/liability	Measurement
Cash	Fair value
Accounts payable and accrued liabilities	Amortized cost

Transaction costs are expensed as incurred.

Capital assets

Capital assets are recorded at cost. Amortization is recorded in the year when the asset is put into use.

Amortization is provided at the following annual rates and bases:

Computer hardware	3 Years Straight line

Use of estimates

In preparing CDRAF's financial statements, management is required to make estimates and assumptions that affect the reported amount of assets, liabilities, and the disclosure of contingent liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Executive search

The executive search costs were incurred in the process of placing the new Executive Director.

4. Capital assets

			2016	2015
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Computer hardware	**1,470**	**490**	**980**	1,470
	1,470	**490**	**980**	1,470

DRAFT

FOR DISCUSSION PURPOSES ONLY

6. CDRAF FINANCIALS AND OPERATIONS

6.2 Reappointment of 2017 Auditors

THAT the CDRAF Board approves the reappointment of Deloitte LLP as its auditors for 2017.

FCORD CDRAF
Fédération canadienne des organismes de réglementation dentaire
Canadian Dental Regulatory Authorities Federation

FUND BALANCE vs. BUDGET REPORT

March 31, 2017

	YTD TOTALS	Annual Budget	Difference	% of Budget Used
FUND BALANCE as at December 31, 2016	**$ 125,221**	**$ 125,000**	221	100.2%
REVENUES				
2017 CDRAF Fees:				
Alberta Dental Association + College	45,000			
College of Dental Surgeons of British Columbia	-			
College of Dental Surgeons of Saskatchewan	8,244			
Dental Council of PEI	1,494			
Manitoba Dental Association	12,330			
New Brunswick Dental Society	-			
Newfoundland Dental Board	3,798			
Ordre des Dentistes du Quebec	84,888			
Provincial Dental Board of Nova Scotia	9,882			
Royal College of Dental Surgeons of Ontario	174,384			
	340,020	386,244	(46,224)	88.0%
Other Revenue				
Govt of Canada	-	-		
	-	-	-	
Total Revenues	**$ 340,020**	**$ 386,244**	**(46,224)**	**88.0%**
2017 DISBURSEMENTS				
Meetings				
Board meetings	-	21,440	(21,440)	0.0%
Management group meetings	3,308	28,240	(24,932)	11.7%
Other meetings/conferences - ED	1,922	20,068	(18,146)	9.6%
Other meetings/conferences - President	-	9,440	(9,440)	0.0%
ISDR Conference	-	13,440	(13,440)	0.0%
Operations				
Salary (ED and Executive Assistant)	49,278	183,000	(133,722)	26.9%
Financial consultant	2,100	8,400	(6,300)	25.0%
External resources	1,459	25,000	(23,541)	5.8%
Legal	-	10,000	(10,000)	0.0%
Administrative fees (banking, etc.)	424	600	(176)	70.7%
Audit	-	3,500	(3,500)	0.0%
Equipment/Support/Maintenance	-	5,000	(5,000)	0.0%
Postage/courier	-	2,400	(2,400)	0.0%
Printing/supplies	499	2,400	(1,901)	20.8%
Phone/internet	607	2,100	(1,493)	28.9%
Information technology (web hosting, conference ca	1,237	8,288	(7,051)	14.9%
ED Professional fees and conferences/PD	-	5,000	(5,000)	0.0%
Insurance	-	2,400	(2,400)	0.0%
Depreciation	123	1,500	(1,377)	8.2%
Memberships				
CNNAR	848	850	(3)	99.7%
ISDR	2,750	5,500	(2,750)	50.0%
Projects	-	20,000	(20,000)	0.0%
Total Disbursements	**$ 64,554**	**$ 378,566**	**$ (314,012)**	**17.1%**
Excess (Deficiency) of Revenue over Disbursements	**$ 275,466**	**$ 7,678**	**$ 267,788**	
FUND BALANCE as at February 28, 2017	**$ 400,688**	**$ 132,678**	**268,010**	

NOTE: *At the end of a Q1, Q2, Q3 & Q4 it is expected that the % of Budget Used will be 25%, 50%, 75% & 100%, respectively.*

FCORD CDRAF
Fédération canadienne des organismes de réglementation dentaire
Canadian Dental Regulatory Authorities Federation

FUND BALANCE REPORT

March 31, 2017

FUND BALANCE as at December 31, 2016			**$ 125,221**
REVENUES			
2017 CDRAF Fees:			
Alberta Dental Association + College	45,000		
College of Dental Surgeons of British Columbia			
College of Dental Surgeons of Saskatchewan	8,244		
Dental Council of PEI	1,494		
Manitoba Dental Association	12,330		
New Brunswick Dental Society			
Newfoundland Dental Board	3,798		
Ordre des Dentistes du Quebec	84,888		
Provincial Dental Board of Nova Scotia	9,882		
Royal College of Dental Surgeons of Ontario	174,384	340,020	
Other Revenue			
Govt of Canada	-	-	
Total Revenues			**$ 340,020**
2017 DISBURSEMENTS			
Meetings/Conferences			
Board meetings	-		
Management group meetings	3,308		
Other meetings/Conferences - ED	1,922		
Other meetings/Conferences - President	-		
ISDR Conference	-		
Operations			
Salary (ED and Executive Assistant)	49,278		
Financial consultant	2,100.00		
External resources	1,459		
Legal	-		
Administrative fees (banking, etc.)	424		
Audit	-		
Equipment/Support/Maintenance	-		
Postage/courier	-		
Printing/supplies	499		
Phone/internet	607		
Information technology (web hosting, conference calls, etc.	1,237		
ED Professional fees and conferences/PD			
Insurance	-		
Depreciation	123		
Memberships	-		
CNNAR	848		
ISDR	2,750		
Projects	-		
Total Disbursements			**$ 64,554**
Excess (Deficiency) of Revenue over Disbursements			**$ 275,466**
FUND BALANCE as at March 31, 2017			**$ 400,688**

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CDRAF
Canadian Dental Regulatory Authorities Federation

BALANCE SHEET

As at March 31, 2017

ASSETS	
Current	
Bank - CIBC	$ 61,464
Bank - RBC	$ 344,580
Prepaid Expenses	-
Total Current Assets	**406,044**
Capital Assets	**858**
TOTAL ASSETS	**$ 406,902**
LIABILITIES AND FUND BALANCE	
Current	
Accounts Payable and Accrued Liabilities	$ 6,214
Total Current Liabilties	**6,214**
Fund Balances	400,688
TOTAL LIABILITIES AND FUND BALANCE	**$ 406,902**

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CDRAF
Canadian Dental Regulatory Authorities Federation

Bank Reconcilition

As at March 31, 2017

Bank Reconciliation March 31, 2017 - CIBC	
Balance per Bank, March 31, 2017	61,464.22
Less: Outstanding Cheques	-
Add: Outstanding Deposits	-
Adjusted Bank Balance, March 31, 2017	61,464.22
Balance per G/L, March 31, 2017	61,464.22
Difference	-

Bank Reconciliation March 31, 2017 - RBC	
Balance per Bank, March 31, 2017	344,579.86
Less: Outstanding Cheques	
Add: Outstanding Deposits	-
Adjusted Bank Balance, March 31, 2017	344,579.86
Balance per G/L, March 31, 2017	344,579.86
Difference	-

APPENDIX C

7. CDRAF STRATEGIC PLANNING

7.1 Report of the Steering Committee

THAT the CDRAF Board approves the Strategic Plan for 2017-2020, as presented at Appendix C of the Board materials;

Canadian Dental Regulatory Authorities Federation (CDRAF) Strategic Plan

2017-2020

Steering Committee Report – 10/04/2017

Contents

Executive Summary 2
History of the CDRAF 3
Message from the president 4
Strategic Framework 5
GUIDING PRINCIPLES 6
CDRAF Mission and Vision 7
  Mission 7
  Vision 7
CDRAF Strategic Initiatives 8
Strategic Initiative # 1: Competency Standards 9
Strategic Initiative # 2: Governance 10
Strategic Initiative # 3- Relationships 11
Strategic Initiative # 4: Trends and Special Topics 12

EXECUTIVE SUMMARY

In 2016, the Canadian Dental Regulatory Authorities Federation (CDRAF) initiated the development of their Strategic Plan.

Strategic Planning involves re-examining the vision, mission and guiding principles of an organization, setting out strategies for achieving its objectives over several years. The strategic plan sets a very clear direction for staff and members and serves as a decision-making tool for the organization. All activity, guided by the principles, should support the strategic mission and vision of the organization.

Data was collected, information gathered, and surveys conducted. A current state analysis was completed based on the data, information and surveys. Board Directors and observers from Provincial Dental Regulatory Authorities (DRA) were invited to participate in a preliminary planning session which helped to develop the framework for the plan.

A steering committee consisting of several registrars, elected officials, as well as the Executive Director was formed to consider all the data and to formulate the plan. Steering Committee meetings were held virtually and face to face and many volunteer hours were contributed to effectively complete the plan.

The next steps for the organization include creating an operational plan, which will provide a road map for how the strategies will be achieved, and implementing a measurement and follow up process that will keep the plan at the forefront.

The time frame for this Strategic Plan is *three years*. In *2020* the CDRAF will revise the Strategic Plan and continue to meet the challenges and opportunities that the future will bring.

HISTORY OF THE CDRAF

The Canadian Dental Regulatory Authorities Federation (CDRAF) is a forum constituted of the provincial dental regulatory authorities (DRAs). These bodies hold the exclusive, legislated mandate of public protection.

The Letters Patent of the Federation were issued on March 3, 2004 marking the official creation date of the CDRAF.

In April 22, 2004, the first meeting of the Federation as a legally constituted organization was held in Ottawa.

At that first meeting in April 2004, Dr. Gordon Thompson was elected by the Federation board as its first President and Chair. Dr. Thompson was at the time the Executive Director and Registrar of the Alberta Dental Association and College.

Since then, the organization benefitted from the talents, dedication and leadership skills of six Presidents country-wide.

Since its inception, the CDRAF has experienced success on very important initiatives notably by ratifying a Mutual Recognition Agreement (2009) for the profession of dentistry in Canada with respect to general dentistry and dental specialties and developing a Memorandum of Understanding (2014) with respect to a uniform Canadian process for the certificate and licensure of internationally trained dental specialists.

These achievements were possible because of the CDRAF's members' vibrant determination to act in the public interest and their willingness to work together in a generous spirit.

MESSAGE FROM THE PRESIDENT

Dear Colleagues and Friends of the Dental Community,

It is my sincere pleasure to present you with the Canadian Dental Regulatory Authorities Federation's first Strategic Plan 2017-2020. I would like to recognize and thank every one involved in its development.

Over the past decade, our Board made great strides and dedicated time and energy to address issues of common interest for our members. Tangible successes were achieved. Nevertheless, we have realized in recent years, that CDRAF's "business as usual" approach was no longer possible. We needed to pull together not only to increase CDRAF's effectiveness and agility but also to create additional membership value and better serve the public interest.

I strongly believe that this ambitious plan will assist in sustaining a collaborative environment that is critical to CDRAF's future and will enhance its leadership role amongst the Canadian dental community.

Dr. Cliff Swanlund, Alberta Dental Association and College

CDRAF President

STRATEGIC FRAMEWORK

GUIDING PRINCIPLES

We recognize and respect the breadth of expertise within our Federation and we support collaboration that contributes to shared knowledge.

We seek every opportunity to share freely and with a generous spirit.

We are sensitive to individual jurisdictional and legislative differences as we strive for consensus.

We practice, in good faith, a willingness to be open and honest with each other.

CDRAF MISSION AND VISION

MISSION

The Canadian Dental Regulatory Authorities Federation fosters collaboration, consistency of approach and supports best practices in dental regulation.

VISION

The CDRAF serves, protects and acts in the interest of the public.

CDRAF STRATEGIC INITIATIVES

Competency Standards

Develop national competency standards for dentists including dental specialists.

Governance

Create a model that enables and supports the mandate of the Forum by Spring of 2018.

Relationships

Form alliances and partnerships with others to achieve our mission.

Trends and Special Topics

Develop regulatory responses to emerging trends in a timely manner.

STRATEGIC INITIATIVE # 1: COMPETENCY STANDARDS

Goal: Develop national competency standards for dentists including dental specialists.

Objectives:

1. Lead the development of a national document describing the set of skills, knowledge and abilities required to obtain an initial licence to practice as an entry level dentist.

2. Lead the development of a national document describing the set of skills, knowledge and abilities required to obtain a specialist certificate for every specialty.

3. Create a common system or process of measuring continuing competence to allow for mobility.

STRATEGIC INITIATIVE # 2: GOVERNANCE

Goal: Create a model that enables and supports the mandate of the Forum by Spring of 2018

Objectives:

1. Determine appropriate legal structure.
2. Re-brand the organization to reflect the nature of the organization's main purpose as a Forum.
3. Create new Bylaws to reflect new structure if necessary.
4. Create terms of reference and responsibilities for all functional groups and staff.
5. Develop a plan for dealing with unforeseen circumstances and emergency responses.
6. Determine processes for reporting on Forum activity.

STRATEGIC INITIATIVE # 3- RELATIONSHIPS

Goal: Form alliances and partnerships with others to achieve the mission of the CDRAF.

Objectives:

1. Enhance awareness and understanding of the role and the purpose of the CDRAF.

2. Define consistent processes and mechanisms for flow of communication with members and other parties.

3. Broaden base of knowledge and share best practices by seeking out and cultivating relationships with health professional organizations and other regulatory authorities.

STRATEGIC INITIATIVE # 4: TRENDS AND SPECIAL TOPICS

Goal: Develop regulatory responses to emerging trends in a timely manner.

Objectives:

1. Establish mechanisms for validating and prioritizing topics.

2. Establish mechanisms for gathering and analysis of data.

3. Establish mechanisms for generation of response.

APPENDIX D

8. STRATEGIC INITIATIVE #2: GOVERNANCE

8.1 CDRAF Governance Review Plan 2017

THAT a Working Group be established to explore the CDRAF Strategic Initiative on Governance.

CDRAF
Canadian Dental Regulatory Authorities Federation

FCORD
Fédération canadienne des organismes de réglementation dentaire

April 22, 2017, Ottawa

BOARD AGENDA ITEM : CDRAF GOVERNANCE

Message from the President of CDRAF

Dear Board Members,

I hope that when we get to this agenda item - CDRAF Governance, we will all have committed to the CDRAF strategic plan and be ready to shape a governance model that will allow us to deliver the expected outcomes creating thereof the added value we are all looking for.

Considering the importance of the topic as expressed at the strategic planning session, in Vancouver, the Steering Committee members tackled the subject more in-depth and elaborated the parameters of a model that should be discussed at the Board.

This model will be the starting point for our discussions and could perhaps be a viable solution moving forward.

The parameters of the model carved by the Steering Committee are as follow:

- CDRAF Board comprised of Registrars meeting 4 times /year. One vote /province.
- The concept of a General Assembly (GA) meeting annually - the 10 provinces being the stakeholders. Powers of the GA would be about the following: approval of the budget/by-laws/strategic plan and ED appointment. Voting privileges of the stakeholders to be determined.
- There was a suggestion that this GA could be the preamble of an educational session which topic would be tied to a CDRAF ongoing project. Bringing added value to all participants.
- A spokesperson chosen within the Board (based on expertise on the issue raised or appointed in turns - to determine). A mechanism to react to “emergency” situations is planned to be defined in another CDRAF strategic goal.

With all the experience gathered around this table over the years, we know that no solution is perfect. We are now reaching a point where we have to accept that a good solution is good enough to make us move forward. I am looking forward to a productive discussion and thank you all for your collaboration.

Dr. Cliff Swanlund, CDRAF President

APPENDIX E

9. WELLNESS CONFERENCE v2.0 – APRIL 2018

THAT the CDRAF Board approves CDRAF being a co-chair at the Wellness Conference v2.0 with the Canadian Dental Association (CDA) in April 2018.

CDRAF
Canadian Dental Regulatory Authorities Federation

FCORD
Fédération canadienne des organismes de réglementation dentaire

WELLNESS CONFERENCE 2.0

BRIEFING NOTE
March 1, 2017

BACKGROUND

At the December 2016, CEO/Registrars meeting the idea of updating from the 2012 WELLNESS CONFERENCE (CDRAF/CDA joint effort) was brought forward and aroused enthusiasm amongst the attendees.

Immediately following the meeting, a consultation with the DRA's registrars resulted in the following:

Generally in favor of moving forward if the workshop is built on progress of the key points set out in the 2012 report; increases collaboration for those who wish to collaborate and enhance programs already in place; aims on best practices; tackle approaches and techniques to deal with other emerging health issues such as diminishing cognitive capacity (ageing populations etc.); deals with the issue of Practice support (locums, business interruption, etc.) for practitioners in "recovery".

This feedback was brought to the attention of MGT group members at their January 6th, 2017 meeting and direction was given to Dr. Legault to send a positive signal to CDA and gather more information to present to CDRAF Board in April.

UPDATE

The CDA member associations would be happy to delay the symposium until April 2018 in Ottawa, immediately following the CDA annual meetings.

There is a strong preference expressed by CDA to have CDRAF as a co-host of the symposium. The symposium would be co-organized by CDA, CDRAF and CDSPI.

Given that the symposium would be held in conjunction with the CDA and CDRAF April 2018 meetings, the costs of the event would be considerably less than holding the symposium at another time.

CDSPI has agreed to sponsor the symposium and cover the related costs (speakers costs, meeting room, resources, meals, etc.). Consequently, as a co-host with CDA, CDRAF would not be required to make any financial commitment.

The cost of the participation of symposium attendees would be covered by the different organizations represented at the symposium.

In terms of the program, it would be developed collaboratively by CDA, CDRAF and CDSPI.

Of course, if CDRAF elects not to co-host the symposium, CDRAF and the provincial regulators would be welcome as full participants at the symposium.

NEXT STEPS
Obtain Registrars feedback on the latest development.
Board's response in April to CDA and CDSPI.

Diane Legault, DMD, MBA

AMS:714118

APPENDIX F

10. ENGLISH PROFICIENCY ASSESSMENT

THAT the CDRAF Board requests the National Dental Examining Board of Canada (NDEB) to develop a proposition for CDRAF with regard to Occupation-Specific Language Assessments.

RED RIVER COLLEGE

Best Practices: Occupation-Specific Language Assessment, Benchmarking and Training - Community of Practice Event: May 21, 2015

Presented by: Catherine Lewis & Blanche Kingdon, Red River College

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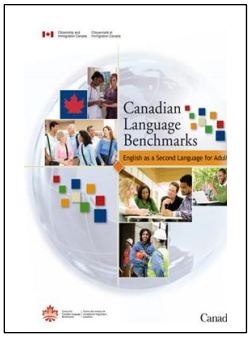
Best Practices:

A. "Benchmarking" - Analyzing the English language demands of occupations/professions and post- secondary programs



- **'Benchmarking'** is analyzing the English language demands of a task, process, occupation/profession, examination, or program using the ***Canadian Language Benchmarks (CLB)*** *2012*

  5 CLB competency areas (within each language skill):

  - *Interacting with others (L/S/R/W)*
  - *Comprehending/Giving Instructions (L/R/S)*
  - *Reproducing Information (W)*
  - *Getting Things Done (L/S/R/W)*
  - *Comprehending/Sharing information (L/R/S/W)*

  5 components of 'communicative language ability':

  1. *Grammatical*
  2. *Textual*
  3. *Functional*
  4. *Sociolinguistic*
  5. *Strategic*

- **Best Practices for Benchmarking:**

  1. **Considerations:**
     - i. Rationale for benchmarking
     - ii. Criteria for selection
     - iii. Stakeholder involvement
     - iv. Qualified researchers

  2. **Methodology:**
     - ➢ Based on global best practices (Douglas, 2000)
     - ➢ Carried out by qualified and trained researchers
     - ➢ Uses a rigorous and comprehensive mixed methods approach

     Six Steps in Methodology:

     Step One: Set up the Process
     Step Two: Gather Data
     Step Three: Analyze the Data
     Step Four: Assign CLB Levels
     Step Five: Report & Discuss Findings
     Step Six: Write Final Report

- Challenges of Benchmarking: 1. Stakeholder buy-in; 2. Process; 3. Outcomes/Implications
- Benefits of Benchmarking: Findings can be used to:
  1. to inform guidelines for entry to practice/entry to programs;
  2. to create new polices or change existing ones;
  3. to meet labour market shortages/enrollment shortages by accessing human capital (IEPs);
  4. to develop comprehensive assessment strategies

B. Developing occupation-specific language proficiency assessment tools:

Four Steps (each with 'best practices'):

1. **A Feasibility study:** Explore/determine interest in developing an occupation-specific assessment tool
2. **Analysis of the language demands of the profession** (Benchmarking)

****

3. **Development of a Language Assessment Tool**
   - A rigorous and comprehensive process

   Best practices during the process include:

   1) involvement of stakeholders
   2) involvement of a wide range of expert consultants
   3) analysis of target language use
   4) pilot testing with target population
   5) rigorous measures of reliability
   6) rigorous measures of validity

   Setting up the process includes:

   - Engage stakeholders and expert consultants
     - Minimum of two test developers with expertise in ESL and CLB
     - Professionals from occupation/profession– to ensure authenticity of content
     - Consultants – applied linguistics, item writing, test review, and statistics
   - Obtain research ethics approval (Tri-Council Policy Statement)
   - Establish a reasonable timeline for components of the process (6-12 months)

   Development is a multi-step process based on global best practices in language proficiency test development (McNamara, 2000):
   Stage One: Planning
   Stage Two: Development of the first draft of the assessment tool
   Stage Three: Piloting Draft One
   Stage Four: Revisions to Draft One and development of Draft Two
   Stage Five: Development of the Final version; writing final report

4. **Implementation of the Language Assessment Tool**

   Issues/concerns:

   - clearly defined purpose of the tool
   - administration and development of systems, processes
   - scores/feedback reports and follow up
   - quality control
   - cost and accessibility
   - information and publicity
   - long-term buy-in from stakeholders (e.g. regulators)
   - development of related products, supports, and other tests
   - ownership and copyright

C. Developing occupation-specific language programming:

Why is it needed?

"Newcomers to Canada often encounter barriers to employment. These barriers are well documented and include ***lack of Canadian work experience,*** *language barriers,* ***differences in workplace culture,*** *difficulties in obtaining recognition for foreign qualifications and international experience, discrimination, and* ***lack of workplace integration and diversity programs"*** (Kukushkin & Watt, 2009).

A. Set up the process:

1. Determine the purpose and need (research studies)
2. Secure funding partners
3. Engage a range of stakeholders with clearly defined roles *(experts from the profession, ESL specialists, curriculum developers, employers)*

B. Develop Curriculum:

4. Design a curriculum framework *(outcomes, tasks, assessment plan)* with stakeholders
5. Determine delivery format *(online, F2F, blended)*
6. Use data from occupation/profession benchmarking *(re: workplace language and socio-cultural communication skills, plus an orientation to the labour market)*
7. Taught by ESL specialist using *Communicative Language Teaching* methodology *(ESL learners)*

C. Deliver Pilot Program:

8. Deliver program *as a pilot* and collect feedback from participants (and other stakeholders)
9. Revise program based on feedback obtained in pilot
10. Formalize final program for ongoing delivery

D. Deliver/Launch Official Program:

11. Deliver program (and conduct periodic review, and update as needed)

D. <u>An overview of how language proficiency requirements are established for</u>:

- post-secondary programs (for entry into programs)
- regulatory bodies (for license to practice)

1. **<u>Post-secondary institutions</u>** establish English language proficiency requirements for entry into programs by **<u>various</u> processes** (some more rigorous than others):
   - *committee of stakeholders*
   - *applied research methodology (task force)*
   - *environmental scan re: compatibility with markets, goals, trends*
   - *comparative analysis (similar institutions)*

2. **<u>Regulatory bodies</u>** establish English language proficiency requirements for license to practice but this is more complicated than for post-secondary programs: it is a regulatory responsibility based on *The Fair Registration Practices in Regulated Professions Act (The Act)*

   OFFICE OF THE MANITOBA FAIRNESS COMMISSIONER

   The Fair Registration Practices in Regulated Professions Act (The Act) is to help ensure regulated professions and individuals applying for registration by regulated professions are governed by registration practices that are transparent, objective, impartial and fair.

   NB: To be registered to practice, IEPS may need to provide regulators with "proof of English language proficiency"

   <u>Regulators</u> establish English language proficiency requirements for license to practice by **<u>various</u> processes** (some more rigorous than others):
   - *comparative analysis with other provinces or regions*
   - *Pan-Canadian approach for the profession*
   - *policy analysts' research and recommendations*
   - *formal working groups with language proficiency policy mandates*
   - *other*

If proof of language proficiency is required by regulators, then regulators must:

- *select specific language proficiency tests*
- *determine appropriate pass scores*
- *be able to defend their choices to the Fairness Commissioner (as part of regulatory review)*

Decisions/Outcomes and must be objective, impartial, transparent and fair, and defensible.

Best Practices: Assessment Use Argument (AUA) *(Bachman & Palmer, 2010):*

- **Claim 1: Consequences** *(beneficial)*
- **Claim 2: Decisions** *(valuable, legal, equitable)*
- **Claim 3: Interpretations** *(meaningful, impartial, generalizable, relevant, sufficient)*
- **Claim 4: Assessment Records** *(consistent – 'reliability')*

Conclusion

***Best practices and processes need to be rigorous and comprehensive* for:**

A. "Benchmarking" - Analyzing the English language demands of occupations/professions and post-secondary programs
B. Developing occupation-specific language proficiency assessment tools
C. Developing occupation-specific language programming

Post-secondary institutions and regulators need to make challenging, high-stakes decisions which are objective, impartial, transparent, fair and defensible for:

D. Establishing language proficiency requirements for entry into programs OR license to practice

Common theme: *In all aspects of any benchmarking initiative and decision-making process (i.e., planning, analysis, development, implementation, reporting, review, etc.), engage a wide range of stakeholders*

Stakeholders include: professionals in the field, regulators, employers, ESL specialists (applied linguistics), curriculum developers, teachers, and statistics consultants, IEPs, funders, etc.

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APPENDIX G

11. OPIOIDS CRISIS: CDRAF PUBLIC COMMITMENT

THAT the CDRAF Board encourage its members to disseminate the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, published by the National Pain Centre at McMaster University.

The 2017 Draft Recommendations for Use of Opioids in Chronic Non-Cancer Pain

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Disclaimer

The draft recommendations in this guideline are presented to encourage public review and comment. The direction ('for' or 'against') and strength ('weak' or 'strong') of each recommendation has been established by a 15-member guideline panel of clinicians, methodologists and patients, and are unlikely to change unless compelling evidence emerges that was not considered by the panel. All feedback received regarding the wording of recommendations and associated text, and/or important considerations (please see Feedback Form), will be carefully considered by the guideline steering committee and used to inform the drafting of the final guideline document.

This guideline was an investigator-initiated study, supported by grants from the Canadian Institutes of Health Research and Health Canada. The funders had no role in the design and conduct of the study; collection, analysis, and interpretation of the data; or preparation, review, or approval of the guideline. Health Canada personnel provided non-binding feedback during the study. Final decisions regarding the protocol and issues that arose during the guideline development process were the purview of the guideline steering committee.

Sections

1 - Initiation and Dosing of Opioids in Patients with Chronic Non-Cancer Pain 7
2 - Rotation and Tapering of Opioids, for Patients with Chronic Non-Cancer Pain..... 33

Summary of recommendations

1 - Initiation and Dosing of Opioids in Patients with Chronic Non-Cancer Pain

Recommendation #1

When considering first-line therapy for patients with chronic non-cancer pain

Strong Recommendation AGAINST

We recommend optimization of non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids

Recommendation #2

Patients with persistent problematic pain despite optimized non-opioid therapy, without current or past substance use disorder or current serious psychiatric disorder

Weak Recommendation

We suggest a trial of opioids rather than continued non-opioid therapy

By a trial of opioids, we mean initiation, titration, and diligent monitoring of response, with discontinuation of opioids if important improvement in pain or function is not achieved

Recommendation #3

Patients with an active substance use disorder and chronic non-cancer pain

Strong Recommendation AGAINST

We recommend against the use of opioids

Clinicians should, if not yet addressed, facilitate treatment of the underlying substance use disorders

Recommendation #4

Patients with a current serious psychiatric disorder whose non-opioid therapy has been optimized, and who still experience persistent problematic pain (REC #4)

Weak Recommendation

We suggest stabilization of the psychiatric disorder before considering a trial of opioids

Recommendation #5

Patients with a history of substance use disorder, whose non-opioid therapy has been optimized, and who still experience persistent problematic pain

Weak Recommendation

We suggest continuing non-opioid therapy rather than a trial of opioids

Recommendation #6

Patients with chronic non-cancer pain beginning long term opioid therapy

Weak Recommendation

We suggest restricting the prescribed dose to under 50mg morphine equivalents daily ,rather than a dose of 50 to below 90 mg

The weak recommendation to restrict the prescribed dose to under 50mg morphine equivalents daily acknowledges that there are likely to be some patients who would be ready to accept the increased risks associated with a dose over 50mg to potentially achieve improved pain control

Recommendation #7

Strong Recommendation

We recommend restricting the prescribed dose to under 90mg morphine equivalents daily rather than no upper, or a higher limit on dosing

Some patients may gain important benefit over 90mg morphine equivalents, but not on lower doses. Referral to a colleague for a second opinion regarding the possibility of increasing above 90mg morphine equivalents daily may therefore be warranted in some individuals

2 - Rotation and Tapering of Opioids, for Patients with Chronic Non-Cancer Pain

Recommendation #8

For patients currently using 90 mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects

Weak Recommendation

We suggest rotation to other opioids rather than keeping the opioid the same

Rotation in such patients may be done in parallel with, and as a way of facilitating, dose reduction

Recommendation #9

For patients currently using 90 mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects

Weak Recommendation

We suggest tapering opioids to the lowest possible dose, including discontinuation, rather than no change in opioid therapy

Some patients are likely to experience significant increase in pain or decrease in function that persist more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients.

Recommendation #10

Patients using opioids and experiencing serious challenges in tapering

Strong Recommendation

We recommend a formal multidisciplinary opioids reduction program

Recognizing the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration including several health professionals (possibilities include, but are not limited to, a primary care physician, a pharmacist, a physical therapist, a kinesiologist, a psychiatrist, and a psychologist).

1 - Initiation and Dosing of Opioids in Patients with Chronic Non-Cancer Pain

Recommendation #1

When considering first-line therapy for patients with chronic non-cancer pain

Strong Recommendation | AGAINST

We recommend optimization of non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids

Rationale

Opioids, when added to non-opioids achieve, on average, modest improvements in pain and function at the cost of very frequent dependence, frequent addiction, and rare non-fatal unintentional overdose and death. A variety of non-opioid therapies as first-line treatment for patients with chronic non-cancer pain achieve a similar magnitude of improvement in pain and function but without the problems of dependence, addiction, and non-fatal overdose

Clinical Question/ PICO

Population: PICO 1a) Patients with chronic non-cancer pain considering first line therapy for pain

Intervention: Trial of opioids.

Comparator: Optimization of therapy with NSAIDs.

Summary

Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Optimization of therapy with NSAIDs.	Trial of opioids.	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Gastrointestinal side effects	Relative risk 2.52 (CI 95% 1.54 - 4.13) Based on data from 3,675 patients in 7 studies. (Randomized controlled) Follow up 6-26 weeks	**37** per 1000	**93** per 1000 Difference: **56 more** per 1000 (CI 95% 20 more - 116 more)	**High**	Opioid therapy slightly worsens gastrointestinal side effects compared to NSAIDS
Pain	Measured by: 10-cm VAS Scale: 0-10 Lower better Based on data from: 2,250 patients in 13 studies. (Randomized controlled) Follow up 1-6 months	cm (n/a)	cm (n/a) Difference: **MD 0.49 fewer** (CI 95% 1.24 fewer - 0.26 more)	**Low** Due to serious inconsistency, Due to serious imprecision	Opioid therapy may have little or no difference on pain compared to NSAIDS

Physical Function	Measured by: SF-36 Scale: 0-100 High better Based on data from: 1,972 patients in 8 studies. (Randomized controlled) Follow up 4-16 weeks	(n/a) (n/a) Difference: **MD 1.5 fewer** (CI 95% 3.08 fewer - 0.08 more)	**Moderate** Due to serious imprecision	Opioid therapy may have little or no difference on physical function compared to NSAIDS
Addiction	Based on data from 22,278 patients in 9 studies	Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)	**Moderate** Due to serious inconsistency.	Opioid therapy increases the risk of addiction
Fatal Overdose	Based on data from 285,520 patients in 1 studies	Estimated annual fatal overdose rates were 0.10%, 0.14%, 0.18% , and 0.23% in patients receiving <20 mg morphine equivalent per day, 20-49 mg/day, 50-99 mg/day, and >100 mg per day respectively.	**High**	Opioid therapy increases the risk of fatal overdose
Non-fatal overdose	Based on data from 9,940 patients in 1 studies	Estimated annual overdose rates were 0.2%, 0.7%, and 1.8% among patients receiving less than 20 mg/d, 50 to 99 mg/d, and more than 100 mg/d of opioids, respectively.	**Moderate** Due to serious imprecision	Opioid therapy increases the risk of non-fatal overdose.
Diversion	Based on data from 472,200 patients in 1 studies	Among US adults, the prevalence of nonmedical use of prescription opioids was 4.9% (95% CI, 4.58%-5.22%) in 2013.	**Moderate** Due to serious risk of bias.	Opioid therapy probably increases the risk of diversion

Details about studies used and certainty down- and upgrading

Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: Serious** The magnitude of statistical heterogeneity was high, with I^2: 94.5 %. ; **Indirectness: No serious** **Imprecision: Serious** Wide confidence intervals which include benefit and harm ; **Publication bias: No serious**
Physical Function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious**

	reference used for intervention	**Imprecision: Serious** Wide confidence intervals include both benefit and harm ; **Publication bias: No serious**
Addiction	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: Serious** Point estimates varied substantially, from 0.7% to 15.7% ; **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Fatal Overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was the Ontario Drug Benefit Database, including Ontarians eligible for drug coverage. This population may be systematically different than other populations with chronic non-cancer pain. ; **Imprecision: No serious** **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** The study setting was Group Health Cooperative (GHC), which provides comprehensive care on a prepaid basis to about 500 000 persons in Washington State. ; **Imprecision: Serious** Small number of events. ; **Publication bias: No serious**
Diversion	**Intervention reference:** Systematic review	**Risk of bias: Serious** Response rate of 66%. Outcome was self-reported. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**

Clinical Question/ PICO

Population: 1b) Patients with chronic non-cancer pain considering first line therapy for pain

Intervention: Trial of opioids.

Comparator: Optimization of therapy with anticonvulsants.

Summary

Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Optimization of therapy with anticonvulsants.	 Trial of opioids.	**Certainty in effect estimates**	**Summary**

			(Quality of evidence)	
Gastrointestinal side effects 5 Important	Relative risk 10.64 (CI 95% 2.01 - 56.24) Based on data from 303 patients in 3 studies. (Randomized controlled) Follow up 4-6 weeks	**6** per 1000 **64** per 1000 Difference: **58 more** per 1000 (CI 95% 6 more - 331 more)	**Low** Due to serious risk of bias, Due to serious imprecision	Opioid therapy may increase gastrointestinal side effects compared to anticonvulsants.
Pain (difference in patients who achieve the MID or greater) 9 Critical	Relative risk 1.26 (CI 95% 1.05 - 1.42) Based on data from 303 patients in 3 studies. (Randomized controlled) Follow up 4-6 weeks	**618** per 1000 **779** per 1000 Difference: **161 more** per 1000 (CI 95% 31 more - 260 more)	**Low** Due to serious risk of bias, Due to serious imprecision	Opioid therapy may increase the proportion of patients who achieve a 1 cm reduction on a 10-cm VAS compared to anticonvulsants.
Pain 9 Critical	Measured by: 10-cm VAS Scale: 0-10 Lower better Based on data from: 303 patients in 3 studies. (Randomized controlled) Follow up 4-6 weeks	cm (n/a) cm (n/a) Difference: **MD 0.9 fewer** (CI 95% 1.65 fewer - 0.14 fewer)	**Low** Due to serious risk of bias, Due to serious imprecision	Opioid therapy may improve pain slightly compared to anticonvulsants.
Physical Function 9 Critical	Measured by: SF-36 Scale: 0-100 High better Based on data from: 303 patients in 3 studies. (Randomized controlled) Follow up 4-6 weeks	(n/a) (n/a) Difference: **MD 0.45 more** (CI 95% 5.77 fewer - 6.66 more)	**Low** Due to serious risk of bias, Due to serious imprecision	We are uncertain whether opioid therapy improves or worsens physical function compared to anticonvulsants.
Addiction 9 Critical	Based on data from 22,278 patients in 9 studies	Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)	**Moderate** Due to serious inconsistency.	Opioid therapy increases the risk of addiction
Fatal overdose 9 Critical	Based on data from 285,520 patients in 1 studies	Estimated annual fatal overdose rates were 0.10%, 0.14%, 0.18% , and 0.23% in patients receiving <20 mg morphine equivalent per day, 20-49 mg/day, 50-99 mg/day, and >100 mg per day respectively.	**High**	Opioid therapy increases the risk of fatal overdose.
Non-fatal overdose 9 Critical	Based on data from 9,940 patients in 1 studies	Estimated annual overdose rates were 0.2%, 0.7%, and 1.8% among patients receiving less than 20 mg/d, 50 to 99 mg/d, and more than 100 mg/d of opioids, respectively.	**Moderate** Due to serious imprecision	Opioid therapy increases the risk of non-fatal overdose.

Diversion 9 Critical	Based on data from 472,200 patients in 1 studies	Among US adults, the prevalence of nonmedical use of prescription opioids was 4.9% (95% CI, 4.58%-5.22%) in 2013.	**Moderate** Due to serious risk of bias.	Opioid therapy probably increases the risk of diversion.
Details about studies used and certainty down- and upgrading				
Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: Serious** Two out of three studies (Sakai 2015, Ko 2010) had no allocation concealment and no blinding. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Wide confidence intervals ; **Publication bias: No serious**		
Pain (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: Serious** Two out of three studies (sakai 2015, Ko 2010) had no allocation concealment and no blinding ; **Inconsistency: No serious** The magnitude of statistical heterogeneity was high, with I^2=71 %. ; **Indirectness: No serious** **Imprecision: Serious** Confidence interval includes both important benefit and no clinically meaningful effect ; **Publication bias: No serious**		
Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: Serious** Two out of three studies (sakai 2015, Ko 2010) had no allocation concealment and no blinding ; **Inconsistency: No serious** The magnitude of statistical heterogeneity was high, with I^2=71 %. ; **Indirectness: No serious** **Imprecision: Serious** Confidence interval includes both important benefit and no clinically meaningful effect ; **Publication bias: No serious**		
Physical Function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: Serious** Two out of three studies (sakai 2015, Ko 2010) had no allocation concealment and no blinding. ; **Inconsistency: No serious** The magnitude of statistical heterogeneity was high, with I^2:67 %. ; **Indirectness: No serious** **Imprecision: Serious** Confidence interval includes both benefit and harm ; **Publication bias: No serious**		
Addiction	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: Serious** Point estimates varied substantially, from 0.7% to 15.7%. ; **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**		
Fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was the Ontario Drug Benefit Database, including Ontarians eligible for drug coverage. This population may be systematically different than other populations with chronic non-cancer pain. ;		

		Imprecision: No serious **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was Group Health Cooperative (GHC), which provides comprehensive care on a prepaid basis to about 500 000 persons in Washington State ; **Imprecision: Serious** Small number of events and no confidence interval provided. ; **Publication bias: No serious**
Diversion	**Intervention reference:** Systematic review	**Risk of bias: Serious** Response rate of 66%. Outcome was self-reported. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**

Clinical Question/ PICO

Population: 1c) Patients with chronic non-cancer pain considering first line therapy for pain

Intervention: Trial of opioids.

Comparator: Optimization of therapy with tricyclic antidepressants.

Summary

Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Optimization of therapy with tricyclic antidepressants. Trial of opioids.	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Pain 9 Critical	Measured by: 10-cm VAS Scale: 0-10 Lower better Based on data from: 183 patients in 3 studies. (Randomized controlled) Follow up 5-8 weeks	cm (n/a) cm (n/a) Difference: **MD 0.15 fewer** (CI 95% 1.04 fewer - 0.74 more)	**Low** Due to serious risk of bias, Due to serious imprecision	We are uncertain whether opioid therapy improves or worsens pain compared to antidepressants.
Physical Function	Measured by: SF-36 Scale: 0-100 High better Based on data from: 107 patients in 2 studies. (Randomized controlled) Follow up 5-6 weeks	(n/a) (n/a) Difference: **MD 5.29 fewer** (CI 95% 13.7 fewer - 3.12 more)	**Low** Due to serious risk of bias, Due to serious imprecision	We are uncertain whether opioid therapy improves or worsens physical function compared to antidepressants.

Addiction 9 Critical	Based on data from 22,278 patients in 9 studies	Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)	**Moderate** Due to serious inconsistency.	Opioid therapy increases the risk of addiction.
Fatal overdose 9 Critical	Based on data from 285,520 patients in 1 studies	Estimated annual fatal overdose rates were 0.10%, 0.14%, 0.18% , and 0.23% in patients receiving <20 mg morphine equivalent per day, 20-49 mg/day, 50-99 mg/day, and >100 mg per day respectively.	**High**	Opioid therapy increases the risk of fatal overdose.
Non-fatal overdose 9 Critical	Based on data from 9,940 patients in 1 studies	Estimated annual overdose rates were 0.2%, 0.7%, and 1.8% among patients receiving less than 20 mg/d, 50 to 99 mg/d, and more than 100 mg/d of opioids, respectively.	**Moderate** Due to serious imprecision	Opioid therapy increases the risk of non-fatal overdose.
Diversion 9 Critical	Based on data from 472,200 patients in 1 studies	Among US adults, the prevalence of nonmedical use of prescription opioids was 4.9% (95% CI, 4.58%-5.22%) in 2013.	**Moderate** Due to serious risk of bias.	Opioid therapy probably increases the risk of diversion.

Details about studies used and certainty down- and upgrading

Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: Serious** High loss to follow up in all studies (>25%) ; **Inconsistency: No serious** **Indirectness: No serious** Follow up time is short, max 6 weeks ; **Imprecision: Serious** Confidence interval includes benefit and harm ; **Publication bias: No serious**
Physical Function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: Serious** High loss to follow up in all studies (>25%) ; **Inconsistency: No serious** **Indirectness: No serious** Follow up time is short, max 6 weeks ; **Imprecision: Serious** Confidence interval includes benefit and harm ; **Publication bias: No serious**
Addiction	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: Serious** Point estimates varied substantially, from 0.7%-15.7% ; **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was the Ontario Drug Benefit Database, including Ontarians eligible for drug coverage. This population may be systematically different than other populations with chronic non-cancer pain. ;

		Imprecision: No serious **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was Group Health Cooperative, which provides comprehensive care on a prepaid basis to about 500 000 persons in Washington State. ; **Imprecision: Serious** Small number of events and no confidence interval provided. ; **Publication bias: No serious**
Diversion	**Intervention reference:** Systematic review	**Risk of bias: Serious** Response rate of 66%. Outcome was self-reported. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**

Recommendation #2

Patients with persistent problematic pain despite optimized non-opioid therapy, without current or past substance use disorder or current serious psychiatric disorder

Weak Recommendation

We suggest a trial of opioids rather than continued non-opioid therapy

By a trial of opioids, we mean initiation, titration, and diligent monitoring of response, with discontinuation of opioids if important improvement in pain or function is not achieved

Rationale

Opioids, when added to non-opioids achieve, on average, modest improvements in pain and function. Adverse effects include relatively frequent constipation, nausea and vomiting, cognitive changes, dependence, and addiction, and rare death and non-fatal unintentional overdose.

Clinical Question/ PICO

Population: PICO 2: Patients with chronic non-cancer pain, without current or past substance use disorder and without other current serious psychiatric disorders, whose therapy is optimized with non-opioids with persistent problematic pain

Intervention: Trial of opioids.

Comparator: Continue established therapy without opioids.

Summary

Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Continue established therapy without opioids.	Trial of opioids.	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Gastrointestinal side effects 4-26 weeks 9 Critical	Relative risk 3.24 (CI 95% 2.69 - 3.89) Based on data from 17,463 patients in 54 studies. (Randomized controlled) Follow up 4-26 weeks	**28** per 1000	**91** per 1000 Difference: **63 more** per 1000 (CI 95% 47 more - 81 more)	**High**	Opioid therapy worsens gastrointestinal side effects
Pain (difference in patients who achieve the MID or greater) 9 Critical	Relative risk 1.29 (CI 95% 1.24 - 1.34) Based on data from 13,948 patients in 35 studies. (Randomized controlled) Follow up 12-24 weeks	**424** per 1000	**547** per 1000 Difference: **123 more** per 1000 (CI 95% 102 more - 144 more)	**High**	Opioid therapy increases the proportion of patients who will achieve a 1 cm reduction of pain on a 10 cm VAS compared with placebo.
Physical function (difference in patients who achieve the MID or greater) 9 Critical	Relative risk 1.24 (CI 95% 1.17 - 1.3) Based on data from 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	**424** per 1000	**526** per 1000 Difference: **102 more** per 1000 (CI 95% 72 more - 127 more)	**High**	Opioid therapy increases the proportion of patients who will achieve 5 point increase on the SF-36 physical component summary scale compared with placebo.
Pain 9 Critical	Measured by: 10 cm VAS Scale: 0-10 Lower better Based on data from: 13,948 patients in 35 studies. (Randomized controlled) Follow up 3-6 months	cm	cm Difference: **MD 0.71 fewer** (CI 95% 0.84 fewer - 0.58 fewer)	**High**	Opioid therapy slightly improves pain
Physical function	Measured by: SF-36 physical component summary scale Scale: 0-100 High better Based on data from:		Difference: **MD 2.16 more** (CI 95% 1.56 more - 2.76 more)	**High**	Opioid therapy slightly improves physical function

9 Critical	12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months			
Addiction 9 Critical	Based on data from 22,278 patients in 9 studies	Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)	**Moderate** Due to serious inconsistency	Opioid therapy increases the risk of addiction.
Fatal overdose 9 Critical	Based on data from 285,520 patients in 1 studies	Estimated annual fatal overdose rates were 0.10%, 0.14%, 0.18% , and 0.23% in patients receiving <20 mg morphine equivalent per day, 20-49 mg/day, 50-99 mg/day, and >100 mg per day respectively.	**High**	Opioid therapy increases the risk of fatal overdose.
Non-fatal overdose 9 Critical	Based on data from 9,940 patients in 1 studies	Risk of non-fatal overdose is 0.2%.	**Moderate** Due to serious imprecision	Opioid therapy increases the risk of non-fatal overdose.
Diversion 9 Critical	Based on data from 472,200 patients in 1 studies	Among US adults, the prevalence of nonmedical use of prescription opioids was 4.9% (95% CI, 4.58%-5.22%) in 2013.	**Moderate** Due to serious risk of bias	Opioid therapy probably increases the risk of diversion.

Details about studies used and certainty down- and upgrading

Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies ;
Pain (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Asymmetrical funnel plot ;
Physical function (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Removed studies with SE>3 (small study effect) ;

Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Asymmetrical funnel plot, Mostly commercially funded studies ;
Physical function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Removed studies with SE>3 (small study effect) ;
Addiction	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: Serious** Point estimates vary widely (0.7%-15.7%) ; **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was the Ontario Drug Benefit Database, including Ontarians eligible for drug coverage. This population may be systematically different than other populations with chronic non-cancer pain. ; **Imprecision: No serious** **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** The study setting was Group Health Cooperative (GHC), which provides comprehensive care on a prepaid basis to about 500 000 persons in Washington State. ; **Imprecision: Serious** Small number of events and no confidence interval provided. ; **Publication bias: No serious**
Diversion	**Intervention reference:** Primary study	**Risk of bias: Serious** Response rate of 66%. Outcome was self-reported. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**

Recommendation #3

Patients with an active substance use disorder and chronic non-cancer pain

Strong Recommendation | AGAINST

We recommend against the use of opioids

Clinicians should, if not yet addressed, facilitate treatment of the underlying substance use disorders

Rationale

Low quality evidence suggests a possible substantial increase in the very serious adverse outcomes of unintentional non-fatal overdose and death in patients with active substance abuse disorder using opioids.

Clinical Question/ PICO

Population: PICO 3: Patients with chronic non-cancer pain with an active substance use disorder whose non-opioid therapy has been optimized

Intervention: Trial of opioids

Comparator: Continue established therapy without opioids

Summary

We did not find any evidence for difference in pain, physical function, or gastrointestinal side effects in patients with an active substance use disorder compared to patients without an active substance use disorder.
Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Continue established therapy without opioids	Trial of opioids	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Gastrointestinal side effects 5 Important	Relative risk 3.24 (CI 95% 2.69 - 3.89) Based on data from 17,463 patients in 54 studies. (Randomized controlled) Follow up 4-26 weeks	**28** per 1000	**91** per 1000 Difference: **63 more** per 1000 (CI 95% 47 more - 81 more)	**High**	Opioid therapy increases gastrointestinal side effects in patients with active substance use disorder.
Pain (difference in patients who achieve the MID or greater) 5 Important	Relative risk 1.29 (CI 95% 1.24 - 1.34) Based on data from 13,948 patients in 35 studies. (Randomized controlled) Follow up 12-24 weels	**424** per 1000	**547** per 1000 Difference: **123 more** per 1000 (CI 95% 102 more - 144 more)	**High**	Opioid therapy increases the proportion of patients who will achieve a 1 cm reduction of pain on a 10 cm VAS compared with placebo.

Physical function (difference in patients who achieve the MID or greater) 5 Important	Relative risk 1.24 (CI 95% 1.17 - 1.3) Based on data from 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	**424** per 1000 **526** per 1000 Difference: **102 more** per 1000 (CI 95% 72 more - 127 more)	**High**	Opioid therapy increases the proportion of patients who will achieve 5 point increase on the SF-36 physical component summary scale compared with placebo.
Pain 5 Important	Measured by: 10 cm VAS Scale: 0-10 Lower better Based on data from: 13,948 patients in 35 studies. (Randomized controlled) Follow up 3-6 months	cm (Mean) cm (Mean) Difference: **MD 0.71 fewer** (CI 95% 0.84 fewer - 0.58 fewer)	**High**	Opioid therapy improves pain slightly in patients with an active substance use disorder.
Physical function 5 Important	Measured by: SF-36 physical component summary scale Scale: 0-100 High better Based on data from: 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	(Mean) (Mean) Difference: **MD 2.16 more** (CI 95% 1.56 more - 2.76 more)	**High**	Opioid therapy slightly improves physical function in patients with an active substance use disorder.
Addiction 5 Important	Based on data from 171 patients in 1 studies	Risk of addiction in patients with active substance use disorder is 8.9% (95% CI 3.7%-20%).	**Low** Due to very serious indirectness	Opioid therapy may increase the risk of addiction in patients with an active substance use disorder.
Fatal overdose 9 Critical	Based on data from 18,122 patients in 3 studies	Risk of fatal overdose in patients with active substance use disorder is 0.46% (95%CI 0.19%-1.1%).	**Low** Due to very serious indirectness	Opioid therapy increases the risk of fatal overdose in patients with active substance use disorder.
Non-fatal overdose 9 Critical	Based on data from 18,122 patients in 3 studies	Risk of non-fatal overdose in patients with active substance use disorder is 0.91% (95% CI 0.39%-2.1%).	**Low** Due to very serious indirectness	Opioid therapy increases the risk of non-fatal overdose in patients with an active substance use disorder.

Details about studies used and certainty down- and upgrading		
Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious**

	reference used for intervention	**Imprecision: No serious** **Publication bias: No serious**
Pain (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Asymmetrical funnel plot, Mostly commercially funded studies ;
Physical function (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Removed studies with SE>3 (small study effect) ;
Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious**
Physical function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious**
Addiction	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse., ; **Imprecision: No serious** **Publication bias: No serious**
Fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse. ; **Imprecision: No serious** **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse. ; **Imprecision: No serious** **Publication bias: No serious**

Recommendation #4

Patients with a current serious psychiatric disorder whose non-opioid therapy has been optimized, and who still experience persistent problematic pain (REC #4)

Weak Recommendation

We suggest stabilization of the psychiatric disorder before considering a trial of opioids

Rationale

Low quality evidence suggests a possible large increase in the very serious adverse outcomes of unintentional non-fatal overdose and death in patients with serious psychiatric disorder using opioids.

Clinical Question/ PICO

Population: PICO 4: Patients with chronic non-cancer pain with a current serious psychiatric disorder whose non-opioid therapy has been optimized, and who still experience persistent problematic pain

Intervention: Trial of opioids

Comparator: Continue established therapy without opioids

Summary

We did not find any evidence for difference in pain, physical function, or gastrointestinal side effects in patients with a current serious psychiatric disorder compared to patients without a current serious psychiatric disorder.
Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Continue established therapy without opioids	Trial of opioids	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Gastrointestinal side effects 5 Important	Relative risk 3.24 (CI 95% 2.69 - 3.89) Based on data from 17,463 patients in 54 studies. (Randomized controlled) Follow up 4-26 weeks	**28** per 1000	**91** per 1000 Difference: **63 more** per 1000 (CI 95% 47 more - 81 more)	**High**	Opioid therapy increases gastrointestinal side effects in patients with current serious psychiatric disorders.
Pain (difference in patients who achieve the MID or greater) 5 Important	Relative risk 1.29 (CI 95% 1.24 - 1.34) Based on data from 13,948 patients in 35 studies. (Randomized controlled) Follow up 12-24 weeks	**424** per 1000	**547** per 1000 Difference: **123 more** per 1000 (CI 95% 102 more - 144 more)	**High**	Opioid therapy increases the proportion of patients who will achieve a 1 cm reduction of pain on a 10 cm VAS compared with placebo.

Physical function (difference in patients who achieve the MID or greater) 5 Important	Relative risk 1.24 (CI 95% 1.17 - 1.3) Based on data from 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	**424** per 1000 **526** per 1000 Difference: **102 more** per 1000 (CI 95% 72 more - 127 more)	**High**	Opioid therapy increases the proportion of patients who will achieve 5 point increase on the SF-36 physical component summary scale compared with placebo.
Pain 5 Important	Measured by: 10 cm VAS Scale: 0-10 Lower better Based on data from: 13,948 patients in 35 studies. (Randomized controlled) Follow up 3-6 months	cm (Mean) cm (Mean) Difference: **MD 0.71 fewer** (CI 95% 0.84 fewer - 0.58 fewer)	**High**	Opioid therapy slightly improves pain in patients with current serious psychiatric disorders.
Physical function 5 Important	Measured by: SF-36 physical component summary scale Scale: 0-100 High better Based on data from: 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	(Mean) (Mean) Difference: **MD 2.16 more** (CI 95% 1.56 more - 2.76 more)	**High**	Opioid therapy slightly improves physical function in patients with current serious psychiatric disorders.
Addiction 5 Important	Based on data from 35,969 patients in 9 studies	The risk of addiction in patients with a current serious psychiatric disorder is 8.0% (95% CI 6.7%-9.5%)	**Low** Due to very serious indirectness	Opioid therapy may increase the risk of addiction in patients with current serious psychiatric disorders.
Fatal overdose 9 Critical	Based on data from 35,969 patients in 9 studies	The risk of fatal overdose in patients with a current serious psychiatric disorder is 0.15% (95%CI 0.12%-0.18%)	**Low** Due to very serious indirectness	Opioid therapy may increase the risk of fatal overdose in patients with current serious psychiatric disorders.
Non-fatal overdose 9 Critical	Based on data from 35,969 patients in 9 studies	The risk of non-fatal overdose in patients with a current serious psychiatric disorder is 0.3% (95%CI 0.25%-0.36%)	**Low** Due to very serious indirectness	Opioid therapy may increase the risk of non-fatal overdose in patients with current serious psychiatric disorders.

Details about studies used and certainty down- and upgrading		
Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator**	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious**

	reference: Control arm of reference used for intervention	**Imprecision: No serious** **Publication bias: No serious**
Pain (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Asymmetrical funnel plot ;
Physical function (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Removed studies with SE>3 (small study effect) ;
Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Physical function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Addiction	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse. ; **Imprecision: No serious** **Publication bias: No serious**
Fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse. ; **Imprecision: No serious** **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse. ;

		Imprecision: No serious **Publication bias: No serious**

Recommendation #5

Patients with a history of substance use disorder, whose non-opioid therapy has been optimized, and who still experience persistent problematic pain

Weak Recommendation

We suggest continuing non-opioid therapy rather than a trial of opioids

Rationale

Low quality evidence suggests a possible appreciable increase in the very serious adverse outcomes of unintentional non-fatal overdose and death in patients with using opioids.

Clinical Question/ PICO

Population: PICO 5: Patients with chronic non-cancer pain with a history of substance use disorder, whose non-opioid therapy has been optimized, who still experience persistent problematic pain

Intervention: Trial of opioids

Comparator: Continuing established therapy without opioids

Summary

We did not find any evidence for difference in pain, physical function, or gastrointestinal side effects in patients with a history of substance use disorder compared to patients without a history of substance use disorder.
Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Continuing established therapy without opioids	 Trial of opioids	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Gastrointestinal side effects 5 Important	Relative risk 3.24 (CI 95% 2.69 - 3.89) Based on data from 17,463 patients in 54 studies. (Randomized controlled) Follow up 4-26 weeks	**28** per 1000	**91** per 1000 Difference: **63 more** per 1000 (CI 95% 47 more - 81 more)	**High**	Opioid therapy increases gastrointestinal side effects in patients with a history of substance use disorder.

Pain (difference in patients who achieve the MID or greater) 5 Important	Relative risk 1.29 (CI 95% 1.24 - 1.34) Based on data from 13,948 patients in 35 studies. (Randomized controlled) Follow up 12-24 weeks	**424** per 1000 **547** per 1000 Difference: **123 more** per 1000 (CI 95% 102 more - 144 more)	**High**	Opioid therapy increases the proportion of patients who will achieve a 1 cm reduction of pain on a 10 cm VAS compared with placebo.
Physical function (difference in patients who achieve the MID or greater) 5 Important	Relative risk 1.24 (CI 95% 1.17 - 1.3) Based on data from 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	**424** per 1000 **526** per 1000 Difference: **102 more** per 1000 (CI 95% 72 more - 127 more)	**High**	Opioid therapy increases the proportion of patients who will achieve 5 point increase on the SF-36 physical component summary scale compared with placebo.
Pain 5 Important	Measured by: 10 cm VAS Scale: 0-10 Lower better Based on data from: 13,948 patients in 35 studies. (Randomized controlled) Follow up 3-6 months	cm (Mean) cm (Mean) Difference: **MD 0.71 fewer** (CI 95% 0.84 fewer - 0.58 fewer)	**High**	Opioid therapy slightly improves pain in patients with a history of substance use disorder.
Physical function 5 Important	Measured by: SF-36 physical component summary scale Scale: 0-100 High better Based on data from: 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	(Mean) (Mean) Difference: **MD 2.16 more** (CI 95% 1.56 more - 2.76 more)	**High**	Opioid therapy slightly improves physical function in patients with a history of substance use disorder.
Fatal overdose 9 Critical	Based on data from 620 patients in 3 studies	Risk of fatal overdose in patients with a history of substance use disorder is 0.38% (95% CI 0.24%-0.62%)	**Low** Due to very serious indirectness	Opioid therapy may increase the risk of fatal overdose in patients with a history of substance use disorder.
Non-fatal overdose 9 Critical	Based on data from 620 patients in 3 studies	Risk of fatal overdose in patients with a history of substance use disorder is 0.762% (95% CI 0.47%-1.23%)	**Low** Due to very serious indirectness	Opioid therapy may increase the risk of non-fatal overdose in patients with a history of substance use disorder.
Details about studies used and certainty down- and upgrading				

Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Pain (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Asymmetrical funnel plot ;
Physical function (difference in patients who achieve the MID or greater)	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Removed studies with SE>3 (small study effect) ;
Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Physical function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse. ; **Imprecision: No serious** **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Very Serious** Differences between the outcomes of interest and those reported. Odds ratios are based on risk of opioid abuse. ; **Imprecision: No serious** **Publication bias: No serious**

Recommendation #6

Patients with chronic non-cancer pain beginning long term opioid therapy

Weak Recommendation

We suggest restricting the prescribed dose to under 50mg morphine equivalents daily ,rather than a dose of 50 to below 90 mg

The weak recommendation to restrict the prescribed dose to under 50mg morphine equivalents daily acknowledges that there are likely to be some patients who would be ready to accept the increased risks associated with a dose over 50mg to potentially achieve improved pain control

Rationale

Observational study results provide moderate quality evidence of a progressive increase in the likelihood of unintentional non-fatal overdose or death as the prescribed dose of opioids increases. These serious outcomes are very rare in those prescribed less than 50 morphine equivalents daily, but increase in those prescribed doses of 50 to 90, and though still rare, are very concerning in those prescribed doses of over 90

Clinical Question/ PICO

Population: Patients with chronic non-cancer pain beginning long-term opioid therapy
Intervention: Limit opioid dose to a particular maximum dose
Comparator: No maximum opioid dose

Summary

A clear dose-response relationship was demonstrated for the outcomes of fatal and non-fatal overdose.
A meta-regression was performed for pain, physical function, and gastrointestinal side effects that demonstrated no dose-response relationship with opioid dose and any of these three outcomes.
No evidence was found for a dose-response relationship between opioid dose and the outcomes of addiction and diversion. The studies that informed these two outcomes included patients on a variety of opioid doses. We therefore assume that the risks presented are applicable to all doses of opioids.
Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** No maximum opioid dose	**Absolute effect estimates** Limit opioid dose to a particular maximum dose	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Gastrointestinal side effects 5 Important	Relative risk 3.24 (CI 95% 2.69 - 3.89) Based on data from 17,463 patients in 54 studies. (Randomized controlled) Follow up 4-26 weeks	**28** per 1000	**91** per 1000 Difference: **63 more** per 1000 (CI 95% 47 more - 81 more)	**High**	Limiting opioid dose to a particular maximum dose may have little or no difference on gastrointestinal side effects

Pain 5 Important	Measured by: 10 cm VAS Scale: 0-10 Lower better Based on data from: 13,948 patients in 35 studies. (Randomized controlled) Follow up 3-6 months	cm (n/a) cm (n/a) Difference: **MD 0.71 fewer** (CI 95% 0.84 fewer - 0.58 fewer)	**High**	Limiting opioid dose to a particular maximum dose may have little or no difference on pain
Physical function 5 Important	Measured by: SF-36 physical component summary score Scale: 0-100 High better Based on data from: 12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months	(n/a) (n/a) Difference: **MD 2.16 more** (CI 95% 1.56 more - 2.76 more)	**High**	Limiting opioid dose to a particular maximum dose may have little or no difference on physical function
Fatal overdose 9 Critical	Based on data from 285,520 patients in 1 studies	Estimated annual fatal overdose rates were 0.10%, 0.14%, 0.18% , and 0.23% in patients receiving <20 mg morphine equivalent per day, 20-49 mg/day, 50-99 mg/day, and >100 mg per day respectively.	**High**	Limiting opioid dose to a particular maximum dose decreases the risk of fatal overdose
Non-fatal overdose 9 Critical	Based on data from 9,940 patients in 1 studies	Estimated annual overdose rates were 0.2%, 0.7%, and 1.8% among patients receiving less than 20 mg/d, 50 to 99 mg/d, and more than 100 mg/d of opioids, respectively.	**Moderate** Due to serious imprecision	Limiting opioid dose to a particular maximum dose decreases the risk of non-fatal overdose
Addiction 5 Important	Based on data from 22,278 patients in 9 studies	Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)	**Moderate** Due to serious inconsistency	Limiting opioid dose to a particular maximum dose may have little or no difference on addiction
Diversion 5 Important	Based on data from 472,200 patients in 1 studies	Among US adults, the prevalence of nonmedical use of prescription opioids was 4.9% (95% CI 4.58-5.22%) in 2013.	**Moderate** Due to serious risk of bias	Limiting opioid dose to a particular maximum dose may have little or no difference on diversion

Details about studies used and certainty down- and upgrading

Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies ;

Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Asymmetrical funnel plot, Mostly commercially funded studies ;
Physical function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Removed studies with SE>3 (small study effect) ;
Fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was the Ontario Drug Benefit Database, including Ontarians eligible for drug coverage. This population may be systematically different than other populations with chronic non-cancer pain. ; **Imprecision: No serious** **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Small number of events. ; **Publication bias: No serious**
Addiction	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: Serious** Point estimates vary widely (0.7%-15.7%) ; **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Diversion	**Intervention reference:** Primary study	**Risk of bias: Serious** Response rate of 66%. Outcome was self-reported. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**

Recommendation #7

Strong Recommendation

We recommend restricting the prescribed dose to under 90mg morphine equivalents daily rather than no upper, or a higher limit on dosing

Some patients may gain important benefit over 90mg morphine equivalents, but not on lower doses. Referral to a colleague for a second opinion regarding the possibility of increasing above 90mg morphine equivalents daily may therefore be warranted in some individuals

Rationale

Observational study results provide moderate quality evidence of a progressive increase in the likelihood of unintentional non-fatal overdose or death as the prescribed dose of opioids increases. These serious outcomes are very rare in those prescribed less than 50 morphine equivalents daily, but increase in those prescribed doses of 50 to 90, and though still rare, are very concerning in those prescribed doses of over 90

Clinical Question/ PICO

Population: Patients with chronic non-cancer pain beginning long-term opioid therapy

Intervention: Limit opioid dose to a particular maximum dose

Comparator: No maximum opioid dose

Summary

A clear dose-response relationship was demonstrated for the outcomes of fatal and non-fatal overdose.
A meta-regression was performed for pain, physical function, and gastrointestinal side effects that demonstrated no dose-response relationship with opioid dose and any of these three outcomes.
No evidence was found for a dose-response relationship between opioid dose and the outcomes of addiction and diversion. The studies that informed these two outcomes included patients on a variety of opioid doses. We therefore assume that the risks presented are applicable to all doses of opioids.
Minimally important difference for pain on a 10-cm visual analogue scale (VAS) is a reduction of 1 cm.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** No maximum opioid dose	Limit opioid dose to a particular maximum dose	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Gastrointestinal side effects 5 Important	Relative risk 3.24 (CI 95% 2.69 - 3.89) Based on data from 17,463 patients in 54 studies. (Randomized controlled) Follow up 4-26 weeks	**28** per 1000	**91** per 1000 Difference: **63 more** per 1000 (CI 95% 47 more - 81 more)	**High**	Limiting opioid dose to a particular maximum dose may have little or no difference on gastrointestinal side effects
Pain 5 Important	Measured by: 10 cm VAS Scale: 0-10 Lower better Based on data from: 13,948 patients in 35 studies. (Randomized controlled) Follow up 3-6 months	cm (n/a)	cm (n/a) Difference: **MD 0.71 fewer** (CI 95% 0.84 fewer - 0.58 fewer)	**High**	Limiting opioid dose to a particular maximum dose may have little or no difference on pain
Physical function 5 Important	Measured by: SF-36 physical component summary score Scale: 0-100 High better Based on data from:	(n/a)	(n/a) Difference: **MD 2.16 more** (CI 95% 1.56 more - 2.76 more)	**High**	Limiting opioid dose to a particular maximum dose may have little or no difference on physical function

	12,058 patients in 33 studies. (Randomized controlled) Follow up 1-6 months			
Fatal overdose 9 Critical	Based on data from 285,520 patients in 1 studies	Estimated annual fatal overdose rates were 0.10%, 0.14%, 0.18% , and 0.23% in patients receiving <20 mg morphine equivalent per day, 20-49 mg/day, 50-99 mg/day, and >100 mg per day respectively.	**High**	Limiting opioid dose to a particular maximum dose decreases the risk of fatal overdose
Non-fatal overdose 9 Critical	Based on data from 9,940 patients in 1 studies	Estimated annual overdose rates were 0.2%, 0.7%, and 1.8% among patients receiving less than 20 mg/d, 50 to 99 mg/d, and more than 100 mg/d of opioids, respectively.	**Moderate** Due to serious imprecision	Limiting opioid dose to a particular maximum dose decreases the risk of non-fatal overdose
Addiction 5 Important	Based on data from 22,278 patients in 9 studies	Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)	**Moderate** Due to serious inconsistency	Limiting opioid dose to a particular maximum dose may have little or no difference on addiction
Diversion 5 Important	Based on data from 472,200 patients in 1 studies	Among US adults, the prevalence of nonmedical use of prescription opioids was 4.9% (95% CI 4.58-5.22%) in 2013.	**Moderate** Due to serious risk of bias	Limiting opioid dose to a particular maximum dose may have little or no difference on diversion

Details about studies used and certainty down- and upgrading

Gastrointestinal side effects	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies ;
Pain	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Asymmetrical funnel plot, Mostly commercially funded studies ;
Physical function	**Intervention reference:** Systematic review **Baseline/comparator reference:** Control arm of reference used for intervention	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious** Mostly commercially funded studies, Removed studies with SE>3 (small study effect) ;

Fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** Study setting was the Ontario Drug Benefit Database, including Ontarians eligible for drug coverage. This population may be systematically different than other populations with chronic non-cancer pain. ; **Imprecision: No serious** **Publication bias: No serious**
Non-fatal overdose	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Small number of events. ; **Publication bias: No serious**
Addiction	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: Serious** Point estimates vary widely (0.7%-15.7%) ; **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Diversion	**Intervention reference:** Primary study	**Risk of bias: Serious** Response rate of 66%. Outcome was self-reported. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**

2 - Rotation and Tapering of Opioids, for Patients with Chronic Non-Cancer Pain

Recommendation #8

For patients currently using 90 mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects

Weak Recommendation

We suggest rotation to other opioids rather than keeping the opioid the same

Rotation in such patients may be done in parallel with, and as a way of facilitating, dose reduction

Rationale

Low quality evidence suggests that substitution of an alternative opioid can reduce pain and adverse effects in patients with chronic non-cancer pain using opioids.

Clinical Question/ PICO

Population: PICO 8: Patients with chronic non-cancer pain with persistent problematic pain and/or problematic side effects
Intervention: Rotation to other opioids
Comparator: No change in opioid therapy

Summary

Minimally important difference for pain on a 11 point Numeric Pain Rating Scale (NRS) is a reduction of 2 points.
Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** No change in opioid therapy	Rotation to other opioids	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Pain 9 Critical	Based on data from 524 patients in 5 studies	Mean change score on 11 point numeric rating scale was -3.3 (95% CI -3.5 to -3.1)		**Low**	Rotation to other opioids may improve pain
Physical function 9 Critical	Based on data from 206 patients in 2 studies	Mean change score of SF-36 physical function subscale was 16.7 (95% CI 15.0-18.4)		**Low**	Rotation to other opioids may improve physical function

Success of opioid rotation 9 Critical	Based on data from 349 patients in 4 studies	Across 4 studies, 253 out of 349 patients (72.5%) successfully rotated opioids.	**Moderate** Due to serious indirectness	Success of opioid rotation is probably high in this patient population.
Addiction 5 Important	Based on data from 167 patients in 2 studies	Choquette (2008) reported no spontaneous reports of abuse or addiction. Quang-Cantagrel (2000) reported one case of addiction.	**Moderate** Due to serious indirectness	Rotation to other opioids probably has little or no difference on risk of addiction.
Diversion 5 Important	Based on data from 48 patients in 1 studies	Four patients (8.3%) failed treatment due to drug diversion.	**Moderate** Due to serious imprecision	Rotation to other opioids probably has little or no difference on risk of diversion
Gastrointestinal side effects 5 Important	Based on data from 610 patients in 6 studies	Risk of nausea was 21% (95% CI 9.0-33.1%) and risk of constipation was 17.6% (95%CI 12.6-22.5%).	**Very Low** Due to serious risk of bias	We are uncertain whether rotation to other opioids improves or worsen gastrointestinal side effects.

Details about studies used and certainty down- and upgrading		
Pain	**Intervention reference:** Systematic review	**Risk of bias: No serious** Included studies lacked a comparison group. Galvez (2013) had 25% loss to follow up for efficacy outcomes, and Choquette (2008) had 24% loss to follow up for efficacy outcomes. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Physical function	**Intervention reference:** Systematic review	**Risk of bias: No serious** Included studies lacked a comparison group. Galvez (2013) had 25% loss to follow up for efficacy outcomes, and Choquette (2008) had 24% loss to follow up for efficacy outcomes. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**
Success of opioid rotation	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Serious** Success of rotation was not measured in the same way in each study: two studies (Malinoff and Rhodin) defined as “not discontinuing therapy” (ie, lack of efficacy or intolerable adverse events); Choquette and Galvez included patients enrolled in a trial, and counted success as “not discontinuing the trial” which included lack of efficacy and adverse events, but also “noncompliance” and “withdrawn consent”. ; **Imprecision: No serious** **Publication bias: No serious**

Addiction	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Serious** Choquette (2008) relied on patients to "spontaneously" report addiction, and only followed patients for 2 months. ; **Imprecision: No serious** **Publication bias: No serious**
Diversion	**Intervention reference:** Primary study	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Low number of patients ;
Gastrointestinal side effects	**Intervention reference:** Systematic review	**Risk of bias: Serious** Included studies lacked a comparison group. ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: No serious** **Publication bias: No serious**

Recommendation #9

For patients currently using 90 mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects

Weak Recommendation

We suggest tapering opioids to the lowest possible dose, including discontinuation, rather than no change in opioid therapy

Some patients are likely to experience significant increase in pain or decrease in function that persist more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients.

Rationale

Reduction in opioid dose may reduce adverse effects including cognitive impairment and the likelihood of non-fatal or fatal unintentional overdose. Reduction, particularly if not done very slowly, may cause increased pain, decreased function, or highly aversive symptoms of opioid withdrawal.

Clinical Question/ PICO

Population: PICO 9: Patients with chronic non-cancer pain on opioids with persistent problematic pain
Intervention: Tapering of opioid
Comparator: Keeping the dose of opioid the same

Summary

Minimally important difference for pain on a 11 point Numeric Pain Rating Scale (NRS) is a reduction of 2 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** Keeping the dose of opioid the same	Tapering of opioid	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Pain 5 Important	Based on data from 73 patients in 2 studies	Baron 2006 (n=23): Pain was reduced from mean (SD) of 8.00 (0.30) at baseline to 3.35 (0.33) at 6 months. Harden 2015 (n=50): 40% of patients reported less pain, 28% reported no change, and 33% reported more pain after tapering.		**Very Low** Due to serious risk of bias, Due to serious imprecision	We are uncertain whether tapering of opioid improves or worsen pain
Success of tapering and end dose 9 Critical	Based on data from 73 patients in 2 studies	Baron 2006 (n=23): 100% of patients successfully tapered opioids. Harden 2015 (n=50): 47 out of 50 (94%) of patients successfully tapered opioids.		**Low** Due to serious indirectness, Due to serious imprecision	Success of tapering may be high in this patient population.

Details about studies used and certainty down- and upgrading		
Pain	**Intervention reference:** Primary study	**Risk of bias: Serious** Two out of three studies (Baron, Harden) implemented tapering strategy without a comparison group ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Small number of patients. ;
Success of tapering and end dose	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: Serious** These two studies defined “success of tapering” differently. Baron 2006 enrolled patients into a voluntary inpatient “detoxification” program intended to taper off of prescription opioids if the patient or physician felt that the patient was not getting benefit from high doses of opioids. No patient was referred for diversion, overuse, abuse, or addiction to opioids. The goal of the program was to taper patients completely off opioids. Harden 2015 included patients drawn from a list of patients initiated on an opioid taper at a VA medical centre. A taper was considered successful if the patient’s dose at 12 months was less than the baseline dose. ; **Imprecision: Serious** Small number of patients. ;

Recommendation #10

Patients using opioids and experiencing serious challenges in tapering

Strong Recommendation

We recommend a formal multidisciplinary opioids reduction program

Recognizing the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration including several health professionals (possibilities include, but are not limited to, a primary care physician, a pharmacist, a physical therapist, a kinesiologist, a psychiatrist, and a psychologist).

Rationale

Studies provide moderate quality evidence that, in patients desiring a reduction or discontinuation of opioid therapy but experiencing serious challenges in tapering or discontinuing therapy, multi-disciplinary programs can substantially increase the likelihood of successful reduction or discontinuation.

Clinical Question/ PICO

Population: PICO 10: Patients who want to taper opioids who are above the threshold dose
Intervention: Multidisciplinary Program
Comparator: No Multidisciplinary Program

Summary

In the Krumova study, 24 out of 102 patients did not completely taper but reduced dose from a mean(SD) 366.5 (524) MED to 72.6 (53.2) MED. 6 patients returned to higher doses of opioids within 12-24 months.
In the Hooten study, 2 out of 101 patients did not completely taper. One patient reduced dose from 422 MED to 22 MED; the second patient reduced dose from 365 MED to 24 MED. Minimally important difference for pain on a 11 point Numeric Pain Rating Scale (NRS) is a reduction of 2 points. Minimally important difference for physical function on a 100 point SF-36 physical component summary score is an increase of 5 points.

Outcome Timeframe	**Study results and measurements**	**Absolute effect estimates** No Multidisciplinary Program	Multidisciplinary Program	**Certainty in effect estimates** (Quality of evidence)	**Summary**
Pain 5 Important	Based on data from 102 patients in 1 studies	Pain was reduced from 7.1 (1.8) at baseline to 5.9 (2.3) at follow up.		**Very Low** Due to serious risk of bias, Due to serious imprecision	We are uncertain whether multidisciplinary programs improve or worsen pain.
Success of tapering 9 Critical	Based on data from 203 patients in 2 studies	Krumova 2013: 78 out of 102 (76.5%) successfully tapered odd opioids in a mean of 22 days. 31 reinitiated opioid treatment within 12-24 months. Hooten 2010: 99 out of 101 (98%) patients successfully tapered off opioids.		**Moderate** Due to serious imprecision	Success of tapering is probably high with multidisciplinary programs.

Physical Function 5 Important	Based on data from 102 patients in 1 studies	Physical function improved from 26.1 (7.7) at baseline to 27.8 (9.8) at follow up.	**Very Low** Due to serious risk of bias, Due to serious imprecision	We are uncertain whether multidisciplinary programs improve or worsen physical function
Details about studies used and certainty down- and upgrading				
Pain	**Intervention reference:** Primary study	**Risk of bias: Serious** Studies lacked a comparison group ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Small number of patients. ;		
Success of tapering	**Intervention reference:** Systematic review	**Risk of bias: No serious** **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Small number of patients. ;		
Physical Function	**Intervention reference:** Systematic review	**Risk of bias: Serious** Studies lacked a comparison group ; **Inconsistency: No serious** **Indirectness: No serious** **Imprecision: Serious** Small number of patients. ;		

References

[1]

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Joint Statement of Action to Address the Opioid Crisis
November 19, 2016

The Royal College of Dental Surgeons of Ontario commits to:

- **By December 2017:** Requesting and reviewing Narcotics Monitoring System data for opioid prescriptions by dentists and dental specialists for the calendar year 2016 and comparing this data to that received for the calendar year 2014 to assess the impact of the Guidelines on the Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice (published in 2015).

David Mock, Professor
for
Irwin Fefergrad, Registrar

RCDC
THE ROYAL COLLEGE OF DENTISTS OF CANADA

January 30, 2017

Dr. James Taylor
Chief Dental Officer of Canada
Public Health Agency of Canada
Government of Canada

Re: Joint Statement of Action to Address the Opioid Crisis

Dear Dr. Taylor,

The Royal College of Dentist of Canada Commits to:

- Engage all chief examiners and examination teams, in all disciplines, to ensure that candidates for examination possess knowledge of current best practices of safe opioid prescribing.

- The development and implementation of a communication plan to disseminate knowledge of current best practices for safe opioid prescribing to Members and Fellows of The Royal College.

Sincerely,

Dr. Christopher Robinson
President

Peter McCucheon
Executive Director

2404 - 180 Dundas St. W., Toronto, Ontario, Canada, M5G 1Z8 | tel 416.512.6571 | fax 416.512.6468 | www.rcdc.ca

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1815 Alta Vista Drive
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613-523-1770
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Alberta Dental Association and College

British Columbia Dental Association

Manitoba Dental Association

New Brunswick Dental Society / Société dentaire du Nouveau-Brunswick

Newfoundland & Labrador Dental Association

Northwest Territories & Nunavut Dental Association / Yukon Dental Association

Nova Scotia Dental Association

Ontario Dental Association

Dental Association of Prince Edward Island

The College of Dental Surgeons of Saskatchewan

February 24, 2017

Dr. James Taylor
Chief Dental Officer of Canada
Public Health Agency of Canada
785 Carling Ave
Ottawa, ON K1A 0K9

Dear Colleague:

As a follow-up to the work initiated at the National Opioid Summit last November, The Canadian Dental Association is proud to make the following commitment:

The Canadian Dental Association commits to

Continuing to create and disseminate educational tools, through both its electronic and paper vehicles, that inform dentists of the dangers related to opioid abuse as well as best practices for pain control in their patients.

We thank you for your support in this matter,

Sincerely,

Dr. Larry Levin
President-Elect

APPENDIX H

Canadian Association of Orthodontists
Association canadienne des orthodontistes
Your Smile is Our Specialty

2800 14th Avenue, Suite 210, Markham, Ontario L3R 0E4
Telephone: 416-491-3186 | Toll Free: 1-877-CAO-8800
Fax: 416-491-1670 | Email: cao@associationconcepts.ca

March 31, 2017

MEMO

FROM: **Dr. Bob Kinniburgh, President**
Canadian Association of Orthodontists

Re: **SmileDirect Club**

With the evolution of technology and alternative delivery methods of orthodontic care, it is incumbent upon the Canadian Association of Orthodontists (CAO) to create awareness to the possibility of the infiltration of mail order, direct-to-consumer aligner systems into the Canadian marketplace. These systems have potential to provide orthodontic treatment without clinical examination or supervision by a licensed dental professional.

Currently in the Unites States, the most prominent direct-to-consumer aligner company is SmileDirectClub (SDC). To start treatment with SDC, the customer completes an online questionnaire and purchases an impression starter kit. Polyvinyl siloxane impressions are then taken by the patient. Intraoral photographs taken by the customer are uploaded to the company website. Alternatively, the patient can have a digital impression scan at a regional "scanning center", again, without the supervision of a licensed dental professional.

SDC and their investors may see the Canadian market as an opportunity in the near future. This system of delivery of orthodontic care raises numerous questions for the provincial licensing bodies and other stakeholders. Does this system of delivery of dental services comply with respective provincial health acts? What are the legal concerns in licensure of reviewing dental professionals out of province or country? Do the dental professionals involved have coverage for this service through malpractice insurance? What standard of care would courts apply to a dental professional involved? Will insurance carriers receive claims from these organizations or patients receiving this service? What protection do the patients have from malpractice with this mode of delivery of care?

Any time an orthodontic procedure is undertaken by an untrained individual or without professional supervision, there is a substantial risk for irreparable damage. The CAO is committed to the health and safety of the public. Consumers of this product are not aware of the risks. The risks associated with the direct-to-consumer orthodontics are predictable

and it is incumbent upon the provincial licensing bodies to be proactive in the prevention of unsupervised delivery of orthodontic care for the protection of the public. The CAO will continue to educate the public on the dangers of do-it-yourself and direct-to-consumer orthodontic care.

The CAO hopes awareness of the pending introduction of direct-to-consumer orthodontic care to Canada will allow provincial DRA's to create and support existing legislation for protection of the public and their members in the utilization of direct-to-consumer orthodontic treatment.

Respectfully,

Dr. Robert Kinniburgh
President, Canadian Association of Orthodontists

cc:

Registrars - Provincial DRA's
President, CDRAF
Dr. Randall Croutze, CDA President
Mr. Jean-Claude Boivin, CDA Executive Director
Presidents, Provincial Orthodontic Component Societies
Dr. Ernest Lam, CDSA President
Health Canada

APPENDIX I

ASSOCIATION of CANADIAN FACULTIES of DENTISTRY
L'ASSOCIATION des FACULTÉS DENTAIRES du CANADA

February 14, 2017

Dr. Cliff Swanlund
President
Canadian Dental Regulatory Authorities Federation
6 Crescent Road
Toronto, ON M4W 1T1

Dear Dr. Swanlund:

On behalf of the Association of Canadian Faculties of Dentistry (ACFD), it is my pleasure to invite you to the 2017 ACFD/AFDC Biennial Conference to be held June 12th to 14th, 2017 in Quebec City. The theme of the Conference is *"The Challenges and Opportunities of Implementing the ACFD Educational Framework for the Development of Competency".*

The Conference will be held at the Fairmont Le Château Frontenac and hosted by Université Laval. A block of rooms has been reserved at the hotel. Please complete the attached reservation form and the ACFD will add your name to the rooming list. While the ACFD will cover the costs of the educational and social activities, we regret it cannot cover travel and hotel expenses. The Preliminary Program is also attached.

We would also like to provide you with the opportunity to submit a report on the Canadian Dental Regulatory Authorities Federation activities of interest to the ACFD for the Annual General Meeting. We would appreciate receiving a written submission by April 30, 2017 for inclusion in the resource material for the meeting.

As always, the ACFD looks forward to continued interaction with the Canadian Dental Regulatory Authorities Federation and hopes that you will be available to attend the Conference.

Please confirm your attendance at the Conference by returning the enclosed registration form **by March 31, 2017**.

Yours sincerely,

Paul Allison
President

Encl. Registration Form
Preliminary Program

cc: Dr. Diane Legault, Executive Director

Suite / bureau 350, 2194 Health Sciences Mall
Vancouver, BC V6T 1Z3
Telephone / Téléphone : (604) 827-1083
Facsimile / Télécopieur : (604) 822-4532
www.acfd.ca

Sherban, Angie

Subject: FW: Registration CCSA November convention

http://www.ccsa.ca/Eng/newsevents/Issues-of-Substance-Conference/Registration/Pages/default.aspx

Registration

Join addictions workers, healthcare professionals, researchers, knowledge brokers, policy and decision makers for presentations and interactive learning workshops at Canada's premier national conference for the addiction field. All registrants — with the exception of exhibit display staff — are entitled to:

- Attend all sessions
- Three continental breakfasts, two lunches and break refreshments

Early Bird
Registered and paid by September 8, 2017

- Early Bird Registration: $795
- Early Bird Student Registration: $300

General
Registered and paid after September 8, 2017

- General Registration: $895
- General Student Registration: $400

To qualify for the student rate, students must provide proof of full-time registration as an undergraduate, Masters or doctoral student at a Canadian post-secondary institution in a program related to substance use, addiction or gambling. Please fax (613-565-2173) or email a letter from your dean indicating your student status to IOS@goldenplanners.ca.

Please note that oral, workshop and poster presenters are required to pay registration fees and must do so by **May 19** in order to secure their spot on the program.

Registration Dates & Deadlines

- March 1 — Registration Opens
- March 1 — Participant Subsidy Application Opens
- May 19 — Presenters' deadline to register
- June 30 — Deadline for Participant Subsidy Applications
- September 8 — Early Bird Registration Closes
- October 13 — Cancellation deadline
- November 9 — Registration transfer deadline
- November 10 — Online registration closes
- November 13 — Onsite registration

A limited number of financial subsidies of up to $1,000 are available. View information about conference subsidies.

REGISTER NOW

Have a question? Review our Frequently Asked Questions, or contact us using the IOS Information Request form.

Dr Diane Legault MBA
Executive Director
Canadian Dental Regulatory Authorities Federation

6 Crescent Road, 3rd Floor
Toronto, ON, M4W 1T1
Direct line : 438 502 3723
info@cdraf.org www.cdraf.org

Memorandum

Date : March 16, 2017

To/À : Dr. Cliff Swanlund, President, Canadian Dental Regulatory Authorities Federation (CDRAF)

Copy/Copie : Dr. Diane Legault, Executive Director, CDRAF
Ms. Monique Bouchard, FCDSA Secretariat

From/De : Mr. Khashayar Gharavi (Toronto '17), FCDSA President

Subject/Objet : **FCDSA Annual General Meeting and Planning Session**
June 13-14, 2017 – Fairmont Le Château Frontenac, Québec City

---

The Federation of Canadian Dentistry Student Associations (FCDSA) will hold its Annual General Meeting (AGM) on Tuesday, June 13, 2017 (8:30 am – 3:00 pm). The Council will hold a Planning Session on Wednesday, June 14, 2017 (9:00 am – 2:30 pm) followed by a short Council Meeting (2:45 – 3:00 pm). The meetings will be held at the Fairmont Le Château Frontenac, Québec City in conjunction with the Biennial Conference of the Association of Canadian Faculties of Dentistry (ACFD).

With this AGM, the FCDSA celebrates the 5th anniversary since its formation in June 2012! Detailed agendas and resources will be circulated to participants in the coming weeks.

On behalf of the FCDSA Council, I would like to extend to your organization an invitation to send one or two representatives to attend the FCDSA Annual General Meeting on Tuesday, June 13 and any of the three social events planned on Monday through Wednesday. Participants are asked to let us know on the Participation Form if they would like to attend. *If you are already planning on attending via the invitation from ACFD, you do not need to complete a second participation form, simply let us know you will be attending the AGM by sending an email to secretariat@fcdsa.ca.*

Meeting Sponsorship
We are happy to announce that CDSPI has once again generously agreed to sponsor the AGM, including funding for travel and accommodations of **two** representatives from each school. This year, along with inviting the FCDSA to hold its meetings during the ACFD biennial conference, ACFD is sponsoring the Planning Session. We thank both CDSPI and ACFD for their most generous support.

Organizing Committee
The program for the AGM will be developed by an Organizing Committee comprised of the members of the FCDSA Executive:

President	Khashayar Gharavi (Toronto '17)	khash.gharavi@gmail.com
Vice-President	Ivy Fangyu Lin (McGill '17)	ivy.lin@mail.mcgill.ca
Regional Councillor – Eastern	Kelsey Eatmon (Dalhousie '18)	kl678615@dal.ca
Regional Councillor – Central	Julie Delcorde (Toronto '18)	julie.delcorde@mail.utoronto.ca
Regional Councillor – Western	Kerri-Lyn Chong (UBC '18)	kerrilyn.chong@gmail.com

Travel/Accommodation
All participants (including Council members) are asked to arrange their own air/train travel. Participants should plan to **arrive on Monday, June 12, 2017 in time for the evening's events** (transportation to the event will leave the hotel at 5:00 pm sharp).

Hotel reservations for all attendees will be handled through the ACFD office in Vancouver. Depending on your travel itinerary, we will reserve a non-smoking room at the Château Frontenac. Confirmation numbers will be sent to you by email. All participants are responsible for paying their hotel bill upon checkout.

Please note that the hotel will request that you present a credit card upon check-in. Please complete the Accommodation section of the Participation Form so that we might make the needed hotel reservation.

Social Events
Université Laval is hosting a ***Pre-event Visit and Cocktail*** on Monday, June 12 at the Laval campus. Transportation has been arranged but participants wishing to attend must book in advance using the Participation Form. A ***Welcome Cocktail Reception*** will be held on Tuesday evening and the ***Conference Dinner*** will be held on Wednesday evening. If you wish to bring a guest to the Conference Dinner, there is a fee of $150. If you wish to bring a guest to all three social events, there is a fee of $350.00. ***For CDRAF, there is also the option of bringing a guest to the Welcome Reception and Conference Dinner for a fee of $200.*** Instructions can be found on the Participation Form. *Please complete the Social Events section of the Participation Form to reserve your space for these events.*

Insurance
FCDSA Council members and other guests travelling to the FCDSA meetings do so as representatives of their member association or other organization. As such, travellers should ensure that their organizations provide adequate insurance, including out-of-province medical insurance when needed. Please see the FCDSA Travel Expense Policy for more complete information on insurance.

Participation Form
Each participant, including each confirmed Council member, is asked to submit a Participation Form. **Please submit the completed and signed Participation Form to ACFD by March 31, 2017 at the latest.** *If you are already planning on attending via the invitation from ACFD, you do not need to complete a second participation form, simply let us know you will be attending the AGM by sending an email to secretariat@fcdsa.ca.*

Presentation to the AGM
The Council invites you to speak for up to 5 minutes during the AGM on recent events, initiatives and/or issues of concern related to your organization. Following the presentation, there will be a question period and an opportunity for everyone to share views and information. Of course, Council members will likely continue the conversation during coffee breaks, lunch and even following the meeting.

To provide Council members with more comprehensive background information on your organization, we invite you to send us a 1-2 page briefing document for circulation prior to the meeting. In addition, please let us know if you would like us to incorporate any PowerPoint presentation slides into the day's PowerPoint presentation.

We'd be most grateful if you could **let us know if you'd like someone from CDRAF to speak by May 5, 2017**. We'd also appreciate receiving any **briefing material by May 12, 2017**.

If you require any further information or assistance, please do not hesitate to contact me by email at president@fcdsa.ca or Ms. Bouchard at secretariat@fcdsa.ca or by telephone at 613-520-5001.

We look forward to hearing from you.

Encls: FCDSA Participation Form

Canadian Dental Association
Association dentaire canadienne
www.cda-adc.ca
1815 Alta Vista Drive
Ottawa ON K1G 3Y6
613-523-1770
info@cda-adc.ca

Alberta Dental Association and College

British Columbia Dental Association

Manitoba Dental Association

New Brunswick Dental Society / Société dentaire du Nouveau-Brunswick

Newfoundland & Labrador Dental Association

Northwest Territories & Nunavut Dental Association / Yukon Dental Association

Nova Scotia Dental Association

Ontario Dental Association

Dental Association of Prince Edward Island

The College of Dental Surgeons of Saskatchewan

February 6, 2017

Dr. Cliff Swanlund
President
Canadian Dental Regulatory Authorities Federation
6 Crescent Road
Toronto ON M4W 1T1

Dear Dr. Swanlund,

I write to you today to invite the Canadian Dental Regulatory Authorities Federation (CDRAF) to participate in the *Future of the Dental Profession* initiative that has recently been launched by the Canadian Dental Association (CDA), in conjunction with other, related, dental organizations. The anticipated product of this initiative is a report that we hope will be finalized by February 2018. CDA and those other related organizations have set up a 25-person Task Force to work to create this report.

Over the coming year, we can envisage potential avenues for CDRAF's involvement in this initiative, and we warmly welcome CDRAF's participation in ways that appear most appropriate to the leadership of your organization. In this light, I can share with you that we will be organizing a face-to-face meeting of the Task Force in November 2017 in Toronto and we would like to see a CDRAF representative at that meeting.

We have created four focused working groups that will analyze different issues that may have an impact on the Canadian oral health care sector between now and 2032, with an eye to making recommendations about positioning the profession to capitalize on the opportunities that those issues are likely to present. We would welcome ongoing dialogue between a designated representative of CDRAF and the members of those working groups over the coming year.

I look forward to hearing from you at your earliest convenience about potential next steps together towards shaping the future of a profession dedicated to the optimal oral health of Canadians.

Sincerely,

Dr. Larry Levin
President-Elect

RCDC

THE ROYAL COLLEGE OF DENTISTS OF CANADA

Dr. Diane Legault
Canadian Dental Regulatory Authorities Federation
6 Crescent Road
Toronto, ON M4W 1T1

March 29, 2017

Dear Dr.Legault,

Component II of the National Dental Specialty Examination, for all specialties, is being held at the Toronto Marriott Downtown Eaton Centre Hotel, 525 Bay St., Toronto, ON, from Friday June 16, 2016 until Monday June 26, 2017. You, or your designate, are invited to attend and observe the examination process.

Specialty-specific Examination Dates:

Date	Specialty
June 16 and 17, 2017	Prosthodontics and Pediatric Dentistry
June 18 and 19, 2017	Orthodontics
June 23, 2017	Periodontics
June 24, 2017	Periodontics and Oral Maxillofacial Radiology
June 25 and 26, 2017	Oral and Maxillofacial Surgery Endodontics, Oral Medicine and/or Oral Pathology

Please note that the examinations start daily at 8:00 am, and that breakfast and lunch will be provided.

A limited block of bedrooms at the Toronto Marriott Downtown Eaton Centre Hotel are being held at a rate of $193.61/night. Please note the rate is available until May 24, 2017. Should you wish to reserve a room, please enter the following link into your web browser to complete your reservation online:

http://cwp.marriott.com/yyzec/rcdc2017/

RCDC

THE ROYAL COLLEGE OF DENTISTS OF CANADA

If you prefer to make your reservation by phone, please call 1-800-905-0667.and quote the promotional group code RCA. No reservations will be made on your behalf by The Royal College of Dentists of Canada.

Please RSVP with the name of your representative(s) to Rose Zahraei at office@rcdc.ca. More detailed information will be provided once you have confirmed attendance.

Should you have any questions or require additional information please do not hesitate to contact me.

Yours sincerely,

Peter McCutcheon
Executive Director

APPENDIX J

Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

6 Crescent Road
Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814
Toll Free: 1.800.565.4591 www.rcdso.org

March 1, 2017

Via Email: drswanlu@telus.net

Dr. Cliff Swanlund
President
Canadian Dental Regulatory Authorities Federation

Dear Cliff,

I write following a recent meeting of the RCDSO Executive Committee in which concerns about current approaches and activities of the CDRAF were raised.

The RCDSO has, from the beginning of the CDRAF, been committed to, and supportive of, a national group for dental regulators. The desire to "create and maintain an effective forum for the exchange of information regarding regulatory trends, policy and legislation" continues to be important to us.

At this time, however, the RCDSO is concerned about the value received from CDRAF. Ontario's financial contribution is sizeable; we also provide huge amounts of staff support ranging from expert opinion to administrative support to website maintenance. Despite these contributions, it is hard for us to see a tangible return on that investment.

The lack of transparency is worrying. There are no management group meeting minutes available to us after August 29, 2016. The RCDSO has an obligation to reassure our nearly 10,000 members across the province that their money is being well spent – but in the case of CDRAF activities, the evidence is lacking.

The brief on Trade Agreements and International Mobility is a case in point. The issue is of critical interest to Ontario and the rest of the country. The brief was developed, researched and written by RCDSO members and staff, and presented to the CDRAF board in October – but not posted on the CDRAF website and therefore not available to Ontario dentists for nearly four months after delivery. This was not dealing with important issues in a timely way.

We have committed to paying our annual membership fees for this year and will, of course, make good on that commitment. However, I feel it is only fair to let you know that the Executive Committee will be looking closely at the value of a continued relationship with CDRAF and will make a recommendation to our Council in due course.

We believe in the CDRAF, but its activities need to be meaningful, with clear goals and delivered outcomes. I hope we can discuss how we can make this happen in the very near future.

Sincerely,

Dr. R.M. Yarascavitch

Dr. Ron Yarascavitch
President

c.: Irwin Fefergrad, Registrar, RCDSO
Dr. Diane Legault, Executive Director, CDRAF

AMS:709957

CDRAF
Canadian Dental Regulatory Authorities Federation

FCORD
Fédération canadienne des organismes de réglementation dentaire

MANAGEMENT GROUP
Dr. Cliff Swanlund, President
Dr. Barry Dolman, Vice-President
Dr. Nancy Auyeung, Treasurer

EXECUTIVE DIRECTOR
Dr. Diane Legault

MEMBERS
College of Dental Surgeons of British Columbia
Alberta Dental Association and College
College of Dental Surgeons of Saskatchewan
Manitoba Dental Association
Royal College of Dental Surgeons of Ontario
Ordre des dentistes du Québec
New Brunswick Dental Society
Provincial Dental Board of Nova Scotia
Dental Council of Prince Edward Island
Newfoundland and Labrador Dental Board

March 3, 2017

Dr. Ron Yarascavitch
President
Royal College of Dental Surgeons of Ontario

Dear Dr. Yarascavitch:

I thank you for your letter dated of March 1st, 2017 voicing your concerns about the CDRAF's membership value to your organization. Numerous CDRAF members have expressed the same over recent years. Those concerns actually triggered CDRAF's Board to engage in its first strategic planning exercise.

In my view, October's full-day session was a success of participation and commitment of DRA's. The Steering Committee met on February 23 and the meeting was productive. Its report will be circulated and discussed notably amongst the Management group and the Registrars in the coming weeks. The draft report will include a simpler mission statement, a unifying vision and it will reaffirm the guiding principles and working spirit animating CDRAF's table.

Of course, the core of the report will describe overarching goals from which an operational plan will be develop specifying detailed objectives and timelines all of which will be matched with budget.

I strongly believe that we can move forward creating value to all. This is the challenge before us and we have to succeed. We owe it to the Canadian population and our external partner dental organizations.

We are very grateful for RCDSO's contribution over the years and we are looking forward to your fulsome participation at our next Board meeting when strategic planning will be discussed. Your input, as always, is important.

Best regards,

Dr. Cliff Swanlund
President

From:	Diane Legault
To:	Fefergrad, Irwin
Cc:	Dr. Cliff Swanlund; Ron Yarascavitch; Sherban, Angie; Diane Legault Travail
Subject:	Follow-up on RCDSO/CDRAF latest correspondence
Date:	March 3, 2017 12:27:24 PM

Dear Irwin,

Following Dr. Ron's letter to Cliff I feel the need to address some of the issues raised. CDRAF pays and intends to pay all its bills (Web hosting, teleconferencing, translator services, auditors, banking, liability insurance, etc.). When I came aboard, clear instructions were given to CDRAF staff that it was expected that CDRAF be invoiced by RCDSO for any service, if any, rendered to us. Over the past year, we did get invoiced for courier services as an example. Irwin, if you are aware of any situation that is not concordant with these directives, I would please urge you to tell me so that we can fix it right away. It is important.

On another note, I was sorry to read about Dr. Ron's disappointment about the posting of the brief on the CDRAF website but I understand it. I could have posted the English version after the Board meeting but by courtesy to our French-speaking colleagues, I decided to share with them the translated version for feedback before I posted both versions at the same time. I thought doing otherwise, would send a wrong signal. It was my call. Like all other organizations, anything we can do to enhance our communications is a good idea. I am happy that the Steering Committee has included a goal on that specific issue in its report. Conversations on the topic with our colleagues will be helpful to make progress and meet expectations. Your thoughts?

On a more personal note, enjoy your well-deserved holidays.

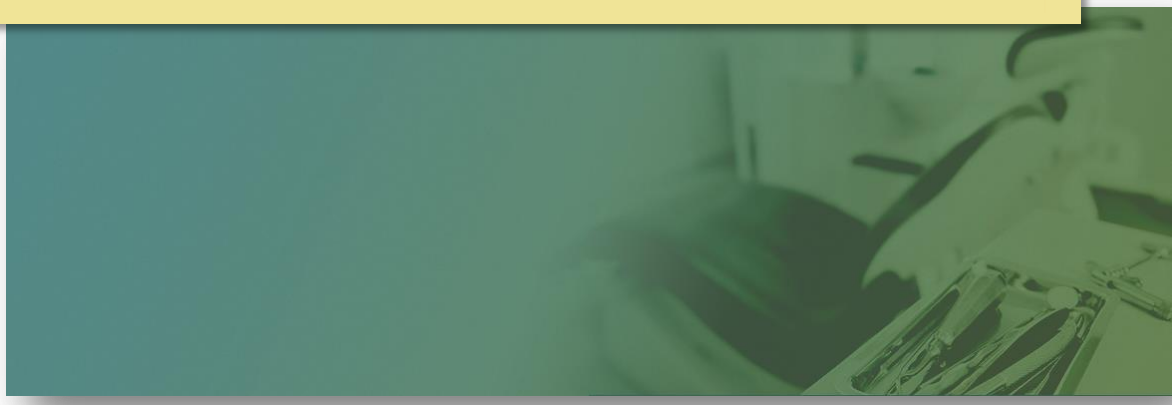
See you at the end of March and take good care Irwin. Get some rest :-)

Cheers,

Dr Diane Legault MBA
Executive Director
Canadian Dental Regulatory Authorities Federation

6 Crescent Road, 3rd Floor
Toronto, ON, M4W 1T1
Direct line : 438 502 3723
info@cdraf.org www.cdraf.org

2016 Annual Report



NDEB BNED

The National Dental Examining Board of Canada

Le Bureau national d'examen dentaire du Canada

Contents

Letter to Stakeholders 3

Message from the Executive Director 4

Year in Review 5

Looking Ahead 10

Who are we? 11

Strategic Priorities 11

NDEB Board 12

How we work 15

Our Team 17

What we do 18

- Certification Process 18
- Equivalency Process 19
- Dental Specialty Core Knowledge Examination 20

Financials 21

Letter to Stakeholders

Dear Stakeholders,

When I was elected President of the NDEB in October 2016, I was both honoured and humbled. It is not an overstatement to say that since I was appointed to the NDEB eight years ago my involvement with this organization has been life changing. Having had limited experience with organized dentistry before that point, I have been continually impressed by the collegial, collaborative, and constructive atmosphere the NDEB fosters.

Accompanying the honour and humility was a fair dose of fear and apprehension. The next couple of years will see some significant changes as we prepare to say goodbye to Dr. Jack Gerrow as Registrar and Executive Director. Dr. Gerrow has served this organization with incredible dedication for over 23 years, and the task of finding a replacement is not to be taken lightly. The Executive Committee spent a significant amount of time planning how to approach the search for Dr. Gerrow's replacement and we are grateful to all those who have helped. In December, the Executive Committee engaged an outside firm, Boyden Canada, to spearhead the search. It is the intent of the Committee to announce that the position has been filled by spring 2017.

At this point, I would be remiss if I did not recognize the contributions of others who have dedicated significant time and energy to the NDEB. Mrs. Margaret Wheaton has served as the NDEB's Public Representative for the past six years, ending her second term in October 2016. During her terms, she has provided insight into the NDEB's examination and assessment processes as a member of the Examinations Committee, and has contributed view point from outside the field of dentistry.

Also in October 2016, Dr. Melanie Wood and Dr. Pierre Duquette completed their terms as Chief Examiners for the Assessment of Fundamental Knowledge and Assessment of Clinical Judgement respectively. Drs. Wood and Duquette have devoted many years to this organization and I cannot thank them enough for their invaluable contributions to the examination and assessments processes.

This year also marks the end of Dr. William Judson's term on the Executive Committee as Past President and as the Board Member from Prince Edward Island. It has been a pleasure working alongside Dr. Judson and I look forward to working with him again as he begins his appointment to the Appeals Committee.

Lastly, I would like to extend a warm welcome to the NDEB's new Board Members, Drs. Anne Charbonneau and Martin Gillis from the Commission on Dental Accreditation, Dr. Ron Yarascavitch from the Royal College of Dental Surgeons of Ontario, Dr. Alan Robinson from the Dental Council of Prince Edward Island, and Ms. Polly Pachu as the Public Representative.

Looking ahead, it seems that 2017 will once again be defined by change. While change can present challenges, with the current supports in place, I am confident that the NDEB will have a positive and productive year.

Dr. Doug Mackey
President

Message from the Executive Director

The rapid growth the NDEB has experienced since the establishment of the Equivalency Process in 2011 has started to level off, but the decision to administer each of the assessments twice a year continues to put demands on the NDEB's resources. In 2016, the NDEB entered into a contract with the Business Sherpa Group to provide finance and human resources services on a part-time basis. These services have streamlined procedures and eliminated the requirement for a full time Director of Finance and Director of Human Resources.

In the fall of 2015, the NDEB adopted a new three-year strategic plan. Since then, the staff and Executive Committee have focused their efforts on the strategic initiatives identified in the plan. NDEB staff has updated the responsibility assignment to align with the revised structure and meets quarterly to monitor and evaluate progress against the initiatives identified in the plan.

I know that the NDEB will continue to be a progressive and respected organization.

In 2016, the operating surplus was remarkably close to the budgeted amount and was a large improvement from the operating deficit last year. With a number of significant one-time costs coming out of Internally Restricted Funds there was a slightly larger net deficiency than budgeted. The Finance and Audit Committee has worked diligently to develop options for ensuring long-term stability.

In October 2016, the NDEB held a standard setting workshop to establish revised passing standards for the Assessment of Fundamental Knowledge (AFK) and the Assessment of Clinical Judgement (ACJ). Revised passing standards will be recommended to the Board at the 2017 Annual Meeting.

The NDEB continues to take steps to help preserve the integrity of its examinations and assessments including changing assessment procedures, sending NDEB staff to every examination/assessment site, and limiting the types of material examinees are allowed to bring to examinations, assessments, and typodont viewings.

The last few years have been an extremely intense, challenging time as the NDEB grew exponentially and experienced issues associated with the growth. Moving forward, there are major decisions to make such as how to implement the Virtual OSCE, which direction our multiple databases should follow including how to handle electronic document management and selecting communications strategies for increasingly diverse and complex stakeholders. These decisions will affect the long-term success of the NDEB and should be made in conjunction with the NDEB Board by the individual/individuals who will be responsible for implementing the decisions. After careful consideration, it became obvious to me that I cannot be that individual and therefore I gave the NDEB notice of my intent to retire. The NDEB has been a significant and rewarding part of my life. It has been an honour to work with so many talented and dedicated people over the years. I know that the NDEB will continue to be a progressive and respected organization.

Jack D. Gerrow

Dr. Jack D. Gerrow
Executive Director & Registrar

Year in Review

Governance

In October 2016, the Board approved a number of changes to the By-laws including the addition of an independent Certified Chartered Accountant to the Finance and Audit Committee and significant changes to the election process for committee members. The newly adopted By-laws also outline the ramifications for individuals engaged in fraud or misconduct and include the ability to revoke the NDEB Certificate.

In early fall, the Nominating Committee canvassed and consulted with members of the Board to determine nominees for NDEB Standing Committees and the Public Representative position. Elections were held during the 2016 Annual Meeting and NDEB Committee members were appointed. The NDEB held a mail vote for the Public Representative in November 2016.

Over the last few years, there has been a small decrease in the number of participants taking the assessments. This coupled with a few significant one-time expenses, resulted in the NDEB drawing on its reserve funds. In September, the NDEB was served with a Judicial Review Application and several other participants have retained legal counsel with respect to their ACS results. In light of these and other circumstances, the Finance and Audit Committee spent significant time reviewing the NDEB's five-year financial projections and examined areas in which it could reduce costs. In order to cover legal costs and the ongoing operational costs of administering the examinations and assessments, the NDEB projects an annual fee increase over the next five years. The Finance and Audit Committee also recommended minor changes to the NDEB's financial policies that were approved at the Annual Meeting.

Communications

The NDEB recognizes the importance of communication with all of its stakeholders. In order to meet the rising demand for information and transparency, the NDEB has established a Communications Department. The Communications Department provides support to all operational areas of the NDEB, while focusing on stakeholder communications and meeting and workshop planning. The department is currently undertaking initiatives to improve, develop, and implement communications strategies with all stakeholders, including applicants, participants, and candidates.

The NDEB continues to work with the Dental Regulatory Authorities (DRAs) to ensure that the examination and assessment processes are fair and transparent. The NDEB has assisted, and will continue to support, the DRAs in providing accurate information to provincial Fairness Commissioners.

The NDEB launched its new website and created the NDEBulletin in January 2016. With over 1500 subscribers, the NDEBulletin is a tool used in conjunction with the NDEB news section of the website to broadcast NDEB information to a diverse audience. Subscription to the NDEBulletin is optional and accessible via the NDEB website.

Assessments and Examinations

Certification Process

In 2016, the NDEB administered the Written Examination and OSCE three times in various locations across Canada, the United States, Australia, and Ireland. Registration for the 2017 examinations opened in the fall of 2016. Registration is expected to decrease for the March administrations, as the University of Minnesota no longer requires its final year students to take the examinations. The pass rate over the past year remains within the normal range (Table 1). In 2016, the NDEB certified 1010 dentists.

Certification Process Pass Rate - 2016		
Examination	**# of candidates**	**% pass**
Written	1262	87
OSCE	1229	93

Table 1

Equivalency Process

In 2016, 1093 individuals applied to participate in the NDEB Equivalency Process. The number of applications to the Equivalency Process has remained relatively consistent over the past four years (Figure 1)

The Assessment of Fundamental Knowledge (AFK), Assessment of Clinical Skills (ACS), and Assessment of Clinical Judgement (ACJ) were administered twice in 2016 in multiple centres across Canada, in New Zealand, United Kingdom, and Hong Kong. The pass rates for the assessments are shown in Table 2.

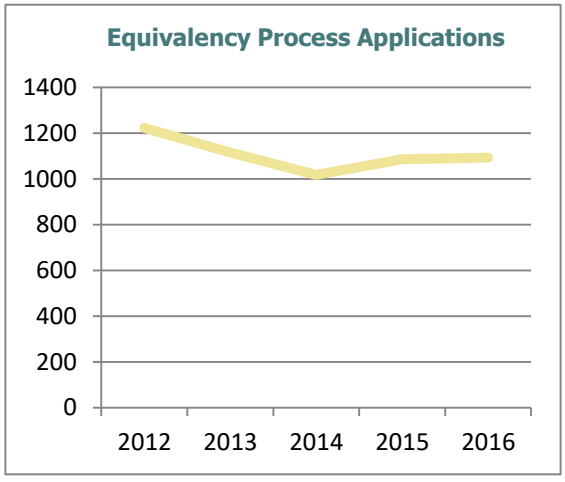


Figure 1

Equivalency Process Pass Rate - 2016		
Assessment	**# of participants**	**% pass**
AFK	1238	51
ACS*	373	39
ACJ*	358	76

** June assessments only*

Table 2

ACS Appeals

The number of participants taking the Assessment of Clinical Skills (ACS) has increased from 482 participants in 2013 to 750 participants in 2016. With the increased numbers comes an increased demand on the NDEB resources, particularly concerning appeals. To meet these demands, the NDEB routinely hires part-time employees to monitor typodont viewings.

The ACS Appeals Committee met six times in 2016 during which they reviewed 267 appeal submissions from the December 2015 and June 2016 ACS. A summary of the appeals is found in Table 3.

Appeal Date	Assessment Date	Total	Result
March 2016	December 2015	53	14 upheld 39 dismissed
April 2016	December 2015	58	9 upheld 49 dismissed
May 2016	December 2015	25	3 upheld 22 dismissed
September 2016	June 2016	65	7 upheld 58 dismissed
November 2016	June 2016	54	2 upheld 52 dismissed
December 2016	June 2016	1	0 upheld 1 dismissed

Table 3

The appeals process is continually evolving. Over the past year, the NDEB has begun to digitize all appeal documents, allowing for the electronic transmission of documents to both participants and Appeals Committee members. This has significantly reduced the time it takes to prepare appeal documentation for both participants and Appeals Committee members. The NDEB has also committed to recording and analyzing more appeal and typodont viewing data. This will be valuable when examining the ACS process including the calibration component of the ACS evaluation and appeals process.

In order to protect the integrity of its evaluation processes, the NDEB also regularly monitors trends and changes in technology that may be used to assist examinees in cheating or defrauding the system.

DSCKE

Prior to 2016, the Dental Specialty Core Knowledge Examination (DSCKE) was administered once a year. In 2016, the NDEB began administering the DSCKE twice a year at the NDEB office. This past year, participation in the DSCKE was slightly higher than in the past five years (Table 4). Combined, the February and September administrations had 25 participants. As in the past, the majority of the DSCKE participants specialize in orthodontics.

DSCKE Participants

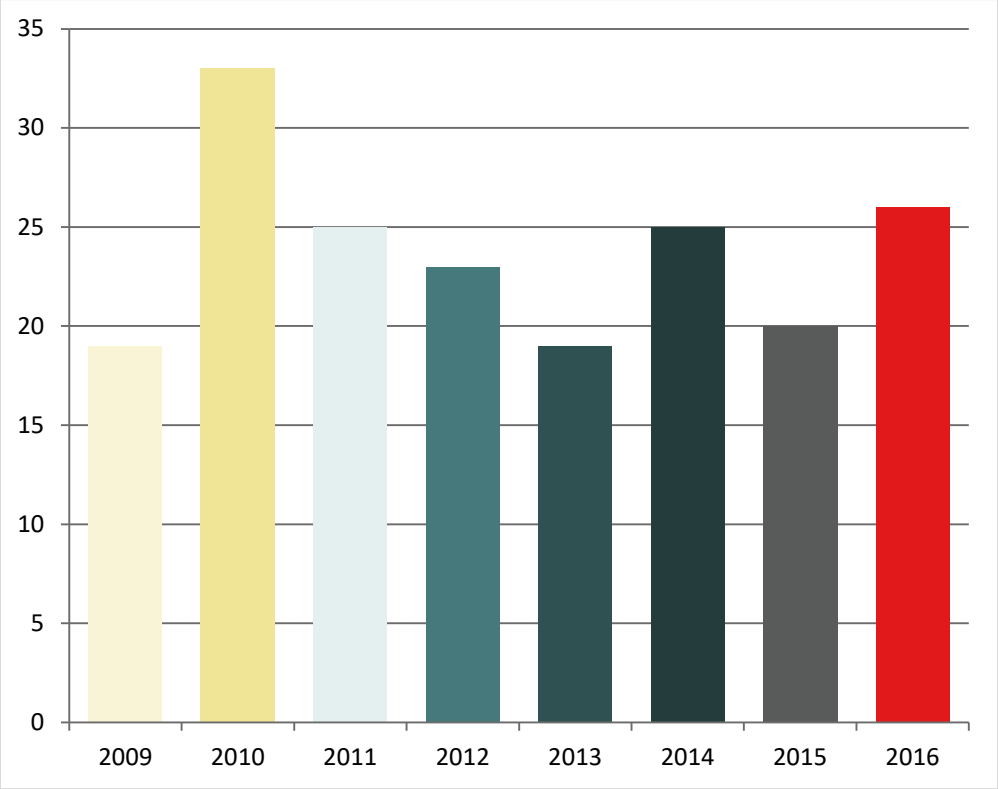


Table 4

DSCKE Stats 2015 – 2016		
Administration	**Range**	**Mean Score**
September 2015	65 – 86	73.5
February 2016	52 – 91	78.85
September 2016	64 – 95	80.5

Table 5

Virtual OSCE

In 2013, the NDEB began investigating the concept of electronic delivery for its assessments and examinations. While the NDEB's Written Examination and OSCE are internationally recognized as valid, reliable, and fair testing instruments for evaluating the competencies of beginning dental practitioners they have limitations. In an evolving profession, where sophisticated technology is present in all areas of dentistry, the NDEB made the decision to development a single examination to replace the Written Examination and OSCE and deliver it electronically. Development of the Virtual OSCE is now well underway with an expected implementation date in 2020. In 2016, the Examinations Committee recommended that the Virtual OSCE be completely computer or tablet based, with no physical models. The NDEB is currently investigating delivery mechanisms that will ensure reliability and consistency in examination sites across Canada and abroad.

This year, seven Virtual OSCE Question Development Workshops were held. Frameworks are being used to ensure consistency of the questions. The frameworks that have been developed are similar to OSCE templates except they contain an unlimited list of possible distractors. Content experts build frameworks, and workshop attendees are asked to bring cases and media (photos, radiographs, and 3D models) that match pre-developed frameworks resulting in high quality questions added to the Virtual OSCE question bank regularly. In addition, the provisionally approved blueprint is being used to help decide on subject areas for future workshops.

Research

The NDEB's Research Committee meets annually to provide input on NDEB documents such as the Technical Manuals, and to propose and conduct various research projects. Most recently the Committee drafted a post examination/assessment survey, created a research framework for a concurrent validity study, and reviews data collected for the integration into practice study.

In 2012, the NDEB and Alpine Testing Solutions conducted a study on the impact of releasing the Written Item bank questions on the website. This past year, two articles were published based on the results of this study.

Dr. Chad Buckendahl of Alpine Testing Solutions and Dr. Jack Gerrow wrote an article titled *Evaluating the Impact of Releasing An Item Pool On A Test's Empirical Characteristics*. The article was published in the Journal of Dental Education in October, 2016.

Dr. Jack Gerrow, Amanda A. Wolkowitz from Alpine Testing Solutions, and Susan L. Davis-Becker from 2ACS Ventures wrote a paper titled *Releasing Content to Deter Cheating: An Analysis of the Impact on Candidate Performance*. The paper was published in the Journal of Applied Testing Technology 2016.

Looking Ahead

The NDEB's strategic plan emphasizes the importance of strengthening communications with its various stakeholder groups. As part of this initiative, the NDEB will be implementing a post examination/assessment survey to gauge the experience of examinees participating in the examinations and assessments. This survey will gather information about the test experience from initial communication and registration through to administration and should provide valuable insight for the NDEB. The post examination survey is expected to be pilot tested in 2017.

In 2015, the NDEB conducted a practice analysis to determine the knowledge, skills, and abilities (KSAs) required of a beginning dental practitioner in Canada. The results of the practice analysis were then used to revise the blueprints for the NDEB's examinations and assessments. In 2017, the NDEB will be looking at the requirements for the Assessment of Clinical Skills (ACS) and determining if changes need to be made for future administrations.

The NDEB has commenced discussions with the Manitoba Dental Association (MDA) regarding the creation of central document repository. A one point of entry system for individuals is a federal and provincial government initiative and supported by fairness commissioners across the country. The NDEB is willing to assist the MDA and other provincial dental regulatory authorities with access to information to facilitate the licensure of dentists across the country. Over the next year, the NDEB will work with the MDA to finalize the agreement and establish an implementation plan including communication with applicants regarding permissions for sharing information.

The current online registration systems for the Certification Process and Equivalency Process were launched in 2010. As the NDEB continues to evolve, it became apparent that both the current online registration system and internal database no longer meet the needs of the organization. In 2017, the NDEB will work with BrightLink Technologies to develop a new online registration portal for graduates of accredited and non-accredited dental programs, and non-accredited specialty programs that will replace both the internal and external database systems. The NDEB expects the new online portal to be active by the end of 2017.

In January 2016, the NDEB launched its new website. Moving into 2017, the website will undergo a series of enhancements based on user feedback. Of particular interest will be the addition of a required documents by country section for Equivalency Process applicants. After an in-depth investigation, the Credential Verification and Program Services Department compiled a list of specific documents applicants are required to submit based on the country of graduation. To facilitate application to the Equivalency Process this list will be provided to applicants prior to submitting their documents. The NDEB intends to start with the addition of the top twenty countries from which it receives applications with the intent of adding countries regularly as information is verified.

Who are we?

Established by an Act of Parliament in 1952, The National Dental Examining Board of Canada (NDEB) is the organization responsible for establishing and maintaining a standard of competence for dentists in Canada.

Mission

To serve the Canadian public, dental regulatory authorities, and dental education institutions by providing a valid and reliable evaluation of competence for dentists in Canada.

Vision

To be the leader and respected authority in reliable and valid certification processes for general dentists.

Values

Integrity, objectivity, reliability, validity, fairness, ethicality, proactivity, transparency, and innovation

Strategic Priorities

In 2015, the NDEB adopted a new three-year strategic plan. The plan focuses on strategies in the areas of governance, communications, examinations/assessments, accreditation standards and reciprocal agreements, and credential verification.

Governance

- Provide financial stewardship.
- Monitor the implementation of strategic initiatives, and revise implementation plan as required.
- Maintain human resources processes consistent with legislative requirements and industry standards.

Communications

- Improve communications with Board members, chief examiners, and staff.
- Improve communications with dental profession.
- Develop strategy to communicate with federal and provincial governments.
- Represent the NDEB at the international level.
- Implement appropriate and effective public relations strategy.
- Improve communications with applicants, participants and candidates.
- Strengthen relationships with CDRAF, DRAs, ACFD, CDAC, FCDSA, and RCDC.
- Enhance a productive working relationship with CDA.

Examinations/Assessments

- Continue to promote validity, reliability and fairness of all examinations/assessments.
- Provide increased security for all examinations/assessments processes (development, administration, scores).
- Improve efficiency of examination and assessment processes.
- Develop and implement the new comprehensive integrated examination as a replacement for the Written Examination & OSCE.
- Develop and implement electronic delivery for AFK and ACJ.
- Review ACS appeals process.
- Review ACS requirements.

Accreditation standards and reciprocal agreements

- Support CDAC efforts to review and revise the dental accreditation process in Canada.
- Review the equivalence of accreditation processes recognized through reciprocal agreements.

Credential verification and examination/assessment services

- Continue implementing the best practices in credential verification.
- Facilitate access to examinations and assessments.

NDEB Board

The NDEB Board is composed of 12 members. Each Provincial Dental Regulatory Authority (DRA) appoints one member and two members are appointed by the Commission on Dental Accreditation of Canada (CDAC). In 2002, it was identified that there was a need for public representation on the Board. Due to existing legislation, the Public Representative is a non-voting member of the Board.

The Board meets two times a year in Ottawa.

Board Members 2015 – 2016

Sneha Abhyanakar, Member – Newfoundland and Labrador

- Practicing dentist
- Member of the NL Dental Association Continuing Education Committee
- Past President, NLDA
- NLDB member

Anne Charbonneau, Member – CDAC

- Practicing dentist
- Professor, Faculty of Dentistry - Université de Montréal
- ACFD representative to the CDAC

Randall Croutze, Member – Alberta

- Practicing dentist
- CEO and Registrar of the Alberta Dental Association and College
- President of the Canadian Dental Association

Dennis Fuchs, Member – Saskatchewan

- Practicing dentist
- Member of the Mediation Committee of the College of Dental Surgeons
- On the Board of Directors of the Broadway Professional Building Group

Martin Gillis, Member – Nova Scotia

- Practicing dentist
- Registrar for the Provincial Dental Board of Nova Scotia
- CDRAF representative to CDAC

Stefan Haas-Jean, Member – Quebec

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- Clinical Associate Professor at University of British Columbia
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- Practicing dentist

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- Practicing dentist
- Part time instructor at Dalhousie University Faculty of Dentistry
- Chair of the Mandatory Continuing Dental Education Committee

Amarjit Singh Rihal, Member – Manitoba

- Full time partner at Assiniboine Dental Group
- Clinical instructor and Didactic instructor at the University of Manitoba
- Chair, Commission on Dental Accreditation

Margaret Wheaton, Member – Public Representative

- B.S.P Univ. of Saskatchewan
- Public Representative, College of Dental Surgeons of Saskatchewan
- Past Chair, SCP Licensing and Policies Committee

Mary Ann Wiseman, President – New Brunswick

- Practicing dentist
- President of the Moncton Dental Society
- President of the New Brunswick Dental Society
- Member of numerous Committees of the NDEB MDS and NBDS

Ron Yarascavitch, Member – Ontario

- President of RCDSO
- Practicing dentist

How we work

The NDEB has six standing committees that report to the Board. The Board can establish ad-hoc committees as needed. The Research Committee is currently the only ad-hoc committee.

Standing Committees

Committee membership in 2015/2016 was as follows.

Executive Committee	Mary Anne Wiseman, President Doug Mackey, Vice President/Treasurer Dennis Fuchs, Member James Richardson, Member William Judson, Past President
Finance & Audit Committee	Doug Mackey, Chair Dennis Fuchs, Member James Richardson, Member

Examinations Committee	James Richardson, Chair Dennis Fuchs, Member Stefan Haas-Jean, (ODQ) Member Jane Hursin (ACFD) Member Cristina Ionescu (ODQ) Member Jim Lai (ACFD) Member Robert Love (DCNZ), Member Doug Mackey, Member
By-laws Committee	Doug Mackey, Chair Randall Croutze, Member Sneha Abhyankar, Member
Appeals Committee	Dave Scott, Chair Craig Myers, Vice-Chair Sneha Abhyankar, Member Maureen Bourgeois, Member Marcia Boyd, Member Janice Brennan, Member James Brown, Member Michaela Burley, Member Bruno Cabana, Member David Crocker, Member Paul Downing, Member Gorman Doyle, Member Derek Gaudes, Member Tana Gilmartin, Member William Judson, Member Jaques Laforce, Member Claude Lamarche, Member James Richardson, Member Denis Robert, Member Conrad Sirois, Member Randy Warkington, Member
Nominating Committee	William Judson, Chair Mary Ann Wiseman, Member

Our Team

Executive Team

Executive Director & Registrar	Jack Gerrow
Director of Examinations & Credential Verification	Marie Dagenais
General Counsel & Director of Administration and Governance	Steven Pink
Director of Finance	Jenny Patterson
Human Resources	Christine Desbiens

Operations

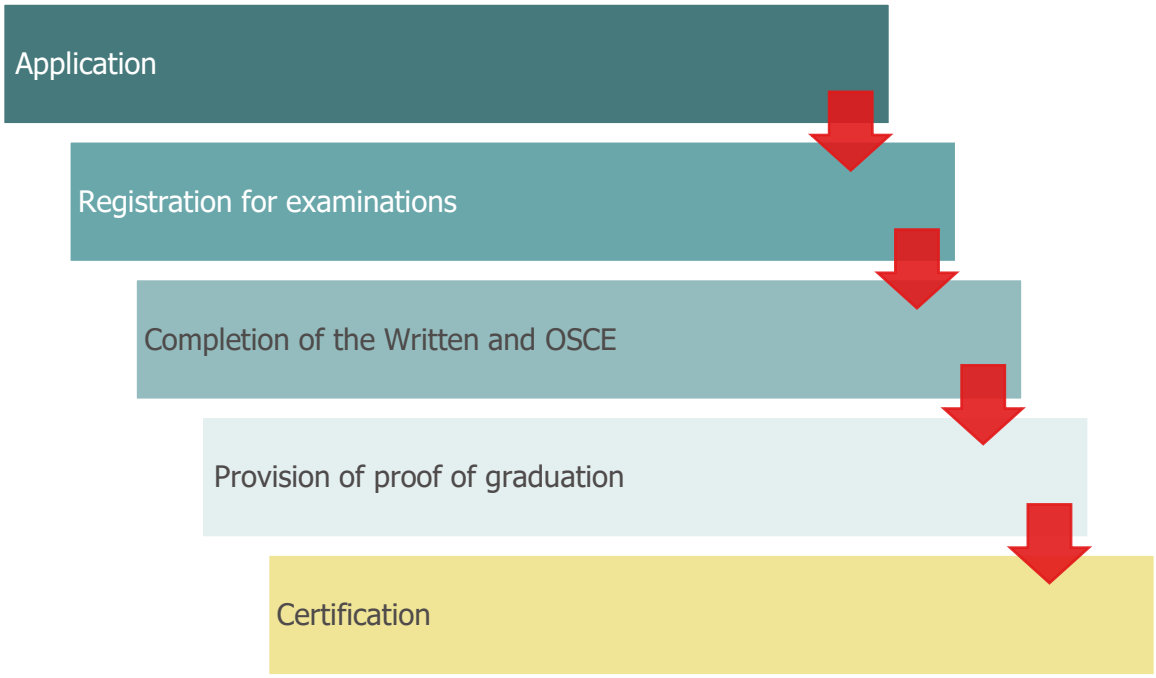
Manager – Examinations	Judy Banke
Coordinator – Examinations	Roxanne Barre
Coordinator, Examinations	Rita Bertola
Team Lead – Program Services	Julia Brown
Assistant – Examinations	Lisette Dean
Coordinator – Assessment of Clinical Judgement	Jennifer Della Valle
Receptionist	Nikki Devine
Administrator – Credential Verification & Program Services	Victoria Dulmage
Electronic Exam Analyst	Karen Frost
Coordinator – Credential Verification	Leah Gunnell
Coordinator – Program Services	Lora Gut
Senior Systems Analyst	Robert Lussier
Accountant	Travis MacCuish
Manager – Communications	Kim Phillips
Manager – Credential Verification & Program Services	Rachel Pyka
Coordinator – Assessment of Fundamental Knowledge	Sophie Raniere
Coordinator – Assessment of Clinical Skills	Sarah Rennick
Coordinator – Program Services, Assessment of Clinical Skills	Lara Sabraoui
Team Lead - Credential Verification	Jennifer Sponchia
Manager – Assessments	Chelsea Worthmann
Information Systems Analyst	Tony Wang

What we do

Certification Process

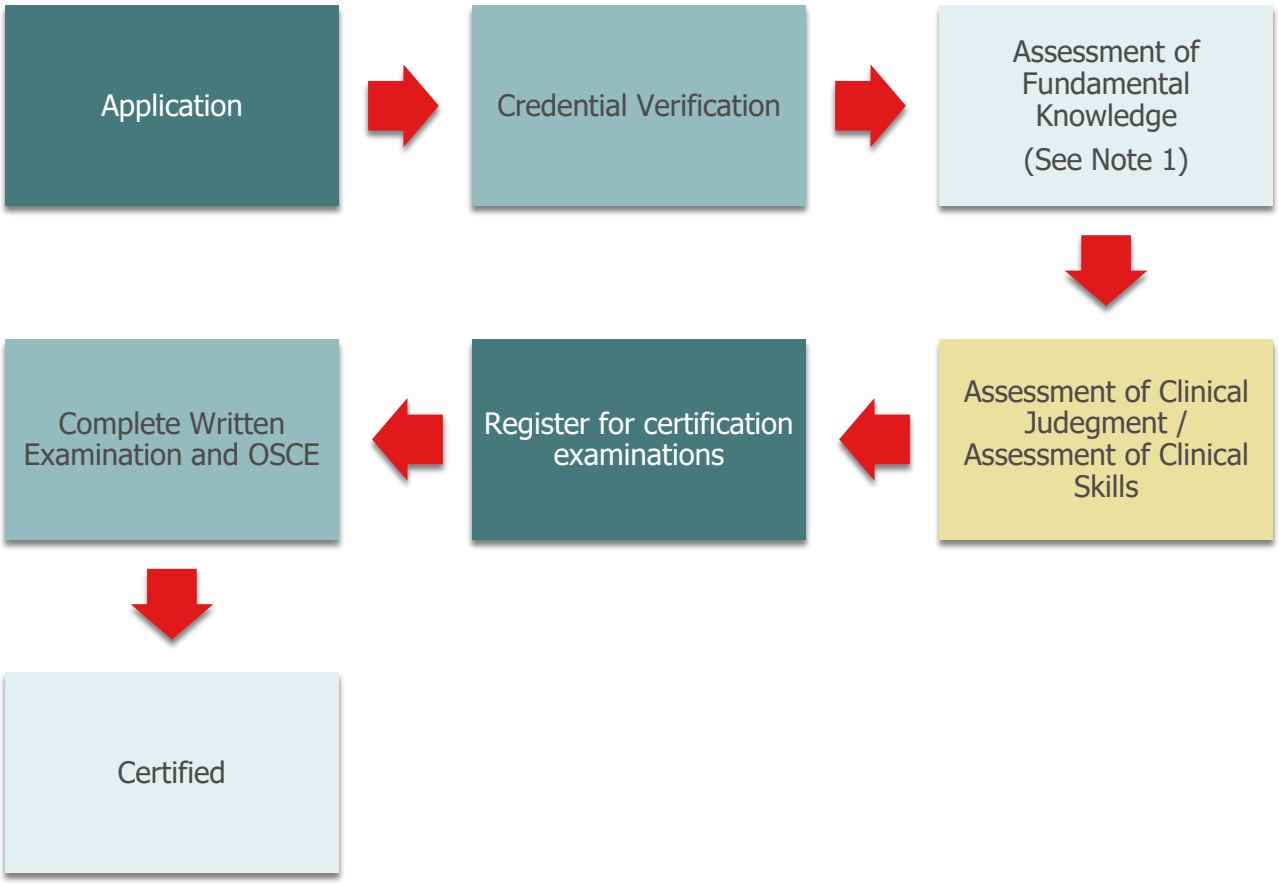
To become a licensed dentist in Canada, graduates of accredited dental programs must successfully complete the National Dental Examining Board of Canada's (NDEB) Certification Process. The Certification Process comprises two examinations; the Written Examination and the OSCE. The examinations are based on the competencies expected of a beginning dental practitioner in Canada. Detailed descriptions of both the Written Examination and OSCE can be found on the NDEB website under Accredited Programs.

Pathway to certification – Graduates of Accredited Dental Programs



Equivalency Process

Graduates of non-accredited dental programs who want to be certified as general dentists in Canada must successfully complete the NDEB Equivalency Process or an accredited Qualifying/Degree Completion Program prior to being eligible for participation in the Certification Process. The Equivalency Process includes three assessments. Details of each of the assessments can be found on the NDEB website under Non-Accredited Programs.



Note 1: The Assessment of Fundamental Knowledge (AFK) is an admission requirement for accredited Qualifying/Degree Completion Programs. Individuals who complete an accredited Qualifying/Degree Completion Program enter the Certification Process as a graduate of an accredited program.

In 2014, the NDEB signed an agreement with the Dental Council – New Zealand to administer the Equivalency Process for graduates of non-accredited dental programs seeking licensure as general dentists in New Zealand. Beginning in 2015, the Equivalency Process assessments could be administered in New Zealand should the minimum number of registrations be received. Canadian Faculties of Dentistry also use the results of select assessments in the Equivalency Process as part of the admission process for the two year Qualifying/Degree Completion Programs. To facilitate this process, the NDEB sends the results of each assessment to faculties of dentistry that offer a Qualifying/Degree Completion Program.

Dental Specialty Core Knowledge Examination

Graduates of non-accredited dental specialty programs who are interested in becoming licensed specialists in Canada may apply to take the Dental Specialty Core Knowledge Examination (DSCKE). The DSCKE is a tool used by accredited specialty programs to evaluate individuals for admission to the Dental Specialty Assessment and Training Programs.

In order to participate in the DSCKE, applicants must show that they have graduated from a dental specialty program in a university that is sanctioned by the government of the country in which it is located to award such degrees. The dental specialty must be one of the nine dental specialty programs recognized in Canada.

The DSCKE is administered twice a year in Ottawa. Detailed information regarding the format and content of the DSCKE can be found on the NDEB website under Non-Accredited Specialty Programs.

Financials

Summary of Financial Operations

The National Dental Examining Board of Canada (NDEB) operates as a non-profit organization. The accounting firm of Collins Barrow conducts the NDEB's financial audit. The audit opinion for fiscal 2015-2016 was unqualified and there were no areas of concern noted during the audit.

In fiscal year 2015-2016, revenues totalled $9.5 million, the majority of which was derived from application and registration fees for accredited examinations and non-accredited assessments. Revenues increased nearly $2 million over the previous year as a result of an increase in the number of individuals in most assessments and examinations and an increase in the number of administrations of the Assessments of Clinical Skills (ACS) and Clinical Judgement (ACJ) from one to two per year.

Operating costs totalled $9 million in 2015-2016, approximately $900,000 more than the previous year largely due to increased costs required to administer the ACS and ACJ twice during the year. Operating costs are allocated directly to examinations/assessments and administrative costs are allocated on the basis of estimated labour costs to administer the corresponding examination/assessment. A major new initiative, the development of a Virtual OSCE, was started during the year at a cost of approximately $200,000. The Virtual OSCE is a new comprehensive examination that will integrate the existing Written Examination and OSCE. It will be delivered electronically and will address a number of limitations identified with the current process. Costs incurred in 2015-2016 supported initial planning and development of a blueprint for the Virtual OSCE.

Overall, the final results for fiscal year 2015-2016 indicated a net loss of approximately $343,000 compared to a budgeted loss of $258,000. An operating surplus of $536,000 was realized prior to the drawdown of $878,000 from Internally Restricted Net Assets (IRNA). Funds set aside for IRNA were used to initiate the development of the Virtual OSCE, as well as internal re-structuring.

Looking forward, NDEB has developed a budget for fiscal year 2016-2017 and a 5-year financial plan. The 2016-2017 budget totals approximately $10 million and incorporates approved fee increases for the Written Examination and OSCE, as well as the ACJ. The longer term plan incorporates estimates for participation in examinations and assessments and establishes fee increases that will be required to recover costs. The development of the Virtual OSCE will continue to be the most important new initiative over the next few years with cost estimates ranging from $400,000 to $500,000 per year. Implementation is currently planned to occur in fiscal 2019-2020, after which the current method of administering the certification examinations, the Written Examination and OSCE, will be eliminated.

The NDEB is also striving to build its Internally Restricted Net Assets (Reserve Fund) to approximately $7.5 million. The fund is intended to provide funding for general and legal contingencies, examination security, research and development.

From:	CDRAF
To:	Sherban, Angie
Subject:	Fwd: Report release: Canadian Youth Perceptions on Cannabis / Publication de rapport : Les perceptions des jeunes Canadiens sur le cannabis
Date:	February 1, 2017 10:32:20 AM
Attachments:	_Users_EDSylva_AppData_Local_Temp_tmp1631_files_image002.png _Users_EDSylva_AppData_Local_Temp_tmp1631_files_image002.png

Begin forwarded message:

From: "communique@ccsa.ca" <communique@ccsa.ca>
Date: January 30, 2017 at 2:50:05 PM EST
To: "Dr. Cam Witmer" <info@cdraf.org>
Subject: Report release: Canadian Youth Perceptions on Cannabis / Publication de rapport : Les perceptions des jeunes Canadiens sur le cannabis

<!--[if !vml]-->

<!--[endif]-->

French version of this message follows | La version française de ce message suit

New Marijuana Research Report

Good morning,

I am pleased to notify you that the report from the Canadian Centre on Substance Abuse (CCSA) on *Canadian Youth Perceptions on Cannabis* is now available on our website.

Canadian Youth Perceptions on Cannabis

CCSA undertook this research project to better understand the conversations about cannabis that are taking place every day in schools, at home and in community centres. As we move towards the introduction of draft legislation on cannabis, these conversations are becoming increasingly relevant.

We need to understand where youth are getting their information and what they are thinking, and help them make informed decisions. We can also use this knowledge to inform effective prevention strategies.

The key findings in the report are categorized according to what youth believe to be true, why youth use cannabis, what are their misconceptions, what else influences youth and what they think about prevention.

I hope that you find the report to be helpful. I invite you to share it widely with interested parties.

Join the conversation on Twitter to help create a healthier society, free of the harms of substance use, by following @CCSACanada.

Best Regards,

Katie Fleming
Knowledge Broker
Email: kfleming@ccsa.ca

<!--[if !vml]--><!--[endif]-->

Nouveau rapport de recherche sur la marijuana

Bonjour,

Je suis ravie de vous annoncer que le rapport du Centre canadien de lutte contre les toxicomanies (CCLT) intitulé *Les perceptions des jeunes Canadiens sur le cannabis* est maintenant disponible sur notre site Web.

Les perceptions des jeunes Canadiens sur le cannabis

Le CCLT a entrepris ce projet de recherche dans le but de mieux comprendre les échanges sur le cannabis qui ont lieu chaque jour dans les écoles, à la maison et dans les centres communautaires. Alors qu'approche l'introduction du projet de loi sur le cannabis, ces échanges deviennent de plus en plus pertinents.

Il faut comprendre où les jeunes obtiennent leur information et ce qu'ils pensent et les aider à prendre des décisions éclairées. Nous pouvons aussi utiliser cette connaissance pour orienter des stratégies de prévention efficaces.

Les principales constatations du rapport sont catégorisées en fonction de ce que les jeunes considèrent comme exact, des motifs qui les poussent à consommer du cannabis, des idées fausses qu'ils se font, des autres influences qui les touchent et de ce qu'ils pensent de la prévention.

J'espère que vous trouverez ce rapport utile. Je vous invite à le partager librement avec les parties intéressées.

Joignez-vous à la conversation en ligne pour créer une société plus saine, exempte des méfaits de la consommation de substances, en suivant @CCLTCanada sur Twitter.

Sincères salutations,

Katie Fleming
Courtière du savoir
Courriel : kfleming@ccsa.ca

Follow us on Twitter @CCSAcanada | Suivez-nous sur Twitter @CCLTcanada
SUBSCRIBE to your choice of e-newsletters | ABONNEZ-VOUS à nos bulletins électroniques

The Canadian Centre on Substance Abuse changes lives by bringing people and knowledge together to

reduce the harm of alcohol and other drugs on society. We partner with public, private and non-governmental organizations to improve the health and safety of Canadians.

Le Centre canadien de lutte contre les toxicomanies transforme des vies en mobilisant les gens et les connaissances afin de réduire les méfaits de l'alcool et des drogues sur la société. En partenariat avec des organismes publics et privés et des organisations non gouvernementales, il travaille à améliorer la santé et la sécurité des Canadiens.

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Canadian Youth Perceptions on Cannabis

January 2017

This research report contains strong language and profanity that some readers could find offensive.

Canadian Youth Perceptions on Cannabis

This document was published by the Canadian Centre on Substance Abuse (CCSA).

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This document can also be downloaded as a PDF at www.ccsa.ca

Ce document est également disponible en français sous le titre :

Les perceptions des jeunes canadiens sur le cannabis

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Table of Contents

Executive Summary 5
Introduction 5
Method 5
Key Findings 6
Discussion 7
Conclusions 8
Introduction 9
International Studies of Youth Perceptions 10
Canadian Studies of Youth Perception 11
Objectives 11
Method 13
Developing the Interview Guide 13
Piloting the Interview Guide 13
Recruitment Strategy 14
Participants 14
Procedure 15
Data Analysis 16
Results 17
Reasons to Use Cannabis 17
Influence from Important Others 17
Availability and Acceptability 18
Positive Effects on the Body and Mind 18
Reasons to Not Use Cannabis 20
Fear of Consequences 20
Negative Effects on the Body and Mind 20
Stigmatizing of People Who Use Cannabis 21
Opinions about Substance Use 22

Understanding the Effects of Cannabis 22
Cannabis and Driving 23
Cannabis and Brain Development 24
Cannabis as a Gateway Drug 25
Cannabis and Addiction 26
Cannabis Overdose 27
Cannabis versus Alcohol 27
Cannabis Use Culture 28
Covering Up Use 28
Cannabis Types and Use 29
Lacing 30
Legal Status of Cannabis 31
Support for Legalization 31
Against Legalization 32
Societal Influences on Cannabis Perceptions 32
Portrayal in the Media and Social Media 33
Cannabis for Medical Purposes 33
Response from Enforcement 34
Experience with Prevention Approaches 34
Suggestions for Future Prevention Approaches 35
Discussion 38
Influence of Friends, Family and Community 39
Perceived Availability and Accessibility 40
Stress and Mental Health Management 40
Misconceptions 40
Internet and Media 42
Legalization 42
Enforcement 42
Implications for Prevention, Practice and Policy 43
Limitations 45
Future Directions for Research 46
Conclusion 47
References 48

Appendix A 53
Interview Guide 53
Appendix B 55
Appendix C 56
Recruitment Poster 56
Appendix D 57
Webpage Text 57
Appendix E 58
Participant Online Screening 58
Appendix F 60
Participant Information and Assent/Consent Form 60
Parent/Guardian Information and Consent Form 63
Appendix G 67
Participant Debriefing Information 67

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Executive Summary

Introduction

Research has shown that youth are unclear on the effects and harms of cannabis, which could put them at an increased risk for use (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2015). This fact is concerning as brain development and mental health can be compromised if cannabis use, particularly frequent use, is initiated in early adolescence (George & Vaccarino, 2015). The World Health Organization compared past-30-day cannabis use among youth aged 15 across 40 countries and found that use by Canadian youth was the second highest of the countries surveyed (13%), being surpassed only by France (15%) (World Health Organization, 2014). This rate of use illustrates the need for a better understanding of the misconceptions and attitudes Canadian youth have towards cannabis.

To effectively prevent harms related to cannabis among adolescents, it is valuable to understand what youth believe are the effects associated with the drug and what could influence a youth to use it or abstain from using it. Youth are best suited to inform researchers about where gaps exist in current cannabis education and awareness efforts. This study aimed to examine what common misconceptions are held by youth, where gaps in evidence-based information exist and how best to move forward with prevention efforts. This work is timely as the current Canadian government intends to legalize and regulate cannabis during its mandate. This report will ensure that parents, teachers and youth are accurately informed of the effects of cannabis use. It will also aid policy makers, prevention specialists and researchers in developing evidence-informed prevention efforts for youth.

This study builds on previous research completed by the Canadian Centre on Substance Abuse (CCSA) (Porath-Waller, Brown, Frigon, & Clark, 2013) that examined Canadian youth's perceptions on cannabis. The current study is based on additional focus groups conducted with youth from jurisdictions that were not included in the last study with the goal of verifying past research and uncovering changes or differences in youth's perceptions.

Method

This investigation adopted a qualitative approach using a series of focus groups to collect data. This method was selected in order to provide participants with the ability to engage in semi-structured discussion, resulting in data that might not be accessible through surveys or one-on-one interviews (Morgan, 1997). Recruitment strategies included collaborating with partners who work with youth, accessing youth through CCSA staff, conducting groups in the locations where youth were present (e.g., high school), and advertising the focus groups through bulletins and the CCSA website (Krueger & Casey, 2009). Due to this complex topic and to ensure that saturation was achieved, 20 focus groups were conducted, in six cities across Canada. The number of participants in the focus groups ranged from one[1] to seven and all groups were run by the same two facilitators. In total, 77 youth between the ages of 14 and 19 participated, 36 (47%) male participants and 41 (53%) female participants. Each focus group was audio-recorded and the recording transcribed. The data were analyzed using inductive thematic analysis adhering to the procedures of Braun and Clarke (2006), and Frith and Gleeson (2004) with the assistance of NVivo 10 software.

[1] There was only one focus group that had one participant. After reviewing the data collected from this individual, there was no indication that his or her responses were meaningfully different from the data collected in the larger groups. As a result, the information was pooled with the rest of the data.

Key Findings

Overall, youth considered cannabis to be less harmful than alcohol and other substances. Participants cited a number of reasons youth use cannabis, including fitting in with friends or family, the availability and acceptability of the drug, and the drug's positive effects such as coping with stress. Fewer reasons were offered for why youth might not use cannabis, but these reasons included fear of getting caught by parents or police and the stigma of being labelled a "drug user." In terms of understanding the harms of cannabis use, participants varied in their knowledge. Generally, they felt that the effects of cannabis are dependent on how often it is used, the amount used and the person. Long-term significant effects were considered to be limited to those who used the drug frequently and for a long period of time. As to driving after cannabis use, most participants understood it can be dangerous and were able to cite reasons why (e.g., slowing down reaction time), but again felt that these effects were dependent on the driver. Similarly, youth believed that cannabis would be detrimental to the brain in some capacity, but had a limited understanding of how and why. Most youth were unaware that cannabis was addictive and could lead to withdrawal even though many youth described characteristics of these conditions such as someone being "grumpy" when they did not have access to cannabis after consistent use.

Participants provided a number of examples of the ways in which cannabis is used (e.g., baked into food), the types of cannabis available to youth (e.g., shatter[2]) and methods for concealing cannabis use (e.g., spraying perfume to mask the smell). Participants viewed impairment due to cannabis as less concerning than impairment due to alcohol. Many participants considered riding with a driver impaired by cannabis as the safer option of the two. This opinion seemed to be related to the conception of impairment as equivalent to the physical characteristics common to alcohol use (i.e., slurring words, drowsy, stumbling behaviours), which are not necessarily present for cannabis impairment. The lack of visible impairment related to cannabis could lead youth to believe cannabis is not impairing.

Other factors influenced youth's perception of cannabis. For instance, confusion around cannabis laws were cited as playing a role in use: some participants assumed it was legal to possess less than a certain amount of cannabis (e.g., three grams) and that police were unable to charge youth for possession under this amount. Similarly, many participants had not heard accounts of peers, friends or drug dealers being arrested due to cannabis possession, pulled over for cannabis impairment or involvement in serious or fatal crashes due to cannabis, making these consequences unrealistic to youth. All participants reported they knew cannabis might be legalized and many were supportive of this change, as they felt that it meant greater regulation as well as greater availability.[3]

According to participants, the media also played a role in youth's understanding of cannabis, acting as a major outlet for the positive positioning of the drug. Almost all participants used the Internet to find out "facts" about cannabis and were overwhelmed with the quantity of information available. Previous prevention efforts were described as ineffective with school assemblies or lessons delivered by teachers being described as unmemorable. Participants suggested future prevention efforts should be interactive, delivered on a smaller scale (small group), ideally by someone who has experience with the drug, and unbiased information should be presented, including methods for reducing harms.

[2] Shatter is a hard, amber-coloured solid made from the THC-rich resins of the cannabis plant (National Institute on Drug Abuse, 2015).

[3] Focus groups were run before the October 2015 election that resulted in a majority for the Liberal party, which ran on a platform that included legalizing cannabis.

Discussion

This study provided an opportunity to uncover what youth know about cannabis and where confusion lies, and to compare this information to the effects demonstrated in the scientific literature. Encouragingly, youth understood that cannabis can cause harm to the lungs and brain, and that there was potential for cannabis to result in addiction and impaired ability to drive, all of which is supported in the literature. That being said, a number of attitudes and contextual factors reported by participants correlate to risk factors for use, including perceived use among friends, low parental monitoring, availability and acceptance of cannabis (within the community, by friends and law enforcement), and the belief cannabis is not harmful. There were also inconsistencies in the thoughts and opinions reported: for example, some youth believed cannabis remedied mental illness, while others believed it triggered it, and some youth claimed cannabis increased confidence in social interaction, while others felt it inhibited the ability to socialize. These findings illustrate the inconsistencies in understanding cannabis's effects among youth. Comparison of results from this study to those observed by Porath-Waller et al. (2013) appear to suggest that there could possibly have been some advancements made in terms of a greater understanding of risks of cannabis use, although direct comparisons between both studies should be interpreted with caution.

The findings from this study and previous studies have a number of implications for prevention practice and policy. Youth made several suggestions for improving prevention initiatives, many of which are supported by prevention research (Canadian Centre on Substance Abuse, 2015a).

- To begin, providing clearer targeted messaging about cannabis to youth, including the role of law enforcement, legality of cannabis, risks related to cannabis-impaired driving and defining cannabis impairment can positively influence perceptions. Similarly, emphasis should be placed on the effects of driving while impaired by cannabis apart from the effects of driving while impaired by alcohol.
- Secondly, education and resources needed by youth to make decisions about substance use are lacking and the lack is potentially contributing to youth substance use. It would be beneficial to provide further access to resources such as supports for managing stress and mental illness, information about the harms of cannabis use, and objective information about cannabis (Griffin & Botvin, 2010).
- Finally, the method of delivery of prevention initiatives should take into consideration the unique needs of youth such as increasing parental involvement and using community-based initiatives to deliver prevention efforts.

With these prevention considerations in mind, the perceptions of youth collected for this report are part of a larger perspective that can help inform the development of policy.

Although findings from this study provide an invaluable perspective in terms of youth perceptions, there were limitations related to the data. Mainly, the study sample is not representative of the Canadian youth population, meaning results cannot be generalized to this age group as a whole. Also, due to the small sample size, it was not possible to analyze data by participant demographics (e.g., gender, jurisdiction). Regardless of these limitations, results from this study add to the growing evidence in the area and highlight potential opportunities for continued research. Future efforts should include an examination of why past prevention efforts related to cannabis harms (e.g., on the lungs) have resonated with youth and what can be done to educate parents and educators. A national level survey of Canadian youth perceptions would help to further contribute to our understanding of this issue.

Conclusions

With changes in cannabis legislation occurring in the near future it is imperative that education includes evidence-based cannabis messaging to ensure youth minimize risks to their brain development, mental health, safety, and educational and occupational goals (Canadian Centre on Substance Abuse, 2015b). As research continues to accumulate about the effects of cannabis, it will be important to integrate this new information into current prevention efforts. The continued improvement of prevention initiatives will also require monitoring of the attitudes and beliefs about cannabis held by youth, as well as factors that influence use. This data can be used to ensure initiatives remain effective and targeted to this vulnerable age group.

Introduction

Interest in cannabis use, norms and effects has been growing over the past decade as Canada began to move towards a change in cannabis policy, especially in terms of its legal status. As a handful of jurisdictions around the world have legalized the substance while others discuss this possibility, it is unsurprising that public perception of risks associated with use and consideration of cannabis as harmful or dangerous is decreasing (McHale, Goddard, & Vásquez, 2016). Despite this perception, research shows that there are harms associated with use, particularly for adolescents (George & Vaccarino, 2015). These harms are concerning as cannabis is one of the most frequently used substances among Canadian youth after alcohol (Statistics Canada, 2016).

Although cannabis use among school-aged youth in Canada has steadily declined over the past decade (World Health Organization, 2014), Canadian youth have one of the highest rates of cannabis use worldwide. The World Health Organization compared past-30-day cannabis use among youth aged 15 across 40 countries and found that use by Canadian youth (13%) was the second highest of the countries surveyed, being surpassed only by France (15%) (World Health Organization, 2014). According to the Canadian Tobacco, Alcohol and Drugs Survey (CTADS), 20.6% of youth aged 15–19 reported using cannabis in the previous 12 months in 2015. In 2013, of youth who reported using cannabis in the past three months, 23.4% reported daily or almost daily use (Statistics Canada, 2015). The average age of initiation for cannabis use among Canadian youth is 15.4 years—a number that has remained relatively consistent over the past six years that data are available (Statistics Canada, 2016). Provincial surveys of student drug use reveal that cannabis use increases with grade level. For instance, in 2012–2013, 3.2% of Canadian youth in Grade 7 reported using cannabis compared to 23% of those in Grade 10 and 35.6% of those in Grade 12 (Health Canada, 2014a).

These rates of use are concerning as consistent evidence indicates there are a number of mental and physical health consequences associated with cannabis, particularly when use begins early and is frequent. Cannabis intoxication can result in anxiety, difficulty focusing, problems with processing information and coordination, as well as slowed reaction time. Cannabis use has also been shown to affect memory, cognition, and planning and decision making, both in the short term and long term. Due to the decrease in ability to concentrate, cannabis use impacts learning and school work, which can negatively affect educational attainment. In some cases, this affect can result in dropping out, thereby decreasing access to post-secondary education. Regular heavy use during adolescence can affect mental health, is associated with the development of psychotic symptoms and doubles the likelihood of being diagnosed with schizophrenia (George & Vaccarino, 2015; World Health Organization, 2016). Of note, THC levels have increased over the past several decades (Office of National Drug Control Policy, 2013), which is concerning as cannabis with higher THC content has been associated with greater risk, earlier onset of psychosis and higher risk of brain damage (Di Forti et al., 2009; Rigucci et al., 2015), as well as higher risk of vehicle collisions for impaired drivers (Ramaekers, Berghaus, van Laar, & Drummer, 2004).

Cannabis has the “fastest rate of transition to substance use disorder among adolescents” when compared to alcohol and tobacco (Ridenour, Lanza, Donny, & Clark, 2006), and those who use cannabis regularly are more likely to use other substances (Silins et al., 2014; Hurd, Michaelides, Miller, & Jutras-Aswad, 2014). Risk for cannabis dependence is approximately 16% among those who initiate use during adolescence (Anthony, 2006). Ceasing regular cannabis use can result in withdrawal, with symptoms such as depression, insomnia, and anxiety (Allsop et al., 2012).

Cannabis use puts youth at risk for other potential harmful behaviours. For instance, although the potential for overdosing on cannabis is low, use can lead to hospitalization at a higher frequency than one might assume: approximately 1,600 hospital stays in Canada in 2011 were recorded as being primarily due to a cannabinoid-related disorder (Young & Jesseman, 2014). Cannabis use can also result in decreased ability to safely drive a motor vehicle. Cannabis delays reaction time, affects a driver's ability to focus and causes variation in speed and steering. Driving while impaired by cannabis can lead to a crash risk double that of a sober driver (Asbridge, Hayden, & Cartwright, 2012), which is concerning as data from a recent roadside survey in Ontario show that cannabis is the most common illegal substance used by young drivers (Beirness, Beasley, & McClafferty, 2015).

Unfortunately, research suggests that youth are not often aware of these harms, especially in comparison to their awareness of the harms of tobacco use or alcohol use. Instead, youth are better able to list what they consider are the benefits of cannabis (Roditis & Halpern-Felsher, 2015).

International Studies of Youth Perceptions

Previous studies have examined youth perceptions on substances, some focusing specifically on cannabis use. Examples of this work are provided below.

An Australian study conducted focus groups with youth ages 18 to 30 with both youth who had and had not used cannabis. All participants were living with a mental illness. Results from this study revealed that motivations for use were connected to youths' desire to cope with their mental illness (i.e., to relax and "escape" their illness as well as combat nausea from their medication). Youth also reported cannabis helped improve their ability to communicate with others. Conversely, it was also reported that use compounded or caused the individual's psychosis and was detrimental to their ability to socialize. Although participants were generally aware of the risks of cannabis use, these were not compelling enough to prompt them to cease use and these risks were always considered as less detrimental than dealing with their mental illness while not under the influence of the drug (Stavropoulos, McGee, & Smith, 2011).

Another study explored perceptions of cannabis and tobacco among a sample of 22 Swiss youth aged 15–21 years who had experience using both substances (Akre, Michaud, Berchtold, & Suris, 2010). It was found that participants considered cannabis to be "natural" and not necessarily harmful to health, which was in direct contrast to the predominantly negative perception of tobacco consumption. Similar findings were apparent in focus groups conducted with 24 youth from Northern California. Participants in this sample were much more aware of the harms of cigarette use than cannabis use, and there was a clear gap in the accuracy of information they were receiving about cannabis. The authors theorized that this gap could be contributing to the positive perceptions of cannabis among the adolescents (Roditis & Halpern-Felsher, 2015).

A Saudi Arabian study of 41 adolescents between the ages of 13 and 18 was conducted to uncover perceptions on substance use, including cannabis. Generally, participants had limited knowledge of the harms of substance use and reported getting their information from friends, family, the media and their peers. Parental monitoring of youth and strong relationships between youth and parents were highlighted as protective factors against use, whereas lack of parental presence was a risk factor. Boredom, availability and low risk of being caught were also reasons listed for use (Alhyas et al., 2015).

Canadian Studies of Youth Perception

A quantitative report, based on the British Columbia Adolescent Health Survey, which is a cross sectional survey of 30,000 British Columbian youth grades seven to 12, explored the correlations between cannabis use and health-related harms, risk factors for use and self-reported consequences related to use. Study authors found that participants who initiated cannabis use at an earlier age were more likely to have used cannabis recently and frequently. These participants were less likely to report positive overall health, but more likely to have tried multiple substances. Those who used frequently (20 days or more in the past month) had the poorest indicators of health (e.g., poor nutritional habits and sleep patterns). This finding illustrates a relationship could exist between early and frequent use and unhealthy outcomes among Canadian youth. Risk factors for use included depression, stress, friends who use and experiences being bullied (McCreary Centre Society, 2016).

Health Canada commissioned focus groups with both youth and parents to identify their misconceptions and lack of knowledge about cannabis. Participants in this study were able to identify some health impacts of cannabis, such as an increase in respiratory issues and mental illness. They also noted that it is difficult to know with certainty what cannabis accessed through the unregulated market consists of. Similar to previous studies, stress alleviation, peer pressure, media, curiosity and availability were identified as contributors to youth use (Health Canada, 2014b). Perth County, Ontario, conducted focus groups with 30 youth ages 16 to 24 in 2012 to investigate their perspective on drug use in their area. Youth identified cannabis as the most popular substance in terms of use, and felt that users were becoming younger and younger over time. Reasons for use included stress, availability, boredom and desire to increase confidence. They believed it was a gateway drug and that availability and price of the drug played a role in its use. Youth had found cannabis information online with some going as far as checking several sources to verify consistency in facts. Participants believed it was very difficult to prevent use among this age group and that the “just say no” approach to drug prevention is ineffective (Perth District Health Unit, 2012).

Finally, Porath-Waller et al. (2013) conducted focus groups with 76 youth across Canada to uncover perceptions and attitudes about cannabis. The results from this study revealed that participants believed several variables influenced cannabis use. These included attitudes towards cannabis among important persons such as family, friends and peers, and the availability and perceived acceptability of the drug. Reasons not to use cannabis included health risks associated with the substance, the effect on academic performance and potential negative impact on family relationships. Participants held misconceptions about cannabis, describing it as “safe.” Some also argued it does not affect driving, whereas others felt it did. In terms of prevention efforts, youth were unsupportive of “scare tactics” and instead suggested that prevention approaches should provide fact-based information at an early age. This current study builds upon the earlier work.

Objectives

Based on what is known from previous studies, it is apparent that youth lack clarity about the effects cannabis use has on the body and brain. This lack of clarity is concerning as the perceived risk of use relates to rates of use, meaning if youth do not consider a substance risky, they are more likely to use it (Johnston et al., 2015). The increased risks that adolescents face in terms of cannabis use and brain development and mental health, paired with the high rate of cannabis use among Canadians illustrates the need for a better understanding of what Canadian youth think about cannabis. This work is timely as the current Canadian government intends to legalize and regulate cannabis during its mandate. This report will ensure that parents, teachers and youth are accurately informed of the

effects of cannabis use. It will also aid policy makers, prevention specialists and researchers in developing evidence-informed prevention efforts for youth by better understanding their attitudes.

The current study builds on the work previously completed by Porath-Waller et al. (2013) by conducting additional focus groups with youth from jurisdictions that were not included in the last study with the goal of verifying past research and uncovering changes or differences in the results. Through CCSA's earlier work on youth perceptions of cannabis and the current study, we aim to provide a clearer picture of what Canadian youth think about cannabis, what common misconceptions are held, where gaps in evidence exist and how best to move forward with prevention efforts, and to add to the available Canadian data on this topic to inform future policy and prevention initiatives.

Method

This investigation adopted a qualitative approach using a series of focus groups to collect data. This method was selected due to the nature of the focus group environment in which participants can engage in semi-structured discussion resulting in the collection of data that might not have been accessible through surveys or one-on-one interviews (Morgan, 1997). Focus groups also allow for the researcher to gain an understanding of the thoughts and opinions of a targeted group around a specific topic (Kruger & Casey, 2009), in this case, youth thoughts on cannabis. This study received ethics approval from the Chesapeake Institutional Review Board Services.

Developing the Interview Guide

CCSA developed a semi-structured interview guide (see Appendix A) for use in the focus groups. This guide was comparable to the one used in the previous study (Porath-Waller et al. 2013). The following issues were among those examined:

a) How social influences, such as peers, educators and family, influence decisions to use or not use cannabis;

b) The possible negative and positive consequences of using cannabis;

c) How and whether cannabis use affects brain development and ability to drive;

d) Clarity around cannabis laws;

e) How cannabis is portrayed in the media; and

f) How youth feel cannabis use can be prevented.

The interview guide was designed to be open and general to facilitate participant discussion. It also contained important instructions for focus group participants. Specifically, the guide notes that participants do not have to disclose information about their own personal use or experience with cannabis, but can describe in general their opinions on how youth perceive and experience cannabis. It should be noted, however, that during the focus groups many participants willingly disclosed information about their own personal experiences with cannabis. This information was anonymized and included in the findings.

Piloting the Interview Guide

A draft version of the interview guide was pilot tested through two focus groups conducted in Ottawa, Ontario. Participants were asked to provide feedback on the interview guide, introduction and questions to ensure that a youth audience would understand and have the capacity to respond. The first pilot consisted of one male and three females, while the second consisted of one female and two males. All participants were between the ages of 14 and 19.

Feedback from the pilot participants resulted in alterations to the interview guide, including changes in wording, simplification of technical questions and the addition of new questions. The feedback provided by participants resulted in a clearer and more succinct discussion guide, targeted at the appropriate age group. Participants found the guide's content relevant and commented that this is an important topic to discuss with youth.

Recruitment Strategy

Youth between the ages of 14 and 19 were targeted for recruitment for the current study. Participants were recruited from seven cities across Canada: Ottawa and Perth, Ontario, Winnipeg, Manitoba, Saskatoon, Saskatchewan, Wainwright and Calgary Alberta, and Pictou County, Nova Scotia. The recruitment strategy was designed to ensure maximal participation rates within the scope of a non-profit organization and included collaborating with partners who serve youth, accessing youth through CCSA staff, conducting groups in the locations where youth were present (e.g., high school), and advertising the focus groups through bulletins and the CCSA website (Krueger & Casey, 2009).

More specifically, CCSA leveraged existing relationships with partners (e.g., community centres, schools) who work with youth in the targeted focus group locations (Ottawa, Winnipeg, Saskatoon, Calgary and Perth) to help recruit participants and provide space for the focus groups. An announcement detailing how to participate in the focus groups was also placed in youth-related newsletters, which resulted in additional jurisdictions (Wainwright and Pictou County) participating in the study. If recruitment was not solidified through the above process, core programs and services that interact with youth were contacted, including large organizations (e.g., Males and Females Clubs, YMCA/YWCA) and youth groups and clubs such as youth sports teams, and group homes.[4] The contacted organizations were asked to distribute an electronic and hardcopy recruitment poster advertising the study and study webpage (see Appendix C and Appendix D).

The project webpage reiterated the topic of the study, outlined its ethics protocol and informed youth how they could become involved. Youth under the age of 16 were also informed that they would require parental consent to participate. The project webpage included a link to the participant online screening form (see Appendix E), as well as the online participant and parent/guardian information and consent forms (see Appendix F).

Participants were also accepted as walk-ins on the days that focus groups were being conducted as long as the appropriate consent forms were signed and provided to the research team. This flexibility was especially important in cities where participants had not been confirmed before researchers arrived to conduct the focus groups.

Participants

A total of 77 youth participated in 20 focus groups. These included three each in Ottawa, Saskatoon and Perth, five in Calgary, two in Wainwright, and four in Pictou County. One of the focus groups in Ottawa was conducted in French and the two focus groups conducted in Wainwright were conducted through videoconferencing. The videoconference format was challenging due to the inability of the researchers to pick up on cues (e.g., body language) with the same accuracy as in-person focus groups because of a lag in the timing of the video feed. Regardless, including this otherwise unreachable group was deemed more valuable than the challenges of the videoconferencing format, and the results from these groups did not differ greatly from the in-person groups.

Given circumstances beyond the control of both the researchers and participating partners, no youth presented for the Winnipeg focus groups. Attempts were made to conduct other focus groups in the area, but were unsuccessful because of organizational barriers. The failure to hold a group in Winnipeg was not concerning methodologically, as it has been recognized that not-for-profit organizations experience challenges with focus group recruitment (Krueger & Casey, 2009). The challenges are due to the difference in resources available to not-for-profit compared to private organizations

[4] See Appendix B for a list of organizations contacted.

(e.g., those conducting market research). In addition, other jurisdictions volunteered to partake in the study that were not included at the outset meaning the goal sample size of 60 or greater was achievable without participants from Winnipeg.

Male participants made up 47% of the sample and female participants 53%. In terms of participant's province, 29% of the participants were from Ontario, 35% were from Alberta, 23% were from Nova Scotia and 13% from Saskatchewan, with 48% living in rural areas and 52% in urban. Overall, 44% were recruited through a community centre (some of which provided services for at risk youth), 34.5% of participants were recruited through their high school, 11% were recruited through personal networks, 8% were recruited from an alternative school and 2.5% heard about the groups through their addiction councillors. This sample was not intended to be representative of all Canadian youth. Instead, participant recruitment was designed to provide contrasting opinions within groups, but to foster an environment where participants related to one another and were able to understand each other's lifestyles so they were comfortable discussing the topic (Krueger & Casey, 2009).

Procedure

The number of participants in the focus groups ranged from one[5] to seven and all groups were conducted by the same two facilitators. Although some qualitative methodology suggests six to 12 participants is an appropriate number per focus group (Krueger & Casey, 2009), small groups were optimal for this study as the topic is complex, controversial and can illicit emotional responses. Because of this, the authors sought to provide a productive environment for discussion, which was afforded by running groups with a smaller number of individuals (Babbie & Benaquisto, 2010). Similarly, due to this complex topic and to ensure that saturation was achieved, 20 focus groups were conducted, which is higher than the average number of focus groups conducted for other topics (i.e., usually 10 to 15 groups).

The focus groups took place from October 28, 2015, to February 11, 2016. Each focus group started with the facilitators outlining the topic of discussion and all ethical considerations. Participants were also informed that it was important to respect the privacy of those in the group and to refrain from repeating what other participants said during the discussion to anyone outside of the focus group. Participants were also told that for note-taking purposes the discussion would be audio-recorded and later transcribed. All participants were required to provide written consent before proceeding with the focus group discussion. In addition, the parents of participants aged 14 and 15 were required to provide consent for their children to participate. Each focus group took approximately 45 minutes. After participating, all participants received a $20 honorarium in the form of a retail or restaurant gift card. They were also provided with a debriefing from the researchers, which included a review of their responses and provision of accurate information to counter misperceptions as well as a handout with resources related to substance use (Appendix G).

Discussions during the focus groups were held in English and French with the French groups being translated into English for coding. Statements translated from French to English are identified as such in the text. As these original statements were in colloquial French, in the case of disputed meaning or wording, the French version prevails.

[5] One focus group had only one participant. After reviewing the data collected from this individual, there was no indication that his or her responses were meaningfully different from the data collected in the larger groups, so that information was pooled with the rest of the data.

Data Analysis

The data were analyzed using inductive thematic analysis adhering to the procedures of Braun and Clarke (2006), and Frith and Gleeson (2004). Inductive thematic analysis allows the analyst to make interpretations of the data rather than use the data to support previous theoretical conceptions, as with a deductive approach (Patton, 2002). An inductive approach was important for this project because it allowed for greater flexibility in capturing participants' perspectives and facilitating a more complete understanding of youth perceptions of cannabis use. NVivo 10 software was used to manage all aspects of the thematic analysis in the current study.

Results

Findings from the focus groups are organized by theme: reasons to use or not use cannabis, understanding of cannabis effects, cannabis and alcohol, cannabis culture, variables that influence cannabis perceptions, the legal status of cannabis, and prevention approaches.

Reasons to Use Cannabis

Participants were able to cite many reasons why they believe youth use cannabis, which included the influence of those around them, the availability of the drug and perceived "positive benefits." These reasons are summarized below.

Influence from Important Others

One of the most common reasons that youth said their peers tried or used cannabis was to fit in with friends. This reason included peer pressure, the desire to be accepted into a particular peer group. Some youth might be seeking an identity and see "stoner" as an option with cannabis use acting as the common ground to make friends. Some participants noted that youth might fear they will be left behind or not invited to parties with their current friend groups if they do not use the drug. In other words, "everyone else is doing it, and they want to be cool, too." Participants also reported that friends might discuss personal accounts of cannabis use where it is described as fun and exciting, enticing their friends to experience it. Cannabis use was also related to improvements in personalities, such as making someone "more fun." One participant reported: "I know someone who smoked it because they felt like everyone thought he wasn't fun when he was sober, because when he got high, he'd be really animated and excited about things." Similarly, cannabis was said to give youth confidence and alleviate the social anxiety of making friends.

The socialization inherent in smoking cannabis was also listed as a reason youth might use cannabis. For instance, cannabis use was labelled as a fun way to spend time with friends, similar to having a beer or glass of wine:

> Well, even on the social drinking, it is not much different from that, if you were to pack a bowl in a pipe, you can pass it around, as you would sitting in a bar and have a beer. It's not really any different except the fact that you could get caught and go to jail. Maybe not go to jail, but get in trouble.

Use was also related to boredom while with friends, especially for those who live in rural areas who do not have as many entertainment options as those in urban areas. It was mentioned by a few participants that youth in "bad areas of town" or in "rough neighborhoods" might be more likely to use cannabis due to the influence of their environments.

Family members were also considered important and influential in some youth's decisions to use cannabis. Youth agreed that if someone's parents were using cannabis, it would be much more likely the children of those parents would use it as well. One participant reflected on his or her experience in this regard:

> I did not realize it. I saw my family do it a lot, so when it came to my friends saying hey, do you want to smoke? I said, well my parents do it, so why shouldn't I? It's like why I started smoking too it's because my mom smoked all the time in the house around me, a subconscious factor that had an influence.

Overall lack of present authority was said to also play a role in influencing use; for example, absent parents, teachers or coaches who are not known for giving severe consequences for substance use. Similarly, few youth spoke of having conversations with parents or other adults about the dangers of cannabis use. Conversely, some youth claimed they used cannabis to "piss parents off." Many youth felt that cannabis use was a result of rebellion on the part of teens, who are often craving independence. Thus, youth reasoned that parents being strict or setting rules could actually backfire in terms of preventing use.

Siblings were also said to play a role, with those using frequently either influencing use or discouraging it. Some participants argued that siblings who have a brother or sister who use a lot of cannabis are likely to use as well. One participant commented using her own sister as an example:

> I think, like, for example, that's my little sister right there. I think, like, say, if I started smoking, and she seen me, then she'd probably think it's a cool type of thing. So she'll eventually want to try it. Or let's say for example, if I don't do it around her, and she doesn't know anything about it, then maybe she won't.

Availability and Acceptability

Youth considered availability as a reason someone might use cannabis as it was viewed as a readily available substance for this age group. Youth mentioned that it is common for there to be cannabis available at house parties and social events. Similarly, locating and contacting a drug dealer was a very easy task, and even youth who did not use were well aware of where they could buy cannabis if they needed to. It was even considered more available than alcohol as there is no legal age of access to purchase cannabis. One participant noted: "Well, I mean if I was 14 I could buy marijuana, but I could not walk into a liquor store and buy alcohol. You need someone else to buy it for you." It was also used in some cases as an alternative to alcohol. One respondent reported availability of cannabis online:

> I forgot to mention this earlier, but there's another way you can get marijuana… It's called the deep web which you need to download a special browser for that but it's basically like a different side of the Internet where you can use a regular Internet connection, but there's all this weird stuff… Like there's drug websites where you can buy up to any amount of weed and have it shipped to your house.

The availability of cannabis and lack of exposure of youth to any negative ramifications could contribute to the overall perception that use of the drug is acceptable. For instance, one participant mentioned that while growing up she always knew the "older kids" were using cannabis, but never saw them get in trouble, so when it was offered to her she assumed "it was not a big deal." It was also mentioned that youth might lack knowledge of cannabis harms, so when deciding to try the drug, their thoughts are "why not?"

Positive Effects on the Body and Mind

Youth classified cannabis as the "safest" of all substances to use and that the side effects were minimal when compared to other drugs. For instance, one participant noted: "It's obviously not good for you to put like smoke into your lungs, but yeah, but if you compare it to heroin, it's like no big deal. I would say it's way better for you than alcohol even, by a lot." This was supported by the apparent "mild" effects of cannabis on the body in comparison to other substances. Youth felt they were more in control and better able to function when under the influence of cannabis. For example, one youth stated "You can't even overdose on [cannabis]. It's actually physically impossible to overdose on marijuana. The only thing that'll happen is you'll pass out, wake up, feel, you know, normal." This

sentiment was echoed in relation to prescription drugs as well. A number of youth considered cannabis use as a much "healthier" method for addressing medical issues than prescription drugs, which were described as "synthetic chemicals" that are addictive and can result in overdose. Cannabis was considered a natural alternative that would not result in any of these issues.

Many medical issues were mentioned as reasons youth might use cannabis, both in terms of prescription from a doctor and self-medication. A number of youth had researched the effects of cannabis on physical and mental health, and often used this information (whether from a credible source or not) as a reason to start cannabis use for what they considered a medical condition without consultation with a doctor. Of concern, this self-diagnosis and self-medication appeared to lead to recreational use. One youth, who had been prescribed cannabis by his doctor described treatment for his depression as more successful in terms of withdrawal effects from using cannabis compared to withdrawal effects of anti-depressants: "Well, personally, depression, I find that [cannabis] works better than an anti-depressant for me, myself. When I am not high I don't find myself as depressed as when the pills are not working."

The following diseases or conditions were cited by participants as those that, in their opinion, could be alleviated or controlled with cannabis:

- Chronic or acute pain (e.g., back pain, pain from concussions);
- Seizures;
- Mental illnesses such as depression, anxiety, post-traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), schizophrenia and bi-polar disorder;
- Cancer and side effects of cancer treatment (i.e., pain relief and stimulating hunger);
- Stress; and
- Arthritis.

Interestingly, many youth cited increased appetite as a reason for using cannabis. It appears as though some youth might not be eating due to stress or other health concerns such as depression or medication effects. Participants reasoned that cannabis, which causes the "munchies" or the desire to eat, can be used to alleviate stress, stimulate hunger and help to hold down food. One participant reported her experience:

> Generally food tastes disgusting, but once you have a few drags of a certain type [of cannabis], it's more… It's complicated, but once you have a few drags you feel like you'll be able to eat more and you get hungry… You're not feeling self-conscious, but you don't feel sorrow from eating or anything.

Youth said that cannabis can also be used to stimulate hunger for eating disorders such as bulimia, anorexia and purging. Individuals suffering from these conditions were said to use cannabis to increase their appetite, to help them to begin eating again and subsequently to gain weight. Similarly, those who have cancer and are undergoing chemotherapy were said to benefit from increased appetite related to cannabis use.

Cannabis was also said to improve sleep, decrease night terrors and allow youth to function properly and worry less. Many youth also said they used cannabis to escape reality or a negative situation they were coping with, as well as decreasing their capacity for caring about a situation. One youth described this as "disassociation from reality" and another as "a daily dose of fuck it all." Other positive effects of cannabis included better concentration and focus resulting in better academic

performance, and increased energy and alertness. Being high on cannabis was described as "joyful," "blissful," "relaxing" and boosting happiness, outgoingness and positivity.

Reasons to Not Use Cannabis

Although youth generally had more to discuss in terms of the positive effects of using cannabis, there were some key points discussed about why youth do not use cannabis. These points included fear of parental or legal consequences, negative effects on the mind and body, stigma of being labelled a drug user and personal beliefs. Many of these effects were in contrast to the previously mentioned positive effects, such as triggering mental illnesses as opposed to treating them, and the possibility of overdosing called "greening out."

Fear of Consequences

Overall, participants did not seem concerned with the consequences of cannabis. There was a small number of youth who were concerned about what their parents would think or whether they would be punished if they were caught using cannabis. An even smaller number of participants were concerned with disappointing family members and losing their trust. One example of positive influence from a parent was a mother sharing her past negative cannabis experiences with her daughter, which affected her greatly. Similarly, siblings were said to deter use in younger siblings by helping them learn from their mistakes or providing an example of "going down a bad path" that their siblings could learn from.

In terms of legal consequences, few youth mentioned the fear of ending up in jail or respect for the law as reasons not to use cannabis. Some participants felt the anxiety of being caught in and of itself was a deterrent. Another deterrent for participants were their experiences growing up. For instance, one youth was greatly affected by his encounters with individuals who were addicted to drugs and did not have homes. In his mind, these people had "ruined their life" and thus this influenced his decision to not use drugs. Of concern, very few participants felt school presentations and learning the health, social and legal consequences of use was enough to deter youth from trying cannabis.

Youth had trouble relating to the consequences of cannabis use if they had not experienced any themselves (e.g., being caught by police driving after cannabis use). Those youth who had experienced something negative, on the other hand, while using cannabis or after trying it (e.g., what they considered as triggering a mental illness, increased fighting with their boyfriends) were more likely to report regretting initiating use.

Negative Effects on the Body and Mind

There were some common negative physical, mental and behavioural effects of cannabis that were reported to possibly deter youth use. Physically, youth recognized cannabis can affect the brain, (mainly brain cells), and the lung and heart, and, because of the inhalation of smoke can, cause irritability in the eyes and throat. Participants pointed out that cannabis can make a person feel tired, hungry and uncomfortable (described as an "ugly feeling"), and affect athletic abilities. In terms of chronic conditions or diseases, youth mentioned that cannabis can cause lung cancer, can "speed up growth of HIV" and hepatitis C, cause asthma attacks and acne, and result in a "depression hangover" after use. Some youth felt that cannabis is an addictive substance; those who were aware of this possibility and did not want to rely on cannabis as a coping mechanism appeared to steer clear of use.

Several changes in behaviour and attitude due to cannabis use were also listed as reasons youth might not use the substance. For instance, participants felt the drug could change a person, by lessening his or her ability to handle things and decrease his or her motivation. It could also make

someone closed off and anti-social, and cause mood swings that could affect his or her interpersonal relationships. Cannabis was said to lower inhibitions, potentially causing someone to do something he or she would regret, as well as making a person unpredictable, especially in terms of anger control. Youth also cited long-term effects on behaviour experienced after cannabis use cessation, including an increase in boredom while sober and difficulty enjoying things they once were interested in.

Youth felt that cannabis could also affect a person mentally, whether through the worsening of mental illnesses or negatively changing thought patterns. Youth reported personal experiences or experience among their peer group with schizophrenia, psychosis or depression that, in their opinion, was induced or aggravated by cannabis use:

> For me, I don't know, I never really like had mental health problems before I started, but then like after, I don't want to say stopped, but at the peak of my use, as soon as I stopped using, because I was literally using every day, like eight times, if not more, so when I stopped doing that it kind of brought out mental health problems in me. So like, I don't know, when I went to the hospital I got diagnosed with like drug-induced depression and anxiety, and I'd never had anything like that before, like I was a really happy kid, so it kind of brought that out of me.

Use was also said to result in anxiety or panic attacks, paranoia, negative thought patterns, memory loss and suicidal thoughts. These findings contrast with what was previously highlighted as benefits of cannabis use, mainly, that cannabis use can improve mental health and make a person more positive and happy.

Stigmatizing of People Who Use Cannabis

Many participants recognized that people who use cannabis, especially those who use frequently, are stigmatized because of their use. This stigmatizing was a significant reason why participants thought youth might not want to use cannabis. Youth outlined the common versions of this stereotype: "stoner," "pot head" or "druggie." Youth described this stereotype using such terms such low income, low education, low social status, laziness, chill, someone with the munchies, deadbeat, loser, partier, sketchy, drop out, crazy or unpredictable, no good, something wrong with them, risk takers (have less to lose), and someone from the 1960's. Generally, participants felt that those who used cannabis infrequently or only in social settings were not subject to this stigma.

One male participant who had used cannabis recreationally, but also had a medical document for cannabis from his doctor to treat his depression expressed facing stigma due to his use:

> Me, myself… I've been known as a pothead and druggie and no-good degenerate… just all of that stuff… where I actually, myself, not trying to brag, I'm quite intelligent versus what they have said before… It's more adult figures [who have these stereotypes], people not really from my generation grew up with the stigma against it.

Often when youth described this stigma, they were not speaking from their own perceptions, but instead were describing what they thought were the perceptions of the general public. For instance, they assumed non-users considered those who use cannabis to be "morons" or "losers." They assumed figures of authority, like parents or "the government," were most likely to believe and perpetuate this stereotype. When describing their parent's negative views on cannabis use, they thought this bias was unfair, as parents often support the use of pharmaceuticals for medical reasons, but not cannabis, even though most youth thought pain medications were much more dangerous. They also felt that "the government" contributes to this stigma by fear mongering and painting the drug in a negative light in order to deter use.

Regardless of the source, youth generally did not want to be associated with the stigma and were still influenced by stereotyping as they mentioned they had been surprised in the past when they discovered a high achieving peer was using cannabis (i.e., a "good student" from a "good home") or that an adult or person of authority used cannabis.

Opinions about Substance Use

A minority of participants held beliefs that were against substance use or cannabis use. Generally, it was hard for participants to articulate the reasons they held such beliefs. They did not attribute them to their parents or peers, but instead considered them a natural part of who they were. For instance, one participant noted that youth could be against drug use: "I don't know. I think some people are just really against that kind of stuff and, like, their morals and beliefs are just… They just don't believe in that, so they don't do it, kind of thing." Youth who fell into this category did not see the benefit in using substances and felt that they would be going down the wrong path if they chose to engage in that behaviour.

Understanding the Effects of Cannabis

Many youth stated that although their peers generally understand the risks of cannabis use they "don't care" about consequences and choose to use the drug anyway. For example, one participant noted: "Even if they understand [the risks], it's like they have stopped caring. They're like, okay, [there are risks], but it's never happened to me any of these times before, so I doubt it's going to happen now." This view could be related to participants describing cannabis as a "soft" drug or "helping drug," as opposed to what youth classified as a "hard" drug, such as cocaine. With this perspective in mind, it was not surprising there was inconsistency among participants about what they thought were the risks of cannabis use. Youth held different opinions on the negative effects of cannabis, which was likely due to the belief that the drug "affects everyone differently." Youth did not think any negative immediate or permanent consequences were guaranteed for everyone who used cannabis. Instead, these consequences changed based on the person, how long they have been using the drug, how often they use the drug, their height and weight, the amount they use, the THC level and the type they use. Cannabis was described by participants as complex, meaning each strain is different and the same strain can have different effects. Because of this, youth felt it was not possible to predict how cannabis will affect someone.

Participants also highlighted individual characteristics as contributors to the effects of cannabis. They observed that some users can function while "high," while others cannot, and felt this depended on a person's levels of control, will power and self-motivation. Similarly, each user has a different tolerance level, (e.g., lightweight or heavyweight), and the effects of smoking cannabis can reflect someone's pre-established mind set and mood. One participant described how cannabis can affect every individual's brain chemistry differently, resulting in different experiences:

> Because [cannabis] is not for everybody, it's not. Everybody is different, every drug, alcohol, anything affects people differently, and the same goes for the THC. Because we do have the receptors in our brain to receive the cannabinoids from the THC, but not, some people have more and some people have less. Some people it affects more in a neurological way than it does some other people who are more sensitive to it. And it might not feel good to them, it might feel more scary, the feeling might be more scary than calming for some people. It is not that they are against it, it's just that it is not for them.

Personality type[6] was also said to contribute to the effect of cannabis:

> I think it also depends on your type of personality. Like, if you've got an addictive personality, like me. Like I just started knitting. I can't put it down. I used to do this. I couldn't stop because I have an addictive personality. So I think it does come down to what kind of person you are because it could change you. But it could also have no effect. It could make you more aggressive. It could make you more calm. It could make you a little bit more rude. It could make you a little bit slower. It could make you too nice to the point where you're, like, letting people walk all over you because you're like, "I'm just so high, and I'm so happy, and I don't care. Here, take whatever you want."

Many youth took comfort in their opinion that cannabis "affects everyone differently" as this allowed them to selectively choose when the drug is or is not safe. This opinion was especially prevalent in relation to their friends and family. For instance, in terms of driving after cannabis use, many youth were comfortable doing so with an adult (such as a family member) as "they can handle it" and "know what they are doing." Similarly, some youth trusted certain friends while high because they "knew them." Interestingly, participants did not think cannabis affected adults. They always described their experience with adult use as something where the adult was "totally fine" and did not show any signs of being impaired.

Further to these effects of cannabis, there were several topics that youth commented on about the risks of cannabis. These topics included driving, brain development, cannabis as a gateway drug and risk of addiction, and are discussed in the following subsections.[7]

Cannabis and Driving

A majority of participants recognized that cannabis can affect driving, but only with the caveat that it depends on the person, how much he or she smoked, and individual tolerance. For example, one participant noted: "I think it depends how high you are. If you're out-of-your-mind high, then yeah, you shouldn't be driving, but I mean, if you're just, like, pretty much sober, and maybe you just had a toke, then I could drive just absolutely fine." Youth were able to identify the dangers of driving while high, but generally had limited understanding as to why cannabis affects driving. Regardless of this knowledge, participants felt youth did not care about the dangers of cannabis-impaired driving.

A large majority of participants knew that cannabis use would slow reaction time and reflexes, impair cognitive functions and motor skills, and distort perceptions of time and space. Youth felt cannabis could cause confusion, disorientation, hallucinations and sleepiness for the driver, as well as alter vision, impair concentration and slow driving. A small number of youth recognized that even though they perceived this impairment as minimal, the one or two second time delay in reaction while driving could be fatal. It was also acknowledged that it can be hard to tell if someone is high, in contrast with drunk, due to only subtle changes in physical behaviour. One participant elaborated on how this can result in the misperception that it is safe to drive high:

> Yeah, I think that [driving high will] become a lot bigger issue because people don't think about it. When people are drunk, I think they think of it differently because if you're really clearly impaired, you know that your judgement and reaction times are off, and people kind of seem to forget—because it's a different type of impairment when you're high—they seem to forget

[6] For more information on the factors that have been shown to modulate an individual's vulnerability to addiction to cannabis (i.e., genetic or environmental) please see George & Vaccarino, 2015.

[7] The term "addiction" is used throughout this section as it was the terminology used by participants.

> that they have, like… Reaction times are one of the biggest parts of driving, and that reaction time is slow, whether you're realizing it or not.

All youth considered alcohol-impaired driving as obviously dangerous and something they would never do, but the dangers of cannabis-impaired driving were dependent on who was driving or how much they had smoked. The same logic applied to driving with a cannabis-impaired driver. Almost all participants were vehemently against getting in a car with someone who was drunk or on prescription medications, but only some participants felt this way about riding with a cannabis impaired driver. They often classified driving while impaired by cannabis as "safer" or "less dangerous" than driving while impaired by alcohol. For instance, some youth argued that someone who is impaired by cannabis will actually be more careful on the road, as he or she is more aware of their impairment and would not want to get caught by police, in contrast with drunk drivers who are not as aware they are impaired due to a decrease in inhibitions. Cannabis was also considered the safer alternative to alcohol because "being high burns someone out" making it less likely he or she would leave the house and thus would not be driving. Similarly, the behaviours associated with being high such as "calm," "happy" and "chill" are not associated with risky driving.

Participants felt that the lack of awareness of the dangers of cannabis-impaired driving among youth could be due to the limited exposure of youth to firsthand accounts of traffic crashes that were attributed solely to cannabis use, especially in regards to deaths. Instead, youth reported growing up hearing "horror stories" about crashes caused by alcohol-impaired drivers: "You hear about all these tragic car accidents and they never say marijuana or drug use. It's always, like, alcohol. People are stupider when they get drunk." Youth were aware that getting caught driving high would result in the same punishment as being caught driving while impaired by alcohol, but had not heard of many of their peers being caught for this offence and thus thought it was unlikely they would be apprehended. Some participants believed that police had limited capabilities to detect if a driver had used cannabis or were unlikely to take the time to reprimand someone who had. Other participants were aware that police looked at physical signs of cannabis impairment such as dilated pupils and red eyes. The concept of a "breathalyzer" for cannabis use was mentioned a number of times by youth, although they were unsure of what this device would actually look like or how it would operate.

Cannabis and Brain Development

When asked about whether cannabis affected the brain, most youth perceived this question as asking about how cannabis changes mood or behaviour via the brain or how it affects mental health. When asked directly about the effect of cannabis on brain development, many participants either guessed or acknowledged that cannabis very likely has some effect on a developing brain, but they were unsure of how or why. Although a majority of youth accepted that cannabis can affect their brain, even if they did not know how, this knowledge did not appear to deter use. Many of those who agreed there were effects only felt they would be an issue for those who smoke large amounts of cannabis for a long period of time, and that effects would not be apparent in the short term. In other words, moderate use or recreational-only use would not affect the brain. For example, one participant argued:

> We're speaking of like the recreational abuse with like buddies and stuff… So basically, if you use it recreationally you're not… it doesn't affect your brain. It doesn't affect much…

Another participant agreed:

> It's like anything within like high doses… Like alcohol, you can drink yourself to dementia. I suppose you could probably smoke to dementia in a certain level of smoking, I guess. I don't know. I've never reached that.

Essentially, youth considered above average amounts of use, such as a gram a day or more than a joint a day to result in negative effects, but less frequent or heavy use was considered safer in this regard.

A smaller number of participants were under the impression that cannabis use resulted in immediate effects on the brain that they often described as changes in behaviour and mind set. For example, one participant observed of his friend: "my friend smoked a joint one time and like he's not right in the head no more, it might have been laced or something but still… Like, he's, like, he lost a couple marbles."

Other youth were aware that cannabis affects brain development in young users, especially before their early 20s, which led them to believe that it is not something that should be used by anyone younger than 21. They were able to identify this age as an appropriate legal age for use once cannabis is legalized. The negative effects of cannabis on the brain that were mentioned included stunting growth and development, negatively affecting brain functioning (e.g., analytic thinking) and the binding and releasing of neurotransmitters, triggering illnesses (e.g., schizophrenia), causing memory loss, decreasing grey matter, affecting decision making, lowering intelligence, and causing hallucinations. A small number of positive effects were also mentioned: making the brain more "awake" and "alive," promoting healthier brain development after the age of 21 and creating new neural pathways.

Cannabis as a Gateway Drug

Youth were asked if they felt that cannabis was a "gateway drug," that is, if cannabis use predisposed someone to the use of other illicit drugs. This theory has been proposed in the past, but is not supported by current research (George & Vaccarino, 2015). Results from the focus groups were mixed, with some youth certain it did act as a gateway drug, while others attributed new drug use to something unrelated to cannabis. The latter felt the transition through the gateway was more dependent on one's peer group, and whether these peers were encouraging the person to use cannabis, and on one's pre-existing personality, that is, if they are impulsive and the type of person to try new things. Transition into other drug use was said to also relate to one's experience with cannabis. For example, one youth raised the possibility that some users function quite well while impaired by cannabis and see no need for new drug use, whereas those who struggled more in their lives might turn to new drugs:

> Not in all cases. Like, my aunt, like for instance, she doesn't even care if anyone knows she smokes weed. She smoked weed and she didn't ever try anything else, and she's got, like, a really, really good paying job, and, like, it doesn't limit her, prohibit her from being able to go into work. In fact, it actually enables her to go into work in a better mind state. But then, I do also see people who are, like… I've seen people who were, like, top of their class, then they had one, like, really rough, like, week, and they tried it. They smoked weed, and they're like, "Yeah, I'll just keep going from this." And someone was like, "Yeah, try this [other drug], and try this [other drug], and try this [other drug]." And eventually, they were like, "fuck school."

Cannabis use was seen as a "slippery slope," as it is perceived as harmless and can lure individuals unknowingly towards other drugs. This attraction could be a result of those who use cannabis craving a bigger and better high than cannabis alone, encouraging them to use what participants considered harder drugs, such as cocaine. Participants also reasoned that cannabis use "shrinks the gap" between refraining from drug use and "hard drug use." In other words, the gap between using no drugs and using "hard" drugs is much smaller when cannabis acts as a "stepping stone" in between. Some participants felt that cannabis use opened doors to interactions with drug dealers and making drug-using friends. From there, a dealer can offer the individual new or different drugs. In other words, cannabis is a "gateway drug by proxy" as it brings people into a new circle of peers who use drugs.

Participants reasoned that if the individual has had no negative experience with cannabis he or she might be more inclined to try a different drug. Similarly, if someone had a positive experience with cannabis he or she might become curious about other drugs and want to try them.

Other participants felt cannabis was not a gateway drug and that any participation in new drug use was the choice of the person and unrelated to their cannabis use. Many based this opinion on their own personal experiences or experiences with their friends who had not transitioned to new drugs after cannabis. Although some acknowledged that cannabis use opened the door to the "drug using world," in their opinion, use of new drugs was not due to cannabis use in and of itself, but instead the choices, struggles or existing problems of the person. For instance, one participant stated "you can't blame it on the drug. You blame it on the person. The drug didn't make me decide to do other drugs… Like you can't blame it on it, if that's all you're doing." Based on this reasoning, participants also argued plenty of people who use cannabis had no interest in trying other drugs or had complete self-control in stopping drug experimentation at cannabis. Similarly, participants felt experimentation with new drugs could be based on lack of knowledge of the harms of these drugs instead of any interaction with cannabis. Participants who had had more experience with cannabis seemed less likely to agree it was a gateway drug.

Cannabis and Addiction

Opinions were divided about whether cannabis is addictive. Several participants felt that cannabis was not addictive at all, while others considered cannabis addiction to be in a different category than addiction to other drugs. For instance, it was suggested by some participants that addiction to cannabis would occur gradually over time, as a habitual thing compared to the immediate physical reactions of other drugs (e.g., cocaine) or only in cases where someone is using copious amounts of the drug. Cannabis addiction was said to be "mental" as opposed to physical, where the person is addicted to the feeling of being high on cannabis as opposed to the body craving the substance. One participant reported: "THC has been confirmed that it's not addictive, but it's not the chemical that's addictive, it's the rush. It's the feeling and it's the notion that there's nothing wrong in that moment is what's addictive."

Addiction was also attributed to a person's propensity for addiction instead of the substance. Some youth felt that only people with "addictive personalities" can become addicted to cannabis and this addiction is more a personal choice, rather than an uncontrollable condition. Some also suggested that addiction to cannabis was related to the need for a person to escape his or her reality or problems, making the "escaping" aspect of use addictive, not the drug itself.

Although it was not necessarily considered addictive, youth pointed out that once you begin using you are "chasing the dragon's tail" and constantly trying to recreate the previous feelings of being high, especially the feeling of when you first tried it. They thought people can become "immune" or tolerant to the effects over time, meaning they would need to smoke stronger or greater amounts of cannabis to recreate the feeling. They also described these urges as more manageable than other types of drug addictions and argued it is much easier to quit cannabis than other substances.

Interestingly, many youth brought up withdrawal symptoms of cannabis, but did not equate them with addiction. For example, they described friends or loved ones who were frequent users as becoming grumpy or mean when they had not used cannabis in some time. This behaviour was also described as a dependence on cannabis that resulted in anxiety, edginess and aggressiveness. Regardless, participants were quick to label this behaviour differently than regular addiction because there are no withdrawal symptoms:

> You can [withdraw], but it's not going to be the same as vomiting, sweating, shaking, screaming, running away… anything like that. It's going to be a lot of trying to calm yourself down and not hurting yourself or getting angry at people. It's not really something that physically upsets your body like an addiction does. It's more of something that mentally you have to get over. It's like a barrier that you have to get over.

A minority of youth believed cannabis was addictive, similar to other substances, and could affect the production of serotonin in the brain. They considered pride to be a contributing factor to individuals who use refusing to admit addiction: youth want to believe they have control over their use and can stop at any time.

Cannabis Overdose

Several participants assumed it was not possible to overdose on cannabis, but some also assumed that heavy cannabis use does not result in severe after effects (e.g., hospitalization). The absence of media stories or personal accounts of severe health effects due to cannabis could be contributing to the perception that it is impossible to overdose on cannabis or experience severe harms from use. Youth mentioned they had never heard of anyone dying from cannabis or heard of any cannabis-related overdoses. One youth commented that it is impossible to overdose on THC, but one could die from suffocating on cannabis smoke. Other participants considered overdosing due to cannabis as a possibility, but only if an individual had taken large amounts, which was described as difficult to do. That being said, a fair number of participants described the process of "greening out," which they defined as an individual smoking too much cannabis resulting in dizziness, becoming light headed and possibly vomiting.

Cannabis versus Alcohol

When describing cannabis experiences or opinions, youth often used alcohol as a comparator. Generally, participants considered alcohol to be a much riskier substance than cannabis, mainly because they thought alcohol can kill someone through overdose or dangerous behaviours such as impaired driving. This difference in risk confused them, as cannabis is illegal and alcohol is not. They tended to assume anything legal was safe, but did not think alcohol was safe. Youth saw alcohol as more "destructive" than cannabis with many more negative effects, meaning they believed they would face less issues or consequences after using cannabis than alcohol.

> Think about this. Here's another thing. If they were to legalize [cannabis], they could criminalize fucking alcohol and think about [how] much better the world would be. Seeing a bunch of stoners walking around instead of a bunch of drunken alcoholics fucking a bunch of shit? Which one seems like the better of two evils, you know?

As similar observation arose about impaired driving: "Well, [cannabis] can [affect driving]. I'm assuming like you still are under the influence of drugs, so it's a terrible idea to drive, but… it's probably not as bad as liquor." When given the choice between getting in a car with someone high or someone drunk, riding with someone who was high was consistently chosen as the more favourable option.

Participants also considered alcohol to be more impairing. For example, some said that people are more in control when high than drunk. This opinion appeared to be manifested in how they visualized a "drunk" person (slurring their speech, staggering) believing alcohol significantly affected behaviour, even resulting in "crazy" or "violent" actions, whereas "high people" only look happy, "chill" and relaxed, and just want to "sit on the couch and eat." Of note, youth's image of impairment is defined by the

characteristics of being drunk, meaning they have more difficulty recognizing if someone is under the influence of cannabis:

> I would totally agree with what [participant] is saying and it kind of freaks me out because if you are out somewhere with your friends and somebody is like "I will give you guys a drive" and you are like they haven't been drinking, but you can't… I don't think [being high] is as identifiable, like I know personally because I have trouble with identifying if someone is high or not…. We were out somewhere and he got in the car with somebody and he didn't even realize and I was like "this person is like stoned" or whatever…

They also saw more negative physical responses to alcohol such as vomiting, memory loss and hangovers, which would "never happen" with cannabis. As with overdosing, youth identified many more examples of negative impacts to the body from drinking too much alcohol, such as liver issues, brain injuries and possible death, but pointed out that cannabis use did not result in these effects. About withdrawal symptoms, they also considered alcohol to result in greater harm than cannabis: "I've also been an alcoholic. Once you get alcoholic shakes, it actually makes you physically sick not to have booze. You can't get physically sick from not having pot."

Youth also commented on the benefits or detriments of mixing alcohol use with cannabis. It was said that alcohol can enhance the high from cannabis and vice versa, and youth were encouraged to mix the substances as it was "fun." Others felt it was unsafe to mix cannabis with alcohol. The feeling of mixing both was described as being wide awake and hyper while simultaneously lacking energy. Some participants also considered cannabis as a means to alleviate their impairment by alcohol: "But I feel like when I drink and then smoke weed, like, I feel like it brings down my alcohol, and the marijuana overpowers the drinking"; that is, participants believed it "sobers them up."

Interestingly, many participants classified alcohol as the gateway drug to cannabis use. For instance, many youth reported trying cannabis while they were impaired by alcohol because they lacked judgment and did not consider the effects. Often this resulted in regret the next day: "I think I've heard of people who, again, were drunk when they tried [cannabis] and then the next morning when they were sober, were like, 'Oh what did I do?' Like, I don't think they would have done that in normal mindset."

Some considered the transition to cannabis use to correlate with a decrease in alcohol use. One participant provided some of the reasons for this correlation:

> I don't know, because I was like comfortable, I was already having a good time and I didn't need to like get any more intoxicated and honestly like alcohol compared to weed sucks, like it makes you feel like crap, you throw up, you don't remember stuff. You could literally die because of it.

In other words, cannabis use replaced alcohol use.

Cannabis Use Culture

Covering Up Use

During the focus groups, some participants identified tactics used by cannabis smokers to cover up their use. For example, the use of sunglasses (titled by the participant as "sneaky shades") and eye drops to cover up bloodshot eyes. Similarly, body spray, hand washing, gum chewing, changing clothing or smoking a cigarette were said to be tactics to mask the smell of cannabis use. In general, it was agreed that the smell of cannabis is very notable and difficult to cover. Another means of hiding use

was via e-cigarettes: one participant noted that e-cigarettes can be used to smoke cannabis, thereby tricking onlookers to assume they are smoking a tobacco e-cigarette and not a cannabis one.

Youth felt that chronic cannabis use was something that could be easily hidden from friends or family, and that it was something the user had the power to disclose if they liked, but if they did not tell anyone no one would know. One participant observed that cannabis use is "a way to do drugs safely, without like having track marks or scabs growing." In other words, other forms of drug use leave visible signs on the body, whereas smoking cannabis does not leave any permanent signs. Youth designated two types of people who use cannabis: those who keep their use a secret, by not speaking about it at school or doing it alone privately, and those who are more public about their use and more likely to talk about it with friends or smoke openly.

In terms of finding excuses to use, some teens noted that being very busy with extracurricular activities did not necessarily prevent them from using. Instead, they could lie about where they were going to their parents, using these activities as a cover, and be able to use without detection. Participants gave examples of code words developed to mean cannabis, such as "tree," that could be used when someone is looking to buy the drug. These codes translated to emoticons used in social media to signify a dealer has cannabis in stock (e.g., a Christmas tree picture on Facebook preceded by "I got…").

Cannabis Types and Use

Participants were aware that cannabis has different strains and types that could affect a person differently. They considered the cheaper priced strains to have the less favourable effects or no effects at all, whereas the higher priced strains would be the "better stuff" with more favourable effects. In terms of knowing which type had which effect, youth relied on their drug dealer, friends, word of mouth and their own experimentation. Youth also understood that the THC levels in cannabis would dictate the psychedelic effects of the drug with some participants even knowing the difference between sativa and indica (i.e., one resulting in a "lazy" experience and the other in an "energetic" one). Most youth also knew that the THC levels in cannabis have gone up in the past several decades, making the modern substance more potent.

The most common terms used for cannabis were "weed" and "pot." Some other terms used to describe cannabis were "bud" or "green leafy awesome" and "hash," which was said to consist of the oil taken from large quantities of cannabis. There were several examples of variances in cannabis that have been produced and have recently become commonly used. For instance, "shatter" was described as the crystalized version of cannabis, which has the highest form of concreted THC (anywhere from 80%–97%). Shatter was said to be created by pulling THC from cannabis or the "street way," which was described as follows:

> So when you make your concentrates, and you take your butane and put it through, like, a tube or whatever, and you get all your yellow putty. You whip it and put it in a vacuum purge, and that makes the shatter. It takes everything out of it.

Shatter was also named as "Phoenix Tears" or "Rick Simpson Oil." One youth had seen local police speak out on the risks of the drug where it was said to result in psychotic breakdowns and overdoses. According to the participant, the police had to "retract their statement the next day because everything they said was false about it." Next, many participants mentioned "dabs" or "mad dabs," which they described as a more concentrated version of weed or a higher concentration of THC. It was said to be "liquidy, sticky stuff you smoke" in a bong. The use of dabs was considered "hard core" and can get someone higher faster than regular cannabis. Other cannabis-related terms youth described included "spice," which youth knew could be bought legally; "kush," described as a hybrid between hash and weed; "coco puffs," described as little brownie balls full of drugs (mainly cannabis); "budder," sticky

white-coloured pot; and "poppers," which were said to be created by taking cannabis remnants from a bong and a small piece of cigarette and "stamping" them together to smoke.

There were also several methods detailed by the groups of how to use cannabis. The most common form was smoking a joint or blunt, or smoking a bong. Joints were said to be rolled using white paper, while a blunt is rolled using cigar paper. It was said that these methods result in different types of high for youth, with a bong tending to lead to a stronger sensation. Participants also described ways to eat cannabis, which they considered safer than smoking due to the lack of risks associated with inhaling. Ways to eat cannabis included baking it into brownies or cookies, or making cannabis butter to cook with. Participants also mentioned drinking cannabis via tea or even alcohol. Participants mentioned mixing alcohol with cannabis, such as inhaling from a joint, drinking alcohol, then blowing out the smoke. Medical methods of use listed by participants included THC pills or injections, as well as oil, but these methods could all be used recreationally as well. Other ways to use cannabis were through a vaporizer, which was also said to be safer than smoking, as the user does not "get all the bumping plaque matter." More creative forms of use included hot boxing and what one participant described as a "lunger":

> [It is a] bottle cut in half and then they get like a bag and then they put it in there and tape it around and then you get the tape, and make a hole in it. It's like an actual lung, you know how you breathe in, and it like expands? And you suck it up… it goes up. Lunger is harder than the bong and papers, you get more than [in] a bong and in papers.

Lacing

The issue of lacing or adding another drug to cannabis came up in a majority of the focus groups, but with varying accounts and opinions. Some participants did not consider lacing to be a common activity among drug dealers. One participant reported they had never experienced an issue with lacing despite being a regular user, whereas another participant estimated that in their inner circle, only about 10% of the cannabis they used was laced. Conversely, other participants considered drug dealers lacing cannabis as very common and a reason some might fear using it. Of those who considered it common, many had accounts of friends or personal experiences of having very negative reactions to what they assumed was laced cannabis (e.g., vomiting blood) or ending up in the hospital. Youth reported that cocaine, methamphetamine, MDMA, bath salts, crack and LSD were used to lace cannabis.

Generally, youth who had what they considered a lacing experience did not know for sure if cannabis was laced or what it was laced with. Other participants claimed there were ways to distinguish if cannabis contained another substance such as the smell and the appearance. For example, the presence of white crystals or powder among the plant materials could mean that cocaine or meth were present. One participant used a microscope to examine his or her cannabis to ensure it was not laced. Some participants disagreed that lacing was detectable and instead argued it is impossible to tell without smoking the drug. Instead, they relied on the trustworthiness of their dealer to disclose if the plant is laced: "Yeah… and the people we got it from… is a known dealer to my friend who got it and he said he would never lace it with anything or anything like that. He knows the guy well enough that that would never be a problem with him… so I believe him well enough."

The main reason that the youth thought dealers might lace cannabis and not inform their consumers was to make the drug more addictive. By increasing the addictiveness of the cannabis, drug dealers ensure "returning customers" who are hooked on their unique brand:

> Participant 1: [Lacing is] so that way people can buy it more and be, like, "It's the good stuff." And people can get more business buzz from it.

> Participant 2: Yeah, that's what I was saying. Depending on what you lace it with, it makes you addicted to it, and then you can't stop.

Participants reasoned that lacing would be the only reason that cannabis would be considered a gateway drug, as without cannabis being laced with another drug, it would not be addictive. Once laced, cannabis would cause individuals to crave a bigger and better high, and thus buy different drugs from their dealer. Participants also reported drug dealers spraying cannabis plants with substances such as soda pop to make the plant appear wet (i.e., fresh). Other youth felt that dealers "touched up" cannabis with an extra chemical to make the effects better.

Legal Status of Cannabis

When asked about the legal status of cannabis use in Canada, most participants knew it was illegal, but were unclear on the circumstances of legality and often thought there were exceptions to the rule based on how much someone possessed or their age. Some youth thought cannabis possession was only illegal if there was intent to sell it and many youth cited different amounts of cannabis that a person is "allowed" to carry before police can charge them with trafficking. For example, more than an ounce, three grams or more, or "amounts divided into individual baggies" were all cited as reasons youth would be charged with trafficking. Some participants felt that police could not do anything if they were caught with cannabis if it was under a certain amount and that "it's legal to smoke on 4/20."

Youth were unclear on what is meant by decriminalization. They considered decriminalization to mean they would not face consequences from police if they possessed cannabis and that this would be the first stage in the process of legalization. One participant remarked: "decriminalization is pretty much the thing they're going to do before they legalize it. What the decriminalization means is that you can walk around carrying a joint, and the cops won't bust you for it." Other youth knew decriminalization would result in fines for possession and use. Of concern, a number of the youth claimed they do not think much about cannabis laws or that they and other youth do not care about the laws.

This confusion could stem from the different ways in which cannabis is being handled across Canada and internationally. For example, some youth brought up the presence of cannabis dispensaries in British Columbia and assumed these dispensaries indicated the drug was legal. Similarly, the prevalence of cannabis use for medical purposes seemed to skew participant's understanding of legality, but they reported that one needed a medical cannabis card from a healthcare provider to obtain cannabis from Health Canada.

All of the participants were well aware of the impending possibility of the legalization of cannabis and enthusiastically contributed their opinions on the matter. Some were aware of the debate surrounding the issue and the complexities of the process. One participant had cited international treaties as a barrier to this legislative change: "[Trudeau] technically can't because there is actually like a treaty that says… I can't remember, but my dad told me that he can't actually do it, it is against the law. It would be breaking something, so…"

Generally, most youth were supportive of legalization, but there were a small number who were not. Youth's opinions on this issue are summarized in the following subsections:

Support for Legalization

Participants identified a number of possible benefits from legalizing cannabis. Primarily, they maintained their opinion that cannabis is not a harmful drug and has several medical benefits (e.g., a natural alternative to prescription drugs). They saw legalization as an opportunity to regulate and monitor the growth and distribution of the drug. Youth speculated that this regulation would result in a safer and

better product, free of any inappropriate additions and less availability of the drug to youth. They also saw legalization as an economy booster or debt reducer in terms of profit, as well as a stimulator of Canadian tourism. Some participants hoped that funds from legalization could be funneled into areas such as health care and education. Similarly, participants hoped the funds saved from the decrease in cannabis-related enforcement and corrections could be allocated to detect what youth considered more "important" criminal activities such as cocaine sales.

Many participants were confident that legalization would put cannabis dealers out of business and effectively shut down the black market. They also argued that legalization will "keep innocent people out of jail," as they did not consider possession or use of cannabis as a valid reason for someone to end up behind bars.

Those who were supportive were less concerned with the ramifications legalization could have for youth. They felt youth would retain the prevention messaging to which they had previously been exposed and continue to base their decisions about use on their understanding of cannabis harms. Similarly, they felt that legalization, in removing the taboo of use, will result in less interest from youth, as it will not be considered rebellious to smoke cannabis legally: "I find too that people always say that when you are a teenager drinking is like scandalous, when you turn 19 it's not like a big deal anymore, so that can be part of the appeal [of smoking cannabis] maybe, is that it is illegal and that's why people might be interested in it." Regardless, in their opinion, youth will smoke cannabis any ways so it might as well be legalized.

Some supporters of legalization recognized the importance of ensuring youth do not access the drug and that impaired driving does not increase. They advocated for secure control of the drug by the government and that it should be treated in the same manner as alcohol or cigarettes, where use would be allowed only in private homes or designated public areas with no access for minors.

Against Legalization

Youth cited fewer reasons against legalization. Mainly, youth were concerned that legalizing cannabis would force drug dealers to push harder drugs on clients in order to maintain their profits. Cocaine was the most common drug cited as the "replacement" drug for cannabis in this situation. It was also thought that legalizing cannabis could cause youth to feel more comfortable using the drug as they might assume they would not be in as much trouble from their parents as they would be if it was illegal. Conversely, one participant suggested that, regardless of legalization, parents will still be against cannabis use, meaning legalization does not benefit youth in any way. Legalization was also seen as unbeneficial because of the age limit that would be put in place: this limit would limit youth access and thus require youth to still purchase through the black market. They felt the drug would be highly taxed, meaning high prices, and participants felt that since the population is going to use cannabis anyway, the government was undeserving of cannabis-generated profits. Youth were also concerned the government would lower the levels of THC in the drug, making it less potent.

Societal Influences on Cannabis Perceptions

Key social influences were found to play a role in shaping youth's perceptions of cannabis such as the portrayal of cannabis in the media, including social media, the use of cannabis for medical purposes and response from enforcement to cannabis-related illegal behaviours. These influences are summarized in the following subsections.

Portrayal in the Media and Social Media

Participants reported that the portrayal of cannabis in the media (such as in the news, movies, songs and online) was inconsistent and biased with depictions often skewing drastically towards positive or negative. In terms of Hollywood portrayal in movies and on TV, youth described cannabis depictions as very happy, fun, mellow and party-related, where characters faced no harms and had "awesome" experiences. Similarly, youth mentioned they had never seen on the news or in fictional shows accounts of someone going to jail for cannabis possession. This bias influenced some of the participants' opinions on the harmfulness of the drug with one participant stating "rich people use it so it can't be bad for you." All youth brought up influential figures they connected with cannabis use, especially musicians such as Miley Cyrus and Snoop Dog. Many even quoted the same line from a popular song, "smoke weed every day." Such influential figures were a major cultural influence that was not specific to any jurisdiction. Most youth realized this portrayal was unrealistic with a few youth acknowledging that it could undermine prevention efforts.

Discussion or information about cannabis appears commonly on social media as well. Youth mentioned cannabis being openly discussed on Snapchat, Twitter, Instagram, YouTube and, to a lesser extent, Facebook through videos, memes (i.e., humorous image shared on the Internet), articles and statistics. Participants were under the impression that youth who posted videos of themselves using cannabis were not worried about getting caught by police or parents, as they believe authority figures do not use social media. Participants described social media as making cannabis seem "friendly" and risk free and felt this portrayal was influential in shaping other youths' opinions about the drug.

Cannabis for Medical Purposes

Participants were divided in their feelings about the validity of common medical uses of cannabis. For some participants, the use of cannabis for medical purposes delegitimized the information about the harms of cannabis, which led them to argue there is no reason for cannabis to be illegal. Some youth felt that cannabis's negative reputation is a result of the "government" and other information sources "exaggerating" the dangers of the drug. With this in mind, they believed that the drug was not harmful, but instead actually very useful for medical conditions such as chronic and acute pain, arthritis or seizures and other practical uses (e.g., hemp).

Some participants, on the other hand, were skeptical of this view and felt there was more to the story. They were under the impression that cannabis might not be as risky as it had been made out to be, but that the information that argues cannabis is a cure to all medical ailments (they used the example of curing cancer) was very unlikely. They thought critically about the information they read or heard that supported the use of cannabis for many medical treatments and realized there might be two sides to the story. For instance, one participant noted:

> Well, now you are seeing all these, like, medicinal like…. The, like, 50,000 diseases it can cure all of a sudden and stuff. Most of it probably could not be true. There is no way one drug can cure like all these diseases. I'm sure it has tons of medical pop. It has medical benefits, just not what we are seeing.

Some participants did not think cannabis should be abused for its recreational purposes, but instead use should be restricted to strictly medical needs: "Yeah, a lot of people say, well, it's medicine. Why can't I use it? But… at the same time it's not just medicine. It's prescription medicine. You can't take someone's Adderall. That's illegal." Others felt it was unfair that cannabis can be used medically, but not recreationally, and went as far as to say they would like to ask their doctor for a prescription, although this was usually said in a joking manner.

Response from Enforcement

Perceptions of the response of enforcement to cannabis appeared to play a significant role in the way that youth perceived the risk of cannabis and cannabis use. Overall, youth did not consider enforcement of cannabis laws, especially for teenagers, to be very strict. Instead, they were under the impression that police officers would let youth go with a warning if they were caught using or possessing a relatively small amount of cannabis. Similarly, youth were not concerned with being reprimanded for driving while high or driving with cannabis in the vehicle. They had only heard of or had experiences where police asked drivers about alcohol, but not cannabis. There were some participants who did not know of the capabilities of police in detecting driving while impaired by cannabis.

These impressions could be related to the lack of visibility noted by participants about cannabis enforcement. Youth, who appear to form opinions on topics through what they hear from friends or older peers and siblings, were often unaware of the legal ramifications of cannabis use and cannabis-impaired driving, or the likelihood of apprehension, reducing their concerns for being caught themselves. They also held the notion that police had "better things to do" than spend resources on enforcement of cannabis laws and that this was not a priority for them:

> See, my dad's a police officer, so I know that they don't crack down as hard anymore [on those who use cannabis] in a lot of situations because it's becoming such a big part of the culture, especially where it's going to be legalized that it's, like, they have to kind of choose what they have to prioritize.

Instead, participants reported that police will "turn a blind eye" and give youth using cannabis a warning. One participant went as far as saying police are corrupt and those who do bust youth for possession are turning around and using or selling the confiscated cannabis.

Conversely, when discussing the legalization of cannabis, participants expressed the opinion that enforcement at this time is too strict in regards to cannabis and that a relatively "safe" drug such as cannabis does not warrant this response. For example, one participant said:

> They treat you like heartfelt, cold-blooded criminals for supposedly having it on you… or without any proof and they treat you like garbage… I don't think so. I don't understand how that's legal… I mean just treat you like… you know, when there's nothing wrong with marijuana… like.

This duality in perceptions — enforcement generally does not prioritize cannabis while simultaneously being too hard on users — was a contradiction that could be contributing to the lack of clarity among youth about the risks and legal status of cannabis.

Experience with Prevention Approaches

Participants identified inconsistent information and messaging as a major barrier to teaching youth about the effects of cannabis. There is a plethora of conflicting research about the harms and benefits of cannabis, as well as pro-cannabis and anti-cannabis groups advocating for different agendas. With access to these resources online, youth are free to make their own assumptions about the drug, being able to pick and choose which information they want to believe. Participants said this lack of clarity was compounded by the availability of cannabis and cannabis-related products to the public.

A majority of participants, if not all of them, reported using the Internet as a source of cannabis information. Many youth struggled to distinguish between credible and not credible sources and

were often confused by contrary research or findings, often causing them to discredit all research on the topic in its entirety. Many youth recognized that proponents of cannabis use might be biased when writing "informative" articles, similarly with those who do not support the drug. Sources youth used to research cannabis included Google, Wikipedia, .org and .edu websites, Reddit, pro-cannabis groups, political parties, and government and health agencies, and, for those who had problematic use, counsellors and treatment providers. Youth had difficulty relating to news sources as these represented a "parental" or "adult" perspective making these sources inherently "anti-drug" in their eyes. Some youth made an effort to find credible sources or to verify results through more than one source, but reported that such verification was challenging. In order to form their opinion on the topic, youth often relied on friends, drug dealers or their own personal experiences.

Although most participants had some memory of receiving prevention messaging about cannabis in previous years, very few remembered what they were taught. The clearest message was the "just say no" message, which did not resonate well with youth. A smaller number of participants commented that they did not receive any prevention messaging and if they did they cannot remember it any longer. The most commonly mentioned prevention efforts that youth remembered participating in were presentations given at assemblies, such as the DARE program, and some graphic imaging. Many youth cited a commercial they had seen on brain damage and drugs. Other media prevention efforts were seen as corny or unrealistic. Some youth remembered harms being touched on in health class, but many youth had not received this information via the standard curriculum. Prevention efforts were often brief, at an early age, with no additional information provided in later years.

Youth felt that an adult or person of authority, such as a police officer, talking to a class in a presentation-style format was boring and ineffective. These presentations were seen as an excuse to skip class or an assembly with those attending tuning out or soon forgetting what they learned. Many were not optimistic about prevention efforts; instead they concluded that youth are going to smoke cannabis regardless of prevention efforts and there is not much that can be done to stop this.

Suggestions for Future Prevention Approaches

Although many participants were under the impression that it was very difficult, if not impossible, to prevent cannabis use among their age group, they did provide some recommendations for future prevention efforts. These recommendations are discussed in the following paragraphs.

Delivery by someone with experience. Participants agreed that someone who had experience with cannabis use, both positive and negative, would be the best positioned to deliver prevention messaging to youth. Many youth assumed that authority figures such as teachers, police, parents and councillors, had no experience with cannabis use, did not understand the circumstances and pressures faced by modern youth, and were thus unable to provide youth with the perspective they are seeking. They felt these figures of authority simply wanted to keep them away from cannabis because it was illegal. Hearing about the harms and benefits of cannabis from someone who has used, especially someone close to their age, on the other hand, was seen as more legitimate by this age group and would provide an opportunity for them to ask questions where they would not have to fear getting in trouble.

Give both sides of the story. One of the most consistent suggestions made by participants was to cease the "just say no" prevention approach and instead provide youth with unbiased, evidence-based information on both the positives and negatives of cannabis use. Youth consider cannabis prevention as an important addition to the curriculum, through health class for example, but only if it is not delivered in a "preachy" manner. Messaging that is overly dramatic, such as "you'll die if you smoke cannabis," is immediately discredited by youth as an exaggeration, but research supported

facts might be taken more seriously. These facts can be used to help youth make informed decisions on their own, as opposed to being told how to behave. Participants also advocated for more research on the positive aspects of cannabis and the incorporation of this research into prevention efforts.

Harm reduction. Although participants did not use the term "harm reduction," many suggested teaching youth harm reduction strategies, in the form of low-risk cannabis use guidelines. In this instance, the analogy of sexual education was often used, where participants pointed out it is ineffective to tell youth not to have sex. Instead, youth should be taught about birth control. Participants felt a similar approach would work well with cannabis use; that is, youth are "going to use it anyways," so it could be beneficial to show them how to do so safely. Participants wanted "cut offs" for how often they can smoke cannabis before it will do any damage, suggesting messaging of "moderation" as a possibly effective route.

Begin efforts earlier with consistent follow up. Participants felt it would have been beneficial for them to receive drug education and information immediately before they entered high school where they were faced with opportunities to use drugs, and then consistently throughout their education, whether through health class, driver education, assemblies or guest speakers. Many youth reported forgetting what they had learned because it had been delivered too early or too infrequently, and suggested prevention education should be frequent and mandatory for teenagers.

Different approaches based on target audience. There were differences noted by the participants in how certain groups of youth responded to prevention messaging. For instance, differences were found to be related to gender, educational aspirations, family life and cannabis use experience. Participants acknowledged that peers who are higher achievers are more likely to respond well to certain prevention messages, whereas those who are less concerned with doing well will be less affected by this type of messaging. Similarly, it was said that those youth who have already started cannabis use at the time they receive prevention programming might be less influenced by this message. They are more likely to apply the "that-won't-happen-to-me" rationale when learning about the harms, whereas a student who has not begun use could be more affected by the potential consequences of cannabis use. Participants felt that prevention messaging needs to be targeted based on a youth's pre-established behaviour and attitudes.

Provide more or different information. Participants suggested a number of topics that they feel are not covered sufficiently by current prevention efforts. These included:

- Drug-impaired driving education;
- Explanation of the ways in which drugs affect the body, as opposed to only learning the effects (e.g., cannabis affects the developing brain vs. cannabis can damage the developing brain due to the increased THC in the pre-frontal cortex, possibly jeopardizing executive functioning);
- Dangers of synthetic cannabis;
- How use will affect you as an adult;
- Potential for cannabis addiction;
- Potential effects on mental health;
- Effects on the brain; and
- Strategies to quit cannabis use.

Those participants who had experienced harms from cannabis use that they were not previously aware of, were particularly adamant about warning youth about these potential consequences. For example, one female participant spoke of the detrimental experience she had with cannabis and how she wished she had been warned:

> But, like, the worst part of marijuana for me is, like, this crippling anxiety I live with day to day. And if somebody would have told me that this is what my life would be like for the rest of my life or until I can find a way to, like, get this out, like, I hate it. I hate it so much. I would rather have my arm chopped off then have to deal with this.

As is often the case during adolescence, youth are less likely to heed warnings of harms if they do not perceive the harm as something realistic to them.

Discussion

Research shows youth are unclear on the effects and harms of cannabis, which could put them at an increased risk for use (Johnston et al., 2015). This increased risk is concerning, as brain development and mental health can be compromised if cannabis use, particularly frequent use, is initiated in early adolescence (George & Vaccarino, 2015). Canadian youth have one of the highest rates of cannabis use worldwide (World Health Organization, 2014), illustrating the need for a better understanding of the misconceptions and attitudes youth have towards cannabis.

The objective of the current study was to confirm and extend the work previously conducted by CCSA (Porath-Waller et al., 2013) with a view to informing prevention initiatives. This study aimed to examine what common misconceptions are held by youth, where gaps in evidence-based information exist and how best to move forward with prevention efforts. To do so, 20 focus groups with 77 youth were conducted across Canada using a similar approach to that of the previous investigation by Porath-Waller et al. (2013). The findings from this research can be used to educate parents, teachers and youth on the effects of cannabis use and to aid policy makers, prevention specialists and researchers in developing effective evidence-based prevention efforts for youth. This discussion will highlight key themes observed from the current study, specifically about risk factors for youth cannabis use, and will compare and contrast how the results differ from previous investigations, including key determinants that influence youth's decisions to use cannabis, misconceptions or gaps in knowledge related to the effects of cannabis, and external factors that can contribute to these misconceptions. The discussion will also identify implications of these results for prevention programs, practice and policy.

What Youth Know

This study intended to uncover the perceptions youth hold about cannabis. Although the study found many misperceptions, there were a number of examples of the correct knowledge youth held about the effects of cannabis for both the 2013 and 2016 focus groups[8]. For instance, participants from each study agreed that smoking cannabis can damage lungs and possibly cause cancer. Respiratory issues were mentioned as a concern in the focus groups conducted by Health Canada (2014b) as well. Similarly, some participants were aware that cannabis is addictive, can affect the brain and impairs driving. It would be beneficial to explore further why these particular harms have resonated with certain youth while others have not. One theory is that past prevention efforts related to similar harms such as those targeting impaired driving or cigarette use and lung damage make similar messaging more easily received. Interestingly, participants in the 2016 groups reported that some youth are changing how they use substances in order to mitigate the potential for harms; for example, baking cannabis into cookies and ingesting it orally to avoid lung damage. This trend was supported in a quantitative study of Colorado high school students conducted by Johnson et al. (2016) that found that high perceived harmfulness of cannabis was associated with vaporizing or ingesting edibles instead of smoking. Similarly, some participants claimed that designated drivers "only smoke weed" at parties instead of drinking, as it is "less impairing." This view suggests that if youth believe there is a significant risk of harm due to substance use, they might alter their behaviour. Unfortunately, this fear might not result in a decrease in use, but instead alteration in how or what is being used, illustrating the importance of understanding how education on harms can impact youth cannabis use.

8 Direct comparisons between both studies should be interpreted with caution as these studies were conducted separately by different researchers with a similar methodology.

Another topic of discussion among youth was about cannabis as a gateway drug. The 2013 groups appeared to be more supportive of this concept, whereas participants in the current study instead attributed the gateway affect to alcohol use, arguing that alcohol use is the gateway to cannabis use. This effect was found by Kirby & Barry (2012) using Grade 12 data from the 2008 Monitoring the Future study. Participants in the present study appeared to have a better understanding of the potential for addiction to cannabis than those who participated in the 2013 focus groups. Similarly, there appeared to be a higher level of agreement that cannabis negatively affects driving. This change is encouraging as it could indicate cannabis prevention messaging is having an impact on youths' knowledge. Youth were also asked about the effect of cannabis on brain development, something that was not discussed in the 2013 groups. Participants were fairly confident that cannabis affects brain health in some manner, but were unsure how. Youth would benefit from more information about the mechanisms behind the effects of cannabis on the developing brain.

Why Youth Use Cannabis

Understanding why youth use cannabis provides an opportunity for researchers to identify potential risk factors for cannabis use and dependence.[9] The reasons for use and the attitudes and beliefs observed in the current study, as well as previous research, correlate with a number of risk factors for use, such as lack of parental monitoring, perceived availability and accessibility, positive attitudes towards use and lack of understanding of harms associated with cannabis use.

Influence of Friends, Family and Community

The current study revealed reasons for use that were also found in the 2013 focus groups and in previous research; mainly, the desire to feel connected, whether it be through friends, family or community. These reasons are discussed in detail in the following paragraphs.

In terms of "important others," participants in the focus groups for the current study reported that youth value their friends and peers, and might use cannabis as a means to penetrate or remain within a peer group. Similarly, the assumption that "everyone's doing it" played a role in youths' acceptance of cannabis use as did the relative normalization of the practice as a means of socializing comparable to having a beer with friends. Other qualitative studies have found that youth report cannabis use to increase confidence and their ability to communicate and socialize (Perth District Health Unit, 2012; Stavropoulos et al., 2011) and that peer pressure plays an important role in influencing cannabis use (Porath-Waller et al., 2013; Health Canada, 2014b). This influence is concerning as peer use of cannabis, perceived use of cannabis among friends and beliefs about peer use are all risk factors for cannabis use (Ali, Amialchuk, & Dwyer, 2011; Stephens et al., 2009; Pinchevsky et al., 2012; Pejnovic, Kuzman, Pavic, & Kern, 2011).

Secondary to peers, parental influence was noted to play a role in youth cannabis use in both the 2016 and 2013 focus groups, albeit 2013 participants seemed more concerned with disappointing parents or getting in trouble than their 2016 peers. Participants in both groups reported that parents who use the substance or do not have a consistent presence in their teen's life could increase the likelihood of use by their child. Weak family cohesion and low parental monitoring were also identified as risk factors by participants in Alhyas et al. (2016). In terms of risk factors for use related to parents, low levels of parental involvement with youth, family disruption and parents having used

[9] Dependence is physical dependence on an addictive substance, where an individual experiences withdrawal symptoms when the substance is removed. Dependence can occur with or without the psychological and behavioural symptoms, such as compulsive use and craving, associated with the disease of addiction. A person who is dependent on a substance is only able to function normally when that substance is present in his or her system.

cannabis all relate to an increased risk for use of cannabis for youth (Low et al., 2012; Pinchevsky et al., 2012; Miller, Siegel, Hohman, & Crano, 2013). Conversely, protective factors related to parents include parental monitoring of youth, beliefs by youth that their parents are monitoring their behaviour and mothers who disapprove cannabis use (Dever et al., 2012; Tang & Orwin, 2009; Musick, Seltzer, & Schwartz, 2008).

Finally, one's environment was also mentioned by participants in the 2016 and 2013 groups as a possible influence on cannabis use; for example, living in a "bad neighborhood" could lead to use. Community is said to increase likelihood for youth cannabis use, for instance, if youth feel that community norms are favourable to substance use and if the neighborhood is unsafe due to crime and drug sales (Van Horn, Hawkins, Arthur, & Catalano, 2007; Nalls, Mullis, & Mullis, 2009).

Perceived Availability and Accessibility

Aside from the influence of others, participants in the current study reasoned that cannabis use could be a result of availability and accessibility. Accessibility and perception of availability have also been highlighted as contributors to use in previous focus groups (Perth District Health Unit, 2012; Alhyas et al., 2016; Health Canada, 2014b). These are also indictors of risk for use: that is, those youth who have cannabis available to them or an accessible opportunity to use it are more likely to do so (Fagan, Van Horn, Hawkins, & Arthur, 2007; ter Bogt et al., 2014; Martino, Ellickson, & McCaffrey, 2008; Collins, Abadi, Johnson, Shamblen, & Thompson, 2011).

Stress and Mental Health Management

In the 2016 focus groups, cannabis was reportedly "self-prescribed" by youth to address serious mental illness such as anxiety, PTSD or depression, as well as for relaxation purposes with the goal of "medicating" cognitive or mental illness. This reason for using cannabis was similarly reported in the 2013 focus groups, as well as others previous studies (Perth District Health Unit, 2012; Health Canada, 2014b, Stavropoulos et al. 2011). The belief that cannabis will relieve stress and help an individual relax has been cited as another risk factor for use (Hayaki, Hagerty, Herman, de Dios, Anderson, & Stein, 2010). This rationale is concerning as research is still inconclusive about the relationship between mental health and cannabis use, meaning caution should be exercised when self-medicating with cannabis to address mental illness as it could have the opposite effect (George & Vaccarino, 2015; McInnis & Porath-Waller, 2016).

Misconceptions

Other risk factors for cannabis use and dependence include a decrease in beliefs about the harms of cannabis, positive attitudes towards use and belief in the positive benefits of cannabis (Stephens et al., 2009; Pérez, Ariza, Sánchez-Martinez, & Nebot, 2010; Johnston et al., 2015). In certain cases these positive beliefs and attitudes are misconceptions about the drug. A number of misconceptions were expressed by the participants in both the 2016 and 2013 focus groups, illustrating the need to rectify these beliefs in order to advance prevention efforts. Some misconceptions are discussed in the following paragraphs.

"Cannabis isn't addictive"

Participants in both the 2016 and 2013 focus groups cited that youth come to rely on cannabis for the positive feeling derived from using the drug. They noted that as time goes on more of the drug is needed for them to maintain that feeling. In addition, many participants observed that when use is stopped the individual becomes "grumpy" or "agitated." These descriptions are consistent with the

signs and symptoms of cannabis dependence and withdrawal. Interestingly, a fair number of participants from the 2016 and 2013 groups did not think that cannabis was addictive in the traditional sense and did not believe that heavy use of the drug would result in withdrawal symptoms. This view suggests a prevention opportunity: there is a need to link youth's observations of dependence and withdrawal due to cannabis with the clinical definition of these conditions to show youth that cannabis is similar to every other drug in terms of risk for negative effects. Encouragingly, there were youth in both the 2016 and 2013 groups, as well as in the Health Canada (2014b) study, who reported that cannabis is addictive.

The concept of "greening out" came up in the 2016 groups, which was described as something similar to a drug overdose. Despite this concept, participants knew that it is not possible to overdose on cannabis. This view illustrates that, although youth might not understand why, there is acknowledgement of immediate negative effects of cannabis use. Youth could benefit from information about immediate risks and harms associated with cannabis use (See George & Vaccarino, 2015 and CCSA's Clearing the Smoke series for information on the risks and harms of cannabis use for youth).

"Cannabis isn't harmful"

Most youth in the current study as well as previous studies (Health Canada, 2014b; Porath-Waller et al., 2013; Alhyas et al., 2015; Roditis & Halpern-Felsher, 2015) were under the impression that cannabis is "safe" or does not have significant harms, especially when compared to other substances. The perception that cannabis is not harmful or is only somewhat harmful has been shown to be a risk factor for use (King, Vidourek, & Hoffman, 2012). Depending on the study, varying arguments are given for this risk factor. For example, participants from the current study relied more on the argument of comparison with alcohol or pharmaceuticals to illustrate the safety of cannabis, whereas participants from Porath-Waller et al. (2013) reasoned that cannabis is safe because it is a plant and is natural. This difference in reasoning could possibly be illustrative of some successes in terms of teaching youth about cannabis harms: 2016's participants were more willing to admit cannabis can be harmful, but did not consider these risks concerning as they are "much less" than alcohol, whereas the 2013 participants relied on the "natural plant" aspect, essentially implying plants are not harmful.

"Cannabis effects depend on the person"

Participants from the current study felt that the effects of cannabis use depended on the person, which aligns with findings from the 2013 study. Youth in the current study rationalized that the reason for this variance in cannabis effects is based on the person and their attitudes, as opposed to the drug itself. This rationale provided youth an opportunity to selectively decide when the substance is safe or harmful, mainly when it was beneficial to them. It provided youth a rationale for smoking "every once and a while" or for getting in a car with a driver who had smoked because "it doesn't affect them." The rationale is concerning as youth appear to depend on this notion in order to justify their use: that is, they acknowledge harmful side effects exist, but these are applicable to "someone else" and not themselves. As mentioned above, the belief by youth that they are not susceptible to these harms puts them at risk for greater use (King et al, 2012). It would be beneficial to alter this perception, where instead youth are concerned with the unpredictability of cannabis effects and would rather not take the risk for exposure to the effects instead of assuming they are exempt.

Other Influencers

There are three other themes apparent throughout the focus groups about the influences on youth perceptions of cannabis. These were the Internet and media, the debate about cannabis legalization and the perceived response by law enforcement to cannabis use.

Internet and Media

Results from the current study revealed that youth appear to receive most of their information about cannabis from friends, peers and media, and to a lesser extent siblings and parents. Similar results were found in a study conducted by Alhyas et al. (2016). Youth from the current study described cannabis use as "normalized" in the media and online, with a plethora of information available that supports or condones cannabis. Participants appeared to struggle with critically evaluating these various types of information and discerning which conclusions are valid and which are highly biased; this perception was also supported in Perth District Health Unit (2012).

Youth in both the 2016 groups and 2013 groups often mentioned the portrayal of cannabis in the media as having an influence on how teens see the drug. For instance, 2016 participants described cannabis in the media as glamourized, while 2013 participants described media presentation of people who use cannabis as negative (where the person is "dumb" or "lazy"). This difference could indicate a shift in how individuals who use cannabis are portrayed in the media, which could have corresponding effects on youth. The current study also asked participants about the influence of social media in youth's perceptions of cannabis. Results show there is a high presence of supportive comments about cannabis on social media and youth are not afraid of exposing their use online. This trend could be detrimental in that it gives youth the impression that cannabis is acceptable and that use is not met with severe consequences.

Legalization

The current study provided an opportunity for youth to share their opinions on the legalization of cannabis, an issue that has not been discussed in much detail in previous studies. Participants reasoned that legalization would lead to better regulated and thus "safer" cannabis, which would also mean the government would be controlling the substance. The debate over legalization appeared to permeate the discussion in other areas as well. For example, participants argued it was unfair that cannabis was illegal as "more dangerous substances" such as pharmaceuticals and alcohol are legal. Compared to participants in the 2013 groups, youth in the current study seemed to express less fear of the health and legal consequences related to cannabis, which could also be due to the prospect of legalization signalling to youth that the drug is "safe."

Enforcement

Participants from the 2016 groups seemed to lack any concern for being apprehended by police for cannabis-related issues. Only a very small number of participants highlighted "fear of getting caught" by police as a reason to abstain from cannabis use. Instead, youth described police as indifferent to their cannabis use and were under the impression law enforcement would not do anything about it, even if they were aware of it. Instead, youth assumed police prioritize "more important" matters and were likely to let youth off with a warning, if they were apprehended. This view illustrates another risk factor for use: the perception that law enforcement agencies are permissive of substance use (Van Horn et al., 2007). Inconsistent reactions from police to youth cannabis use were also documented in the Porath-Waller et al. (2013) study as something that confused and frustrated youth.

A finding unique to the current study was that participants had never or rarely heard of car accidents due solely to cannabis. On the other hand, they had heard of many instances where alcohol-impaired driving caused a crash. Consequently, participants lacked concern about cannabis-impaired driving. Youth appear to have internalized an anti-impaired driving attitude towards alcohol, but do not extend this attitude to cannabis-impaired driving. This gap could be related to youth's concept of impairment, which has been developed by the discourse on alcohol-impaired driving. Individuals who use cannabis are unlikely to exhibit these behaviours, which means cannabis impairment is less visible to youth, putting them at risk for unknowingly riding with a cannabis-impaired driver.

Implications for Prevention, Practice and Policy

The findings from this study point to the complexity surrounding youth perceptions of cannabis, and confirm the importance of evidence-informed messaging to youth about the effects of the substance. In particular, clearer, targeted messaging about the role of law enforcement, the legal status of cannabis, the risks related to cannabis-impaired driving and the definition of cannabis impairment could help to increase awareness of the harms associated with cannabis use while also influencing youth to examine their misperceptions in light of factual information. The findings also highlight implications for the increased involvement of parents and the community, and for programming.

Provide clarity around cannabis-impaired driving. A shift toward recognizing cannabis-impaired driving as unsafe needs to occur that is equivalent to the shift in public understanding of the risks of alcohol-impaired driving. Currently, youth visualize impairment as someone being drunk. Prevention efforts should emphasize that just because cannabis impairment is not easily identifiable, that does not mean a driver is not impaired (Beirness, 2014). Messaging such as "impairment isn't only on the outside" and that it is different among individuals could be useful. Youth should be encouraged to plan a safe ride home or ask friends or adults who are driving if they have used cannabis and to not get in a car with someone who has. It is important that youth refrain from using alcohol-impaired driving as the standard by which they measure impaired driving due to cannabis. While cannabis-impaired driving appears "safer" in comparison, the baseline should be sober driving, not alcohol-impaired driving. It could also be beneficial to increase awareness of the ability of Drug Recognition Evaluators to detect cannabis-impaired driving and to emphasize that police are checking for cannabis along with alcohol and other substances at sobriety checkpoints.

Increase education about the risks of cannabis use. An apparent lack of awareness of the negative effects of cannabis points to the need for more education for youth through schools and youth-based organizations. Youth should be aware that there are health and legal consequences associated with cannabis use, and this awareness can be achieved by targeting youth's personal priorities and making the potential for long-term consequences clear. For instance, education programs can illustrate how cannabis can affect academic performance through impacts on the brain and athletic performance through harms to the body. Programs could use social norming campaigns, where information is provided on the actual prevalence of drug use among youth of a particular age, thus illustrating that youth might be overestimating that "everyone's doing it"(Berkowitz, 1997). Education should act as one piece of a multifaceted approach to prevention.

Provide both sides of the story, including harm reduction strategies. Youth consistently recommended adding content on the positive effects of cannabis to prevention initiatives, which have traditionally focused on the harms. Many youth claimed that this gap in information made the more harmful claims appear overstated, causing youth to disregard these initiatives all together. Instead, youth would value a breakdown of what research exists about cannabis harms as well as its positive uses, mainly those that are medical in nature. Similarly, youth wished guidelines were available that outlined

"safe" cannabis use, such as "how much you can smoke before you damage your brain" or "how often you can smoke before risk of lung cancer." Participants reasoned that youth will be using cannabis regardless, so resources would be better spent aiming to reduce harms related to use. Harm reduction has been shown to decrease risky behaviour among this population (Leslie, 2008; Poulin, 2006).

Begin efforts earlier with consistent follow up. Several participants were of the opinion that prevention efforts should begin earlier in youths' education. Some participants felt messaging was delivered "too late" because use had already started. Other participants had no recollection of these interventions or could not recall the key messaging. This lack of recall points to the need for follow up with prevention messaging and efforts to target appropriate age groups. Both of these recommendations have been shown to be effective (Canadian Centre on Substance Abuse, 2015a).

Teach youth skills for critical analysis. With scientific information becoming more available, it becomes crucial that youth understand how to critically analyze the "facts." Almost all youth who participated in the current study reported using the Internet and social media to find information about cannabis, but only a small number stated they had attempted to verify information by consulting multiple sources. Enhancing youth competency to critically analyze information could prevent ill-informed decisions about cannabis use (Griffin & Botvin, 2010). Youth should be made aware that not all information is accurate or evidence-based. Similarly, there is no conclusive evidence on certain issues about cannabis use (e.g., cannabis use and mental health). Youth should use caution when interpreting research results. Youth need to be encouraged to access evidence-based resources, possibly through school or youth-friendly avenues (e.g., social media).

Target approaches based on audience. Each focus group included youth from various backgrounds including those from rural or urban settings, those accessing community services, those who had experience with addiction and other issues, those enrolled in advanced education courses and those with Indigenous heritage. Each demographic group connected differently with different types of prevention efforts. Research shows there is value in targeting prevention efforts to the audience: cannabis use has been shown to vary by country, GDP, family affluence, race and gender (ter Bogt et al., 2014; Wu, Swartz, Brady, Hoyle, & NIDA AAPI Workgroup, 2015). Targeting efforts can be done by involving youth in the development of initiatives and allowing youth to deliver programming to their peers. If their peers are perceived to be unsupportive of cannabis use, youth might be more likely to reject the drug and abstain from use (ter Bogt et al., 2014; Pinchevsky et al., 2012; Walker, Neighbors, Rodriguez, Stephens, & Roffman, 2011; Pejnovic et al, 2011).

Provide youth with tools to manage stress and mental illness. Many youth reported using cannabis to manage their stress, anger or anxieties. This evidence illustrates a need to educate youth on alternative options to manage these issues and to provide more avenues for communicating about and discussing their difficulties (Griffin & Botvin, 2010). Options include treatment services, peer or school counsellors, and support from parents and friends. By addressing these issues through other avenues than cannabis consumption youth will be better equipped to maintain their mental health and will no longer need to rely on cannabis as a means to escape. Youth could be motivated by the possibility of using another form of treatment apart from cannabis and need to be informed that there are alternatives available (Stavropoulos et al., 2011).

Strengthen parental involvement. Parental monitoring or perceived parental monitoring have been shown to play a protective role in adolescent substance use (Schofield, Conger, & Robins, 2013; Dever et al., 2012; Farhat, Simons-Morton, & Luk, 2011; King et al, 2012). Participants in the current study believed that a lack of parental involvement or parental encouragement of youth could play a role in youth cannabis use. Very few youth from the 2016 focus groups reported having open and

honest conversations with their parents about cannabis use. Similarly, parents and youth in the Health Canada (2014b) study reported parent–teen conversations about cannabis were reactive in nature as opposed to proactive. The Health Canada study also found that parents want more information on the effects of cannabis use on brain development, mental functioning and mental health. It could be beneficial to provide parents with education on cannabis harms and the tools for monitoring and speaking with youth about use (Canadian Centre on Substance Abuse, 2010; Boyle, Sanford, Szatmari, Merikangas, & Offord, 2001; von Sydow, Lieb, Pfister, Höfler, & Wittchen, 2002).[10]

Increase capacity for addressing cannabis use among those working with youth. Providing practitioners such as teachers, coaches and community workers with evidence-informed tools and resources on cannabis will ensure they are equipped to inform youth about it. Teachers are well positioned to deliver prevention initiatives related to cannabis due to their familiarity with students. For instance, Moffat, Haines-Saah, & Johnson (2016) found that a classroom intervention that focused on decision making created a neutral environment to engage students in discussion. This dialogue supported critical inquiry and provided an opportunity to encourage youth who use cannabis to stop or reduce use. Both teachers and students were receptive to this intervention format. Similarly, healthcare professionals working with youth can help to identify risky cannabis use early. Screening for cannabis use followed with referral to treatment can prevent more serious use of cannabis (i.e., chronic use, dependence) and encourage youth to access services they would not have accessed without guidance from their healthcare provider (George & Vaccarino, 2015).

Use findings from this and other qualitative studies to inform policy. Qualitative research provides a deeper understanding of the thoughts and attitudes of a specific population, providing additional depth compared to the data available from quantitative surveys. Using this information, along with other data, to inform policy will ensure well-rounded, robust laws that take into consideration the contextual and demographic circumstances of youth. The misperceptions documented in this report, and the implications for prevention and practice, can also be used to inform policy makers tasked with developing or revising cannabis regulations. An evidence-informed approach to regulation that incorporates research, education, prevention, treatment, enforcement and harm reduction will be key in minimizing the risks and harms of cannabis use among Canada's youth.

Limitations

The limitations of this study need to be considered when interpreting its findings. Although researchers took all measures possible to include a diverse cross section of Canadian youth, the study sample is not representative. There was an overrepresentation of youth who were above the age of 16 and a higher number of participants in the Alberta and Ontario groups. Due to the small number of participants, results cannot be analyzed by jurisdiction, age, gender or background, as this analysis would compromise the anonymity of participants. Regardless, researchers were confident saturation was met as the amount of new information presented decreased, while previous themes from earlier groups were supported. By the time the final groups were held, the moderators were able to anticipate with some accuracy the issues and viewpoints that would arise (Babbie & Benaquisto, 2010).

The interpretations of the data in this study are those of the analyst. A number of steps were taken to help ensure the reliability of the research findings. First, the analyst was involved in every aspect of the study (i.e., data collection, analysis and writing), ensuring full immersion in the data. Second, reliability can also be assessed by consistency between the study's findings and previous research. Some findings in the current work have been reported in previous cannabis literature (Perth District

[10] See Canadian Centre on Substance Abuse. (2016). Parents: Help your teen understand what's fact and fiction about marijuana (infographic). Retrieved from www.ccsa.ca/Resource%20Library/CCSA-Marijuana-Fact-and-Fiction-Infographic-2016-en.pdf.

Health Unit, 2012; Stavropoulos et al., 2011; Health Canada, 2014b; Alhyas et al., 2016). Third, a second investigator was present for all data collection and provided input when completing the analysis and developing findings. This process helped ensure that interpretations accurately reflected the focus group dialogue and provided opportunities for clarification between the two investigators, supported by event transcripts. Finally, participants' quotes pertaining to themes and interpretations were provided verbatim in this report to further contribute to transparency.

Future Directions for Research

The results of this study have implications for future research and point to opportunities to strengthen current prevention efforts. These opportunities are especially important because the current Canadian government intends to proceed with legalization and regulation. Future research could explore the effectiveness of the prevention approaches suggested in this report, including providing youth with information on both positive and negative effects of cannabis, and incorporating in service delivery peers and people with lived experience (Canadian Centre on Substance Abuse, 2010). Future research could explore how and why some messaging (e.g., harm to the lungs) has resonated with youth and resulted in behaviour change (e.g., taking cannabis in a form other than smoking) in order to uncover methods for use in future prevention efforts. It will be important to understand how knowledge of harms will influence youth behaviour, so that measures can be put in place to ensure youth are not switching from one risky behaviour to another (e.g., baking cannabis into food instead of smoking it).

While conducting the focus groups, it became apparent that adults, similar to adolescents, would value information related to the effects of cannabis. Based on the discussions with youth, it might be the case that parents are reinforcing incorrect perceptions about cannabis, possibly through their own behaviours, such as driving after using cannabis. Teachers could benefit from greater availability of cannabis information that they can incorporate in their lesson plans. Future efforts to conduct qualitative studies, similar to this current study, to uncover the perceptions and attitudes parents and teachers hold about cannabis and develop corresponding material are warranted. Understanding these gaps can help inform the development of resources to help parents play an active role in preventing youth cannabis use. Similarly, educational material outlining the effects of adolescent cannabis use would be useful to teachers and other youth service providers who can also participate in prevention delivery. These measures should be evaluated for effectiveness.

National-level data on youth cannabis perceptions would also be useful to obtain a more representative picture and to monitor changes over time. This data would be particularly timely as Canada moves towards the legalization and regulation of cannabis, as they would contribute to the ability to evaluate the impact of the policy change. The data could be collected via an independent survey or through the expansion of existing national data collection initiatives, such as the Canadian Student Tobacco and Drug Survey.

Conclusion

The evidence base for the impacts of cannabis use among youth is growing, increasing the quality of information needed for effective prevention, education and intervention. To effectively prevent harms related to cannabis among adolescents, it is also valuable to understand what youth believe are the effects associated with the drug and what can influence a youth to use or abstain. Youth are best suited to inform researchers about where gaps exist in current cannabis education and awareness efforts. To contribute to this understanding, CCSA conducted 20 focus groups on the topic of cannabis with youth across Canada.

This study revealed that participants underestimated some of the harms associated with cannabis, such as driving while impaired, the impact on brain development, risk for addiction and other mental and physical consequences. It revealed that youth do not feel they will be reprimanded by enforcement for cannabis use. Participants also believed there are several benefits related to cannabis use, such as stress relief and increased social confidence. However, they expressed their belief that the effects of cannabis are experienced differently at the individual level. Because of this difference, and in combination with the various cannabis-related resources online, youth are able to pick and choose when they consider the drug “safe” and when it is detrimental to one’s health.

Findings from this study highlight the importance of raising awareness about cannabis risks and providing youth the tools to critically assess the available information about cannabis. Misperceptions can be altered through appropriate, targeted prevention efforts that provide evidence-informed facts about cannabis use by adolescents. These efforts should also promote resiliency, for example through tools for youth to manage stress and combat peer pressure, in order to refrain from engaging in use at an early age. Providing those who work with youth resources to address this issue can also lead to early intervention and the prevention of harms due to use. Research supports prevention initiatives that involve or are delivered by youth (or someone other than an authority figure), that are informative and that suggest less harmful alternatives, as opposed to prescriptive measures (Massey & Neidigh, 1990; Janz & Becker, 1984).

With changes in cannabis regulation anticipated in the near future, it is imperative that education is proactive in nature (i.e., before legalization occurs) and provides youth with factual information they can use to inform their decisions to use cannabis (Canadian Centre on Substance Abuse, 2015b). As research on the effects of cannabis continues to accumulate it will be important to integrate this new information into prevention and intervention initiatives, and policy. The effective management of targeted prevention for this vulnerable age group will also require continued monitoring of the attitudes and beliefs about cannabis held by youth and those variables that influence their decision making.

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Appendix A

Interview Guide

Thoughts about Marijuana Study

Instructions to participants prior to beginning the focus group:

Because the focus group will involve a group discussion, your responses will be known to each other, and therefore, only limited confidentiality can be guaranteed. By confidentiality, we mean keeping what you say private. We want to make sure that we all respect each other's opinions and answers. To do this, it is important that you do not share what other participants say to people outside of this group. We also want to remind you that you do not have to answer any questions that you are uncomfortable with. You won't get in any trouble for not answering questions and you will still get your gift card for participating.

In order to assist with note taking, we are going to audio record our discussion. No one else but Katie and I will have access to this recording. After our discussion we are going to type out everything that is said. During this process, we will make sure no names of people or places that are mentioned are included. We will do this to make sure you cannot be identified by your answers. Only those people working directly on this study will be able to see what is typed up. Your parents, teachers, and school administrators will not have any access to your answers.

Does anyone have any questions before we get started?

Question Guide:

1) Why do you think some teens your age start using or smoking marijuana?
2) Why do you think some teens your age choose not to use or smoke marijuana?
    a) How is this decision influenced by the people in a teen's life (e.g., friends, siblings, and peers)?
3) Does using or smoking marijuana change a person?
    a) If yes, how? For example, what are the social, physical, and mental changes?
4) What are the negative effects of using or smoking marijuana?
    a) Do you think that using or smoking marijuana can lead to the use of other drugs?
5) What are the positive effects of using or smoking marijuana?
6) Do you think that using or smoking marijuana can affect the brain and its development?
7) Does using or smoking marijuana affect driving ability? Why or why not?
8) Is it illegal to use or smoke marijuana?
    a) What do you find confusing about marijuana being illegal to use or possess?

9) How is marijuana presented in the media (e.g., social media, movies, music videos)?
   a) How do you think the media influences teens in making decisions about marijuana?
10) How might the use of medical marijuana by people influence teens' decisions to use marijuana?
11) How do you think youth could be prevented or discouraged from using marijuana (e.g., advertisements on TV, drug education in school)?

Appendix B

Organizations contacted included, but were not limited to:

- Joint Consortium for School Health
- Students Commission of Canada
- Sandbox Project
- Young Canadians Roundtable on Health
- Youth Centres Canada
- Substance Abuse and Youth in School Coalition
- RCMP National Advisory Committee
- Alberta Health Services
- Addiction Foundation of Manitoba
- University of Saskatchewan
- Calgary Youth Addictions Services
- YAK Youth Services
- Youth Services Bureau of Ottawa
- Youville Centre

Appendix C

Recruitment Poster

Appendix D

Webpage Text

Thoughts About Marijuana Study

The Canadian Centre on Substance Abuse (CCSA) is conducting a research study that is looking at what youth think about marijuana.

This study is looking at what youth between the **ages of 14 and 19** think about marijuana. Through multiple in-person focus groups taking place across Canada, youth will be asked about their thoughts on topics such as:

1. What contributes to youth choosing to use or not use marijuana? For example, how do the community, family, and school impact these decisions?
2. How does marijuana use change a person?
3. How can marijuana use among youth be prevented?

Participants **will not** be asked to talk about their specific experiences with marijuana. Furthermore, they **will not have to answer any questions that make them uncomfortable** and may withdraw from the study at any time.

Each focus group will have a maximum of six youth and two researchers involved. They will be 45 minutes in length. Any identifying information, such as names, will be removed from all study material (e.g., transcripts) and excluded from the final research report.

To participate please click on the following links:

- If you are 14 or 15 years old, click here to participate in this study.
- If you are 16, 17, 18 or 19 years old, click here to participate in this study.

For information you can print use the links below:

- Parent/Guardian Information Form
- Youth Information Form

If you have any questions or concerns, contact Anna McKiernan at: 1-613-235-4048 ext. 224, amckiernan@ccsa.ca.

Appendix E

Participant Online Screening

Thoughts about Marijuana Study

The following information is needed to help us select participants for the focus groups. Your answer to these questions will be kept strictly confidential. Only the researchers will have access to this information. Your parents, teachers, school administrators and anyone outside of the research team will not be able to see your answers. Please answer the questions honestly. To ensure confidentiality of your answers on this form, you should complete this form in private.

1. How old are you?

   _____

2. What is your gender?

Male	Female
M	F

3. What language do you speak?

English	French	Both English and French
E	F	B

4. In which city and province do you live? _____

5. What is your ethnicity?

A	Caucasian/White
B	Black Canadian
C	East Asian (e.g., China, Japan, Korea, etc.)
D	South Asian (e.g., India, Pakistan, etc.)
E	Aboriginal (e.g., Metis, Inuit, Treaty or Non-Treaty First Nations)
F	Other

6. Have you ever used marijuana?

No	Yes
N	Y

7. If yes, when was the last time you used marijuana?

A	In the last 24 hours
B	In the last week
C	In the last month
D	In the last 4 months
E	In the last year
D	It has been more than one year since I last used marijuana

If you are selected to participate in one of the focus groups, we will need to contact you to schedule the focus group.

8. What is your name? _____

9. What is your phone number? _____

10. What is your email address? _____

Submit this Form

By submitting your complete answers, you are telling us that you would like to participate in the focus group. If you are eligible to participate, we will contact you.

Appendix F

Participant Information and Assent/Consent Form

Thoughts about Marijuana Study

The Canadian Centre on Substance Abuse is conducting a research study that is looking at what youth think about marijuana. You are invited to participate in this study and share your thoughts about why teenagers your age might choose to use or not use marijuana. The following provides some important information about the study. If you have any questions after reading this information please contact Anna McKiernan (613-235-4048 ext. 224 or amckiernan@ccsa.ca).

WHAT:

- The study is looking at what Canadian teenagers between the ages of 14 and 19 think about marijuana.
- More specifically, you and other teens your age will be asked:
  1. Why teens would choose to use or not use marijuana. For example, how do the community, family, and school impact these decisions?
  2. How does marijuana use change a person?
  3. How can marijuana use among teens be prevented?
- The study involves participating in a focus group (i.e., a small group discussion facilitated by two researchers).

WHO:

- You and other teens across Canada are invited to participate in the study.

WHY:

- Information gathered from the study will help the Canadian Centre on Substance Abuse to understand some of the ways teens think about marijuana.
- Such information will help to develop future prevention and intervention programs that will help teens make informed decisions about marijuana and decrease its negative effects.

WHEN & WHERE:

- The study will take place on:
  - Ottawa: October 21 and 22 at 6:00 pm at the Canadian Centre on Substance Abuse, 75 Albert St (please note these groups will be offered in French and English).
  - Winnipeg: October 28 and 29 at 6:00 pm at the Addictions Foundation of Manitoba, 200 Osborne St N.
  - Saskatoon: November 4 and 5 at 5:00 pm at Station 20 West, 1120 20 St W.

  - Calgary: November 9 and 10 at 5:30 pm at the Alberta Health Services, Youth Addiction Services Calgary, 1005 17 St NW.
  - Perth: November 23 and 24 at 3:00 pm at YAK Youth Services, 1 Sherbrooke St E.
- The focus group for this study will require 45 minutes to complete.

WHAT YOU NEED TO KNOW:

- If you would like to participate in the study, you will need to complete the screening form by clicking on the participation link on the study webpage.
- If you are under the age 16, you will also need to get your parent or guardian's permission to participate in this study.
- Participation in this study is not a requirement. You may choose not to participate. You will not be penalized if you do not participate.
- Even if you choose to participate, you do not have to answer any questions you are uncomfortable with. You may also withdraw from this study at any time.
- Because of the general nature of the questions asked during the focus group, there are no anticipated risks to you.

THE FOCUS GROUP:

- A group of five to six teens and two researchers will be involved in each focus group.
- To help protect confidentiality, those participating in the focus group will be asked not to share the other participants' responses.
- For note taking purposes, the discussion will be audio recorded.
- **Only those working directly on this research study will have access to the transcripts.** All notes and audio files will be kept in a protected and confidential manner.
- Any identifying information, such as names, will be removed from transcripts and excluded from the final research report.
- Participants will be asked about why teens may or may not choose to use marijuana.
- During the focus group participants **will not** be asked to talk about their specific experiences with marijuana.

THE SCREENING FORM:

- In order to help select participants to take part in this study, you will need to complete the screening form by clicking on the participation link on the study webpage.
- To ensure confidentiality of your answers on this form, you should complete this form in private.
- This form will ask you to identify your age, gender, the city you live in, and your experience using marijuana.
- The information collected on this form is only to help select participants for each focus group.

- No one outside of the research team will have access to this information.
- After you finish the form, you might or might not be contacted to participate in the study, which involves the focus group.

QUESTIONS?

- If you have any questions about the proposed study, you can contact Anna McKiernan from the Canadian Centre on Substance Abuse (613-235-4048 ext. 224 or amckiernan@ccsa.ca).
- You may also contact Dr. Amy Porath-Waller from the Canadian Centre on Substance Abuse (613-235-4048 ext. 252 or aporath-waller@ccsa.ca).
- Institutional Review Board Services is an independent committee that reviewed this research. If you have any general questions about your rights as a participant, please contact Institutional Review Board Services (1-866-449-8591 or subjectinquiries@irbservices.com).

ADDITIONAL INFORMATION

- In recognition of the time required for you to participate in the focus group (which you may or may not be asked to participate in), you will receive a $20 gift card following completion of the focus group.
- Results of the study will be summarized in a research report written by the Canadian Centre on Substance Abuse.
- The information provided in all reports will be grouped across all participants and cannot be used to identify you.

DO YOU WANT TO PARTICIPATE?

Yes, I agree to participate in this study	No, I do not agree participate in this study

- Your name _____
- Your last name _____
- Today's date _____
- Your email address _____
- Your signature _____

Thank you for your time,

Sincerely,

Anna McKiernan
Canadian Centre on Substance Abuse
Tel: 613-235-4048 ext.224
Email: amckiernan@ccsa.ca

Parent/Guardian Information and Consent Form

Thoughts about Marijuana Study

The Canadian Centre on Substance Abuse is conducting a research study that is looking at what youth think about marijuana. Your child is invited to participate in this study and share his or her thoughts about what influences other youth his or her age to use or not use marijuana. The following provides some important information about the study. If you have any questions after reading this information please contact Anna McKiernan (613-235-4048 ext. 224 or amckiernan@ccsa.ca).

WHAT:

- The study is looking at what youth between the ages of 14 and 19 think about marijuana.
- More specifically, participants will be asked:
    4. What they think contributes to youth choosing to use or not use marijuana. For example, how do the community, family, and school impact these decisions?
    5. What misusing marijuana means and looks like?
    6. How can marijuana use among youth be prevented?
- The study involves your child participating in a focus group (i.e., a small group discussion facilitated by two researchers).

WHO:

- Your child, along with other youth across Canada, is invited to participate in the study.

WHY:

- Information gathered from the study will help the Canadian Centre on Substance Abuse to understand some of the ways youth think about marijuana.
- Such information will help to develop future prevention and intervention programs that will help youth make informed decisions about marijuana and decrease its negative effects.

WHEN & WHERE:

- The study will take place on:
    - Ottawa: October 21 and 22 at 6:00 pm at the Canadian Centre on Substance Abuse, 75 Albert St (please note these groups will be offered in French and English).
    - Winnipeg: October 28 and 29 at 6:00 pm at the Addictions Foundation of Manitoba, 200 Osborne St N.
    - Saskatoon: November 4 and 5 at 5:00 pm at Station 20 West, 1120 20 St W.
    - Calgary: November 9 and 10 at 5:30 pm at the Alberta Health Services, Youth Addiction Services Calgary, 1005 17 St NW.
    - Perth: November 23 and 24 at 3:00 pm at YAK Youth Services, 1 Sherbrooke St E.

- The focus group for this study will require 45 minutes to complete.

WHAT YOU NEED TO KNOW:

- **You or your child may choose not to participate.** Your child will not be penalized in any way if he or she does not participate.
- If you consent to your child's participation, it does not mean that your child will automatically take part in this study. **Each child will be asked whether or not he or she wants to participate** before participating in the study.
- Your child will not have to answer any questions he or she is uncomfortable with and may withdraw from the study at any time.
- Because of the general nature of the questions asked during the focus group, there are no anticipated risks to your child.

THE FOCUS GROUP:

- A maximum of six youth and two researchers will be involved in each focus group.
- To help protect confidentiality, those participating in the focus group will be asked not to share the other participants' responses.
- For note taking purposes, the discussion will be audio recorded.
- Only those working directly on this research study will have access to the transcripts. All notes and audio files will be kept in a protected and confidential manner.
- Any identifying information, such as names, will be removed from transcripts and excluded from the final research report.
- Participants will be asked about why youth may or may not choose to use marijuana.
- During the focus group participants **will not** be asked to talk about their specific experiences with marijuana.

THE SCREENING FORM:

- If you and your child would like to participate in this study, your child will need to complete the screening form on the study webpage that will be used to help select participants to take part in the focus groups.
- To ensure confidentiality of your child's answers on this form, your child should complete the form in private.
- This form will ask about your child's age, gender, the city of residence, and experience using marijuana.
- The information collected on this form is only to help select participants for each focus group.
- No one outside of the research team will have access to this information.
- After your child completes the screening form, he or she might or might not be contacted to participate in the study, which involves the focus group.

QUESTIONS?

- If you have any questions about the study, you can contact Anna McKiernan from the Canadian Centre on Substance Abuse (613-235-4048 ext. 224 or amckiernan@ccsa.ca).
- You may also contact Dr. Amy Porath-Waller from the Canadian Centre on Substance Abuse (613-235-4048 ext. 252 or aporath-waller@ccsa.ca).
- Institutional Review Board Services is an independent committee that reviewed this research. If you have any general questions about your child's rights as a participant, please contact Institutional Review Board Services (1-866-449-8591 or subjectinquiries@irbservices.com).

ADDITIONAL INFORMATION

- In recognition of the time required for your child to participate in the focus group (which he or she may or may not be asked to participate in), he or she will receive a $20 gift card following completion of the focus group.
- Results of the study will be summarized in a research report written by the Canadian Centre on Substance Abuse.
- The information provided in all reports will be grouped across all participants and cannot be used to identify your child.

MAY YOUR CHILD PARTICIPATE?

- If you **want** your child to participate, then you will need to complete the following questions and submit this form. Please remember that the researchers will also ask your child if he or she wants to participate and if he or she agrees to participate.
- By answering the following questions, you are telling us that you agree for your child to participate in the focus group.
- If you do not want to participate then we thank you for your time and you can simply close your Internet browser.

1. Your first name _____
2. Your last name _____
3. The city and province in which you reside _____
4. Your child's first name _____
5. Your child's last name _____
6. Your telephone number _____
7. Your email address _____

Yes, I agree to let my child participate in this study	No, I do not agree to let my child participate in this study

Thank you for your time,

Sincerely,

Anna McKiernan
Canadian Centre on Substance Abuse
Tel: 613-235-4048 ext. 224
Email: amckiernan@ccsa.ca

Appendix G

Participant Debriefing Information

Thoughts about Marijuana Study

Thank you for your participation!

The group discussion you just completed was intended to provide the researchers with information regarding how teens think about marijuana. The overall purpose of this research is to understand some of the important reasons why some teens choose to use marijuana and why other teens choose not to. With this knowledge, prevention and intervention programs aimed at reducing the negative effects of marijuana can be developed. Most importantly, the information that you provided will be used to ensure that such programs are relevant to teens.

We want to remind you that all the information we collected in today's discussion will be kept confidential. We will also ensure that you cannot be identified by your responses.

In order to further protect the identity of the other teens participating in this study, it is important that you do not discuss what you heard other teens say during the group discussion.

If you have any further questions regarding this study, please contact Anna McKiernan from the Canadian Centre on Substance Abuse (613-235-4048 ext. 224 or amckiernan@ccsa.ca) or Dr. Amy Porath-Waller from the Canadian Centre on Substance Abuse (613-235-4048 ext. 252 or aporath-waller@ccsa.ca). You may also contact Anna McKiernan if you would like to receive a copy of the research report from this study. If you have any general questions about your rights as a participant in this research study, please contact Institutional Review Board Services (1-866-449-8591 or hrpp@irbservices.com).

For more information about the effects of marijuana, the following are some good websites to check out:

www.ccsa.ca/Eng/topics/Marijuana/Pages/default.aspx

www.nationalantidrugstrategy.gc.ca/prevention/youth-jeunes/index.html

www.whatswithweed.ca

www.deal.org

www.drugabuse.gov/students-young-adults

If you would like to speak to someone in an anonymous and confidential way, then help is available 24/7 through the Kids Help Phone at 1-800-668-6868.

Manitoba Dental Assistants Association
142 – 99 Scurfield Boulevard
Winnipeg, MB R3Y 1Y1
Phone: 204 586-7383
Fax: 204 489-8033
Email: mdaa@mdaa.ca
Website: www.mdaa.ca

February 16, 2017

Dre. Christiane Gagnon, Vice Presidente
Office des professions Quebec
800, place D'Youville, 10 etage
Quebec (Quebec) G1R 5Z3

Dear Dre. Gagnon:

I have been advised that the Office des professions Quebec is in the process of reviewing the dental assistant file. I am very pleased that the profession of dental assisting in the province of Quebec may soon join the rest of Canada in recognition, education and standards.

Dental Assisting became a legislated health care discipline in many provinces in our country in the late 1960's and has continued to evolve since that time. In ten provincial jurisdictions (including the territories) dental assisting has been recognized, and in eight of those provinces dental assistants hold registration and are licensed. Through the Canadian Dental Assisting Regulatory Authority, a standardized level of education and regulatory practice ensure a dental assistant can solicit employment in each of those provinces based on their current license and scope of practice.

In the province of Manitoba over 1400 dental assistants are licensed through the provincial regulator, The Manitoba Dental Association. The Manitoba Dental Assistants Association works collaboratively with the MDA, as a member services organization to facilitate continuing education is available to its members and the current scope of practice is abided by. The MDAA is proud of our high standard of professionalism and is committed to protecting and safeguarding the public.

The MDAA recognizes accreditation as the benchmark standard for the profession of dental assisting through the Commission on Dental Accreditation of Canada. Manitoba graduates of a dental assisting program are required to write the National Board Examination available through the National Dental Assisting Examining Board. These two agencies recognize a common base of competencies which aids in meeting the regulatory requirements of each provincial jurisdiction. Of note, is the fact that all regulatory authorities including the MDAA also require applicants who are not graduates of a CDAC accredited program to undertake a Clinical Practice Evaluation administered through the NDAEB.

Manitoba Dental Assistants Association
142 – 99 Scurfield Boulevard
Winnipeg, MB R3Y 1Y1
Phone: 204 586-7383
Fax: 204 489-8033
Email: mdaa@mdaa.ca
Website: www.mdaa.ca

Dental assisting continues to be considered a mobile profession and for that reason each provincial regulator has established a list of competencies that can legally be performed in their jurisdiction. I have attached a list of those particular competencies were taken from the current Scope of Practice Document.

It is my understanding that your jurisdiction has expressed an interest in the application of prophy, fluoride and sealants by trained dental assistants. These competencies have been instructed in the province of Manitoba and practiced safely for many years. To date, there has not been a complaint brought forward related to the performance of any of these listed competencies.

If at any time you would like to discuss the profession of dental assisting in Manitoba or any other concerns discussed in my letter, I would welcome an opportunity to do so.

Sincerely,

Janet Neduzak, RDA
President, Manitoba Dental Assistants Association

cc Canadian Dental Assistants Association
National Dental Assisting Examining Board
Canadian Dental Assisting Regulatory Authorities
Association of Dental Assistants of Quebec

Canadian Dental Assisting Legal Scope of Practice by Province - 2016
Portée de compétences légales d'assistantes dentaires au Canada - 2016

Skill/Compétence	BC*	AB	SK	MB	ON			QC	NB	NS*	PEI	NL
					CDA1	PDA	CDA11					
Chairside / Extra-orale	•	•	•	•	•	•	•	•	•	•	•	•
Radiography / Radiographie	•	•	•	•	•	•	•		•	•	•	•
Preliminary Impressions / Empreintes préliminaires	•	•	•	•		•	•		•	•	•	•
Dental Dam / Digue	•	•	•	•		•	•		•	•	•	•
Treatment Liners / Traitement protecteur	•	•	•	•			5		•	•	•	•
Matrices & Wedges / Matrices et coins	•	•	•	•			5		•	•	•	•
Selective Coronal Polishing / Polissage sélectionné de couronnes dentaires	•	•	•	•		•	•		•	•	•	•
Oral Hygiene Instruction / Instruction d'hygiène buccale	•	•	•	•		•	•		•	•	•	•
Dietary Counselling / Instruction en nutrition	•	•	•	•	•	•	•		•	•	•	•
Fluoride Application / Application de fluor	•	•	•	•		•	•		•	•	•	
Fabricate & Insert Bleaching Trays / Fabrique et mise en place les porte-empreintes de blanchiment	9	9	9	•			•		6	•	•	•
Pit & Fissure Sealants / Scellements de puits et fissure	•	•	•	•			•		•	•	•	•
Topical Anaesthetic / Anesthésie topique	•	•	•	•			•		•	•	•	•
Desensitizing Agents / Agents de désensibilisation	•	•	•	•			•		•	•	•	•
Bonding Materials/												
Suture Removal / Retirer les points de suture	•	•	•	•					•	•		•
Take & Record Vital Signs / Prendre et noter les signes vitaux	•	•	•	•	•	•	•		•	•		•
Acid Etch Prepared Cavities / Burinage à l'acide de la cavité	•	•	•	8					•	8		•
Pulp Vitality Testing / Détection de la vitalité pulpaire	•	•	1									•
Polish Amalgams / Polir amalgam **		3	1				•			•	4	
Retraction Cord Placement /Mise en place la corde de rétraction	1	•	1									
Remove Retraction Cord / Retirer la corde de rétraction	•	•	•									
Fabricate, Cement & Remove Provisional Crowns - Prostho Module / Fabrication, mise en place et retirement de couronnes provisoires	7	•	1									
Provisional Restoration / Restoration Provisoire		•	1									
Take & Record Gingival Plaque Indices / Enregistrer les marges gingivales	•	•	•	•								•
Applying anti-microbial Agents / Application d'agent anti-microbians	•	•	•	•								
Remove Perio Dressings / Retirement de pansements pérodontales	•	•	•									•
Face Bow Transfer / Transfer d'arc facial	•	•							1			
Ortho Module / Module orthodontie	1	1	1	1					1		1	1
Place & Finish Amalgam Restorations / Place et sculpter restaurations à l'amalgame			1									
Restorative Implant Assisting Tech. Module / Module Technologie d'assistance en implant de restauration			1									
Level 'C' CPR / RCP niveau 'C'	4	4	•	•								•
Periodontal Screening & Recording (PSR) / Dépistage et		•		1								

documentation en paradontie												
Skill/Compétence	**BC***	**AB**	**SK**	**MB**	**ON**			**QC**	**NB**	**NS***	**PEI**	**NL**
					CDA1	PDA	CDA11					
Fabricate Mouthguards / Fabrique les protège-dents	•	•	•	•			•		2	2	•	•
Fabricate Occlusal Rims / Fabrique les boudins	•	•	•	1			•			2	•	
Recall Consultations with Dentists / Rendez-vous de rappel	•	•	•	•	•	•	•					
Public Health Screening / Dépistage de santé publique	•	•	•	•								
Assessing and Reporting Oral Health Status /Évaluer et documenter le niveau de santé buccale	•	•	•	•	•	•	•					
Preventative (Scaling) Module / Module (détartrage) préventif		1		1					1			
Dental Probing		10										

Last updated 2016

Mandatory Skills for NDAEB Certificate / Compétences requises pour certificat de BNEAD:
Skills may be performed by licensed CDA's only
For licensed level II dental assistants

1. Completion of module or training required / Instruction requise.
2. Only extra-oral procedure / Procédures extra-orales seulement.
3. Using rubber tips & cups; no shaping or finishing / Utilisant instruments en caouchouc. Polir et façonner ne sont pas permis.
4. Recommended but not mandatory for licensure / Recommandé mais pas obligatoire pour la licence.
5. CDA II's in Ontario are trained in this skill but are not permitted to perform it. / Les ADA de niveau II, en Ontario, reçoivent la formation dans cette tâche mais n'ont pas la permission de l'exécuter.
6. Licensed CDA's may only fabricate bleaching trays. / Les ADAs licencié(e)s peuvent fabriquer exclusivement des plateaux de blanchiment.
7. CDA's with a minimum of one year full-time chairside experience may fabricate single unit provisional restorations intraorally, including try-in, adjusting occlusion outside the mouth, temporary cementation, removal of provisional cement, and removing provisional restorations. Prostho module required for additional duties. / Les ADAs possédant un minimum d'une année d'expérience à temps plein d'assistance à la chaise, peuvent fabriquer une unité de restauration provisoire intra-buccale, incluant essai, ajustement de l'occlusion hors bouche, cimentation temporaire, retrait du ciment provisoire et retrait des restaurations provisoires. Le module de prosthodontie est nécessaire pour accomplir des tâches additionnelles.
8. With dentist supervision when initiated in the office. / Sous la direction du dentiste lorsque exécuté en clinique.
9. Includes chairside bleaching systems/Comprend les systèmes de blanchiment à la chaise.
10. A licensable duty in Alberta. Considered a pre-requisite for both post-graduate modules (orthodontics and preventative)/ Une tâche réglementée en Alberta. Considérée comme un pré-requis pour les deux modules de formation complémentaire (orthodontie et prévention).

** A practice which is not very common across the country, having been largely replaced with more advanced techniques/Une pratique qui n'est pas très commune au Canada, ayant été en grande partie remplacée par des techniques plus avancées.

CANADIAN DENTAL REGULATORY AUTHORITIES FEDERATION

CDRAF MANAGEMENT GROUP
MINUTES OF MEETING

Friday, January 6, 2017

Manitoba Dental Association, #202, 1735 Corydon Ave., Winnipeg, MB

A meeting of the CDRAF Management Group was held on Friday, January 6, 2017 8:30 a.m. CST.

PARTICIPANTS:

CDRAF Executive

- Dr. Cliff Swanlund (CDRAF President), Board Representative, Alberta Dental Association and College
- Dr. Barry Dolman (CDRAF Vice-President), President, L'Ordre des dentistes du Québec
- Dr. Nancy Auyeung (CDRAF Treasurer), Past-President, Manitoba Dental Association

Administration

- Dr. Diane Legault (CDRAF Executive Director)
- Ms. Angie Sherban (CDRAF Executive Assistant)
    - (participated via video-conference for morning session)
- Ms. Kelly Tripp (CDRAF Controller)
    - (participated via video-conference for financial discussion)

1. CALL TO ORDER

Dr. Swanlund called the meeting to order at 8:30 a.m. CST. There was an item on Open Discussion added to the agenda that was circulated.

2. APPROVAL OF MINUTES

There were no revisions made to the draft minutes of the CDRAF Management Group teleconference meeting of August 29, 2016 and they were approved, as circulated.

MOTION: Swanlund/Auyeung

THAT the CDRAF Management Group meeting minutes of August 29, 2016 be approved, as circulated.

CARRIED
(Unanimously)

3. EXECUTIVE DIRECTOR'S REPORT

Dr. Legault reported that since the CDRAF Board meeting on October 14, 2016, she has attended Annual General meetings of the National Dental Examining Board of Canada and the Royal College of Dentists of Canada as an observer. She also attended retirement events for Susan Matheson (Commission on Dental Accreditation of Canada) and Dr. Gordon Thompson (Alberta Dental Association and College).

She stated that she has been attending Registrars' meetings as an observer, although she chaired the meeting held in October 2016. She found the meetings to be beneficial, but she would like to discuss her role further when governance of CDRAF is reviewed.

The CDRAF Management Group agreed that the independence of an Executive Director has been successful and good relationships with stakeholders are being established.

4. FINANCES AND OPERATIONS

The CDRAF Management Group was provided with the following documents, as at December 23, 2016:

(a) Balance Sheet
(b) Bank Reconciliation
(c) Fund Balance vs Budget Report
(d) Fund Balance Report

Ms. Tripp reviewed the financial documents with the CDRAF Management Group. She noted that the Balance Sheet now shows a line for the Royal Bank and CIBC as CDRAF is in the process of changing banking

institutions. The 2017 dues will be deposited into the Royal Bank account and when there is a strong balance in that account, the CIBC account will be transferred over and then closed, hopefully, by the end of February. Ms. Tripp stated that the Royal Bank was familiar with working with not-for-profit organizations.

The pre-paid expenses are for Dr. Legault's flight expenses for this meeting and the 2017 membership fee for CNNAR. Capital expenses cover amortized computer equipment.

The CDRAF Management Group asked for a template to be designed for submitting expenses and Ms. Tripp undertook to do this.

In the Bank Reconciliation there was no unusual activity. Ms. Tripp reviewed the Fund Balance vs Budget Report and answered questions from the CDRAF Management Group. She noted that there was discrepancy in some of the budget items and this was due to the fact that some of the pertinent information was not available when the budget was prepared. Dr. Legault added that when the strategic planning exercise has been completed, it will assist her with preparing the budget for next year.

Ms. Tripp reported that the annual audit is scheduled for January 13, 2017. There are no issues anticipated and the financial statements will be available for the April 2017 CDRAF Board meeting for approval.

Ms. Tripp was thanked for the financial information, and she left the meeting.

5. STRATEGIC PLANNING

Dr. Legault reported that the Steering Committee held its first meeting via teleconference on November 25, 2016 and will be holding a full-day meeting in person in Montreal on Thursday, February 23, 2017. It is anticipated that at the end of the February meeting there will be a first draft of a strategic plan for the Registrars and Board to review at the April 22 meeting.

There was discussion on reviewing the present governance structure of CDRAF that included:

(a) the Board having more input;
(b) considering a change to the current structure of one vote per province;
(c) maintaining continuity and institutional memory on the Board;
(d) reducing the number of members on the Board;
(e) having the Management Group comprised of the Registrars.

The CDRAF Management Group looked forward to seeing a draft strategic plan when available.

6. REPORT ON OPIOID CONFERENCE

The CDRAF Management Group was provided with a copy of Dr. Legault and Dr. David Segal's report on the Opioids Conference that was held in Ottawa on November 18, 2016.

At its October 14, 2016 meeting, the CDRAF Board approved having Dr. Legault and Dr. Segal attend the conference only, as the second day of the event was a Summit reserved for those organizations that committed to specific actions to be included in a Joint Action Statement. Dr. Legault stated that the topic of opioid prescriptions by dentists was discussed at the Registrars' meeting in October 2016.

The CDRAF Management Group reviewed the Joint Statement of Action to Address the Opioid Crisis that was released following the Summit. It was noted that the Royal College of Dental Surgeons of Ontario committed to requesting and reviewing the Narcotics Monitoring System data for opioid prescriptions by dentists and dental specialists for the calendar year 2016 and comparing the data to that received for the calendar year 2014 to assess the impact of the Guidelines on the Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice (published in 2015).

The CDRAF Management Group requested Dr. Legault to ask the RCDSO to share its data analysis when available at which time it could determine

whether there is a need for a national project on this issue and if so, how to proceed.

7. CETA COMMISSION

Dr. Legault reported that the briefing document has been translated into French. The translator used has regulatory experience and will be used for future translation engagements. Out of courtesy, she asked Ms. Caroline Daoust to review the translation for accuracy. The document in both languages will be posted on the CDRAF website in due course. Each dental regulatory authority will be able to use the document as it wishes in its own province.

The next steps will be to prepare letters for federal government officials to ask for meetings to express CDRAF and RCDSO's concerns about permit-to-permit registration. Government needs to be educated in registration processes in Canada. Dr. Legault undertook to work with Dr. Trainor in drafting a letter.

The CDRAF Management Group agreed the briefing document was very informative and thanked Ontario for its assistance in producing it.

There was discussion on having dialogue with the Commission on Dental Accreditation of Canada to give consideration to reciprocal agreements with countries other than those that have accreditation programs. It was also suggested looking at other models to see how entry competencies for licensure are assessed.

8. PGY1 ACFD/CDAC/NDEB JOINT PROJECT

At the CDRAF Board meeting in October 2016, it was suggested that Dr. Bernie White be appointed as CDRAF's representative on this joint project, but the final decision was left to the CDRAF Management Group. Dr. White expressed his willingness to be part of the working group and he was appointed.

The CDRAF Management Group was provided with a copy of the letter from CDAC agreeing to participate and Dr. Legault undertook to follow-up with NDEB to receive written agreement as well.

MOTION: Auyeung/Dolman

THAT Dr. Bernie White be appointed to represent CDRAF on the Joint Working Group on PGY1 Training, together with the Association of Canadian Faculties of Dentistry, the Commission on Dental Accreditation of Canada and the National Dental Examining Board of Canada at a commitment of $5,000.00 per organization, pending written confirmation of all parties.

CARRIED
(Unanimously)

9. NATIONAL DENTAL EXAMINING BOARD OF CANADA (NDEB)

9.1 Dr. Legault reported on the Annual General Meeting of NDEB held in Ottawa on Saturday, October 21, 2016. A written report of the meeting was provided to the CDRAF Management Group for information.

9.2 At the CDRAF Board meeting in October 2016, NDEB raised several questions to consider, in particular, language proficiency requirements. Dr. Legault was asked to canvass the provinces for their requirements and the CDRAF Management Group would determine how to proceed.

There was discussion on entry level requirements and whether CDRAF supports the conversation with CDAC, ACFD and NDEB to explore a framework for adoption. Dr. Legault was directed to contact her counterparts at CDAC, ACFD and NDEB to create a project and bring it back to the CDRAF Management Group for consideration.

10. ROYAL COLLEGE OF DENTISTS OF CANADA (RCDC)

Dr. Legault reported on the bilateral agreement initiative with some provinces. Ms. Caroline Daoust is drafting a document that will be

circulated to the Registrars for input before being provided to the CDRAF Board. Dr. Legault will keep the CDRAF Management Group apprised of the progress of this file.

11. CDA – 'FUTURE OF DENTISTRY' INITIATIVE

Dr. Swanlund informed the CDRAF Management Group members that he will attend the January 21, 2017 CDA working group meeting as the Alberta substitute member and that he intends to seize that opportunity to re-affirm the importance to consult with CDRAF if regulatory matters surface in the course of this initiative.

12. CEO/REGISTRARS' CONFERENCE, NOVEMBER 29-DECEMBER 3, 2016

Dr. Legault reported on highlights of the program which included a presentation of ADEA's snapshot of American Dental Education, a presentation by Dr. Ken Sutherland of the Saskatchewan University concerning the revamping of the Faculty curriculum followed by a large group discussion on the topic.

Dr. Legault also mentioned that there were some discussions about the appropriateness to organize a Wellness v2.0 conference in the spring of 2017, notably because five years had already passed since the first conference and that the topic was still very much on the radar. Dr. Legault mentioned that the program did not include a Registrars' meeting. That decision had been made by the Registrars when they had last met in October of 2016.

Dr. Legault reported that attending the meeting was certainly an occasion to meet with some of the key players of Canadian organized dentistry.

Some discussions arose about Dr. Legault's attendance at the 2017 meeting. Dr. Dolman reiterated his concerns and displeasure for a Canadian dental profession meeting to be held outside the country and the optics that are perceived.

Dr. Legault mentioned that the 2017 CDRAF budget adopted in October by the Board included the financial resources for her to attend if this was

the wish of the Board. Management asked for the topic to be added temporarily to the April Agenda Board meeting until it makes its final decision at the April conference call meeting.

13. REGISTRARS' MEETINGS

Dr. Legault indicated that the next Registrars' meeting will be set at the end of March or early April. The plan is to set the 2017-2018 Registrars' meetings schedule. Registrars will notably decide if they want to meet three or four times a year.

14. 2017 CALENDAR OF ACTIVITIES

14.1 Dr. Dolman kindly offered to host the October 2017 CDRAF Board meeting in Montreal and CDRAF Management Group meeting dates were agreed upon. It was suggested that the April 6, 2017 conference call meeting would be held through ZOOM and that the August 18, meeting will be held in Winnipeg.

14.2 The teleconference meeting schedule that was provided to the CDRAF Management Group was adopted. It will be circulated as soon as possible to all CDRAF Board members.

15. ON THE ROAD TO WELLNESS, VERSION 2.0

Dr. Legault informed the CDRAF Management Group members that she had consulted with the Registrars to find out if they had any interest in participating in such an activity and, if yes, in their views, what would be the objectives to pursue? The outcome of the consultation was positive and the general view expressed was to the effect that the version 2.0 needed to follow up on the outcomes of the 2012 conference that were accomplished, where there are gaps, what the needs are, next steps, etc. and that we come up with specific concrete actions.

There was consensus amongst the CDRAF Management Group members that CDRAF should engage in this initiative, but it was felt that Spring 2017 did not give sufficient time for proper planning.

16. INTERNATIONAL SOCIETY OF DENTAL REGULATORS (ISDR)

Dr. Dolman gave an update on ISDR's recent activity. He informed the members of the date of the next ISDR Conference, October 5, 2017, and shared some thoughts about the challenges ahead related to establishing future MRA's with countries that might have robust education programs, but no CDAC counterpart bodies.

16. FOR INFORMATION

There was no discussion on the information circulated.

17. OPEN DISCUSSION

Dr. Swanlund invited his colleagues to bring forward any other topic not covered by the agenda of the day. Emphasis was made about the importance of the February 23 Steering Committee meeting and the importance of getting feedback from the CDRAF Board members before the draft strategic plan is formally put forward for decision at its April meeting.

18. ADJOURNMENT

On behalf of the group, the President thanked Dr. Auyeung for her warm welcome and beautiful hosting.

There being no further business, the meeting was adjourned.

CDRAF
Canadian Dental Regulatory Authorities Federation

FCORD
Fédération canadienne des organismes de réglementation dentaire

CDRAF MONTHLY TELECONFERENCE MEETING

November 24, 2016

Participants:

CDRAF Management Group:	Dr. Nancy Auyeung, Treasurer
	Dr. Cliff Swanlund, Vice-President
British Columbia:	Mr. Jerome Marburg
Manitoba:	Dr. Marcel Van Woensel
Ontario:	Mr. Irwin Fefergrad
	Dr. David Segal
Quebec:	Ms. Caroline Daoust
Nova Scotia:	Dr. Martin Gillis
Prince Edward Island:	Dr. Ray Wenn

Regrets:

British Columbia:	Dr. David Tobias
Alberta:	Dr. Gordon Thompson
Saskatchewan:	Dr. Bernie White
Ontario:	Dr. Ron Yarascavitch
Quebec:	Dr. Barry Dolman
New Brunswick:	Dr. Brian Rinehart, President
	Mr. Dan Leger
Newfoundland & Labrador:	Dr. Paul O'Brien

Administration:

Dr. Diane Legault, Executive Director
Ms. Angie Sherban, Executive Assistant

Dr. Swanlund welcomed participants to the teleconference meeting and it was called to order at 3:00 p.m EDT.

Dr. Legault reported that since the CDRAF Board meeting in October, the CETA brief is being translated into French. The translator who was engaged works

with CNAR and is familiar with regulatory terminology. It is anticipated the translated document will be ready within two weeks and it will be posted on the CDRAF website. Dr. Trainor will be making arrangements to have a conference call with the CDRAF Commission members for follow-up.

1. Opioid Conference and Summit

   Dr. Legault and Dr. David Segal attended and represented CDRAF at the Conference held in Ottawa on Friday, November 18, 2016. The conference was co-hosted by the Honourable Jane Philpott (Federal Minister of Health) and the Honourable Dr. Eric Hoskins (Ontario Minister of Health). Participants from dentistry included Dr. David Mock, Dr. David Segal, Dr. Harry Levin, Dr. Paul Allison, Dentist-in-Chief, Dr. James Taylor, and Dr. Michael Gardner.

   There were other attendees from different levels of government, organizations advocating for patients, human rights lawyers, physicians, nurses, police, border officers and patients affected by addiction/abuse issues.

   From the conference it was evident that addiction is a complex issue, as well as being a public health and public safety issue.

   Five panels of experts discussed the crisis of opioid addiction throughout Canada, including the illicit market, recreational use of opioids, specifically Fentanyl, and the use, misuse and risks associated to prescriptions of opioids by health professionals.

   The federal government will be publishing new evidence-based guidelines in 2017 that physicians, nurses, pharmacists and dentists will be expected to follow.

   Dr. Legault and Dr. Segal will be preparing a report of the conference for distribution to the CDRAF Board. A course of action for the CDRAF will be discussed at a future CDRAF Management Group meeting.

   There was also a one-day Summit held on Saturday, November 19, 2016. CDRAF did not attend, as it was dedicated to those organizations that had already made commitments in this area.

2. Fluoride Varnish Applications

Dr. Legault thanked the Registrars for information related to the controlled or non-controlled act status of fluoride varnish application within their provinces. This could be a potential national initiative in the future. Dr. James Taylor will be meeting with Registrars over the next couple of months to identify regulatory challenges.

There was discussion about 3M Canada Company that is promoting its fluoride varnish to encourage pharmacists to apply the varnish directly to consumers' teeth. Dr. Legault advised that she would send the Registrars a copy of the letter from 3M that has been sent to pharmacists recently.

3. Antibiotics Stewardship

Dr. Legault reported that she has had further discussions with Health Canada on over-prescribing of antibiotics by physicians and dentists. There is a meeting scheduled on December 8, 2016 and Health Canada will determine next steps on how to move forward. The CDRAF Board expressed an interest in learning more and she hopes to have information before the next CDRAF Management Group meeting in January 2017.

4. National Dental Examining Board of Canada (NDEB)

The NDEB Annual Meeting was held in Ottawa on October 22, 2016. Some of the highlights covered:

- Development and implementation of the virtual OSCE exam, expected for 2020;
- Judicial review of an appeal that is pending. Significant legal costs are expected;
- New President elected, Dr. Douglas MacKey from Halifax, NS.
- An executive search company will be engaged for hiring new Registrar/Executive Director to replace Dr. Jack Gerrow who is retiring next year.

Dr. Legault has sent her report of the meeting to the CDRAF Management Group and will be providing it to the Registrars at its next meeting.

5. Royal College of Dentists of Canada (RCDC)

Dr. Legault, Ms. Daoust and Mr. Fefergrad met with representatives from RCDC in Ottawa on Sunday, November 20, 2016. The meeting was held to discuss and develop the framework of a third-party agreement to separate all of the RCDC functions from the examination process and provide the

Education Committee with authority to meet the provincial legislative imperatives.

There was very positive discussion. In conclusion, it was agreed that Ms. Daoust would write a briefing note for Registrars to report on the discussions and then an agreement will be drafted.

6. CDRAF Steering Committee

Dr. Legault reported that the CDRAF Steering Committee is scheduled to have its first meeting on November 25, 2016. She thanked Registrars and CDRAF Board members for replying to the survey that was sent out by the facilitator, Brenda Fair, and reiterated that all Board members will be kept apprised of the Steering Committee's progress.

7. CDRAF Management Group Meeting

The next CDRAF Management Group meeting is scheduled for Friday, January 6, 2017 in Winnipeg

8. CDRAF Board Meeting

The next interim CDRAF Board meeting will be held in Ottawa on Saturday, April 23, 2017.

9. Annual Operating Fee

Invoices for the 2017 annual operating fee will be sent to provinces in the coming weeks. $17.64 per member per province was approved by the CDRAF Board and it will be rounded up to $18.00 per member per province.

10. Other Business

There was no other business to report.

11. Adjournment

The teleconference call was adjourned at 3:40 p.m. EDT.

CDRAF
Canadian Dental Regulatory Authorities Federation

FCORD
Fédération canadienne des organismes de réglementation dentaire

CDRAF MONTHLY TELECONFERENCE MEETING

March 2, 2017

Participants:

CDRAF Management Group:	Dr. Nancy Auyeung, Treasurer
	Dr. Barry Dolman, Vice-President
	Dr. Cliff Swanlund, President
British Columbia:	Mr. Jerome Marburg
Manitoba:	Dr. Marcel Van Woensel
Ontario:	Mr. Irwin Fefergrad
	Dr. Ron Yarascavitch
	Dr. Flavio Turchet
Nova Scotia:	Dr. Martin Gillis
New Brunswick:	Mr. Dan Leger
Prince Edward Island:	Dr. Ray Wenn
Newfoundland & Labrador:	Dr. Paul O'Brien

Regrets:

British Columbia:	Dr. David Tobias
Alberta:	Dr. Gordon Thompson
Saskatchewan:	Dr. Bernie White
Ontario:	Dr. David Segal
Quebec:	Ms. Caroline Daoust

Administration:

Dr. Diane Legault, Executive Director
Ms. Angie Sherban, Executive Assistant

Dr. Swanlund welcomed participants to the teleconference meeting and it was called to order at 3:00 p.m EDT. He invited Dr. Legault to report on the current files of CDRAF.

1. Finances

It was reported that the CDRAF audit was conducted on January 13, 2017. Dr. Legault reported that there were no recommendations from the auditor for changes to enhance the current accounting practices. The disbursement controls and approval mechanisms that are being used are deemed to be satisfactory.

She added that there was a surplus of $134,421 at the end of the fiscal year in 2016 and the audited financial statements will be prepared and ready for presentation to the CDRAF Board in April.

2. Strategic Planning

Following the Board meeting and strategic planning session in October, the Steering Committee met by teleconference on November 25, 2016 and a face-to-face meeting was held on February 23, 2017 to draft a strategic plan.

At the Management Group meeting on January 6, 2017 there was discussion on the need for increasing membership value to CDRAF and to make it more efficient. Concerns raised during that meeting were relayed to the Steering Committee and resulted in a productive discussion.

The vision, mission statement, guiding principles and overarching goals were revisited and time was spent on governance with a view to enhancing CDRAF's agility, capacity and cost effectiveness.

A draft report from the Steering Committee will be distributed to the Registrars for review at the meeting scheduled to be held in Montreal on March 30, 2017. The Management Group will also be provided with a copy of the draft report prior to the Board meeting in April. Ms. Brenda Fair will attend the Board meeting to facilitate the discussion on the strategic plan.

3. Opioid Crisis

It was reported that a report by Dr. Segal and Dr. Legault on the Opioid Conference was provided to the Management Group at its January 6, 2017 meeting. The report suggests several courses of action for the CDRAF to consider. This topic will be discussed again at the upcoming Registrars' meeting.

She reminded participants that the RCDSO committed to requesting and reviewing the Narcotics Monitoring System data for opioid prescriptions by dentists and dental specialists for the calendar year 2016 with a view to comparing the data to that received for 2014 to assess the impact of the College's Guidelines on the Effective Use of Opioids for Chronic Non-Cancer Pain.

Dr. Legault thanked RCDSO for its feedback on the consultation initiated with Registrars about the appropriateness of the Guidelines published by Dr. Jason Busse's team of McMaster University regarding best prescription practices.

4. PGY1

As directed by the Board, the Management Group appointed Dr. Bernie White as the CDRAF representative on the working group to explore PGY1. Other representatives on the working group are: Dr. Amarjit Rihal (CDAC), Dr. Martin Gillis (NDEB) and Dr. Esfanfiari (ACFD). The next step will be approval of a written agreement confirming financial commitment of the four organizations, timelines and outcomes. Dr. Paul Allison is preparing the draft document.

5. Entry-Level Competency for Seeking Licensure or Specialist Certificate

Dr. Legault reported that currently there are three Canadian documents (NDEB, CDAC and ACFD) that refer or describe the set of skills and knowledge deemed required. She reported that she has been directed to contact her counterparts at ACFD, NDEB and CDAC and that she will be meeting with the three organizations on March 8, 2017 to start working on a framework that will be reported to the Registrars, Management Group and Board.

6. National Dental Examining Board of Canada (NDEB)

At the CDRAF Board meeting in October, NDEB raised several questions for CDRAF to consider. One of the questions related to the appropriateness to assess English proficiency by internationally-trained dentists and make it a requirement for licensure across the country.

Dr. Legault was asked to canvass the provinces for their requirements and desire to move forward with this.

7. Royal College of Dentists of Canada (RCDC)

Dr. Legault, Ms. Daoust and Mr. Fefergrad attended a meeting in Ottawa with representatives from the RCDC to discuss the need for establishing bi-lateral agreements for RCDC and DRAs. Ms. Daoust has drafted an agreement, with the input of Dr. Van Woensel and Mr. Fefergrad, and this will be presented to the Registrars at the March 30, 2017 meeting. It was also reported that the draft agreement had been recently provided to RCDC's leadership for feedback.

8. On The Road of Wellness, v2.0

Dr. Legault reported that at the CEO/Registrars' conference in December 2016, CDA suggested that a follow-up to the 2012 conference on wellness be planned and CDRAF was asked to participate in a joint effort. CDSPI has agreed to sponsor the symposium and cover all related costs. As co-hosts, CDA and CDRAF would not be required to make any financial commitment.

In order to alleviate travel costs, the participated timeline for the event would be in April 2018, to be held in conjunction with other CDA and CDRAF meetings being held at that time.

The Management Group asked Dr. Legault to further explore this initiative and report on it at the April Board meeting.

9. Important Dates

Registrars' Meeting	March 30, 2017, Montreal
Management Group Meeting	April 6, 2017 via Zoom
Next Conference Call	Thursday, May 25, 2017

10. Other Business

There was no other business to report.

11. Adjournment

The teleconference call was adjourned at 3:35 p.m. EDT.