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

RCDSO Office, 6 Crescent Road, Toronto, ON M4W 1T1

MEMBERS' REPRESENTATIVES

Friday, October 12, 2018

8:30 a.m.

CDRAF Canadian Dental Regulatory Authorities Federation

FCORD Fédération canadienne des organismes de réglementation dentaire

AGENDA

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

CDRAF MEETING OF MEMBERS' REPRESENTATIVES

RCDSO Offices, 6 Crescent Road, Toronto, ON

8:30 a.m. - Friday, October 12, 2018

		Resources
1.	Call to Order	
2.	Approval of Agenda	
3.	Review of Minutes • CDRAF Board, October 13, 2017 • CDRAF Board (renewed), October 13, 2017	**A**
4.	Business Arising	
5.	Report from Board of Directors	**B**
6.	CDRAF Strategic Plan 2017-2020	**C**
7.	CDRAF By-Laws	**D**
8.	Reports • Association of Canadian Faculties of Dentistry • Canadian Dental Association • Canadian Dental Specialists Association • Commission on Dental Accreditation of Canada • National Dental Examining Board of Canada • Royal College of Dentists of Canada • International Society of Dental Regulators (ISDR) • Opioids	**E**

9. Finance
   - Financial Statements, December 31, 2017 **F**
   - Restricted Net Asset Policy
   - Draft Budget 2019

10. Election of Officers

11. Next Members' Representatives Meeting:
   - October 11, 2019, Location to be determined

12. Correspondence **G**

13. Adjournment

AMS:826594

APPENDIX A

CANADIAN DENTAL REGULATORY AUTHORITIES FEDERATION

MINUTES OF MEETING
BOARD OF DIRECTORS

Friday, October 13, 2017
Le Westin Montréal, Palais Room, 270 Saint-Antoine West, Montréal, QC

The 28th meeting of the Canadian Dental Regulatory Authorities Federation took place on Friday, October 13, 2017.

PARTICIPANTS:

Dr. Nancy Auyeung, Delegate, Manitoba Dental Association
Dr. Mintoo Basahti, President, Alberta Dental Association and College
Dr. Randall Croutze, Registrar, Alberta Dental Association and College
Ms. Caroline Daoust, Directrice générale et secretaire, L'Ordre des dentistes du Québec
Dr. Barry Dolman, President, L'Ordre des dentistes du Québec
Mr. Irwin Fefergrad, Registrar, Royal College of Dental Surgeons of Ontario
Dr. Véronique Gagnon, Board member, L'Ordre des dentistes du Québec
Dr. Martin Gillis, Registrar, Provincial Dental Board of Nova Scotia
Dr. Guy Lafrance, Vice-President, L'Ordre des dentistes du Québec
Mr. Dan Leger, Registrar, New Brunswick Dental Society
Dr. Patti Ling, Acting Registrar, Manitoba Dental Association
Dr. Paul O'Brien, Registrar, Newfoundland & Labrador Dental Board
Dr. Kirk Preston, New Brunswick Dental Society
Dr. David Segal, Council member, Royal College of Dental Surgeons of Ontario
Dr. Cliff Swanlund, CDRAF Chair, Alberta Dental Association & College
Dr. David Tobias, Delegate, College of Dental Surgeons of British Columbia
Dr. Flavio Turchet, Vice-President, Royal College of Dental Surgeons of Ontario
Dr. Kevin Walsh, Provincial Dental Board of Nova Scotia
Dr. Ray Wenn, Registrar, Dental Council of Prince Edward Island
Dr. Ronald Yarascavitch, President, Royal College of Dental Surgeons of Ontario

STAFF:

Dr. Diane Legault, CDRAF Executive Director
Ms. Angie Sherban, CDRAF Executive Assistant

REGRETS:
Dr. Louie Kriel, President, College of Dental Surgeons of Saskatchewan
Dr. Bernie White, Registrar, College of Dental Surgeons of Saskatchewan

Thirty-party providers were invited to attend the meeting at 10:30 a.m., following an *in-camera* session of the CDRAF Board:

Dr. Jack Gerrow and Dr. Marie Dagenais, National Dental Examining Board of Canada.
Dr. Chris Robinson, Dr. Adel Kauzman and Mr. Peter McCutcheon, Royal College of Dentists of Canada.
Dr. Amarjit Rihal and Mr. Frédéric Duguay, Commission on Dental Accreditation of Canada.

8. INITIATIVE UPDATES

(a) RCDC Bi-Lateral Agreement/Report on RCDC Council Meeting

Dr. Legault reported on the work of the Working Group (Caroline Daoust, Irwin Fefergrad, Martin Gillis and Jerome Marburg) to develop a draft thirty-party assessment service agreement to clarify the responsibilities and obligations of RCDC and the dental regulatory authorities. A copy of the draft agreement was provided to the CDRAF Board for its information.

The draft agreement was presented to the RCDC Council at its meeting on September 23, 2017 during an *in-camera* session. Positive feedback was received. Dr. Legault hoped to receive additional financial information from RCDC on organization specifics, etc. and will examine the financial implications. The Working Group will recommend the final document to the new CDRAF Board at its next meeting.

(b) Dental Specialty Recognition

Dr. Legault reported that at the request of the CDRAF Board, Dr. Marcel Van Woensel and Mr. Jerome Marburg reviewed the current process for recognition of dental specialty recognition. A draft document has been prepared and Registrars have been asked for their input. Dr. Legault reminded Registrars to provide feedback directly to Mr. Marburg.

(c) Central Repository Agreement with NDEB

Dr. Legault reported that this initiative was brought forward by Dr. Marcel Van Woensel. At the August 24, 2017 Registrars' Council meeting, Dr. Gerrow and Dr. Dagenais attended and amongst other items presented on a draft Central Repository Agreement. Registrars were asked to consider three options in order to obtain the necessary transcript of records from applicants:

(a) NDEB would deliver certificates upon receipt of original certified transcripts. Canadian graduates require a letter from the Dean of dental school, but this could delay licensure for up to two weeks. It was felt that all applicants should be treated the same and provide original certified transcripts.
(b) NDEB could explore issuing temporary provisional certificates to graduates until transcripts are received.
(c) Remain with the transcript and letter from the Dean.

Option (a) was preferred with all graduates being treated equally. Some Registrars felt that it could be too long for graduates to wait for some Canadian dental faculties to issue the transcripts and consequently delay the issuing of their licences. The dental faculties are being asked to confirm how quickly the transcripts can be issued.

(d) Proposal re Language Proficiency Assessment

Dr. Legault reported that some organizations conduct assessment capabilities to speak English. Universities (dental faculties) are using tests at the Centre for Canadian Language Benchmarks (CLB) at Level 8 as functioning proficiency for communicating effectively with patients.

NDEB asked the CDRAF Board if it was willing to make English proficiency a requirement for licensure within NDEB processes. It was noted that there may be legal implications by doing so.

9. REPORTS

(a) Emerging and Best Practices to Eliminate Barriers to Foreign Qualification Recognition Conference, October 2, 2017 – Halifax, NS

Dr. Legault's written report on the conference was provided to the CDRAF Board for its information. She reported that there were many national organizations in attendance, the following topics were highlighted:

- Mentorship, MOU – can we do more to facilitate the introduction of new dentists?
- The changing face of the dental profession and the importance. Is it important to stick to our values for newcomers?
- Observership for foreign-trained dentists – confidentiality issues? This program has been introduced in Nova Scotia for medicine; privacy and confidentiality implications will be taken into account if introduced for dentistry.
- Opening borders becoming more favourable.

(b) International Conference of Dental Regulators, October 5-6, 2017, London, UK

Mr. Fefergrad reported that the conference had six top notch speakers and a very engaging audience. There were 40 attendees who discussed and shared similar issues within their jurisdictions.

The speakers did not request payment, but some travel and hotel expenses were reimbursed.

At the Annual General Meeting on October 6, 2017, it was decided to reinstate the current Executive Committee to maintain continuity. A new Treasurer was elected, Narelle Mills from Australia, to replace Michael Carpenter who resigned earlier in the year. Dr. Irving McKenzie from Jamaica is no longer a member of the Executive Committee.

Support was given for ISDR to continue negotiations with FDI World Dental Federation on combining forces to include a dentistry regulatory aspect which currently is absent from FDI's programs. There are discussions with FDI to try to work together at the next World Health Professions Conference in the spring of 2018.

The draft Accreditation Principles document was presented and will be further refined with assistance from the NDEB (Dr. Gerrow and Dr. Dagenais) who have kindly offered to review the document so that is does not impinge on current regulations in Canada, but will help others around the world.

10. INVITATIONS

(a) CDA Committee on the Identification of Future Dentists

Dr. Legault reported that the CDRAF received an invitation from the CDA to attend the inaugural meeting of the CDA Committee on the Identification of Future Dentists (CIFD) on November 20-21, 2017 in Ottawa as an observer. It was suggested and agreed that Dr. Legault attend the meeting on behalf of CDRAF.

(b) CDA National Task Force on the Future of the Dental Profession

Dr. Swanlund reported that he received an invitation from CDA to participate in the *Future of the Dental Profession* initiative taking place in Toronto in November. Dr. Swanlund stated that he attended an initial meeting as representative of the Alberta Dental Association and College and that was likely the reason he received the new invitation.

There was discussion on why CDA would have one of its major committees review a regulatory matter. Some felt this was inappropriate for CDA. One suggestion was to write to CDA expressing concerns about it addressing regulatory issues, and request that CDRAF be at least included in a joint venture.

A question was raised on who should be attending events that usually the President would attend. Dr. Legault advised that the Board of Directors (Registrars) would decide who attends and reporting would be communicated to the DRAs through its reporting mechanism on the Board of Directors meeting.

It was agreed that Dr. Legault should attend this meeting, but the Registrars wished to discuss it further during its meeting later in the day.

11. REPORTS FROM THIRD-PARTY PROVIDERS AND STAKEHOLDERS

(a) Commission on Dental Accreditation of Canada
Mr. Frédéric Duguay presented the report on behalf of CDAC. A written report was provided to the CDRAF Board for information.

(b) National Dental Examining Board of Canada
Dr. Jack Gerrow presented the report on behalf of NDEB. A written report was provided to the CDRAF Board for information.

(c) Royal College of Dentists of Canada
Dr. Chris Robinson presented the report on behalf of RCDC. A written report was provided to the CDRAF Board for information.

(d) Association of Canadian Faculties of Dentistry
A written report from ACFD was provided to the CDRAF Board for information.

(e) Canadian Dental Association
A written report from CDA was provided to the CDRAF Board for information.

(f) Canadian Dental Specialties Association
A written report from CDSA was provided to the CDRAF Board for information.

(g) Royal Canadian Dental Corps
A written report from RCDC was provided to the CDRAF Board for information.

12. OTHER BUSINESS

There was no other business discussed.

13. ADJOURNMENT

There being no further business, Dr. Swanlund called for adjournment at 12.05 p.m. He thanked CDRAF Board members for attending and for their participation in the meeting. He thanked Dr. Marcel Van Woensel for all his efforts with CDRAF over the years.

Speaking on behalf of the group, Dr. Legault thanked Dr. Swanlund for the sound leadership he provided during important changing times for CDRAF.

There was an education session that commenced at 1:15 p.m. The two guest speakers were:

- Dr. Jack Gerrow, Registrar and Executive Director, National Dental Examining Board of Canada
  "Dental Education and Licensure in a Global World: Can Competence be measured?"

- Mr. André Gariépy, Commissioner of Professional Admission, Office des professions du Québec
  "International, national and provincial trends, expectations and sensitivities"

Copies of their PowerPoint presentations are available upon request.

CANADIAN DENTAL REGULATORY AUTHORITIES FEDERATION

NOTES OF MEETING
BOARD OF DIRECTORS (Renewed)

Friday, October 13, 2017
Le Westin Montréal, Palais Room, 70 Saint Antoine Ouest, Montreal, QC

A meeting of the CDRAF Board of Directors (renewed) took place on Friday, October 13, 2017 at 3:30 p.m.

PARTICIPANTS:
Dr. Randall Croutze, Chief Executive Officer, Alberta Dental Association and College
Ms. Caroline Daoust, Directrice générale et secretaire, L'Ordre des dentistes du Québec
Mr. Irwin Fefergrad, Registrar, Royal College of Dental Surgeons of Ontario
Dr. Martin Gillis, Registrar, Provincial Dental Board of Nova Scotia
Mr. Dan Leger, Registrar, New Brunswick Dental Society
Dr. Patti Ling, Acting Registrar, Manitoba Dental Association
Dr. Paul O'Brien, Registrar, Newfoundland and Labrador Dental Board
Dr. Ray Wenn, Registrar, Dental Council of Prince Edward Island

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

OBSERVERS:
Dr. Nancy Auyeung, Delegate, Manitoba Dental Association
Dr. Mintoo Basahti, President, Alberta Dental Association and College
Dr. Barry Dolman, President, L'Ordre des dentistes du Québec
Dr. Guy Lafrance, Board member, L'Ordre des dentistes du Québec
Dr. Cliff Swanlund, President, Delegate, Alberta Dental Association & College
Dr David Tobias, Delegate, College of Dental Surgeons of British Columbia

REGRETS:
Mr. Jerome Marburg, Registrar, College of Dental Surgeons of British Columbia
Dr. Bernie White, Registrar, College of Dental Surgeons of Saskatchewan

1. CALL TO ORDER

The Chair, Dr. Legault, called the meeting to order at 3:30 p.m.

2. APPROVAL OF AGENDA

There were no amendments to the agenda circulated.

MOTION: Daoust/Leger

THAT the agenda of the meeting of October 13, 2017 be approved, as circulated.

CARRIED
(Unanimously)

3. APPROVAL OF MEETING NOTES

The meeting notes of the Registrars' Council meeting of August 24, 2017 were approved, as circulated.

MOTION: Daoust/Ling

THAT the notes of the Registrars' Council meeting of August 24, 2017 be approved, as circulated.

CARRIED
(Unanimously)

4. APPOINTMENT OF CDRAF OFFICERS

At the August 24, 2017 meeting, it was agreed that a Chair would be appointed once a year on a rotation basis from east to west, starting with Dr. Paul O'Brien in 2018. Dr. Wenn advised that he intended to retire in 2018 and, therefore, Dr. Gillis was appointed Vice-Chair in his stead. Mr. Leger was appointed Treasurer.

MOTION: Wenn/Fefergrad

THAT the CDRAF Officers for 2018 be appointed, as follows:

Chair:	**Dr. Paul O'Brien**
Vice-Chair:	**Dr. Martin Gillis**
Treasurer:	**Mr. Dan Leger**

CARRIED
(Unanimously)

5. MEETING SCHEDULE

The Registrars were provided with a schedule for meeting dates in 2018. It was agreed to reschedule the proposed meeting on February 2, 2018 to February 9, 2018. The meeting will be held in Montreal.

Registrars will be permitted to participate via Zoom, if necessary.

The meeting dates for 2018 agreed to are as follows:

- Friday, February 9, 2018
- Friday, April 20, 2018
- Friday, August 24, 2018
- Thursday, October 11/Friday, October 12, 2018 (GA Meeting)

6. OTHER BUSINESS

6.1 <u>CDA National Task Force on the Future of the Dental Profession</u>

There was discussion on the invitation sent by CDA to CDRAF to participate in this initiative being held in Toronto in November. There was discussion on the appropriateness of CDA being involved in regulatory initiatives. While some Registrars felt that CDA should not be taking on this type of project on its own, others felt it was a kind gesture on the part of CDA to invite CDRAF and that it should attend the meeting.

It was agreed that Dr. Legault would attend the Task Force meeting on behalf of CDRAF and report back to the Registrars at the next meeting.

Dr. Swanlund will also attend the meeting on behalf of the Alberta Dental Association and College.

It was agreed to have further discussion on CDA involvement at a future Registrars meeting.

7. ADJOURNMENT

There being no further discussion, the meeting was adjourned at 4:10 p.m.

APPENDIX B

CDRAF
Canadian Dental Regulatory Authorities Federation

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Fédération canadienne des organismes de réglementation dentaire

October 12, 2018

CDRAF Board of Directors Report

The CDRAF Board of Directors is pleased to present this update on activities during the past 12 months.

1. Revised Governance Model

Following an in-depth strategic planning process and consultations with stakeholders, revised CDRAF Bylaws were approved at the CDRAF Annual Meeting in October 2017. The revised Bylaws include the establishment of a ten-member Board. The Bylaws also designate that the Board Members must be the Registrar (or equivalent) of each provincial Dental Regulatory Authority (DRA). The CDRAF Board will meet 4 times a year with a meeting of the Member Representatives being held once a year. Representatives of Third Party Providers (CDAC, NDEB, RCDC and ACFD) and Member Representatives of the DRAs are invited to attend all CDRAF meetings as observers. All CDRAF Board meetings are open. Written requests from other stakeholders to attend as observers will be considered by the Chair, and normally granted.

2. National Dental Specialty Recognition

In 2010-2011, at the request of the DRAs, CDRAF became responsible for the national dental specialty recognition process. At that time the process was developed upon receipt of an application for a new dental specialty. The application was circulated to organizations for feedback and a Committee comprised of key stakeholder groups reviewed the application for the new dental specialty. Following the denial of an application, the CDRAF Board would review the process.

A revised process was approved by the CDRAF Board at the February 2018 meeting. The revised process describes the purpose and rationale for new specialty recognition with a clear explanation of the how the application is evaluated when it is received. The process defines the composition of the Committee appointed by CDRAF for the evaluation and addresses important issues such as conflict of interest.

3. Finances

In 2016 and 2017, CDRAF fees were $18.00 per dentist per province. The fees were reduced to $5.50 per dentist per province which provided revenue of less than $125,000 which will result in a significant budget deficit. At the September 5, 2018 meeting, the CDRAF unanimously agreed on the Policy on Restricted Net Assets and also agreed that fees would need to be increased to facilitate reaching the amount stated in the policy over a five-year period.

4. Working Group on National Competency Standards for General Dentists

The CDRAF Strategic Plan includes developing National Competency Standards for General Dentists as one of the major initiatives.

In consultation with ACFD, NDEB and CDAC, CDRAF has established a Working Group on National Competency Standards for General Dentists. The Working Group, comprised of Dr. Jack Gerrow (Chair), Dr. Chris Hacker, Caroline Daoust, Irwin Fefergrad, Dr. Martin Gillis, Dr. Patti Ling, Dr. Larisa Naderiani and Dr. Sébastién Greiche, has established a process to develop Standards including receiving input from all DRAs and a workshop with stakeholders. The workshop will be held on November 9-10, 2018 to create a draft document that will be circulated to all stakeholders prior to it being considered for approval by the CDRAF Board.

Once approved, the CDAC will be requested to include the CDRAF competencies in the Accreditation Standards.

5. Opioids Crisis

The CDRAF Board continues to work with the Canadian Centre on Substance Abuse (CCSA) and facilitates the distribution of information in this important area. Dr. David Mock, an RCDSO Council member and representative on opioids, has also agreed to be the CDRAF representative on this issue. He will provide reports to CDRAF on a regular basis.

6. Website

The mission of CDRAF has changed substantially since the website was developed. A review of the purpose, maintenance, and cost of the website is underway.

7. Academic Pathway

Following the adoption of the Mutual Recognition Agreement (MRA) on General Dentistry and the Memorandum of Understanding (MOU) on Dental Specialties,

academic pathway for special/restrictive licenses has been eliminated. ACFD has indicated that the Faculties of Dentistry are experiencing increased challenges in recruiting academics. The CDRAF Board requested that ACFD provide specific suggestions on how CDRAF and the provincial DRAs can assist with this issue.

8. CDAC Initiatives

Mr. Frédéric Duguay, Director of CDAC, presented to the CDRAF Board at the February 2018 meeting on the following: the CDAC strategic planning process being undertaken in 2018; the funding and process for site visits; international accreditation; and reciprocal agreements.

During his presentation, the CDRAF Board confirmed the importance of transparency and recommended that finalized CDAC Reports from site visits be posted on CDAC's website. The CDRAF Board also suggested that the CDAC Strategic Planning Process consider the advisability of having CDAC become a fully independent organization.

9. National Repository

CDRAF is supportive of NDEB providing a national repository for all documents required for initial certification of new candidates. A national repository managed by NDEB would eliminate the DRAs requirement for applicants to submit the same documents. NDEB will provide a proposal to the CDRAF Board once it has obtained information on the timing of licensure for new graduates of Canadian programs.

10. Language Proficiency Assessment and other potential revisions to the NDEB Equivalency Process

NDEB has reported to CDRAF that it is working with the Centre for Canadian Language Benchmarks (CLB) to develop a language proficiency assessment for dentistry. NDEB also indicated that it is considering revising the Equivalency Process including making the ACS a conjunctive assessment. NDEB will provide a detailed proposal once it is developed.

11. RCDC Third-Party Assessment Service Agreement

A Third-Party Assessment Service Agreement between the Royal College of Dentists of Canada (RCDC) and the Dental Regulatory Authorities (DRAs) was recommended at the June 6, 2018 CDRAF meeting. Recent events have caused the DRAs to reconsider their participation in the agreement and the CDRAF Board has established a CDRAF Working Group to look at all options

for the certification of Dental Specialties. Three Working Group meetings have been scheduled in the Fall of 2018.

12. New Executive Director

Dr. Jack Gerrow was appointed as the new Executive Director following the resignation of Dr. Diane Legault. Dr. Legault was named as the President of the Office des professions du Quebec. The CDRAF Board looks forward to working with Dr. Gerrow and wishes Dr. Legault success in her new position.

AMS:830699

APPENDIX C

Canadian Dental Regulatory Authorities Federation (CDRAF) Strategic Plan

2017-2020

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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 CDRAF 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 CDRAF 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

CDRAF

Canadian Dental Regulatory Authorities Federation

FCORD

Fédération canadienne des organismes de réglementation dentaire

STATEMENT OF PURPOSES AND PRINCIPLES and BY-LAW NO. 2 – RELATING GENERALLY TO THE CONDUCT OF THE AFFAIRS OF THE FEDERATION

Adopted and in Force as of October 13, 2017

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STATEMENT OF PURPOSES AND PRINCIPLES

A. OVERVIEW

The Canadian Dental Regulatory Authorities Federation (CDRAF), incorporated under the *Canada Corporations Act*, was created 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 is not-for-profit.

CDRAF provides a leadership and responsive infrastructure and forum where dental regulatory authorities in Canada can anticipate and respond to current regulatory challenges on interprovincial/territorial, national and global levels, in effective and efficient ways.

As a discerning information coordinator for dental regulatory authorities, CDRAF examines the impact of regulatory trends, policy and legislation in the public interest and keeps its Members informed of similar regulatory forces in other professions, industries, and for major stakeholders, in Canada and other jurisdictions. CDRAF facilitates the collective generation of strategies and options for responding to global regulatory forces and their impact in Canada. In addition to being an advisory service and supportive network, it provides one voice for dental regulatory authorities with the federal government, external regulatory regimes and other major stakeholders, and is the official spokesperson for Canadian dental regulatory authorities on interprovincial/territorial, national and global matters.

B. PURPOSES

CDRAF is the national forum and collective voice of provincial and territorial dental regulatory authorities regarding interprovincial/territorial, national and global regulatory matters for the dental profession and was incorporated under the *Canada Corporations Act* and will continue pursuant to the *Canada Not-For-Profit Corporations Act.*

C. OBJECTS

CDRAF will achieve its purpose by pursuing the following objects:

- Creating and maintaining an effective forum for the exchange of information regarding regulatory trends, policy and legislation.
- Tracking and reporting on interprovincial/territorial, national and global issues related to the regulation of dental practice.
- Developing and promoting harmonized and global perspectives on inter-jurisdictional matters that relate to mobility and the regulations related to dental practice.
- Providing one voice in Canada for regulatory matters for dentists, in interprovincial/territorial, national and global matters.
- Advising on and promoting best regulatory practices and standard approaches to

assessment and regulation of initial and continuing competence for dentists.

- Undertaking research and projects of shared interest to the Members in collaboration with other national and global entities.
- Identifying those advisory, research and support services to be made available to its Members.
- Establishing external liaisons and partnerships to assist its Members to deal effectively with new and innovative regulatory challenges.
- Monitoring the effectiveness of its purpose, stated objects and guiding principles.

D. GUIDING PRINCIPLES

At all times, CDRAF will be guided by the following principles:

- The intact authority and regulatory autonomy of each Member will be recognized as foundational and considered paramount in all CDRAF deliberations and decisions.
- In keeping with the mandate of its Members and its purposes and objects, the context for all CDRAF's recommendations, support, and external relations will be a focus on regulation and the role of regulatory authorities.
- Formal decision making of the CDRAF will be by the applicable majority vote and will include an attempt to seek consensus on all issues.
- As the national voice for dental regulatory authorities, Members collectively acknowledge the importance of one voice on dental regulatory matters. CDRAF will be a voice that reflects and respects diversity among its Members, while speaking externally with an agreed harmonized voice to external stakeholders, or engaging in external liaisons and partnerships.
- CDRAF will exercise due diligence with respect to ethics and fiduciary duties in its overall decision making and management of human and fiscal resources on behalf of its Members.
- CDRAF members recognize and respect the breadth of expertise within the Federation and support collaboration that contributes to shared knowledge.
- CDRAF members seek every opportunity to share freely and with a generous spirit. They are sensitive to individual jurisdictional and legislative differences as they strive for consensus. They practice, in good faith, a willingness to be open and honest with each other.

By-Law No. 2 - relating generally to the conduct of the affairs of CANADIAN DENTAL REGULATORY AUTHORITIES FEDERATION/ FÉDÉRATION CANADIENNE DES ORGANISMES DE RÉGLEMENTATION DENTAIRE (the "Corporation") BE IT ENACTED as a by-law of the Corporation as follows:

I. DEFINITIONS AND INTERPRETATION

1. Definition

In this By-Law and all other By-Laws of the Corporation, unless the context otherwise requires:
"Act" means the *Canada Not-For-Profit Corporations Act* S.C. 2009, c. 23 including the Regulations made pursuant to the Act, and any statute or regulations that may be substituted, as amended from time to time;

“Annual Meeting” means the meeting of the Members held between September 1st and November 30th at which time elections of Officers is held;

"Articles" means the original or restated Articles of incorporation or Articles of amendment, amalgamation, continuance, reorganization, arrangement or revival of the Corporation;

"Board” means the Board of directors of the Corporation and "Director" means a Member of the Board;

"By-Law" means this by-law and any other by-law of the Corporation as amended and which are, from time to time, in force and effect;

"Corporation" means the Canadian Dental Regulatory Authorities Federation/Fédération canadienne des organismes de réglementation dentaire and may include “CDRAF”, “FCORD’ and “Federation”;

"Meeting of Members" includes an Annual Meeting or a special meeting of Members; "special meeting of Members" includes a meeting of all Members entitled to vote at an Annual Meeting;
"Member" means the provincial or territorial body established by provincial or territorial statute responsible for the professional regulation of dentists within the province or territory who has been granted Membership in the CDRAF;

"Observer" means an individual, other than a Director, who is entitled to attend a meeting of the Board or the meeting of Members but who is not entitled to vote at any such meeting;
"ordinary resolution" means a resolution passed by a majority of not less than 50 percent plus 1

of the votes case on that resolution;

"proposal" means a proposal submitted by a Member of the Corporation that meets the requirements of section 163 (Shareholder Proposals) of the Act;

"Regulations" means the regulations made under the Act, as amended, restated or in effect from time to time;

"special resolution" means a resolution passed by a majority of not less than two-thirds (2/3) of the votes cast on that resolution;

“strong majority vote” means a resolution with requires not less than 4/5th of the votes capable of being cast by the full Membership of CDRAF or the CDRAF Board.

2. Interpretation

In the interpretation of this by-law, words in the singular include the plural and vice- versa, words in one gender include all genders, and "person" includes an individual, body corporate, partnership, trust and unincorporated organization.

Other than as specified above, words and expressions defined in the Act have the same meanings when used in these By-Laws.

3. Corporate Seal

The Corporation may have a corporate seal in the form approved from time to time by the Board. If a corporate seal is approved by the Board, the secretary of the Corporation shall be the custodian of the corporate seal.

4. Execution of Documents

Deeds, transfers, assignments, contracts, obligations and other instruments in writing requiring execution by the Corporation may be signed by any two of its officers or directors. In addition, the Board may from time to time direct the manner in which and the person or persons by whom a particular document or type of document shall be executed. Any person authorized to sign any document may affix the corporate seal (if any) to the document. Any signing officer and the executive director may certify a copy of any instrument, resolution, by-law or other document of the Corporation to be a true copy thereof. Any payment by CDRAF to its Members, Directors or Observers shall not be executed by an officer or director from the same province (i.e. payment by CDRAF to an individual from New Brunswick is executed by any two officers or directors who are not from New Brunswick.)

II. FINANCIAL MATTERS

5. Financial Year

The financial year of the Corporation shall be December 31 in each year unless otherwise determined by the Board.

6. Banking Arrangements

The banking business of the Corporation shall be transacted at such bank, trust company or other firm or corporation carrying on a banking business in Canada as the Board may designate, appoint or authorize from time to time by resolution. The banking business or any part of it shall be transacted by an officer or officers of the Corporation and/or other persons as the Board may by resolution from time to time designate, direct or authorize.

7. Borrowing Powers

If authorized by a by-law which is duly adopted by the directors and confirmed by a strong majority vote of the Members, the directors of the corporation may from time to time:

- borrow money upon the credit of the Corporation;
- limit or increase the amount to be borrowed;
- issue debentures or other securities of the Corporation;
- pledge or sell such debentures or other securities for such sums and at such prices as may be deemed expedient; and
- secure any such debentures, or other securities, or any other present or future borrowing or liability of the Corporation, by mortgage, hypothec, charge or pledge of all or any currently owned or subsequently acquired real and personal, movable and immovable, property of the corporation, and the undertaking and rights of the Corporation.

Any such by-law may provide for the delegation of such powers by the directors to such officers or directors of the Corporation to such extent and in such manner as may be set out in the by-law. Nothing herein limits or restricts the borrowing of money by the Corporation on bills of exchange or promissory notes made, drawn, accepted or endorsed by or on behalf of the Corporation.

8. Management of Corporate Funds

An ordinary resolution of the Board shall be required for the adoption of the budget.

A strong majority vote of the Board shall be required for approval of expenditures exceeding the budget.

All monies received by the Corporation shall be deposited in an interest bearing account in the name of CDRAF at a financial institution approved by the Board.

9. Annual Financial Statements

The Corporation shall send to the Members a copy of the annual financial statements and other documents referred to in subsection 172(1) (Annual Financial Statements) of the Act or a copy of a publication of the Corporation reproducing the information contained in the documents. Instead of sending the documents, the Corporation may send a summary to each Member along with a notice informing the Member of the procedure for obtaining a copy of the documents themselves free of charge. The Corporation is not required to send the documents or a summary to a Member who, in writing, declines to receive such documents.

III. MEMBERS

10. Membership Conditions

Subject to the Articles, there shall be one class of Members in the Corporation. Each Member shall be entitled to receive notice of, attend and exercise at least one vote at all meetings of the Members of the Corporation.

Membership in the Corporation shall be available to a provincial or territorial body established by statute, and responsible for the provincial or territorial regulation of dentists within said province or territory, which has an interest in furthering the Corporation's purposes and which has applied for and been accepted into Membership of the Corporation by resolution of the Board or in such other manner as may be determined by the Board.

Membership acceptance includes a commitment to remain a Member for two years and pay the required annual fees for two years.

There shall be a minimum of eight Members of the Corporation at all times.

Each Member shall promptly be informed in writing by the secretary of their admission as a Member.

Membership vote allocations are based on the following formula:

Number of Dentists Within the Province-Territory/Number Votes Accorded to the Member

- up to 1,000/1 vote
- 1,000 to 4,999/2 votes
- 5,000 and over/3 votes

Pursuant to subsection 197(1) (Fundamental Change) of the Act, a strong majority vote of the Members is required to make any amendments to this section of the By-Laws if those amendments affect Membership rights and/or conditions described in paragraphs 197(1)(e), (h), (l) or (m).

11. Termination of Membership by Member

A Member who wishes to terminate its Membership shall give one full year's notice of such termination. All fees assessed or due are required to be paid by the terminating Member in full until the termination is complete.

Pursuant to Section 197(1) (Fundamental Change) of the Act, a strong majority vote of the Members is required to make any amendment to add, change or delete this section of the By-Laws.

12. Notice of Members Meeting

Notice of the time and place of a meeting of Members shall be given to each Member entitled to vote at the meeting by the following means:

1. by mail, courier or personal delivery to each Member entitled to vote at the meeting, during a period of 21 to 60 days before the day on which the meeting is to be held; or
2. by telephonic, electronic or other communication facility to each Member entitled to vote at the meeting, during a period of 21 to 35 days before the day on which the meeting is to be held.

Pursuant to subsection 197(1) (Fundamental Change) of the Act, a strong majority vote of the Members is required to make any amendment to the By-Laws of the Corporation to change the manner of giving notice to Members entitled to vote at a meeting of Members.

13. Members Calling a Members' Meeting

The Board shall call a special meeting of Members in accordance with Section 167 of the Act, on written requisition of Members carrying not less than 5 percent of the voting rights. If the directors do not call a meeting within 21 days of receiving the requisition, any Member who signed the requisition may call the meeting.

Pursuant to subsection 197(1) (Fundamental Change) of the Act, a strong majority vote of the Members is required to make any amendment to the By-Laws of the Corporation to change the manner of giving notice to Members entitled to vote at a meeting of Members.

14. Absentee Voting at Members' Meetings

Pursuant to section 171(1) (Absentee Voting) of the Act, a Member entitled to vote at a meeting of Members may vote by mailed-in ballot or by means of a telephonic, electronic or other communication facility if the Corporation has a system that:

1. enables the votes to be gathered in a manner that permits their subsequent verification; and
2. permits the tallied votes to be presented to the Corporation without it being possible for the Corporation to identify how each Member voted.

Pursuant to subsection 197(1) (Fundamental Change) of the Act, a special resolution of the Members is required to make any amendment to the By-Laws of the Corporation to change this method of voting by Members not in attendance at a meeting of Members.

15. Membership Dues

There should be no Membership fees or dues unless otherwise directed by the Board.
The Membership fee shall mean annual fee paid by each Member based on a formula approved by the Board that accords a dollar amount for each dentist regulated by the Member in their respective province or territory excluding short-term, emergency, *pro bono*, or similar classifications of licensure.

Membership fees or dues levied must be paid in full by February 1 in any year.

In the event of default, monies plus interest at the prime rate, calculated, compound not simple, are due. Non-payment for a year for a payment not remitted by February 1 in each year is an act of default.

Where a Member defaults on payment of Membership fees, the Member is automatically suspended and shall be terminated unless all outstanding monies and interest are paid within sixty 60 days of default.

16. Termination of Membership by Board– Except Non-Payment of Fees

Membership in the Corporation may be terminated on a strong majority vote of the Board for a Member's breach of the By-Laws or other deficiency, except the non-payment of dues, and is automatically terminated when:

- in the case of a Member that is a corporation, the corporation is dissolved;

- a Member resigns by delivering a written resignation to the chair of the Board of the Corporation, such resignation shall be effective one full year following delivery of the resignation;
- a Member's Membership expires; or
- the Corporation is liquidated or dissolved under the Act.

17. Effect of Termination of Membership

Subject to the Articles, any termination of Membership means that the rights of the Member, including any right in the property of the Corporation, automatically cease to exist.

18. Place of Members' Meeting

Subject to compliance with section 159 (Place of Members' Meetings) of the Act, meetings of the Members may be held at any place within Canada determined by the Board.

19. Cost of Attendance at Meetings

Members of the Corporation shall attend meetings of the Corporation at the expense of the Member.

20. Members representatives and Persons entitled to be present at Members' Meetings

Such representative appointed by the Members -up to three (3) representatives- holding the Member voting privileges. One of the Member's representatives has to carry the function of Registrar, acting registrar, Secretary or Acting Secretary of the Board of the Member.

Such other persons entitled, invited or required under any provisions of the Act, Articles or By-Laws to be present at the meeting.

21. Chair of Members' Meetings

In the event that the Chair of the Board and the Vice-Chair of the Board are absent, the members who are present and entitled to vote at the meeting shall choose one of their number to chair the meeting.

22. Quorum at Members' Meetings

A quorum at any meeting of the Members (unless a greater number of Members are required to be present by the Act), shall be 60 percent (6 out of 10) of the Members of the Corporation present and eligible to vote at the meeting. Proxies are not allowed to contribute to the establishment of a quorum. If a quorum is present at the opening of the meeting of Members, the Members present may proceed with the business of the meeting even if a quorum is not present throughout the meeting.

23. Votes to Govern at Members' Meetings

At any meeting of Members every question shall, unless otherwise provided by the Articles or By-Laws or by the Act, be determined by a majority of the votes cast on the questions. In case of an equality of votes either on a show of hands or on a ballot or on the results of electronic voting, the chair of the meeting shall not have a second or casting vote.

24. Participation by Electronic Means at Members' Meetings

If the Corporation chooses to make available a telephonic, electronic or other communication facility that permits all participants to communicate adequately with each other during a meeting of Members, any person entitled to attend such meeting may participate in the meeting by means of such telephonic, electronic or other communication facility in the manner provided by the Act. A person participating in a meeting by such means is deemed to be present at the meeting. Notwithstanding any other provision of this by-law, any person participating in a meeting of Members pursuant to this section who is entitled to vote at that meeting may vote, in accordance with the Act, by means of any telephonic, electronic or other communication facility that the Corporation has made available for that purpose.

25. Members' Meeting Held Entirely by Electronic Means

If the directors or Members of the Corporation call a meeting of Members pursuant to the Act, those directors or Members, as the case may be, may determine that the meeting shall be held, in accordance with the Act and the Regulations, entirely by means of a telephonic, electronic or other communication facility that permits all participants to communicate adequately with each other during the meeting.

IV. DIRECTORS

26. Composition and Mandate of the Board

The Board is comprised of 10 directors as refer to in article 30. The property and business affairs of CDRAF shall be managed by the Board. The Board shall oversee the direction and management of the objects, fiduciary duties, funds, external relations of CDRAF.

27. Election Policy

Method of voting: Voting in an election for the Board Directors shall be secret ballot.
Eligibility: Only representatives carrying the function of Registrar, acting Registrar Secretary or acting Secretary of the Members’ Board can be elected as a Director of CDRAF Board.

Vacancy at the CDRAF Board: Upon receipt of a written confirmation of a new appointment by a member (DRA) of an acting registrar, registrar, acting secretary of ODQ Board or Secretary of ODQ Board, CDRAF Executive Director calls for an election within 5 working days.

28. Cost of Attendance at Board Meeting

Directors shall attend Board meetings at the expense of the Member that has appointed the Director.

29. Powers of the Board

The Board shall administer the affairs of the Corporation in all things and may make or cause to be made for the Corporation, in its name, any kind of the contract which the corporation may lawfully enter into and, save as hereinafter provided, generally, may exercise all such powers and do all such other act and things as the Corporation, by its Articles, By-Laws or the Act, is authorized to exercise and do. The Board shall have the power to authorize expenditures on behalf of the Corporation from time to time and may delegate, by resolution, to any officer or officers of the Corporation the right to make such expenditures on such terms and conditions, as they may deem appropriate.

30. Director Qualifier, Number of Directors and Votes

Only representatives carrying the function of Registrar, acting Registrars Secretary or acting Secretary of the Members' Board can be elected as a Director of CDRAF Board.

The Board is comprised of ten (10) directors holding one vote each.

31. Calling of Meetings of the Board

Meetings of the Board may be called by the chair of the Board, the vice-chair of the Board or any two directors at any time.

32. Notice of Meeting of the Board

Notice of the time and place for the holding of a meeting of the Board shall be given in the manner provided in the section on giving notice of meeting of directors of this by-law to every director of the Corporation not less than 30 days before the time when the meeting is to be held.

Notice of a meeting shall not be necessary if all of the directors are present, and none objects to the holding of the meeting, or if those absent have waived notice of or have otherwise signified their consent to the holding of such meeting. Notice of an adjourned meeting is not required if the time and place of the adjourned meeting is announced at the original meeting. Unless the by-law otherwise provides, no notice of meeting need to specify the purpose or the business to be transacted at the meeting except that a notice of meeting of directors shall

specify any matter referred to in subsection 138(2) (Limits on Authority) of the Act that is to be dealt with at the meeting.

33. Regular Meetings

The Board shall hold a minimum of three (3) meetings a year. Board meetings are open to Members representatives in an observer status.

34. Quorum & No Proxies

Six (6) directors need to be present for a Board meeting to take place. No proxies are permitted to establish quorum at meetings of the Board.

35. Board Governance

Recognizing the nature of regulation and the regulatory mandate of its Members, the Board will assume a public policy context for its deliberations, and operate in a policy governance style. As a policy governing Board, the Board will:

- oversee the direction and management of the objects, fiduciary duties, funds, and external relations of the CDRAF;
- manage the property, business, and affairs of CDRAF;
- set strategic directions and responses to strategic issues regarding regulation;
- establish parameters and benchmarks for demonstrating excellence in regulatory leadership, in the context of the pubic interest;
- put in place operating guidelines to ensure due diligence and fulfillment of all fiduciary duties of the CDRAF; and
- identify and negotiate the terms of relations, liaisons and partnerships with external stakeholders at interprovincial/territorial, national, or global levels.

36. Administrative Duties and Powers of the Board

In accordance with the By-Laws, the Board shall carry out the following duties and exercise the following powers:

1. elect the officers;
2. insure oversight of statutory committees;
3. set policies with respect to the election of officers;
4. ratify decisions of the officers made on its behalf between meetings of the Board;
5. set policies regarding expenses;
6. approve financial statements;
7. recommend appointment of auditors;
8. approve a budget and oversee compliance with such a budget;
9. set policies to diligently identify budget overruns and intervention to prevent overruns;
10. approve the hiring, renewal or termination of CDRAF Executive Director;
11. set such other policies and determine any positions taken by CDRAF on regulatory

matters as may be required from time to time;

12. set the time, place and location of Board meetings;
13. set agendas for meetings including annual meeting of the Members;
14. except as otherwise provided in the By-Laws, generally, do all things necessary for the better administration of the affairs of CDRAF.

37. Board Reporting

The Board will provide a report of each of its meeting to the Members and present an annual report at the Annual Meeting of the Members.

38. Votes to Govern at Meetings of the Board

Except as otherwise provided in these By-Laws, every question and decision of the Board shall be decided by a majority of the votes cast on the question. In case of an equality of votes, the chair of the meeting shall not have a second or casting of vote.

V. ELECTED AND APPOINTED OFFICERS

39. Elected Officers

The Board may designate the offices of the Corporation, elect officers from its Directors on an annual or more frequent basis, specify their duties and, subject to the Act, delegate to such officers the power to manage the affairs of the Corporation. A Director may not hold more than one office at any given time.

40. Description of Elected Offices

Unless otherwise specified by the Board (which may, subject to the Act modify, restrict or supplement such duties and powers), the offices of the Corporation, if designated and if officers are elected or appointed, shall have the following duties and powers associated with their positions:

(a) Chair of the Board – The Chair shall be a director. The Chair, shall, when present, preside at all meetings of the Board and of the Members. The Chair of the Board shall have general supervision of the business of CDRAF and shall have such other duties and powers as the Board may specify.

(b) Vice-Chair of the Board – The Vice-Chair shall be a director. If the chair of the Board is absent or is unable or refuses to act, the Vice-President, shall, when present, preside at all meetings of the Board and of the Members. The Vice-Chair shall have such other duties and powers as the Board may specify.

(c) Treasurer – The Treasurer shall be a director and shall have such powers and duties as the Board may specify.

41. Term of Elected Office

Each officer shall hold office from the date of his or her election/appointment until the date of the election in the next year and may not hold any elected/appointed office for more one (1) term.

42. Vacancy in Elected Office

In the absence of a written agreement to the contrary, the Board may remove, whether for cause or without cause, any officer of the Corporation by way of a strong majority vote. Unless so removed, an officer shall hold office until the earlier of:

1. the officer's successor being appointed,
2. the officer's resignation,
3. such officer ceasing to be a director (if a necessary qualification of appointment) or
4. such officer's death.

43. Executive Director

The Board shall appoint an Executive Director who shall be the Chief Executive Officer of the CDRAF and subject to the authority of the Board shall have responsibility for the general supervision of the affairs of the CDRAF but whom will not have any voting rights at any meeting of the CDRAF or its Committees.

The Board may remove the Executive Director without prejudice to any contract of employment or other right, statutory or otherwise at any time by a strong majority vote.

VI. COMMITTEES

44. Committees of the Board

The Board may appoint standing committees, ad hoc committees, special task forces and other Committees from time to time with such terms and conditions as the Board may determine. Committees, if appointed, will report to the Board at each meeting and each year regarding progress agreed upon activities, impact and outcomes, significant external relations on behalf of CDRAF, statement of incurred expenses, balance sheet and details of all expenditures.

VII. GENERAL

45. Method of Giving Any Notice

Any notice (which term includes any communication or document), other than notice of a meeting of Members or a meeting of the Board, to be given (which term includes sent, delivered or served) pursuant to the Act, the Articles, the By-Laws or otherwise to a Member, director, officer or Member of a committee of the Board or to the public accountant shall be sufficiently given:

1. if delivered personally to the person to whom it is to be given or if delivered to such person's address as shown in the records of the Corporation or in the case of notice to a director to the latest address as shown in the last notice that was sent by the Corporation in accordance with section 128 (Notice of directors) or 134 (Notice of change of directors);
2. if mailed to such person at such person's recorded address by prepaid ordinary or air mail;
3. if sent to such person by telephonic, electronic or other communication facility at such person's recorded address for that purpose; or
4. if provided in the form of an electronic document in accordance with Part 17 of the Act.

A notice so delivered shall be deemed to have been given when it is delivered personally or to the recorded address as aforesaid; a notice so mailed shall be deemed to have been given when deposited in a post office or public letter box; and a notice so sent by any means of transmitted or recorded communication shall be deemed to have been given when dispatched or delivered to the appropriate communication company or agency or its representative for dispatch. The secretary may change or cause to be changed the recorded address of any Member, director, officer, public accountant or Member of a committee of the Board in accordance with any information believed by the secretary to be reliable. The declaration by the secretary that notice has been given pursuant to this by-law shall be sufficient and conclusive evidence of the giving of such notice. The signature of any director or officer of the Corporation to any notice or other document to be given by the Corporation may be written, stamped, type-written or printed or partly written, stamped, type-written or printed.

46. Invalidity of any Provisions of this By-law

The invalidity or unenforceability of any provision of this by-law shall not affect the validity or enforceability of the remaining provisions of this by-law.

47. Omissions and Errors

The accidental omission to give any notice to any Member, director, officer, Member of a committee of the Board or public accountant, or the non-receipt of any notice by any such

person where the Corporation has provided notice in accordance with the By-Laws or any error in any notice not affecting its substance shall not invalidate any action taken at any meeting to which the notice pertained or otherwise founded on such notice.

48. Liaison with Other Organizations

The Corporation shall communicate as required with other organizations from time to time. The degree of formalization which will be arranged with such external relations, liaisons or partnerships will be determined by the Board.

49. Membership in Other Organizations

The Corporation will from time to time seek affiliation of Membership in other organizations pertinent to its objects and purposes.

50. Spokesperson

The Chair of the Board and/or the Executive Director, or any other persons as directed by the Board may speak on behalf of the Corporation. Such persons shall not bind the Corporation beyond the instructions from the Board or those implied in the Objects and Guiding Principles of the Corporation.

51. Consensus

Unless otherwise required by the Act, the Articles, or these By-Laws, questions arising at any meeting of the Members, the Board, or its Committees shall be decided by the consensus.
A consensus will be considered to have been reached when no Member objects to the question on the floor before the meeting. Should the Chair of the meeting determine, after a reasonable effort to achieve consensus has been made, that the consensus will not be reached regarding particular questions, then the Chair shall refer the question to be decided by a majority vote.

52. Rules and Policies

The Board may, from time to time, establish rules and policies in matters such as, but not limited to, expense policy, election policy and such other rules and policies as may be required for the better administration of the affairs of the Corporation. CDRAF has enacted an Elections Policy and Expense Policy which it includes in the body of its By-Laws herein but which can be modified at any time by a simple majority of the Board.

53. CDRAF Expense Policy is as follows:

1. Each Member is responsible for all expenses and any compensation for Directors appointed by that Member attending Board meetings or any other meeting.
2. The CDRAF is not responsible for compensation, per diems or honorariums for Directors or officers at any meetings.
3. The CDRAF will reimburse reasonable travel expenses incurred by the Executive

Director while engaged in CDRAF business to a maximum of $15,000 per year.

4. To be eligible for reimbursement, expenses must be necessary, reasonable and effective. At all times, prudence should be exercised by using the most cost effective means of travel and accommodation.
5. Whenever possible, arrangements should be made to take advantage of corporate or preferred rates.
6. Expenses must be supported by original receipts.

54. By-Laws and Effective Date

Subject to the Articles, the Board may, by resolution, make, amend or repeal any By- Laws that regulate the activities or affairs of the Corporation. Any such by-law, amendment or repeal shall be effective from the date of the resolution of the Board until the next meeting of Members where it may be confirmed, rejected or amended by the Members by ordinary resolution. If the by-law, amendment or repeal is confirmed or confirmed as amended by the Members it remains effective in the form in which it was confirmed. The by-law, amendment or repeal ceases to have effect if it is not submitted to the Members at the next meeting of Members or if it is rejected by the Members at the meeting.

This section does not apply to a by-law that requires a special resolution of the Members according to subsection 197(1) (fundamental change) of the Act because such by-law amendments or repeals are only effective when confirmed by Members.

ENACTED by a unanimous vote of the Members at a meeting of the Members of the Corporation held on the 13th day of October, 2017.

APPENDIX E

REPORT TO THE
CANADIAN DENTAL REGULATORY AUTHORITIES FEDERATION
ANNUAL GENERAL MEETING
OCTOBER 12, 2018

ACFD Structure

The ACFD Board for the period July 1, 2017 through June 30, 2019 is:

Dr. Paul Allison, McGill University - President
Dr. Andrea Esteves, University of British Columbia – Vice President / Treasurer
Dr. Steve Patterson, University of Alberta - Chair, Academic Affairs Committee
Dr. Blaine Cleghorn, Dalhousie University – Chair, Clinical Affairs Committee
Dr. Paul Major, University of Alberta – Chair, Deans' Committee
Dr. Patrick Flood, University of Alberta – Chair, Research Affairs Committee
Dr. Daniel Haas, University of Toronto – Immediate Past President
Dr. Edwin Yen, University of British Columbia, Executive Director

The Board meets three times annually, either in person or by video conference call.

The ACFD's mission is to be the national voice and resource for academic dentistry in Canada by helping advance the teaching, research, and service activities of our members by facilitating collaboration and communication among our members and related organizations.

The ACFD has five main goals.

1. To establish the visibility of ACFD as the focal point of academic dentistry in Canada.
2. To promote faculty development at Canadian Faculties of Dentistry.
3. To facilitate collaboration among the Canadian Faculties of Dentistry to enhance teaching, research, and leadership/management.
4. To advocate on behalf of the Canadian Faculties of Dentistry to promote the interests of academic dentistry.
5. To be a national source for areas of academic interest.

The ACFD recognizes excellence in dental education teaching and service through the presentation of the ACFD Distinguished Service Award, the National Dentistry Teaching Award, and the W.W. Wood Award for Excellence in Dental Education. In partnership with the Canadian Association of Dental Research (CADR), the ACFD has also recently introduced a national research award, which will be first awarded in summer 2019.

Through conferences and meetings the ACFD provides the opportunity for faculty to exchange information and share best practices. ACFD is working with NCOHR and CADR to develop the oral health research community.

Committees

1. Deans' Committee
   The Deans Committee includes the ACFD President, Executive Director and the Dean, Director or equivalent from each Canadian dental program. The Deans' Committee meets four times a year either by video conference or in person at the ACFD Biennial Conference or Annual General Meeting.

2. Academic Affairs Committee
   The Academic Affairs Committee includes the Associate Dean Academic or equivalent from each Canadian dental program. The Academic Affairs committee meets twice a year either by video conference or in person at the ACFD Biennial Conference or Annual General Meeting.

3. Clinical Affairs Committee
   The Clinic Affairs Committee includes the Clinic Director or equivalent from each Canadian dental program. The Clinic Affairs committee meets twice a year either by video conference or in person at the ACFD Biennial Conference.

4. Research Affairs Committee
   The Research Affairs Committee includes the Associate Dean of Research or equivalent from each Canadian dental program. The Research Affairs committee meets once a year either by video conference or in person at the ACFD Biennial Conference.

Communication and Members Services

The ACFD web site, www.acfd.ca, provides information for both ACFD Members and graduates of non-accredited dental and dental specialty programs. The web site includes the ACFD directory, information about awards presented by the Association, upcoming meetings, links to related organizations, academic opportunities and general information.

W. W. Wood Award

The Association of Canadian Faculties of Dentistry established the W.W. Wood Awards for "Excellence in Dental Education" to commemorate Dr. Bill Wood whose academic career exemplified dedication to research, teaching and service. One ACFD "W.W. Wood Award for Excellence in Dental Education" is available to be awarded each year, in each Canadian Faculty of Dentistry, to a full or part-time faculty member who has completed at least three years of teaching in a Canadian Faculty of Dentistry.

We wish to congratulate the following recipients who received the award in 2018

Dr. Anne Charbonneau – Université de Montréal
Dr. Irwin Fried – McGill University
Dr. Tamara Wright – Dalhousie University
Ms. Alexandra Sheppard – University of Alberta

Distinguished Service Award

The Distinguished Service Award recognizes individual lifetime achievement in dental education. Award criteria and nomination information can be found on the ACFD web site. Ms. Susan Matheson received this distinguished award on June 14th, 2017 in Quebec City for her long time commitment to dentistry in Canada through her leadership and professionalism at CDAC.
Dr. William MacInnis will receive this prestigious award during Dalhousie's Homecoming and 200th Anniversary celebrations on September 28th, 2018 for his contributions to teaching and service within dental education and the dental community.

ACFD National Dental Teaching Award

The National Dental Teaching Award recognizes exceptional contributions to dental education at Canadian Universities by demonstration of teaching excellence, contributions to education, knowledge and understanding, demonstration of work on innovative curriculum projects, innovative teaching methodologies, and demonstration of educational leadership. Award criteria and nomination information can be found on the ACFD web site. The 2018 award was given to Dr. Dieter Schönwetter, of the University of Manitoba on March 18th, 2018 in Orlando, Florida.

ACFD National Dental Research Award

The ACFD National Dental Research Award recognizes exceptional contributions to dental research within Canadian Universities by demonstration of research excellence as shown by publications, awards, seminars, workshops, conferences; demonstration of scholarship; demonstration of strong commitment to and excellence in the mentorship of future scientists and scholars; demonstration of innovative research methodologies or special research techniques; demonstration of leadership in the creation of new knowledge. This honor will be first awarded in June 2019.

Biennial Conference

The 2017 Biennial Conference was hosted by the Université Laval in June 2017 in Quebec City. The education day focused on "The Challenges and Opportunities of Implementing the ACFD Educational Framework for the Development of Competency". The keynote speaker was Dr. Marilou Bélisle who spoke about "The Assessment of Generic Competencies: Towards Adopting a Development and Collective Approach in Dental Education."
The 2019 Biennial Conference will be hosted by the University of British Columbia on June 16th to 18th, 2019 in Vancouver and will focus on Research in Dentistry. It will be jointly held with the FCDSA, NCOHR and CADR and is timed to occur immediately prior to the IADR meeting in Vancouver June 19-22, 2019

Dental Research

ACFD has committed to support oral health research in Canada by giving funds to the Network for Canadian Oral Health Research (NCOHR) for the next three years. This funding has been used to support the creation of research networks, team projects, graduate research training, interdisciplinary research and other areas relevant to building capacity in oral health research in Canada. NCOHR was recently awarded five-year funding through CIHR / IMHA for the continued

support of oral health researchers in Canada.

Competency Educational Framework

The ACFD Academic Affairs Committee (AAC) received an ISBN 978-0-9952789-0-5 for the publication of the "ACFD Educational Framework for the Development of Competency in Dental Programs". The translation into French is completed and is on the ACFD website.

Collaboration with CDRAF, CDAC, CDA, and NDEB ACFD continues to strengthen liaisons with external organizations for the dental community nationally. In 2017- 2018 ACFD met with the following organizations to discuss topics of mutual concerns.

The ACFD / CDRAF met in person in Vancouver in March, Quebec City in June, Montreal in October, via phone in December 2017, Montreal in February 2018 Ottawa in May 2018 and most recently in Winnipeg in June 2018. They discussed support for the Specialty Program Directors criteria, the future of PGY1, as well as the ACFD Competency document and the standardization of Academic licensing in Canada.

The ACFD / CDAC met in Vancouver in March, in Quebec City in June and in Ottawa in October 2017 to continue their discussions about credentials regarding Specialty Program Directors. They also discussed the ACFD Competency Framework document and how it was used during their accreditation visits as well as discussions on unified support for one competency document. They also discussed the newly formed PGY1 working group.

The ACFD / CDA interface committee met in Montreal in February 2017, in Quebec City in June 2017 and via video conference in November 2017 and in person on March 8th, 2018 and discussed a number of issues.
These included:

- The next steps for the Committee on the Identification of Future Dentists (CIFD)
- Discussion on developing consensus nationally amongst the dental organization bodies regarding the new ACFD Competency document
- Discussion on the opioid issue
- Dental research advocacy in Canada and CIHR
- Use of CDAnet by the dental schools
- Diagnostics codes, such as "Big Mouth"
- Future of the Profession
- Building ACFD's relationship with FCDSA
- CDA's participation in the new working group on PYG1
- Follow-up report of the CDA-ACFD Special Care in Dentistry Working Group
- The use of ADEA's AADSAS system by Canadian schools

On top of this, the new Committee on the Identification of Future Dentists was formed and had its initial meeting in Ottawa in November 2017. The mandate and make-up of the CIFD had previously been agreed between CDA and ACFD as well as the funding for its work. At this meeting, the process and subject matter for two "Requests for Proposals" (RFPs) were discussed and agreed. These RFPs were subsequently widely distributed in February 2018 and the deadline for submissions is April 27th, 2018.

ACFD met with NDEB in Quebec City in June and in Montreal in October 2017 and in Orlando in March 2018 and discussed, the initiation of tablet-based NDEB exams, the new format for exam questions and an RFA for "Integration into Practice" research proposals looking at the performance of dentists graduating through the traditional pathway (i.e. Canadian dental school and NDEB exam) versus those trained in non-accredited schools and going through the NDEB series of exams. They also discussed the progress of the virtual OSCE, the PGY1 working group, use of the ACFD Competency documents and the need to develop an MOU to accept it as the basis for future accreditation reviews by CDCA and future NDEB assessments. They also discussed how schools could possibly set up programs to help prepare candidates for the NDEB exams for those who have completed non-accredited programs. NDEB also brought to ACFD's attention the emergence of several private for-profit programs training overseas (non-accredited program) trained dentists to pass the NDEB exams.

The Federation of Canadian of Dental Students Associations (FCDSA) held their Annual General Meeting and Annual Planning Session in Quebec City in June concurrently with the ACFD 2017 Biennial conference. The ACFD President attended the first FCDSA student conference held in Toronto in January 2018.

Challenges Facing Dental Education

The ACFD strives to identify, communicate and address challenges facing dental education, including:

- Recruitment and retention of full- and part-time faculty for dental schools.
- Recruitment of directors for specialty programs.
- Research in dental schools, including access to CIHR funding and other granting agencies
- Certification processes for general dentists and specialists from non-accredited dental programs
- Government funding for dental schools
- Financial assistance programs for students (scholarships, bursaries and loans)
- Sustaining a future for academic dentistry in Canada
- The need for research and development of selection tools for dentistry students
- The need to explore residency programs and PGY1 programs as a means to increase clinical learning opportunities for recently graduated dental students

Respectfully submitted,

Dr. Paul Allison
President, ACFD

CANADIAN DENTAL ASSOCIATION
ASSOCIATION DENTAIRE CANADIENNE

Report of the
Canadian Dental Association
to
The Canadian Dental Regulatory Authorities Federation

This is the report of the Canadian Dental Association (CDA) on the major areas of activity in the past year.

Mission

The Canadian Dental Association is the national voice for dentistry, dedicated to the promotion of optimal oral health, an essential component of general health, and to the advancement and leadership of a unified profession.

Vision

A Healthy Public
A Strong Profession
A United Community

Priorities

Knowledge – to capture, organize and disseminate relevant knowledge and information to Corporate Members and key stakeholders.

Advocacy – to protect, promote and advance the dental profession.

Practice Support – to support Corporate Members in dealing with practice management issues.

Priority Projects

In addition to its ongoing activities, the CDA Board has identified six priority projects for implementation in the short to medium-term.

1. **Future of the Profession** – Recommendations to CDA and Corporate Members to foster the strategic adaptation of the profession to a changing environment.

2. **People with Special Health Needs** – Develop advocacy and program strategies to enhance access to oral health care by people with special health needs.

3. **Indigenous Children Oral Health** – Engage in dialogue with First Nations to explore how dentistry can work with Indigenous Peoples to improve the oral health of Indigenous Children through preventative measures and oral health education in a culturally appropriate manner.

4. **Claims Transmission** – Maintain CDA's position in the electronic claims market.

5. **Secure Send** – Provide a user-friendly, electronic, secure document sending system.

6. **Insurance Audits** – Collaboratively develop a universal audit process.

Future of the Profession

To implement one of its top strategic priorities, the CDA Board of Directors established a 25-person Task Force on the 'Future of the Profession' representative of a cross-section of dentistry in Canada. The mandate of the Task Force was to identify and analyze issues related to the longer-term prospects of the dental profession in Canada and propose innovative approaches that can address the opportunities and threats facing dentistry over the next 10 to 15 years and assist the profession in leading, managing and influencing change that will advance optimal oral health and the evolution of a strong dental profession. After consultation with its stakeholders, 12 priority recommendations from the report were identified and they are attached to this report. In October 2018, the CDA Board of Directors will be beginning work on developing a plan to implement those recommendations.

Environmental Scan

The CDA's annual environmental scan is a key instrument for identifying significant trends and emerging issues specific to dentistry in order to assess how they may impact the profession, either positively or negatively. CDA does that through an analysis of the political, economic and social environment as well as the health and dentistry environment. CDA's current environmental scan has identified and prioritized **10 megatrends**.

Significant:

Megatrend 1: Human resources challenges in dentistry
Megatrend 2: Growing income inequalities affecting access to care
Megatrend 3: Expansion of alternative providers
Megatrend 4: Changing landscape of dental benefits

Important:

Megatrend 5: Integration of internationally trained dentists
Megatrend 6: Perception of increasing commercialization in dentistry
Megatrend 7: Rise of empowered consumers

Emerging:

Megatrend 8: Evolution of alternative dental delivery models
Megatrend 9: Shifting care needs for an aging population
Megatrend 10: Changing educational competencies and new technologies

Access

The CDA's focus in this area is on five specific components: 1) Special needs patients; 2) Early childhood caries; 3) Seniors oral health; 4) First Nations and Inuit oral health; 5) Canadian Oral Health Roundtable (COHR).

In order to align its efforts and resources, the CDA has established a National Coordinating Working Group on Access to Care which brings together representatives from all of the Corporate Members, the specialty groups and the Association of Canadian Faculties of Dentistry (ACFD). The goal has been to advocate for access to care for children and seniors, and for 2018 the emphasis will be on access to care for special needs patients and on indigenous children oral health.

For issues related to **special needs patients**, the CDA established a joint task force with ACFD to study the matter and make recommendations on how to improve the availability of dentists capable and willing to meet the needs for special care dentistry in Canada. Key recommendations from that report were reviewed and addressed by the CDA National Coordinating Working Group on Access to Care and a national advocacy strategy was developed.

Over the past three years, the CDA has been coordinating an initiative to promote a "First Visit to Dentist by Age One" and is undertaking a communication campaign to inform Canadian dentists about the issue, and the benefits of making these visits a part of their practice.

With respect to **First Nations oral health**, the CDA continues to participate in the work of a national task force in order that it can contribute to the joint Health Canada and Assembly of First Nations review of the Non-Insured Health Benefits (NIHB) program.

The CDA's effort for the development of a Canadian Oral Health Roundtable has brought together some 30 stakeholder organizations both within and outside oral health to a national symposium. In 2018, the COHR discussions were on family violence.

Two Special Priority Projects

Advocacy Against the Taxing of Health and Dental Benefits
Given the impact that the taxing of health and dental benefits would have on Canadians and on the delivery of health services, the CDA undertook to coordinate a major national grass-roots advocacy campaign, in collaboration with its Corporate Members, and organized strategic alliances with various stakeholder groups in order to influence the federal government not to tax those benefits. The advocacy campaign was extremely successful and the Prime Minister of Canada rose in the House of Commons to indicate that there would be no taxing of health and dental benefits.

Advocacy Against the Federal Government's Consultation Paper on Tax Planning Using Private Corporations
Given the major impact that the federal government's tax proposal would have on Canadian dentists, the CDA, in collaboration with its Corporate Members, took an active role in designing and implementing an advocacy strategy to oppose the proposed tax measures. The CDA played a key support role in the organization of a national alliance of other stakeholders against the tax proposals. The coordinated advocacy campaign was successful in that the federal government first withdrew its plans related to capital gains and modified its proposal on passive investments and further clarified its policy on income sprinkling. In its 2018 Federal Budget, the government made further modifications to the proposed tax measures that went a long way in addressing many of the concerns. The government's change in direction on this issue represents a retreat by the government and a significant softening of the tax measures that were originally proposed.

Practice Support

The key activities under the CDA practice support priority were the CDA ITRANS Claim Service, CDA Secure Send and the development of a framework for insurance audits. In order to maintain its position in the electronic claims market, CDA initiated work on the design and development of CDA ITRANS 2.0 which should be available to members by the end of 2018. CDA also renegotiated the CDAnet agreement with the Canadian Life and Health Insurance Association (CLHIA) and its members. To provide a user-friendly, electronic secure document transmission system for member dentists, the CDA launched Secure Send and agreement was obtained from the Corporate Members to make that service available to the Canadian dental regulatory authorities and dental laboratories on a pilot basis for two years. In terms of the relationship with the Canadian insurance industry, the CDA pursued its efforts to develop a framework for audits of dentists by insurance companies that will serve as a guideline for audits.

Policy Issues

CDA serves as a facilitator in the development of common national policy statements to ensure that the profession speaks with one voice on key oral health issues. Under the current governance and membership model, CDA and the Corporate Members are committed to working together on questions of national policy. To that end, a National Policy Formulation and Implementation Process was established to promote consultation with Corporate Members, academia and specialists. In order to communicate with external audiences, CDA has also prepared a bank of possible questions and answers that may be raised by media or government officials on key oral health issues.

Currently, CDA has official position statements on:

- Access to Oral Health Care for Canadians
- Association between Periodontal Disease and Systematic Disease
- Dental Amalgam
- Breastfeeding and Early Childhood Caries
- Dental Patients with Total Joint Replacement
- Delivery of Oral Health Care
- Drug Product Substitution
- Early Childhood Caries
- First Visit to the Dentist
- Use of Fluorides in Caries Prevention
- Frequency of Dental Care
- Funding Hospital-Based Dental Services and Post-Graduate Dental Education
- Junk Food and Child Health
- Lasers
- Use of Latex in Dentistry
- Oral Appliance Therapy for Snoring and Sleep Apnea
- Oral Jewellery
- Personal Data Protection
- Prevention of Infective Endocarditis
- Prevention of Traumatic Oral Facial Injuries
- Oral Health Care Standards for Residents in Long-Term Care in Canada
- Pit-and-Fissure Sealants
- Sweeteners in Medication
- Tobacco Cessation
- Tobacco Products and Health
- Tooth Bleaching and Whitening
- X-Radiation in Dentistry

Dental Stakeholders

In the past year, the CDA has maintained its strong relationships with all dental stakeholders in Canada by ensuring ongoing dialogue with the leadership of the various national dental groups, including the Canadian Dental Specialties Association (CDSA) and the dental specialty groups, the Canadian Dental Regulatory Authorities Federation (CDRAF), the Association of Canadian Faculties of Dentistry (ACFD), the National Dental Examining Board (NDEB), the Royal Canadian Dental Corps (RCDC), Canadian Association of Hospital Dentists (CAHD) and the Federation of the Canadian Dentistry Student Associations (FCDSA). The CDA also has ongoing communications with other oral health-related organizations including the Dental Industry Association of Canada (DIAC) and the Canadian Life and Health Insurance Association (CLHIA). The CDA maintained its ongoing communication with the Canadian Dental Hygienists Association (CDHA) and the Canadian Dental Assistants Association (CDAA).

Healthcare Stakeholders

CDA has been active in establishing strong links to the health care community in Canada including the Canadian Medical Association (CMA) and the Canadian Pharmacists Association (CPhA). CDA is also a member of a number of health coalitions including the Health Action Lobby (HEAL), the Canadian Coalition for Public Health in the 21st Century (CCPH21), the Canadian Health Leadership Network (CHLnet), the Canadian Patient Safety Institute (CPSI), the Canadian Coalition for Action on Tobacco (CCAT), the Canadian Institute of Health Information (CIHI), the Standards Council of Canada (SCC), the Canadian Standards Association (CSA) and Canada Health Infoway. CDA is also working closely with the Assembly of First Nations (AFN) and its NIHB caucus in making representations to the federal government on health and oral health services. CDA has also invited Diabetes Canada and the College of Family Physicians of Canada to join the Canadian Oral Health Roundtable as participants.

Key Activities – Knowledge

- **Environmental Scan**: produced the 2017 edition
- **State of Oral Health in Canada**: disseminated the companion publication to the CDA Environmental Scan to external audiences
- **FDI Congress and Parliamentary Meetings**: contributed to the development of global position statements
- **Oasis**: published regular online postings of practical articles that support the clinical work of dentists
- **CDA essentials**: produced 16 issues of the CDA magazine (8 English – 8 French)
- **JCDA.ca**: continued to operate the JCDA.ca website to house the online peer-reviewed scholarly journal that contributes to the body of knowledge of the profession
- **Seal Program**: implemented a new marketing strategy for the program
- **Dental Aptitude Test**: conducted two exams
- **Identification of Future Dentists**: the CDA is collaborating with the ACFD towards the evaluation of tests that are either used or could be used to assess the aptitude of candidates for entry into dental schools

Key Activities – Advocacy

- **Small Business Tax Rate**: conducted a major advocacy campaign on corporate tax issues dealing with income sprinkling; passive investments and capital gains working closely with Corporate Members and an alliance of external like-minded stakeholders
- **Taxing of Health and Dental Benefits:** as a top priority, developed a series of collaborative advocacy tools and a network of strategic alliances with other organizations to oppose the taxing of health and dental benefits by the federal government
- **Advertising of sugar products to children**: in collaboration with external national organizations, participated in an advocacy campaign to limit advertising targeting children
- **Sugar Reduction**: established contacts with third party organizations to collaboratively develop a public education campaign on sugar reduction
- **Days on the Hill**: conducted the 2017 edition of Days on the Hill
- **NIHB Review**: ongoing liaison with the AFN and the NIHB

- **First Visit/First Tooth**: ongoing coordination of the education program
- **COHR**: planned and organized the 2017 symposium which focused on special needs dentistry and sugar reduction
- **Media response**: on a priority basis, responded in a timely manner to all media inquiries
- **Media monitoring**: on a daily basis, prepared a summary of media stories with an oral health component
- **Trust and Value**: continued to coordinate the Trust and Value Working Group composed of a representative of each of the Corporate Members

Key Activities - Practice Support

- **Claims Transmission**: maintained CDA's position in the electronic claims market
- **Secure Send**: launched a user-friendly, electronic, secure document transmission system for dentist who are members of the CDA Corporate Members
- **Insurance Audits**: pressured the insurance industry for the development of a framework for audits
- **NIHB Guide for Providers**: disseminated a guide for use by interested parties
- **Practice Support Service Website**: integration of 'Secure Send' and the expansion of the electronic national list of dentists
- **CDA Digital ID:** managed the operation of the CDA Digital ID
- **Dental Benefits Issues:** liaised with CLHIA and individual carriers on many dental benefits issues
- **USC&LS**: Published the 2018 edition, convened a Code Review Working Group to address codes identified as problematic by stakeholders and ongoing liaison with Corporate Members
- **Electronic List of Dentists**: maintained the registration process through the development of the validation procedure for the CDA Digital ID on the practice support web site
- **Privacy Booklet**: disseminated a privacy booklet which is now available for distribution through the CMs
- **CDAnet program:** coordinated the operations of the program including the helpdesk
- **CDAnet agreement:** successfully negotiated a CDAnet agreement with the insurance industry
- **ISO TC 106**: served as international secretariat for ISO TC 106, the technical committee for dentistry of the International Organization for Standardization (ISO) and provided input in the development and maintenance of dental standards published by ISO

Key Activities - General

- **Joint Conventions**: held a very successful convention with ODA for the 2017 joint convention and liaised with DAPEI for 2018 joint convention and the CDSS for the 2019 joint convention
- **Affiliate Memberships**: conducted annual campaign for membership in Quebec
- **NDEB relationship**: implemented a framework for an interface committee for ongoing discussions of issues of common interest
- **Board Education**: maintained the services of an external expert on governance for education sessions with the CDA Board
- **Students:** continued to provide secretariat services to the Federation of Canadian Dental Students Associations (FCDSA) and provide general coordination support
- **Survey of Canadian Dental Schools:** conducted annual survey of dental schools
- **Common Membership Database with Corporate Members**: liaised with Corporate Members on this matter

Stakeholders Priority Recommendations

Future of the Profession – Task Force Report

Prioritization of Recommendations

A Category Priority Recommendations

- The Canadian dental profession should articulate and promote a clear definition of oral health that enables the measurement of oral health and systemic health outcomes, and that helps to demonstrate the value of oral health care. Vision #1 – Recommendation #1

- The Canadian dental profession should promote the intrinsic importance of oral health and highlight the relationship between oral health and systemic health. It is the responsibility of the dentist to lead interdisciplinary teams in the collaborative management of oral diseases and conditions. Vision #1 – Recommendation #2

- The Canadian dental profession should take all possible steps to ensure that the basic oral health needs of the entire Canadian population are met, regardless of geography or individual socioeconomic circumstances. Vision #2 – Recommendation #2

- The Canadian dental profession should ensure that all dentists licensed to practice have an excellent grounding in the principles of professionalism, ethics and empathic communication. Vision #3 – Recommendation #3

- The Canadian dental profession should facilitate the provision of business education and resources for dentists that are appropriate for their chosen model of practice. Vision #4 – Recommendation #6

- The Canadian dental profession should ensure that graduates are aware of the full range of career options available to them, including alternative practice models. Vision #4 – Recommendation #7

B Category Priority Recommendations

- The Canadian dental profession should determine what constitutes a "basket" of medically-necessary oral health care services. Vision #2 – Recommendation #1

- The Canadian dental profession should collaborate and create coalitions with health care and other professional groups as well as civil society groups interested in improving the oral health, overall health and social and living conditions of people in Canada. Vision #2 – Recommendation #3

- The Canadian dental profession should embrace the principle of person-centred care, and encourage the delivery of oral health care to vulnerable patient groups in locations and by delivery methods that are most appropriate for these groups. Vision #2 – Recommendation #5

- The Canadian dental profession should establish a formalized mentorship program for new graduates to facilitate the transition into professional practice and to encourage lifelong learning. Vision #3 – Recommendation #6

- The Canadian dental profession should advocate for funding of health care technology assessment research that will help practicing dentists make wise choices when considering incorporating new technologies into practice. Vision #4 – Recommendation #2

- The Canadian dental profession should establish a national certification body for continuing dental education that assesses courses, to ensure that they are based on sound scientific evidence and free of funding bias and conflicts of interest. Vision #3 – Recommendation #7

Report to the Canadian Dental Regulatory Authorities Federation (CDRAF)

October 2018

The National Dental Examining Board of Canada

NDEB BNED
The National Dental Examining Board of Canada
Le Bureau national d'examen dentaire du Canada
™

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Introduction

The National Dental Examining Board of Canada (NDEB) was established by an Act of Parliament in 1952. The Act makes the NDEB responsible for the establishment of qualifying conditions for a national standard of dental competence for general practitioners, for establishing and maintaining an examination facility to test for this national standard of dental competence, and for issuing certificates to dentists who successfully meet this national standard.

The following report highlights the NDEB's key activities relating to the certification of dentists in Canada.

Governance

Strategic Plan

The NDEB is in the final stages of implementing a new five-year strategic plan. The Board, Executive Committee and management team have held multiple planning meetings over the last several months to finalize key result areas, objectives and performance measures. The plan has been circulated to stakeholders for feedback and will be presented to the Board for approval in October 2018.

Communications

The NDEB has administered three post examination surveys following the Written Examination and OSCE, Assessment of Fundamental Knowledge, and Assessment of Clinical Judgement. The survey was developed to gain information from examinees about their examination experience. The survey asked questions about the examination centre, content, timing, and communications. Approximately one third of examinees have participated in the survey. The feedback gathered from survey will be used to help improve the delivery of the examinations.

Early this year, the NDEB updated its website including visual enhancements, improved navigation, and enhanced content. Feedback received from a website usability survey administered in 2017 was considered during the planning stages of the update. Based on the feedback, the design and structure of the site was reworked to make it easier to find the information visitors look for the most. Specific content areas have been expanded to provide

additional information about NDEB policies and processes. A specific area to keep stakeholders informed about the NDEB's transition to electronic delivery was added and regular updates are posted.

Communication and collaboration with stakeholders are a priority. The NDEB will continue to hold regular interface meetings with CDA and ACFD to discuss areas of mutual interest. In the coming months, the NDEB and the CDA will be collaborating to create awareness of the NDEB's role in Canadian dentistry.

Legal

The NDEB continues to face legal challenges from participants who have failed the Assessment of Clinical Skills (ACS). These challenges take up a significant amount of resources both human and financial. The NDEB is working closely with representatives from Dentons LLP on seven different Judicial Review applications.

The NDEB has filed trademark applications for all its wordmarks and logos. This process will help assure the public of the quality of the products and services which the trademark is associated. Use of the any of the NDEB's wordmarks or logos will require the permission of the NDEB and must be used in conjunction with a description of the relationship between the NDEB and the other party. The NDEB continues to actively enforce its trademark and copyright by monitoring social media and the web and issuing take down notices.

The NDEB is also working with Dentons to ensure it is General Data Protection Regulation (GDPR) compliant, a requirement as the NDEB moves to administer examinations at Prometric test centres in the European Union.

Financials

The NDEB Board held its Interim Meeting on May 12, 2018. During the meeting the members approved the budget for the 2018-2019 fiscal year. Goals for the budget are to increase the reserve fund, maintain fees, and recover costs. The budget includes fee changes effective for examinations and assessments administered in 2019. Most of the fee increases are small and consistent with increases over past years. The most significant increase is the fee for ACS Appeals. This fee will be increased to $1700 from $850 in 2019. Fees are established on a cost recovery basis, and the expenses to run the appeals processes have continuously exceeded the income. In addition, the NDEB has implemented a typodont viewing fee of $100 effective July 1, 2018. This fee is charged to any participant who wants to view their assessment typodonts after the assessment.

Board Members

The NDEB Board is comprised of one representative from each of the provincial Dental Regulatory Authorities, and two representatives from the Commission on Dental Accreditation. There is also a public representative appointed to the Board as a non-voting member.

NDEB Board 2017-2018	
James Richardson, Executive Committee Member	British Columbia
Mintoo Basahti	Alberta
Dennis Fuchs, President-elect/Treasurer	Saskatchewan
Amarjit Singh Rihal, Executive Committee Member	Manitoba
Ron Yarascavitch	Ontario
Stefan Haas-Jean	Quebec
Doug Mackey, President	Nova Scotia
Mary Ann Wiseman, Past President	New Brunswick
Sneha Abhyankar	Newfoundland
Alan Robinson	Prince Edward Island
Polly Pachu	Public Representative
Martin Gillis	CDAC
Nancy Auyeung	CDAC

Examinations and Assessments

Examination Integrity and Misconduct

Examination security remains an ongoing issue. Security violations range from reconstructing questions to bringing prohibited devices into the examination room. Since March 2017, the Examinations Committee has considered 25 cases of misconduct during examinations and assessments.

As part of the NDEB's strategy to maintain exam security, all examinees, Test Administrators and Invigilators are required to sign a confidentiality and non-disclosure agreement before each examination.

Equivalency Process Blueprint Review

The NDEB has begun a process to review the blueprint for the Equivalency Process. Invitations to participate on a working group have been sent to identified stakeholders. The objective of the working group will be to propose changes to the Equivalency Process blueprint. The working group is currently comprised of Drs. Noriko Boorberg, Andrea Esteves, Dennis Fuchs, Martin Gillis, Dan Haas, Gord Janke, and Robert Love.

Electronic Delivery

The NDEB is moving forward with its plan to move all paper and pencil exams to electronic delivery. On September 7, 2018, the NDEB administered its first computer-based examination at Prometric testing centres in Canada. The Dental Specialty Core Knowledge Examination (DSCKE) was administered flawlessly to a small cohort of examinees.

Leading up to the administration of the DSCKE, the NDEB ran three pilot tests. The first test took place at the Prometric test centre in Ottawa. Eight NDEB staff members and Dr. Jim Posluns, DSCKE Assistant Chief Examiner, participated in the e-exam tutorial and practice test prior to attending the examination. At the test centre, they were exposed to Prometric check-in procedures before taking the exam. In a focus group following the test, valuable information was collected about the tutorial, check-in, and user interface. This feedback was used to make changes ahead of the second pilot test by NDEB Board members in early April. The NDEB administered a third pilot test in June 2018.

Next the NDEB will transition the Assessment of Clinical Judgement (ACJ) to the digital platform for the May 2019 administration. The cohort for the ACJ will be significantly larger than that of

the DSCKE and the NDEB intends to make all Prometric test centers world-wide available to participants, allowing for easier access and decreased travel expenses.

The NDEB plans to provide participants for the ACJ with information about the new format of the assessment well in advance of test day. Like the DSCKE, an e-exam tutorial will be made available as well as a practice test to help participants familiarize themselves with the user interface and functionality of the online platform so that the technology does not become part of the test.

Virtual OSCE Development

The NDEB continues to move forward with the development of a Virtual OSCE, an integrated examination replacing both the Written Examination and OSCE. The first administration of the Virtual OSCE is scheduled for March 2021.

Developing the Virtual OSCE question bank is a major undertaking, and question development continues with nine workshops scheduled in both 2018 and 2019. Question banking is underway, using Zoomorphix System's electronic testing platform (Exam Studio).

In July 2018, the Virtual OSCE Chief and Assistant Chief Examiners, the Executive Director, and NDEB staff met with a psychometrician from Yardstick Assessment Strategies. The purpose of the meeting was to determine the structure of the Virtual OSCE, including the number of questions required per examination, timing, test reliability, and standard setting options. The NDEB will continue to work with Yardstick as we transition to electronic examinations.

Credential Verification

After a lengthy investigation, the NDEB has determined that it can no longer accept applications to the Equivalency Process from applicants with documents for Magadh University in India.

The NDEB Executive Committee reviewed the results of the investigation in June and accepted a recommendation that the NDEB has insufficient information regarding the validity and authenticity of documents issued by Magadh University; therefore, those documents would no longer be eligible for verification until the NDEB is confident in the validity and authenticity of the documents provided. This is the first time a decision of this type has been made since the implementation of the Equivalency Process in 2010.

NDEB has notified all applicants affected by this decision and will be in contact with the Canadian DRAs, Canadian Faculties of Dentistry offering Degree Completion Programs, the Dental Council of India, University Grants Commission, and Magadh University to inform them of the decision.

Certification

NDEB certification is a requirement prior to registration as a general dentist in Canada. To become certified an individual must successfully complete the NDEB Written Examination and OSCE.

Table 2 shows a breakdown of certified candidates by year up to August 1, 2018. This information is made available to the public through the NDEB website.

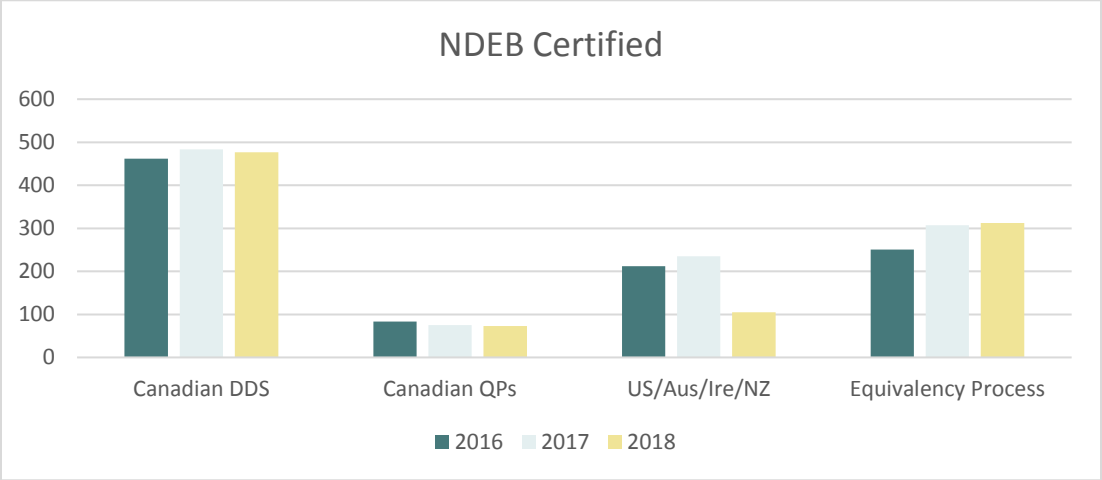


Table 2

Pass Rates

Certification Process

Historical Pass Rates – Certification Process				
	Written		OSCE	
	# of candidates	% pass	# of candidates	% pass
2015	1209	88	1165	95
2016	1262	87	1229	93
2017	1363	88	1295	97
2018*	1060	84	1002	92

*March and May only

Table 3

Equivalency Process

Historical Pass Rates - Equivalency Process						
	AFK		ACS*		ACJ*	
	# of participants	% pass	# of participants	% pass	# of participants	% pass
2016	1238	51	732	37	754	75
2017	1384	46	812	39	836	34
2018	1585	49	351	40	410	43

*June 2018 only

Table 4

Dental Specialty Core Knowledge Examination

DSCKE Results		
	Range	**Mean**
Feb 2016	52-91	78.85
Sept 2016	64-95	80.5
Feb 2017	51-92	82.62
Sept 2017	69-89	81.78
Feb 2018	66-90	77.8
Sept 2018	59-93	77.90

Table 5

Appeals

ACS Appeals

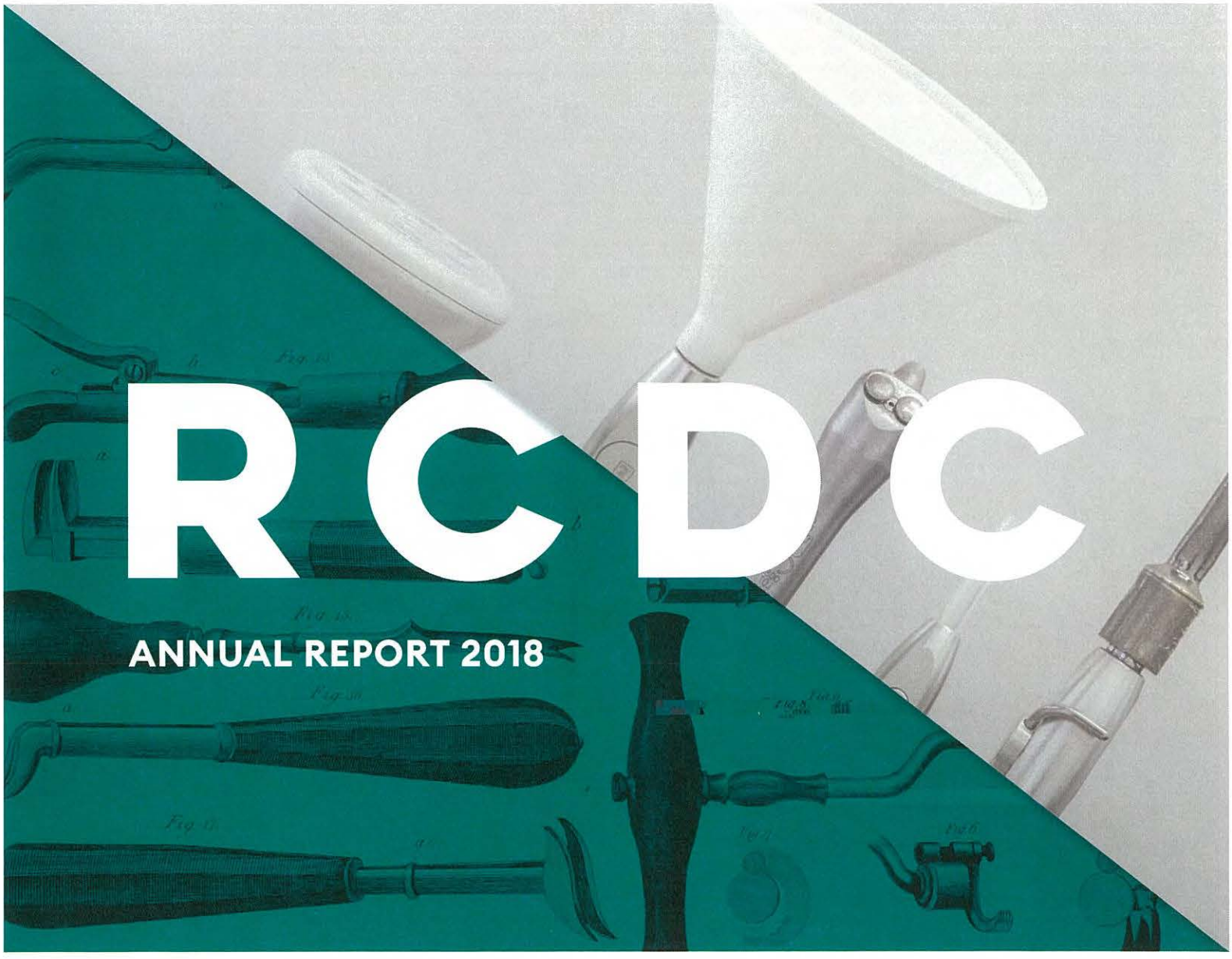
2016			2017		
Total Appeals	**Upheld**	**Dismissed**	**Total Appeals**	**Upheld**	**Dismissed**
253	32	221	250	43	207

Table 6

Compassionate Appeals

2016			2017		
Total Appeals	**Upheld**	**Dismissed**	**Total Appeals**	**Upheld**	**Dismissed**
37	23	14	48	26	22

Table 7



RCDC

ANNUAL REPORT 2018

Presidents

Dr. Frank A. Smith	1966 – 1967	**Dr. James. H. P. Main**	1981 – 1983	**Dr. James Shosenberg**	2001 – 2002
Dr. C. H. M. Williams	1967 – 1969	**Dr. K. J. Paynter**	1983 – 1984	**Dr. David Kennedy**	2002 – 2004
Dr. R. L. Scott	1969 – 1970	**Dr. James. H. P. Main**	1984 – 1985	**Dr. Elie M. Wolfson**	2004 – 2006
Dr. C. Ames	1970 – 1971	**Dr. Michael J. Cripton**	1985 – 1987	**Dr. James L. Leake**	2006 – 2008
Dr. Arthur M. Hayes	1971 – 1972	**Dr. Rod L. Moran**	1987 – 1989	**Dr. J. Richard Emery**	2008 – 2010
Dr. W. H. Feasby	1972 – 1973	**Dr. Charles G. Baker**	1989 – 1991	**Dr. Garnet Packota**	2010 – 2012
Dr. Arthur W. S. Wood	1973 – 1974	**Dr. Guy Maranda**	1991 – 1993	**Dr. Leland McFadden**	2012 – 2014
Dr. Franklyn W. Lovely	1974 – 1975	**Dr. R. John McComb**	1993 – 1995	**Dr. Hugh Lamont**	2014 – 2016
Dr. Sheldon M. Claman	1975 – 1977	**Dr. Michael I. MacEntee**	1995 – 1997	**Dr. Christopher Robinson**	2016 – 2018
Dr. George S. Beagrie	1977 – 1979	**Dr. John G. Fraser**	1997 – 1999		
Dr. Norman Levine	1979 – 1981	**Dr. Allen S. Wainberg**	1999 – 2001		

Registrars

Dr. John A. Speck	1966 – 1993 (Registrar Emeritus)	**Dr. Garnet V. Packota**	2014 – 2015 (Interim)
Dr. Keith Titley	1993 – 2008	**Dr. Keith Morley**	2015 – 2016
Dr. Patricia A. Main	2008 – 2012		
Dr. David S. Precious	2012 – 2014		

Council

Dr. Christopher Robinson, President (Chair)
Dr. Adel Kauzman, Vice-President
Dr. Hugh Lamont, Immediate Past President
Dr. James Posluns, Treasurer
Mr. Peter McCutcheon, Secretary
Dr. Benjamin Davis, Examiner-in-Chief
Dr. Kalyani Baldota, Dental Public Health
Dr. John Odai, Endodontics
Dr. Daniel Turgeon, Oral and Maxillofacial Radiology
Dr. Michel El-Hakim, Oral and Maxillofacial Surgery
Dr. Karen Burgess, Oral Medicine and Oral Pathology
Dr. Tarek El-Bialy, Orthodontics
Dr. Felicity Hardwick, Pediatric Dentistry
Dr. Bernard Linke, Prosthodontics
Dr. Carolyn Mason, Periodontics

PRESIDENT'S MESSAGE

Success at The Royal College of Dentists of Canada has been tangible on many fronts. As always, time will be the arbitrator of the success of current initiatives. The need to be sensitive and responsive to the demands placed upon our valued stakeholders is not new to The Royal College of Dentists of Canada. Fortunately, we have been able to collaborate openly and creatively with our key stakeholders. We trust that acting in good faith, and with common intent, will direct us positively toward our mutual success in the interest of the Canadian public.

Change is the only constant. Change always arises with a measure of uncertainty, as the familiar past gives way to the reality of the present. Rapid change produces robust challenges, broad opportunities and the potential for enduring and deep societal rewards. The Royal College of Dentists of Canada has a knowledgeable, experienced and uniquely humane and collegial organizational culture. In this context, we can remain confident that a shared commitment to the safety and interest of the Canadian public will enable ongoing success.

I remain deeply grateful for the integrity, ethics, transparency and quality of support provided by The Royal College of Dentists of Canada's leadership, our highly competent and dedicated staff, and the committed altruistic volunteer Fellows and Members. Every single person, whether paid staff or volunteer, associated with The Royal College of Dentists of Canada defines, through their actions, our enduring culture in which change is positively and creatively embraced. How better to serve our profession, our country and its deserving citizens?

Personally, I have been honored, humbled and inspired whilst bearing witness to this ongoing evolution. My sincere appreciation is extended to all who continue to support The Royal College of Dentists of Canada with competence, intelligence, tolerance and dedication.

My kindest personal regards,

Christopher Robinson
President,
The Royal College of Dentists of Canada

EXECUTIVE COMMITTEE REPORT

Dr. Christopher Robinson, Chair (President)
Dr. Hugh Lamont, Immediate Past President
Dr. Adel Kauzman, Vice-President
Dr. Felicity Hardwick, Council Representative
Dr. James Posluns, Treasurer
Dr. Benjamin Davis, Examiner-in-Chief
Mr. Peter McCutcheon, Secretary (Executive Director)

Executive Committee activity was continuous, varied and demanding. However, the primary attention and energy of the Executive Committee was focused upon the negotiations and organizational changes relating to the Third-Party Service Agreement (the "Agreement"), collab-oratively being developed with the Canadian Dental Regulatory Authorities Federation (CDRAF) consequent to the requirements of Provincial Fairness legislation. Anticipating the signing of the Agreement, and meeting and implementing its specific terms, required the wholesale revision of RCDC and the National Dental Specialty Examination (NDSE) governance structure. This led to an obligatory revision of RCDC's bylaws, position descriptions, policies and procedures, committee terms of reference and communication pathways. A required segregation of RCDC and NDSE financials and cost allocations was derived from a detailed 7-year retrospective financial audit.

Amidst this key focus, the ongoing logistics of delivery of the 2018 NDSE was required. Derivative refinements and efficiencies continued, including: request for proposals for (potential) future electronic Component I delivery, investigation and initiation of a search for a permanent, owned RCDC Head Office, which potentially could include a facility for examination delivery. NDSE quality improvements included: graduated introduction of the Angoff cut point method; and continuous examiner training through the dynamic imbedding of our Phsychometrician. Specialty training program inclusion and participation was surveyed and augmented, and a diversity assessment was begun. Scheduled examination blueprint reviews were introduced, as were Examiner-in-Chief (EIC), Chief Examiner (CE) and Examiner performance improvement tools. RCDC conducted a membership (services) survey; added a (second) Spring Convocation opportunity and an additional Board of Directors meeting, in addition to an Educational Conference which will inaugurate in March 2020. Two-year, in-depth, financial planning and budgeting were completed for RCDC and NDSE for 2019 and 2020. Governance recruitment included: a new Board Representative, Registrar, Admissions Officer, and Associate EIC.

RCDC is at a crucial "tipping point" in its evolution. Navigating change constructively at the exponential rate which has been experienced by this Executive Committee has been both challenging and rewarding. Should we wisely choose to define success by commitment, intent and the quality of effort; then indeed this Executive has been exemplary.

Respectfully submitted,

Christopher Robinson
Chair, Executive Committee

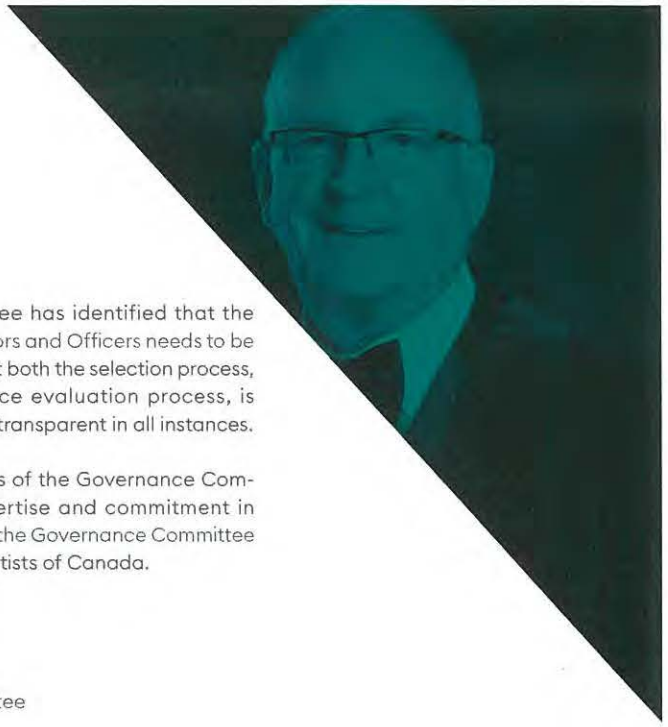
GOVERNANCE COMMITTEE REPORT

Dr. Hugh Lamont, Chair (Immediate Past President)
Dr. Carolyn Mason, Councillor, Periodontics
Dr. Bernard Linke, Councillor, Prosthodontics
Dr. Christopher Robinson, President (Ex-officio)

The Governance Committee activities over the past year included:

- The formation of a set of questions to be asked of candidates who apply for the position of Registrar to better assess their qualifications and suitability for the position;
- Recommendation that the search to fill the position of Registrar be expanded to include non-Fellows, if necessary; and
- Initiation of the process to find qualified and suitable candidates to run for the position of Council Representative.

The Governance Committee is aware that there seems to be a reluctance of Fellows to assume a more active role in the running of the College and to volunteer for positions. Qualified individuals should be identified early in their careers to encourage participation on examination teams and as potential candidates for Chief Examiners and on Council.



The Governance Committee has identified that the selection process for Directors and Officers needs to be more clearly outlined so that both the selection process, as well as the performance evaluation process, is standardized, uniform, and transparent in all instances.

I wish to thank all members of the Governance Committee for their time, expertise and commitment in carrying out their duties for the Governance Committee of The Royal College of Dentists of Canada.

Respectfully submitted,

Hugh Lamont
Chair, Governance Committee

BYLAW COMMITTEE REPORT

Dr. Felicity Hardwick, Chair (Council Representative)
Dr. John Odai, Councillor, Endodontics
Mr. Peter McCutcheon, Executive Director
Dr. Christopher Robinson, President (Ex-officio)

The Bylaw Committee reviewed, updated, and drafted new bylaws. The new bylaws were presented to the Executive Committee on July 21, 2018. The Executive reviewed and approved with a number of minor amendments. The new organizational bylaws will be presented at the AGM in September in Fredericton.

Highlights of the new bylaws are:

1. There shall be two classes of members in the Corporation, namely, Class A voting members, and Class B non-voting members. Class A voting membership shall be available to: Charter Fellows and Fellows. Class B non-voting membership shall be available to: Life Fellows, Honorary Fellows, Members and Life Members.
2. RCDC Council will be known as the Board of Directors - The board shall consist of the directors, one (1) representing each of the nationally recognized specialties, the officers, and a public member.
3. Members can now call a Members' Meeting - The Board of Directors shall call a special meeting of members on written requisition of members carrying not less than 5% of the voting rights.

Recruitment of committee members was a challenge this year. It is anticipated that changes in the recruitment policies and procedures will help to prevent this in future. Dr. John Odai is a welcome addition to the committee.

The Committee would like to thank Mr. Peter McCutcheon, Executive Director, for all his work and assistance on the review and drafting of the new bylaws.

Respectfully submitted,

Felicity Hardwick
Chair, Bylaw Committee

MEMBERSHIP

SPECIALTY	FELLOWS	MEMBERS	TOTAL
Dental Public Health	21	0	21
Dental Science	3	0	3
Endodontics	308	4	312
Oral and Maxillofacial Radiology	24	3	27
Oral and Maxillofacial Surgery	379	31	410
Oral Medicine	10	0	10
Oral Medicine and Oral Pathology	37	0	37
Oral Pathology	12	0	12
Orthodontics	610	18	628
Pediatric Dentistry	317	10	327
Periodontics	280	29	309
Prosthodontics	186	5	191
TOTAL	**2,187**	**100**	**2,287**

LIFE FELLOWSHIP & LIFE MEMBERSHIP

SPECIALTY	LIFE FELLOWS	LIFE MEMBERS	TOTAL
Dental Public Health	14	4	18
Dental Sciences	8	0	8
Endodontics	16	9	25
Oral and Maxillofacial Radiology	3	0	3
Oral and Maxillofacial Surgery	42	13	55
Oral Medicine	3	0	3
Oral Medicine and Oral Pathology	8	0	8
Oral Pathology	2	0	2
Orthodontics	45	13	58
Pediatric Dentistry	15	13	28
Periodontics	24	15	39
Prosthodontics	17	13	30
TOTAL	**197**	**80**	**277**

In Memoriam

Dr. Edward Grodecki

Member

Oral and Maxillofacial Surgery

Brampton, ON
Canada

Dr. Simon Weinberg

Life Fellow

Oral and Maxillofacial Surgery

Toronto, ON
Canada

Dr. J. L. Bertrand

Life Fellow

Orthodontics

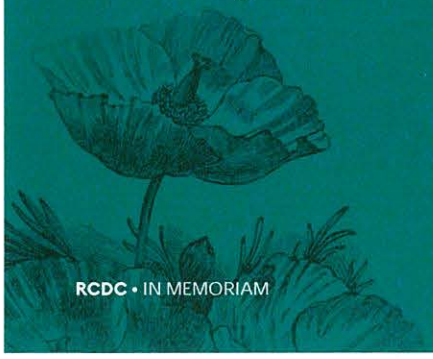
L'Orignal, ON
Canada

Dr. Stephanie Vinh

Fellow

Pediatric Dentistry

Rochester, NY
United States



SUSPENSIONS 2018

On March 3, 2017, the Executive Committee resolved to publish the list of names of Fellows and Members suspended for the non-payment of dues in the Annual Report. In accordance with College Bylaws, only Fellows and Members in good standing are entitled to the use of the FRCD(C) and MRCD(C) designations.

NAME	MEMBER TYPE	SPECIALTY	CITY/PROVINCE	COUNTRY
Dr. Laleh Sadeghi	Fellow	Dental Public Health	Toronto, ON	Canada
Dr. Raymond Greenfeld	Fellow	Endodontics	Richmond, BC	Canada
Dr. Reem Sabano	Fellow	Endodontics	Jeddah	Saudi Arabia
Dr. Michael Sherman	Member	Endodontics	Hamilton, ON	Canada
Dr. Sharma Sinanan	Fellow	Endodontics	Vancouver, BC	Canada
Dr. Morris Gourgi	Member	Oral and Maxillofacial Surgery	Montréal, QC	Canada
Dr. Meghan Alexander	Fellow	Orthodontics	Alabama	United States
Dr. Mirna Baboselac	Fellow	Orthodontics	San Diego, CA	United States
Dr. Hisham Badawi	Fellow	Orthodontics	Calgary, AB	Canada
Dr. Paramvir Bhalla	Fellow	Orthodontics	Williams Lake, BC	Canada
Dr. Hélène Huard	Fellow	Orthodontics	Dieppe, NB	Canada
Dr. Laura Iwasaki	Member	Orthodontics	Kansas City, MO	United States
Dr. Keith King	Fellow	Orthodontics	Medicine Hat, AB	Canada
Dr. Derek Leung	Fellow	Orthodontics	Richmond Hill, ON	Canada

NAME	MEMBER TYPE	SPECIALTY	CITY/PROVINCE	COUNTRY
Dr. Eileen I-Lin Lo	Fellow	Orthodontics	Calgary, AB	Canada
Dr. Peter Luu	Fellow	Orthodontics	Burnaby, BC	Canada
Dr. Pierre Messier	Fellow	Orthodontics	Saint-Jérôme, QC	Canada
Dr. Je rey Nickel	Member	Orthodontics	Kansas City, MO	United States
Dr. Ouliana Oguienko	Fellow	Orthodontics	California	United States
Dr. Jose Roberto Pereira	Fellow	Orthodontics	Edmonton, AB	Canada
Dr. Roy Queen	Member	Orthodontics	Kamloops, BC	Canada
Dr. Sahza Hatibovic-Kofman	Fellow	Pediatric Dentistry	London, ON	Canada
Dr. Edina Heder	Fellow	Pediatric Dentistry	Gormley, ON	Canada
Dr. Mawlood Kowash	Fellow	Pediatric Dentistry	Dubai	United Arab Emirates

SUSPENSIONS 2017

NAME	MEMBER TYPE	SPECIALTY	CITY/PROVINCE	COUNTRY
Dr. Turky Al Saeed	Fellow	Endodontics	Riyadh	Saudi Arabia
Dr. Gregory Frazer	Fellow	Endodontics	Pointe-Claire, QC	Canada
Dr. Paul Kobernick	Fellow	Endodontics	Chevy Chase, MD	United States
Dr. Dean Dover	Member	Oral and Maxillofacial Surgery	Toronto, ON	Canada
Dr. Happy Ghag	Fellow	Orthodontics	Chilliwack, BC	Canada
Dr. Oleg Kopytov	Fellow	Orthodontics	Montréal, QC	Canada
Dr. Krista Lee	Fellow	Orthodontics	Stouffville, ON	Canada
Dr. Yi-Ping Liu	Fellow	Orthodontics	Greensboro, NC	United States
Dr. Chung Yue	Fellow	Orthodontics	Calgary, AB	Canada
Dr. Alan Milnes	Fellow	Pediatric Dentistry	Kelowna, BC	Canada
Dr. Winsome Smith	Member	Pediatric Dentistry	Toronto, ON	Canada
Dr. Zhemeng Wang	Fellow	Pediatric Dentistry	Toronto, ON	Canada
Dr. Mandeep Dhillon	Member	Periodontics	Oshawa, ON	Canada
Dr. Ann Goziotis	Member	Periodontics	London, ON	Canada
Dr. Karl Gravitis	Member	Periodontics	St. Catharines, ON	Canada

NAME	MEMBER TYPE	SPECIALTY	CITY/PROVINCE	COUNTRY
Dr. Terrie Logue	Member	Periodontics	Dartmouth, NS	Canada
Dr. Carol Oakley	Member	Periodontics	Vancouver, BC	Canada
Dr. Patrick Pierce	Member	Periodontics	Edmonton, AB	Canada

SUSPENSIONS 2016

NAME	MEMBER TYPE	SPECIALTY	CITY/PROVINCE	COUNTRY
Dr. Ashkan Hafezi	Fellow	Endodontics	Vancouver, BC	Canada
Dr. A. J. Camarda	Member	Oral and Maxillofacial Surgery	Montréal, QC	Canada
Dr. Ritchie Mah	Fellow	Orthodontics	Burnaby, BC	Canada
Dr. Avin Gupta	Fellow	Pediatric Dentistry	Burlington, ON	Canada
Dr. Zarmin Lalani-Walji	Fellow	Pediatric Dentistry	Dallas, TX	United States
Dr. Murray Arlin	Fellow	Periodontics	Toronto, ON	Canada
Dr. Paul Shaw-Wood	Member	Periodontics	Courtenay, BC	Canada
Dr. Duane McNeil	Fellow	Prosthodontics	Little Canada, MN	United States

SUSPENSIONS 2015

NAME	MEMBER TYPE	SPECIALTY	CITY/PROVINCE	COUNTRY
Dr. Michel Desjardins	Member	Oral and Maxillofacial Surgery	North Bay, ON	Canada
Dr. Monica Dosanjh	Fellow	Orthodontics	Ajax, ON	Canada
Dr. Bartosz Konarski	Fellow	Orthodontics	Brampton, ON	Canada
Dr. Jeremy Molon	Fellow	Orthodontics	Stevensville, ON	Canada
Dr. Daniel Sullivan	Fellow	Orthodontics	Winnipeg, MB	Canada
Dr. Edsard van Steenbergen	Fellow	Orthodontics	Kelowna, BC	Canada
Dr. Harling Pang	Member	Pediatric Dentistry	Shatin, N.T.	Hong Kong
Dr. Jim Robertson	Member	Periodontics	Kitchener, ON	Canada

SUSPENSIONS 2014

NAME	MEMBER TYPE	SPECIALTY	CITY/PROVINCE	COUNTRY
Dr. Jacques Goulet	Fellow	Oral and Maxillofacial Surgery	Saint-Jérôme, QC	Canada
Dr. Anthony Antoniazzi	Fellow	Orthodontics	Stouffville, ON	Canada
Dr. Ronald Brown	Fellow	Orthodontics	Madison, AL	United States
Dr. Nghe Luu	Fellow	Orthodontics	Leduc, AB	Canada
Dr. Joanie Roy	Fellow	Orthodontics	Rimouski, QC	Canada
Dr. Casey Warren	Fellow	Orthodontics	Springville, UT	United States
Dr. Sara Behmanesh	Fellow	Periodontics	St-Lambert, QC	Canada
Dr. Angie Lee	Fellow	Periodontics	Fort Collins, CO	United States
Dr. Steven Richmond	Member	Periodontics	Toronto, ON	Canada

BUDGET AND AUDIT COMMITTEE REPORT

Dr. James Posluns, Chair (Treasurer)
Mr. Peter McCutcheon, Executive Director
Dr. Felicity Hardwick, Council Representative
Dr. William Wilson, Member-at-Large
Ms. Laura Gay, Auditor Representative
Mr. Chris Delorme, Investment Representative
Mr. Robert Cosman, Legal Representative
Dr. Christopher Robinson, President (Ex-officio)

The Royal College of Dentists of Canada (RCDC) remains in a solid financial position, with RCDC reporting a surplus of revenues over expenses; and the National Dental Specialty Examination (NDSE) reporting a deficit of revenues over expenses less than expected. In addition, both investment funds have reported conservative gains over the previous twelve month period. In order to meet expected future expenses, the Executive Committee approved a modest dues increase of 2.3% for 2019 and an increase to NDSE fees of an additional $3,000 (i.e.: $9,500 in 2019 vs. $6,500 in 2018).

The committee met at RCDC's Head Office on June 4, 2018, to discuss the design and structure of the annual audit. The financial needs of the Third-Party Service Agreement with the provincial dental regulators were discussed at length. Other topics of discussion included the requirement for the presentation of the audited financial statements and the potential models of funding a real estate purchase. On July 4, 2018, a draft of the audited financial statements and supporting documents were circulated to the Committee members for review. The Committee has approved the statements as presented. The audited financial statements will be reviewed at the Annual General Meeting on September 22, 2018, in Fredericton, NB.

Draft RCDC and NDSE budgets for 2019–2020 and 2020–2021 were prepared for review by the Executive Committee at their meeting on July 21, 2018. The 2019/2020 budget was approved in principle with minor revisions. The 2019/2020 RCDC and NDSE budgets will be presented for approval at the Annual General Meeting.

Operationally, the conversion to on-line invoice and payment approvals, via the Sage 50 system, is complete and working well. Work on an on-line expense claim form is ongoing. Thank you to Ms. Amandine Perdebat and Mr. Kyle Todt for their hard work on both of these projects.

The Financial Administration Manager tendered her resignation on May 30, 2018. The position has been eliminated with the inherent responsibilities subcontracted to Fuller Landau LLP in Toronto. To date, the transition has been smooth. This reorganization has the potential to realize significant cost savings.

We have audited the accompanying financial statements of The Royal College of Dentists of Canada, which comprise the statement of financial position as at March 31, 2018, and the statements of revenue and expenses, cash flow and changes in net assets for the year then ended and a summary of significant accounting policies and other explanatory information.

Management's Responsibility

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

STATEMENT OF REVENUE AND EXPENSES

FOR THE YEAR ENDED MARCH 31, 2018	Note 1(g) RCDC $	Note 1(g) NDSE $	Total 2018 $	RCDC $	NDSE $	Total 2017 $
REVENUE						
National Dental Specialty Examination	-	1,352,000	1,352,000	-	1,659,279	1,659,279
Members' fees	1,023,656	-	1,023,656	861,029	-	861,029
Other	26,228	-	26,228	23,135	-	23,135
	1,049,884	**1,352,000**	**2,401,884**	**884,164**	**1,659,279**	**2,543,443**
EXPENSES						
Finance and administration	383,964	811,704	1,195,668	432,503	803,535	1,236,038
Professional learning and development	-	88,759	88,759	-	92,526	92,526
Governance and international relations	78,502	23,602	102,104	79,365	29,347	108,712
Publications, products and services	-	580,380	580,380	-	578,856	578,856
Strategic communications, branding and public affairs	96,127	28,244	124,371	73,962	15,338	89,300
	558,593	**1,532,689**	**2,091,282**	**585,830**	**1,519,602**	**2,105,432**
EXCESS (DEFICIENCY) of revenues over expenses before the following	491,291	(180,689)	310,602	298,334	139,677	438,011
Investment income, net (Note 7)	39,514	-	39,514	75,613	-	75,613
EXCESS (DEFICIENCY) of revenues over expenses	**530,805**	**(180,689)**	**350,116**	**373,947**	**139,677**	**513,624**
ALLOCATED AS FOLLOWS:						
Self-insurance fund			**206**			14,220
Operations (unrestricted)			**349,910**			499,404
			350,116			**513,624**

FOR THE YEAR ENDED MARCH 31, 2018			2018	2017
	Self-insurance Fund $	Operations		

STATEMENT OF CASH FLOW

FOR THE YEAR ENDED MARCH 31, 2018	2018 $	2017 $
OPERATING ACTIVITIES		
Excess of revenues over expenses for the year	**350,116**	513,624
Items not involving cash		
Amortization of capital assets	**32,404**	33,729
Amortization of deferred tenant inducements	**(10,245)**	(10,245)
Fair value adjustments to investments	**(42,415)**	(9,540)
Working capital from operations	**329,860**	527,568
Net change in non-cash working capital balances related to operations	**93,901**	(165,203)
Cash from operations	**423,761**	362,365
Investing activities		
Purchase of capital assets, net	**(14,418)**	(13,495)
Investments, net	**(102,133)**	(360,057)
	(116,551)	**(373,552)**
Change in cash during the year	**307,210**	(11,187)
Cash (bank indebtedness) Beginning of year	**(6,780)**	4,407
End of year	**300,430**	(6780)

STATEMENT OF FINANCIAL POSITION

FOR THE YEAR ENDED MARCH 31, 2018	2018 $	2017 $
ASSETS		
Current assets		
Cash	300,430	-
Hst recoverable	79,967	77,400
Investment (Note 2)		
Operations (unrestricted)	2,609,753	2,465,411
Self-insurance fund	1,127,002	1,126,796
Prepaid expenses and inventory	30,159	21,783
	4,147,311	3,691,390
Capital assets (Note 3)	151,378	169,364
	4,298,689	3,860,754
LIABILITIES		
Current liabilities		
Bank indebtedness	-	6,780
Accounts payable and accrued liabilities	119,586	81,706
Current portion of deferred tenant inducement (Note 5)	10,245	10,245
Deferred revenue (Note 4)		
Dues	850,350	723,386
Examination revenue	648,000	708,000
	1,628,181	1,530,117
Deferred tenant inducement (Note 5)	51,225	61,470
	1,679,406	1,591,587
NET ASSETS		
Self-insurance fund (Note 8a)	1,127,002	1,126,796
Operations (unrestricted)	1,492,281	1,142,371
	2,619,283	2,269,167
	4,298,689	3,860,754

1. Significant accounting policies

These financial statements were prepared in accordance with Canadian accounting standards for not-for-profit organizations (ASFNPO) and include the following significant accounting policies:

(a) Purpose and incorporation

The Royal College of Dentists of Canada was established in 1965 by an Act of Parliament as a not-for-profit corporation without share capital for the purpose of:

i. promoting high standards of specialization in the dental profession;
ii. qualifying and providing recognition and designation to properly trained dental specialists;
iii. encouraging the establishment of training programs in the dental specialties in Canadian schools; and
iv. providing for the recognition and designation of dentists who possess special qualifications in areas not recognized as specialties.

The College is a registered charity under the Income Tax Act and is exempt from income taxes.

(b) Revenue recognition

Annual dues are recognized as income in the year to which they relate. Examination fees are recognized as income on the examination date. Application, convenience, review fees and donations are recognized as income when received. Product sales are recognized as income when the product is delivered. Investment income is recognized on an accrual basis.

(c) Capital assets

Capital assets are stated at cost. Amortization is recorded at rates calculated to charge the cost of the assets to operations over their estimated useful lives. Maintenance and repairs are charged to operation as incurred. Gains and losses on disposals are calculated on the remaining net book value at the time of disposal and included in income.

Amortization is charged to operations on the declining balance basis at the following annual rates:

- Computer equipment - 30%
- Furniture and equipment - 20%
- Examination software - 20%

Leasehold improvements are amortized on a straight-line basis over the term of the lease.

3. Capital assets

	Cost $	Accumulated amortization $	Net 2018 $	Net 2017 $
Furniture and equipment	51,556	30,912	**20,644**	25,805
Computer equipment	131,846	122,122	**9,724**	9,024
Leaseholds	123,427	49,332	**74,095**	86,444
Examination software	87,421	40,506	**46,915**	48,091
	394,250	242,872	**151,378**	169,364

4. Deferred examination revenue

	2018 $	2017 $
Balance, beginning of year	**708,000**	994,500
Received during the year		
Examination fees	**1,305,000**	1,407,000
Application, convenience and review fees	**175,925**	185,229
Fees refunded during the year	**(188,925)**	(219,450)
Earned during the year	**(1,352,000)**	(1,659,279)
Balance, end of year	**648,000**	708,000

Deferred dues revenue consists of 2018 annual dues already received that will be recognized as income from the period of April 1, 2018 through December 31, 2018.

5. Deferred tenant inducement

In 2015, the College received a cash rental inducement in the amount of $102,450. It has been deferred and recognized as a reduction of rental expense on a straight-line basis over the term of the lease.

6. Credit facility

The College has credit facility in the form of a line of credit available up to $100,000, bearing interest at bank prime + 1%. As of March 31, 2018 the line was not drawn upon.

7. Investment income

			2018	2017
FOR THE YEAR ENDED MARCH 31, 2018	Self-insurance Fund $	Operations (Unrestricted) $	**Total $**	Total $
Interest income	-	8,051	**8,051**	5,665
Mutual fund income	31,650	52,452	**84,102**	74,634
Realized gain	692	12,944	**13,636**	7,597
Unrealized gain (loss)	(21,660)	(20,755)	**(42,415)**	9,540
Investment income	10,682	52,692	**63,374**	97,436
Less: management fees	10,476	13,384	**23,860**	21,823
	206	39,308	**39,514**	75,613

8. Other information

(a) Self-insurance fund

The Self-insurance fund was originally established by the College from RCDC funds. Its use is restricted for the following purposes:

i. to cover the cost from any potential lawsuit against the College; and

ii. to meet certain statutory and contractual obligations in the event of termination of the College's operations.

Management assesses the magnitude of the Self-insurance fund annually to ensure that it is sufficient to cover these purposes.

(b) Lease commitment

The College is committed under a net lease for premises until March 2024. Annual rents, exclusive of operating costs in subsequent fiscal years are approximately as follows:

	$
2019	121,000
2020	126,000
2021	126,000
2022	126,000
2023	126,000
Thereafter	126,000
	751,000

(c) Financial instruments

The College is exposed to the following significant risks:

i. **Interest rate risk**

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. Fluctuations in interest rate will affect the organization's earnings and cash flow.

ii. **Market risk**

A portion of the College's investments are subject to the risk that their value will fluctuate as a result of changes in market prices. These fluctuations will affect the amount that the company will realize when it disposes of these investments.

EDUCATION COMMITTEE REPORT

Dr. Christopher Robinson
Chair (President)
Dr. Benjamin Davis
NDSE Committee Chair (Examiner-in-Chief)
Dr. Adel Kauzman
Credentials Committee Chair (Vice-President)
Mr. Peter McCutcheon
Appeals Committee Chair (Executive Director)
Dr. Garry Aslanyan
Chief Examiner, Dental Public Health
Dr. Sheldon Best
Chief Examiner, Endodontics
Dr. Noura Alsufyani
Chief Examiner, Oral and Maxillofacial Radiology
Dr. Brian Rittenberg
Chief Examiner, Oral and Maxillofacial Surgery
Dr. Iona Leong
Chief Examiner, Oral Medicine and Oral Pathology
Dr. Susan Eslambolchi
Chief Examiner, Orthodontics
Dr. Gordon Payne
Chief Examiner, Pediatric Dentistry
Dr. Jean-Pierre Picard
Chief Examiner, Periodontics
Dr. Izchak Barzilay
Chief Examiner, Prosthodontics
Dr. Randall Croutze
Member, Alberta Dental Association and College
Mr. Jerome Marburg
Member, College of Dental Surgeons of British Columbia
Dr. Gerald Uswak
Member, College of Dental Surgeons of Saskatchewan
Dr. Patricia Ling
Member, Manitoba Dental Association
Dr. Louis-René Charette
Member, Ordre des dentistes du Québec
Dr. Martin R. Gillis
Member, Provincial Dental Board of Nova Scotia
Dr. David Segal
Member, Royal College of Dental Surgeons of Ontario
Ms. Amandine Perdebat
Director of Examinations
Dr. Brian Hess
Psychometrician
Dr. David Kennedy
Member, Association of Canadian Faculties in Dentistry
Dr. Christina McCord
Member, Canadian Dental Specialties Association
Dr. Amarjit Rihal
Member, Commission on Dental Accreditation of Canada

The Education Committee last met on March 23, 2018. The primary activities of the Education Committee over 2018 were focused upon open collaboration between The Royal College of Dentists of Canada (RCDC) and its key Dental Regulatory Authority (DRA) stakeholders respecting the development of a Third-Party Service Agreement (the "Agreement"). The Agreement is intended to enable compliance with the requirements of fairness legislation in four regulatory jurisdictions.

Consequent governance changes were identified, reviewed and approved. Updates, discussion and recommendations were provided respecting the final implementation of the components of the current (ending 2018) RCDC Strategic Plan and the request for proposals for development of future electronic Component I examinations.

Examiner-in-Chief (EIC) reporting occurred regarding: EIC and Chief Examiner (CE) performance improvement tools; Examiner involvement tracking; as well as Examiner and volunteer recognition initiatives. This reporting was supplemented by the detailed, specialty specific, reporting by CEs. These reports provided data and observations on: examination blueprints; content development; calibration; delivery; key validation; and outcomes. Recommendations for quality improvement were both provided and received. Recruitment, initial and ongoing examiner training, mentorship and leadership transition plans were also communicated.

Psychometrician reporting discussed: initiatives for regularly scheduled examination blueprint review and revision; and graduated roll-out of the Angoff cut point determination. Efficient and effective, initial and ongoing Examiner training implementation, via the active, dynamic imbedding of the Psychometrician throughout the examination blueprint design; content development; calibration; Component I and II delivery; and key validation processes, for all specialties.

Activity reporting occurred for the Appeals Committee, including an advisement regarding amendments to the terms of reference. Updates were provided respecting Formal Review Panel policy review and amendment.

The Education Committee demonstrated success through accountable communication, clarity of roles and effective implementation of the current strategic plan. Important to the mission of RCDC and the NDSE was the measurable improvement in examination quality, advancements in inclusiveness and diversity of recruitment. These forward-looking initiatives illustrated a commitment from RCDC and key stakeholders towards continuing quality improvement, fairness, relevance and defensibility of the NDSE assessment instruments, in the interest of the health and safety of the Canadian public.

The Committee, RCDC and its key stakeholders are all actively challenged by the rapid, and often unpredictable, changes in their respective environments. This extends from accountability and oversight demands to the exponentially escalating costs of examination development and delivery. As we proceed forward, collective caution, collaboration and creativity will be required; whilst keeping the safety and interest of the Canadian public at the forefront of all participants' intent.

At the end of the March 23, 2018 meeting, the Education Committee was disbanded in anticipation of the implementation of the new

Dr. Benjamin Davis
Chair (Examiner-in-Chief)
Dr. Christine Corbeil
Associate Examiner-in-Chief
Dr. Garry Aslanyan
Chief Examiner, Dental Public Health
Dr. Sheldon Best
Chief Examiner, Endodontics
Dr. Noura Alsufyani
Chief Examiner, Oral and Maxillofacial Radiology
Dr. Brian Rittenberg
Chief Examiner, Oral and Maxillofacial Surgery
Dr. Iona Leong
Chief Examiner, Oral Medicine and Oral Pathology
Dr. Susan Eslambolchi
Chief Examiner, Orthodontics
Dr. Gordon Payne
Chief Examiner, Pediatric Dentistry
Dr. Jean-Pierre Picard
Chief Examiner, Periodontics
Dr. Izchak Barzilay
Chief Examiner, Prosthodontics
Mr. Peter McCutcheon
Executive Director
Dr. Brian Hess
Psychometrician
Ms. Amandine Perdebat
Director of Examinations

Mr. Kyle Todt
Systems and Support Manager
Dr. Christopher Robinson
President (Ex-Officio)

The National Dental Specialty Examination Committee (NDSEC) is responsible for maintaining and enhancing the high standards of the National Dental Specialty Examinations (NDSE) through program development and volunteer engagement. The NDSEC reports to the Education Committee.

The NDSEC develops and recommends examination policies, procedures, and standards to the Education

The NDSEC undertook numerous action items during the past year. The NDSEC ensured that the NDSE complied with the Government of Canada's Joint Statement of Action to address the opioid crisis by having each specialty include examination content on the topic of safe use and prescribing of opioids. The present appeals process was reviewed, and procedural concerns that have triggered appeals were discussed to minimize their future occurrence. A (Candidate/Examiner) conflict resolution policy was also developed that allows the EIC to evaluate perceived conflicts and make consistent rulings on them.

The NDSEC spent considerable time discussing our most valuable resource – our volunteer Examiners. We helped create an online Examiner application form, which will be located on the RCDC website, with the goal of both cultivating interest in becoming an NDSE Examiner and increasing the diversity of our examination teams. The NDSEC sought ways to improve Examiner recognition: we will continue to provide Examiners with continuing education certificates, long service awards, and seek other means of recognizing our Examiners.

The Committee has developed a Chief Examiner (CE) performance management process which will be implemented in the second half of 2018. This satisfies Strategic Goal A1. This annual review will provide CEs with constructive feedback and support their growth and development while serving the NDSE in this critically important capacity. Considerable time was also spent discussing ways to decrease Component I and II NDSE expenses. This will be one of the principal points of discussion during our strategic planning session in September.

Our Psychometrician, Dr. Brian Hess, provides the Committee with regular updates on the performance of the NDSE. Dr. Hess has now implemented the Angoff Method for each specialty's examination. Dr. Hess has also developed web-based Examiner training modules for the NDSE. These training modules must be completed by all new Examiners and will become part of the ongoing development and maintenance of competency of our existing Examiners.

Each specialty's examination blueprint is regularly reviewed. This past year, Pediatric Dentistry undertook a review of their examination blueprint with the input of Canadian Pediatric Dentistry Program Directors, existing Examiners, and pediatric dentists. Oral and Maxillofacial Surgery will be under-taking a similar examination blueprint review in September. Finally, an Examiner involvement tracking form has been created to help Examiners track the time they spend in creating, vetting, delivering, and correcting NDSE content. Examiners are encouraged to use this tool routinely to allow RCDC to capture the tremendous number of hours that our volunteer Examiners spend on the NDSE.

The NDSEC would not be able to function without the tremendous assistance of the RCDC office staff and, in particular, the Director of Examinations, Ms. Amandine Perdebat.

Respectfully submitted,

Benjamin Davis
Chair, National Dental
Specialty Examination Committee

CREDENTIALS COMMITTEE REPORT

Dr. Adel Kauzman, Chair (Vice-President)
Dr. Felicity Hardwick, Council Representative
Dr. Karen Burgess, Councillor, Oral Medicine and Oral Pathology
Dr. Carolyn Mason, Councillor, Periodontics
Dr. Christopher Robinson, President (Ex-officio)

The Credentials Committee was not convened during the reporting period. However, in the absence of an Admissions Officer, the Chair undertook:

- Review and approval of National Dental Specialty Examination (NDSE) applications;
- Review and approval of requests for special accommodations for both NDSE Components I and II; and
- Approval of requests for withdrawals, and reimbursements when applicable.

The Chair's completion of these tasks was facilitated by the continuous support of The Royal College of Dentists of Canada's (RCDC) Head Office staff, in particular Ms. Catalina Ponce de Leon, Registration Manager.

Completed applications were assessed during two credentialing periods: applications completed between June and July were credentialed in August 2017; those completed in August and September were credentialed in October 2017. Applications completed after the application deadline were credentialed within 10 business days.

Respectfully submitted,

Adel Kauzman
Chair, Credentials Committee

APPEALS COMMITTEE
REPORT

Mr. Peter McCutcheon, Chair (Executive Director)
Ms. Amandine Perdebat, Director of Examinations
Ms. Catalina Ponce de Leon, Registration Manager
Dr. Christopher Robinson, President (Ex-officio)

The Appeals Committee is convened to ensure that Formal Reviews of the National Dental Specialty Examination are carried out as directed by policy in a standard, timely and confidential fashion.

Candidates who are unsuccessful in either component of the National Dental Specialty Examination have 30 days from the communication of their results to initiate a Formal Review of their examination. Appeals may only be launched on the grounds of procedural irregularities that may have affected the candidate's performance.

The Formal Review process consists of three distinct stages: stage one is a review of the appeal by the Examiner-in-Chief; stage two is a document review by a Formal Review panel, and; stage three is an oral hearing with a Formal Review panel. Each stage of the appeals process may only be launched once the previous stage has been completed.

There was one appeal inquiry following the communication of the results of the 2018 Component I Examination; it did not proceed to the first stage of the Formal Review process. There were 10 appeal inquiries following the 2018 Component II Examination, four of which proceeded to the review by the Examiner-in-Chief.

Respectfully submitted,

Peter McCutcheon
Chair, Appeals Committee

EXAMINER-IN-CHIEF'S REPORT

The Royal College of Dentists of Canada (RCDC) administers the National Dental Specialty Examination (NDSE) for each of the nine dental specialties recognized by the Commission on Dental Accreditation of Canada (CDAC). Qualified candidates challenge the Component I (written) Examination and, if successful, the Component II (oral) Examination. Dental Regulatory Authorities use successful completion of the NDSE as a step in the specialty licensure process.

Component I Examination

The Component I Examination was held on Thursday March 1, 2018 and 180 candidates challenged it. To provide easier access to the examination, candidates were given the opportunity to challenge the Component I Examination in two Canadian locations, Vancouver and Toronto. 129 candidates challenged the examination in Toronto, while 51 sat the examination in Vancouver. The Component I Examination continues to be delivered in a hard-copy format, with candidates providing hand written answers.

Component II Examination

The Component II Examinations were held in Toronto at the Marriott Downtown at CF Toronto Eaton Centre Hotel over a two-week period. Pediatric Dentistry, Orthodontics, Oral Medicine/Pathology, Periodontics, and Oral and Maxillofacial Radiology held their calibration sessions, Component II Examinations, and key validation sessions during the period of June 13–June 19, 2018. Prosthodontics, Endodontics, Dental Public Health, and Oral and Maxillofacial Surgery held their calibration sessions, Component II Examinations and key validation sessions during the period of June 20 – June 26, 2018. There were 182 candidates who challenged the Component II Examinations.

All examination teams held pre-examination calibration sessions during which the entire examination team reviewed the content so that the delivery of questions, support material and marking of answers was standardized among all team members.

Special Accommodations

Candidates may petition for special accommodations at the examinations on the grounds of a disability or medical condition, or for religious reasons. The special accommodation policy is compliant with accessibility standards outlined in the Accessibility for Ontarians with Disabilities Act.

In order for appropriate arrangements to be made, interested candidates must identify their requirement for accommodation in writing and submit the relevant supporting documentation as part of their request. Depending on the nature and extent of the request, supporting documentation may be submitted as a medical report, a detailed physician's note or an official letter from the leader of a religious congregation.

At the 2018 Component I Examination, five candidates were granted special accommodations:

- 2 x time and a half (disability);
- 2 x allowances for adaptive equipment (medical);
- 1 x access to private breastfeeding room (medical).

At the Component II Examinations, there were six inquiries for special accommodations. Overall, four candidates were granted special accommodations:

- 1 x time and a half (disability);
- 1 x single-day examinations (religious restriction);
- 1 x morning-online examinations (medical)
- 1 x additional time (medical).

External Observers

Our external stakeholders have always been welcomed to send observers to the examinations. The Ordre des dentists du Québec had representatives at both Components of the NDSE; Dr. Thiem Diem Thao Phan was present at Component I and Drs. Samer Mesmar, Thiem Diem Thao Phan, Farid Amer-Ouali, and Bilal E-Khatib were present at Component II.

We welcome all input and constructive feedback from external stakeholders present at the NDSE.

Psychometrician

Having a Psychometrician involved in the development, delivery and review of each examination cycle is critical. Dr. Brian Hess, the College's Psychometrician for the past four years, has been wonderful to work with and has quickly appreciated the complexities of our high stakes examination. Dr. Hess has helped numerous specialties during their content creation workshops and has implemented the Angoff method to further strengthen our key validation process during the Component II Examinations. I look forward to not only continuing to work with Dr. Hess and am very glad to see that he has an increasing involvement in all aspects of the examination process.

Examiner Training

Dr. Hess continues to providenew Examiner training prior to every Component II examination. In addition, Dr. Hess has also developed Component I and Component II Examiner re-training modules that will be used to ensure that existing Examiners have standardized, up to date, knowledge in examination development, delivery, and evaluation.

I am deeply grateful for the support and assistance of the NDSE staff, the Executive Director and my friends and colleagues on the Executive. Dr. Brian Hess and Dr. Christine Corbeil, the associate EIC, are incredible assets for the NDSE and constantly provide me guidance and direction.

Finally, by means of this report I would like to thank the Chief Examiners: Drs. Sheldon Best, Garry Aslanyan, Noura Alsufyani, Jean-Pierre Picard, Brian Rittenberg, Iona Leong, Susan Eslambolchi, Gordon Payne, and Izchak Barzilay. I would also like to thank two incoming CEs, who will be starting in the role after this coming convocation: Drs. King Chong Chan and Riva Black. All these individuals are fundamental to their specialties' NDSE. They are all devoted and work tirelessly on behalf of the College and their specialties to ensure that the NDSE is a high-quality assessment tool.

Respectfully submitted,

Benjamin Davis
Examiner-in-Chief

exceeded 0.85, indicating that the questions consistently measured the same construct. In addition, the interrater reliability of the scores from each examination was good, indicating that Examiners were consistent in their markings.

Over the next year the Psychometrician will embark on a number of strategic initiatives to enhance the NDSE. Namely, the Psychometrician will engage with the specialty examination teams to conduct a formal review of their examination blueprints. This is typically done every five years to maintain the validity of the examination content and results that are produced. Additionally, the Psychometrician will develop enhancements to the training that specialty teams receive for creating new examination content and for conducting the Component II examination.

Each year, the National Dental Specialty Examination publishes a five-year average of the pass rate for candidates challenging the examination for the first time. The specialty-specific examinations statistics provided in this report refer to the success rate of candidates from dental specialty training programs accredited by the Commission on Dental Accreditation of Canada (identified as Canadian First-Time Takers) or by the Commission on Dental Accreditation (identified as American First-Time Takers), and of candidates who were internationally-trained (identified as International First-Time Takers) for the period 2014-2018.

Respectfully submitted,

Brian Hess
Psychometrician

CHIEF EXAMINER'S REPORT
DENTAL PUBLIC HEALTH

THE TEAM

CHIEF EXAMINER
Dr. Garry Aslanyan

ASSOCIATE CHIEF- EXAMINER
Dr. Constantine Batsos

EXAMINERS
Dr. Albert Adegbembo
Dr. Kalyani Baldota
Dr. Rafael Figueiredo
Dr. Alyssa Hayes
Dr. Ferne Kraglund
Dr. Gordon W. Thompson
Dr. Maria Van Harten

Examination Development in 2018
Dental Public Health is using our current blueprint which continues to help ensure that all important domains are covered in both components of the examination. In 2017, examiners held one workshop and another workshop is planned for September 2018. This helped to develop new set and update the existing questions. As many of the questions for Dental Public Health Speciality require to reflect current events in public health policy and environment, it is particularly important to update the content on regular basis.

Examination Blueprint Review and Development
It is invisioned that the blueprint for Dental Public Health will be reviewed and revised in the coming years.

Examiner Recruitment and Training in 2018
One new Examiner has joined the Examination Team in 2017 and another one will join the workshops in September 2018. It is planned that both will undergo training and observe examinations in 2019 provided there are sufficient applicants to the specialty.

Respectfully submitted,

Garry Aslanyan
Chief Examiner, Dental Public Health

Due to the limited number of candidates in this specialty, examinations statistics cannot be reported in order to maintain confidentiality

CHIEF EXAMINER'S REPORT
ENDODONTICS

Examination Development in 2018
The Component I examination development workshop will be held in October 2018 at RCDC office in Toronto.

Examiners have been tasked with the development of new material for Components I and II.

Development of a new examination blueprint and instruction to candidates is underway in conjunction with Dr. Brian Hess.

Recruitment of new Examiners is ongoing. Several recent Fellows have been invited to attend our Fall workshop.

Respectfully submitted,

Sheldon Best
Chief Examiner, Endodontics

COMPONENT I STATISTICS

5 year Rolling Pass Rate (2014-2018)

	CANADIAN First-time Takers	AMERICAN First-time Takers
TOTAL NUMBER OF CANDIDATES	32	91
NUMBER OF SUCCESSFUL CANDIDATES	32	78
NUMBER OF SUCCESSFUL CANDIDATES	100%	85.7%

COMPONENT II STATISTICS

TOTAL NUMBER OF CANDIDATES	32	77
NUMBER OF SUCCESSFUL CANDIDATES	31	63
NUMBER OF SUCCESSFUL CANDIDATES	96.9%	81.8%

THE TEAM

CHIEF EXAMINER
Dr. L.A. Sheldon Best

EXAMINERS
Dr. Herb Borsuk
Dr. Kenneth Dick
Dr. Mahmoud Reza Ektefaie
Dr. Mahsa Farzaneh
Dr. Douglas Herrera
Dr. Ma hew Kerner
Dr. Gillian Layton
Dr. Debbie Levin
Dr. Rachele Luciano
Dr. Sandra Makkar
Dr. Gevik Malkhassian
Dr. Mana Mirfendereski
Dr. Carlos Ochoa
Dr. Lisane Paque e
Dr. Jonathan Rapp
Dr. Yaser Roumani
Dr. Samer Salama
Dr. Esther Tam
Dr. Peter Tawil
Dr. Blayne Thibodeau
Dr. Elie Wolfson

CHIEF EXAMINER'S REPORT
ORAL MEDICINE AND ORAL PATHOLOGY

Examination Development in 2018
The Component I and II Examinations in the specialty of Oral Medicine were conducted in March and June 2018, with two candidates successfully challenging both components.

Both Component I and Component II Examinations were executed successfully. I would like to thank the examinations team for their dedication and commitment to producing and delivering examinations of excellent quality that are fair, accurate and reproducible tests of knowledge and clinical judgment. Ms. Amandine Perdebat and the staff of The Royal College of Dentists of Canada play a critical role in the implementation of the examinations. I am especially grateful to them and to the Examiner-in-Chief, Dr. Ben Davis, for their professionalism and collegiality.

Examination Blueprint Review and Development
The examinations team continues to develop and improve the examinations using feedback from the individual examiners, past candidates, other specialties, and residency training programs. The examination content reflects what is currently being taught in Canadian residency programs. The examinations blueprint and examination database continue to be expanded and refined, with a workshop being held in Toronto in December 2017. Criteria for passing in terms of numerical and qualitative scores and definition of critical errors have been defined and validated.

Examiner Recruitment and Training in 2018
Dr. Riva Black has graciously agreed to become the Chief Examiner in Oral Medicine and Oral Pathology at the end of my second term in September 2018. Dr. Black has extensive experience in examining, plays a significant role in examinations development and has all the qualities required of an outstanding Chief Examiner.

Respectfully submitted,

Iona Leong
Chief Examiner, Oral Medicine and Oral Pathology

ORAL MEDICINE AND ORAL PATHOLOGY

NORTH AMERICAN
First-time Takers

13
TOTAL NUMBER OF CANDIDATES

12
NUMBER OF SUCCESSFUL CANDIDATES

92.3%
NUMBER OF SUCCESSFUL CANDIDATES

NORTH AMERICAN
First-time Takers

12
TOTAL NUMBER OF CANDIDATES

11
NUMBER OF SUCCESSFUL CANDIDATES

91.7%
NUMBER OF SUCCESSFUL CANDIDATES

THE TEAM

CHIEF EXAMINER
Dr. Iona Leong

EXAMINERS
Dr. Riva Black
Dr. Seema Ganatra
Dr. Sarah Gordon
Dr. Adel Kauzman
Dr. Christina McCord
Dr. David Mock
Dr. Samson Ng
Dr. Ed Peters
Dr. Eli Whitney

ORAL AND MAXILLOFACIAL RADIOLOGY

NORTH AMERICAN
First-time Takers

12

8

66.7%

THE TEAM

CHIEF EXAMINER
Dr. Noura Alsufyani

EXAMINERS
Dr. King Chong Chan
Dr. Anna Csillag
Dr. Fatima Jadu
Dr. Catherine Nolet-Lévesque
Dr. Daniel Turgeon
Dr. Robert Wood

CHIEF EXAMINER'S REPORT
ORAL AND MAXILLOFACIAL SURGERY

Examination Development in 2018
Component I and II Examination preparation for the 2018 examination cycle took place at two workshops. The Component I content was vetted at a workshop in April 2017 and the Component II content was vetted at a workshop in September 2017. The examination content that was prepared at these workshops was reviewed by a group of senior examiners and finalized for submission to the College where it was translated and reviewed by our psychometrician, Dr. Brian Hess. The examinations were then reviewed one final time by me and a group of Senior Examiners. During this final review process, any changes to wording/scoring proposed by Dr. Hess, were made.

Examination Blueprint Review and Development
A blueprint update is planned for the upcoming year. In order to facilitate this update, a questionnaire will go out to all Oral and Maxillofacial Surgery Examiners to gain information regarding the scope of practice in Canada. This information will be used at a blueprint workshop which will be held in New Brunswick in September, as part of RCDC's convocation weekend. All Oral and Maxillofacial Surgery Program Heads will be invited to attend the workshop.

Examiner Recruitment and Training in 2018
Two new Examiners were recruited in the past year. They attended the recent Component II Examination where they received new Examiner training, and both participated in the recent examination. To plan for the future, I think that it is important to continue adding one to two Examiners per year.

With respect to long-term succession planning, I am working with the Examiner-in-Chief to find my successor. I hope to have someone selected in the next calendar year so that they can shadow me for my final year in the role. My last examination as Chief Examiner is the 2020 examination cycle.

In addition to the Chief Examiner position, I am also working toward having an official assistant in place for each of the three section heads in Oral and Maxillofacial Surgery. These assistants would eventually replace the existing section heads however the timing of those changes has not yet been decided and will likely be different for each of the three sections of the Examination.

Respectfully submitted,

Brian Rittenberg
Chief Examiner, Oral and Maxillofacial Surgery

COMPONENT I STATISTICS

5 year Rolling Pass Rate (2014-2018)

	CANADIAN First-time Takers	AMERICAN First-time Takers
TOTAL NUMBER OF CANDIDATES	41	41
NUMBER OF SUCCESSFUL CANDIDATES	40	38
NUMBER OF SUCCESSFUL CANDIDATES	97.6%	92.7%

COMPONENT II STATISTICS

TOTAL NUMBER OF CANDIDATES	40	38
NUMBER OF SUCCESSFUL CANDIDATES	36	27
NUMBER OF SUCCESSFUL CANDIDATES	90%	71.1%

THE TEAM

CHIEF EXAMINER
Dr. Brian Ri enberg

SENIOR EXAMINERS
Dr. Joseph Friedlich
Dr. Pierre-Éric Landry
Dr. Henry Lapointe
Dr. André Rousseau

SECTION LEADERS
Dr. Curtis Gregoire
Dr. Kevin Lung
Dr. Julia Pompura

EXAMINERS
Dr. Keyvan Abbaszadeh
Dr. Olivier Béchard
Dr. Nick Blanas
Dr. Susan Bourque
Dr. James Brady
Dr. René Caissie
Dr. Marco Caminiti
Dr. Carol Judith Chahine
Dr. Daisy E. Chemaly
Dr. Marco Chiarot
Dr. Geneviève Chiasson
Dr. J. Graham Cobb
Dr. Alexandre Dostie
Dr. Jean-Charles Doucet
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Dr. William L. Frydman
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Dr. FritzKienle
Dr. Kristopher Lee
Dr. Mathieu Lenis
Dr. ZainManji
Dr. Nicholas Makhoul
Dr. Kevin J. McCann
Dr. Taylor McGuire
Dr. Maico D. Melo
Dr. Iain Nish
Dr. Joel Eric Powell
Dr. Eddie Reinish
Dr. Chad G. Robertson
Dr. André Rousseau
Dr. Michael S. Shimizu
Dr. Miller Smith
Dr. Mark Shuren
Dr. Sarah Théberge
Dr. Simon Touchan
Dr. Robert Wagner
Dr. Je rey Wallace

CHIEF EXAMINER'S REPORT
ORTHODONTICS

Examination Development in 2018
The Orthodontic team is continually improving its examinations to produce a comprehensive and fair Orthodontic's examination. This past year, the highlights were:

- The blueprint for Component I was modified to better reflect some of the more recent advances in our specialty. The Orthodontic team will continue to update the blueprint every 2 years.
- Two workshops took place in Toronto, one in October 2017, and one in January 2018. The October workshop involved developing questions for the Case Analysis portion of Component II, while the January workshop focused more on the remainder of Component II. Both workshops were attended by Senior Examiners and contributed to fine tuning the Component II Examinations.
- The examination content continues to be vetted extensively by most of our Examiners.
- The addition of three new Examiners.
- Additional statistical analyses to improve the post-examination Key Validation.

Examiner Recruitment and Training in 2018
Three new Examiners were recruited in 2018. These Examiners underwent training and were mentored by more senior Examiners. This diverse team of Examiners are from all across Canada, and are involved in either university teaching and/or private practice.

Conclusion
This was my first year as the Chief Examiner of Orthdontics. I would like to thank Dr. Lesley Williams, our former CE for preparing me for this role, and for her leadership over the past six years. The entire Orthodontic team worked very hard this past year and I would like to thank everyone for their contribution, especially the section leaders, Drs. Julianne Peterson, Austin Chen, and James Posluns. Thanks also to Dr. Brian Hess (Psychometrician), and Mr. Kyle Todt (Systems and Support Manager), who were instrumental in our key validation procedures. The Orthodontic Team would like to thank Mr. Peter McCutcheon (Executive Director), Ms. Amandine Perdebat (Director of Examinations), and her team for working tirelessly to support me and the entire team to ensure perfect delivery of high quality Component I and Component II exams. Lastly, our thanks for Dr. Benjamin Davis, our Examiner-in-Chief, for his leadership and guidance.

Respectfully submitted,

Susan Eslambolchi
Chief Examiner, Orthodontics

COMPONENT I STATISTICS

5 year Rolling Pass Rate (2014-2018)

	CANADIAN First-time Takers	**AMERICAN** First-time Takers	**INTERNATIONAL** First-time Takers
TOTAL NUMBER OF CANDIDATES	113	88	14
NUMBER OF SUCCESSFUL CANDIDATES	111	72	14
NUMBER OF SUCCESSFUL CANDIDATES	98.2%	81.8%	100%

COMPONENT II STATISTICS

TOTAL NUMBER OF CANDIDATES	111	70	14
NUMBER OF SUCCESSFUL CANDIDATES	101	55	12
NUMBER OF SUCCESSFUL CANDIDATES	91%	78.6%	85.7%

THE TEAM

CHIEF EXAMINER
Dr. Susan Eslambolchi

COMPONENT I SECTION LEADER
Dr. Timothy Agapas

COMPONENT II SECTION LEADERS
Dr. Austin Chen
Dr. Julianne Peterson
Dr. James Posluns

SENIOR EXAMINERS
Dr. Ron Sperber
Dr. C. Lesley Williams

FRENCH CONTENT REVIEWER
Dr. Sonya Lacoursière

EXAMINERS
Dr. Shervin Abbaszadeh
Dr. Mostafa Altalibi
Dr. Paula Baby
Dr. Eva Berka
Dr. Allyson Bourke
Dr. Claude Boutin
Dr. David Briss
Dr. Steven Budd
Dr. Clara Chow
Dr. Leonard Chumak
Dr. Glenna Grykuliak
Dr. Brandon Huang
Dr. Paul Helpard
Dr. Alexa Herberston
Dr. Karim Jarjoura
Dr. Lorne Kamelchuk
Dr. Asef Karim
Dr. Darrel Kemp
Dr. Jules Lemay III
Dr. Sandra Maduke
Dr. Grant MacColl
Dr. Melanie Ma son
Dr. Todd Moore
Dr. Michael O'Toole
Dr. Benjamin Pliska
Dr. Akbar Rawji
Dr. Stephen Roth
Dr. Jean-Marc Retrouvey
Dr. Khushee Sharma
Dr. Daniel Tanguay
Dr. Liat Tzur-Gadassi
Dr. Bill Wilson
Dr. Camilo Yamin-Lacouture

CHIEF EXAMINER'S REPORT
PEDIATRIC DENTISTRY

Examination Development in 2018

- A Component I Examination development workshop was held at the June 2018 examination session in Toronto. A mini Component II workshop was also held. A formal Component II workshop will be held on October 26-28 in Toronto at Head Office.
- Current approval process for Component I Examination development:
  - Section Heads assign topics to Examiners for content submission.
  - Written questions are submitted by Examiners.
  - At the Component I workshop, every question is reviewed by a team of Examiners and edited.
  - The Component I Examination is built by the Section Heads with further edits as necessary.
  - The complete Component I Examination is reviewed by the Chief Examiner.
- Current approval process for Component II Examination development:
  - Oral examination cases are submitted by Examiners.
  - At the Component II workshop, case are edited by a team of Examiners and the examination is built.
  - The completed Component II Examination is reviewed by a team of Examiners.
  - It is then reviewed by Component II Section Heads, and finally by the Chief Examiner.
  - The examination is reviewed by the examination team the day before the examination is given to the candidates.

Examination Blueprint Review and Development

- A blueprint survey was developed in 2017 and was recently launched to Canadian Program Directors and members of our examination team. The survey wil next be sent to RCDC Pediatric Dentistry Fellows.
- After the survey results are tabulated, Senior Examiners will consult with Dr. Hess to discuss changes to the Component I and II blueprints.

Examiner Recruitment and Training in 2018

- Six new Examiners joined our examination team in 2018: Drs. Mark Casafrancisco (BC), Rebecca Cohen (ON), Trang Nguyen (NL), Jill Oxner (ON), Aisha Romain (ON), Tim Seto (AB).
- All received Component II training at the June 2018 examination session in Toronto.

Respectfully submitted,

R. Gordon Payne
Chief Examiner, Pediatric Dentistry

COMPONENT I STATISTICS

5 year Rolling Pass Rate (2014-2018)

	CANADIAN First-time Takers	AMERICAN First-time Takers
TOTAL NUMBER OF CANDIDATES	55	78
NUMBER OF SUCCESSFUL CANDIDATES	54	73
NUMBER OF SUCCESSFUL CANDIDATES	98.2%	93.6%

COMPONENT II STATISTICS

TOTAL NUMBER OF CANDIDATES	54	72
NUMBER OF SUCCESSFUL CANDIDATES	53	60
NUMBER OF SUCCESSFUL CANDIDATES	98.1%	83.3%

THE TEAM

CHIEF EXAMINER
Dr. Gordon Payne

SENIOR EXAMINERS
Dr. Christine Corbeil
Dr. Felicity Hardwick
Dr. Lorne Koroluk
Dr. Je rey Richmond

COMPONENT I SECTION LEADERS
Dr. Karen Campbell
Dr. Elsa Hui-Derksen

COMPONENT II SECTION LEADERS
Dr. Jay Biber
Dr. Heather Dyment

FRENCH CONTENT REVIEWERS
Dr. Marie-Eve Asselin
Dr. Marie-Claude Chole e
Dr. Basma Dabbagh
Dr. Stéphanie Lauziere
Dr. Duy-Dat Vu

EXAMINERS
Dr. Robert L. Barsky
Dr. Marc Casafrancisco
Dr. Daniel Charland
Dr. Isabelle Chase
Dr. Sonia Chung
Dr. Rebecca Cohen
Dr. Tracy Doyle
Dr. Michal Goralski
Dr. Leslie May Lawrence
Dr. Warren Loeppky
Dr. Trang Nguyen
Dr. Sean Ostro
Dr. Jill Oxner
Dr. Gerry Pochynok
Dr. Rocio B. Quinonez
Dr. Aisha Romain
Dr. Elizabeth Ross
Dr. Timothy Seto
Dr. Michelle Thal
Dr. Christopher Yue

CHIEF EXAMINER'S REPORT
PERIODONTICS

Examination 2018 - General Updates

Our Periodontics examination team is comprised of over 50 Examiners from clinical and academic settings across Canada and the United States, and this year we have welcomed two new Examiners, Dr. Sari Hershenfield as a Periodontics Examiner and Dr. Patricia Brooks as an Oral Pathology Examiner. I take this opportunity to extend my gratitude to our team of dedicated and talented Examiners that makes an invaluable and indispensable contribution to the quality of our examinations and our Specialty.

Following the 2018 Component I (written) Examinations, Dr. Brian Hess, our Psychometrician, continued to provide us with robust psychometric analysis which proved extremely valuable in ensuring the validity and reliability of the examinations. Our team has continued to work hard towards having the Component I Examinations ready a year ahead of schedule and the 2019 examinations are now in their final stage of review. Component I consists of two papers covering the following topics: Oral Medicine and Oral Pathology, Anatomy/Embryology/Radiology, Immunology and Microbiology, Etiology/Physiology/Periopathology, Treatment of Periodontal Disease, Implantology, Medically Compromised Patients and Medical Emergencies, Anxiety and Pain Management Pharmacology.

After the 2018 Component II (oral) Examinations, Dr. Hess was also instrumental in reviewing our process and facilitating our key validation. Component II consists of three oral examinations: Oral A and Oral B (Clinical Applications in Periodontics) and Oral C (Oral Pathology). The blueprint for the examinations includes twenty three domains that are being modified over the years to ensure continuous quality improvement of our examinations. A group of Examiners met in December 2017 to develop new content for future examinations and to review the 2019 oral examinations and ensure that all aspects of the blueprint were covered. Dr. Usman and Dr. Andreou are the leads for the development of Oral A and B respectively and once again they have done exemplary work. My gratitude also goes to the Oral Pathology team members, led by Dr. Kristina Perschbacher, for their ongoing contribution to the quality of our examinations.

Throughout the years, Ms. Amandine Perdebat has provided exceptional support to our team of Examiners. Ms. Perdebat and her team have been tremendous enablers to the preparation and delivery of high-quality examinations.

Respectfully submitted,

Jean-Pierre Picard
Chief Examiner, Periodontics

COMPONENT I STATISTICS

5 year Rolling Pass Rate (2014-2018)

	CANADIAN First-time Takers	AMERICAN First-time Takers
TOTAL NUMBER OF CANDIDATES	60	58
NUMBER OF SUCCESSFUL CANDIDATES	56	44
NUMBER OF SUCCESSFUL CANDIDATES	93.3%	75.9%

COMPONENT II STATISTICS

TOTAL NUMBER OF CANDIDATES	56	44
NUMBER OF SUCCESSFUL CANDIDATES	53	30
NUMBER OF SUCCESSFUL CANDIDATES	94.6%	68.2%

THE TEAM

CHIEF EXAMINER
Dr. Jean-Pierre Picard

COMPONENT I SECTION LEADERS
Dr. Gregory Austin
Dr. Edmund Ghiabi
Dr. Kevin Guze
Dr. E.M. Hershen eld
Dr. Heinrich Tillmanns
Dr. René Voyer
Dr. Chris Wojcicki

COMPONENT II SECTION LEADERS
Dr. Vana Andreou
Dr. Omar Usman

ORAL PATHOLOGY SECTION LEADER
Dr. Kristina Perschbacher

FRENCH CONTENT REVIEWER
Dr. René Voyer

EXAMINERS
Dr. Charles Alleyn
Dr. Saljae Aurora
Dr. Rémi Arseneau
Dr. Mathieu Beaudoin
Dr. Vinay Bhide
Dr. Riva Black
Dr. Patricia Brooks
Dr. Karen L. Burgess
Dr. Laura Chano
Dr. Deepika Chug
Dr. David Clark
Dr. Ellen Lee Colfer
Dr. Robert Durand
Dr. Sayegh El Tarek
Dr. Ali Fakhry
Dr. Karen Fung
Dr. Simon Gauthier
Dr. Georgios Giannelis
Dr. Sari Hershen eld
Dr. Andrea Hsu
Dr. Paul Jackson
Dr. Fayaaz Ja er
Dr. Adel Kauzman
Dr. Ja er Kermalli
Dr. Hugh Kim
Dr. Vivien Kwok
Dr. Eric Lacoste
Dr. Maud Lassonde
Dr. Kevin MacDonald
Dr. Nadia Marchese
Dr. Carolyn A. Mason
Dr. David Mock
Dr. Samson Ng
Dr. Isabelle Quenneville
Dr. Yanik Roussy
Dr. André Rousseau
Dr. Bram Salis
Dr. Alexandre Taché
Dr. Guillaume Tremblay
Dr. Priscilla Walsh
Dr. Sco Yamaoka
Dr. Ron Zohar

CHIEF EXAMINER'S REPORT
PROSTHODONTICS

Examination Development in 2018
Over the past year, two examination development workshops were held. The first workshop was held at the RCDC office in November 2018 and the second in June 2018 in advance of the oral examination. This has been a constant feature within the prosthodontic team. Examiners are asked to submit questions for content creation and during the workshops, up to 12 Examiners gather together and review both oral and written questions. These new questions are reviewed in advance of the workshop by team leaders to ensure clarity, consistency, and blueprint adherence. At the workshops, Examiners are then asked to review questions of others and adjust those questions to make them ready for examination. We also take this opportunity to invite new Examiners to participate in content creation and involve them in the examination process. Once the general content has been created key Examiners (Dr. Linke and Dr. Habsha) are responsible to assemble the examinations and then review these examinations with the Chief Examiner. We aim to work 12 months in advance, so the examination is set well in advance of any deadlines. Our goal is to continuously set a new examination which is in line with prosthodontic teaching and current practice trends. The examination follows our published blueprint which is continuously updated and is published on the NDSE website for candidate reference.

Examiner Recruitment, Training and Retention in 2018
This past year two new Examiners were recruited, and they participated in both CI and CII sections of the examination. They are invited to submit questions for both written and oral sections and are paired up with seasoned Examiners during the oral Examination. In advance of the oral exam, new Examiners are given "New Examiner Training" by staff of the College and this training and development continues as more examinations are encountered.

Our examination team for both CI and CII is made up of specialists from both academia and from private practice. They cover the full spectrum of prosthodontic practice and are evenly distributed across the country. We continue to look for additional Examiners and have several applications on file for new positions. Examiners are rotated through the examination cycles to allow others to participate. This past CII examination showed a need for many Examiners as the specialty examined the second highest number of candidates compared to other groups.

The Chief Examiner has two years left in his second term, so succession planning has been initiated. Two names will be submitted for consideration and then one will be chosen who will shadow the Chief Examiner for the last year of his term. This shadowing will ensure that there is an uneventful handoff of responsibilities so that future examinations are produced and delivered without fail and on time.

Respectfully submitted,

Izchak Barzilay
Chief Examiner, Prosthodontics

COMPONENT I STATISTICS

5 year Rolling Pass Rate (2014-2018)

	CANADIAN First-time Takers	**AMERICAN** First-time Takers
TOTAL NUMBER OF CANDIDATES	30	77
NUMBER OF SUCCESSFUL CANDIDATES	25	65
NUMBER OF SUCCESSFUL CANDIDATES	83.3%	84.4%

COMPONENT II STATISTICS

TOTAL NUMBER OF CANDIDATES	25	63
NUMBER OF SUCCESSFUL CANDIDATES	21	46
NUMBER OF SUCCESSFUL CANDIDATES	84%	73%

THE TEAM

CHIEF EXAMINER
Dr. Izchak Barzilay

COMPONENT I SECTION LEADER
Dr. Bernard Linke

COMPONENT II SECTION LEADER
Dr. E rat Habsha

EXAMINERS
Dr. Francine Albert
Dr. Sara Abdulaziz Al-Fadda
Dr. Nariman Amiri
Dr. Bobby Baig
Dr. Robert Carmichael
Dr. Duncan Chambers
Dr. Ansgar Chi-Chung Cheng
Dr. David Chvartszaid
Dr. Ming-Yi Chou
Dr. Tonino Ciocca
Dr. Louis De Koninck
Dr. Ngoc Tuan Dinh
Dr. Nancy Dubois
Dr. Patrice Fan
Dr. Kevin Goheen
Dr. David Lalande
Dr. Terry Lim
Dr. Kieth Manning
Dr. Peter T. McDermo
Dr. Pierre-Luc Michaud
Dr. Anh Bang-Tuyen Nguyen
Dr. Caroline Nguyen
Dr. Igor Pesun
Dr. Oliver Pin Harry
Dr. Kirk Preston
Dr. Mohammad Taheri
Dr. Ian Thornton
Dr. Berge Wazirian
Dr. Brent Winne
Dr. Christopher Wya
Dr. John Zarb

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June 12, 2018

Dear Members,

As directed by consensus from our last AGM in London, I have spared no effort to move our strategic plan forward with respect to the establishment of a permanent regulatory section within FDI.

Much of this work, as you might expect, was and continues to be networking behind the scenes and we have every expectation of a positive vote in favor at the FDI AGM in Buenos Aires in late August.

The focus of FDI from an organizational perspective would be our first joint session in San Francisco in 2019.

In the interim, the Executive Committee has had some vigourous discussions regarding two major internal issues, both of which I feel require some polling before taking a formal decision at our conference call on July 5, 2018.

The first issue involves dues.

I proposed that we waive the dues for 2018 given that we have no official conference planned and do not want to lose any members so as to diminish our position with FDI after a successful London conference and possibly affect the vote.

We have enough funds at this point in time to cover any required expenditures surplus and can certainly review what funding would be required to move forward with a conference in 2019, along with any other operational costs.

It is our hope that we would begin to gain some membership traction for the FDI Section meeting.

CONTACT: 6 Crescent Road, Toronto, ON M4W 1T1 ■ IRWIN FEFERGRAD ■ DIRECT LINE: 416-934-5625

Some members of the Executive Committee favored billing dues this year to maintain the ‘value of ISDR’, combined with perhaps offering free memberships as an enticement to those ‘have not countries’ to join.

The second issue is governance as we are required to hold some type of meeting this year even if we are in a period of new direction and transition.

There are 2 choices before the Executive Committee.

1. Meet at the FDI in Argentina and try to hold a meeting or teleconference without the benefit of organizational facilities;
   or
2. Clone a meeting with the Canadian CEOs and Registrars conference in Montreal in December, which would maximize the presence of the founding members and use GoToMy pc, Zoom, or Skype for those who could not attend by using the ODQ technical facilities.

Given that our inertia is to produce a new format in 2019, my sense is to minimize the logistics until that meeting.

Normally the Executive Committee would make these decisions.

I feel that the financial implications ultimately falls upon the dentist members and others who still have clinical obligations so I thought it would be most transparent to poll each of your organizations so as to direct the Executive Committee.

1) Are you in favour of a dues assessment for 2018?
2) Are you in favour of deferring the dues assessment until 2019?
3) Are you in favour of holding the AGM in Buenos Aires?
4) Are you in favour of an AGM in Montreal?
5) Would you be in favor a derogating the regulations and not hold an AGM in 2018?

I look forward to your response.

Yours truly,

Dr. Barry Dolman
President

AMS:806877

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PROFESSOR KACK-KYUN KIM (Republic of Korea), *Member-at-Large*
DR. AMARJIT RIHAL (Canada), *Member-at-Large*

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IRWIN FEFERGRAD (Canada)

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August 10, 2018

Dear Members of ISDR,

Following an earlier poll of the membership to garner an interim consensus position on a number of issues, your executive voted in favor of the following positions:

1) Invoices for 2018 would be sent out and you should have already received the statements by e-mail.

   I encourage your organizations to forward payments which are currently due.

2) In order to comply with the delays and to minimize the overall costs for most members attending, it was confirmed that the **ISDR AGM for voting members will be held on the morning of Saturday, December 8, 2018 in Montreal at the L'Ordre des dentists du Québec (ODQ) headquarters: 800 René Lévesque Blvd. West, #1640.**

3) It was also approved that, given the unusual absence of a formal conference, **any voting member could attend and vote by visual electronic presence**, details of which will be forwarded once you confirm that option and the contact information of the voting member.

By the date of the ISDR AGM we should have the final decision of the FDI AGM from Argentina with respect to our proposed creation of a specific independent regulatory Section of FDI which of, course, will require formal approval at this AGM.

If we are successful in this endeavor, all future AGMs and our annual ISDR regulatory conferences will follow the international schedule and venue of the FDI, our first major event being held in 2019 in San Francisco followed by China (2020) and Australia (2021).

CONTACT: 6 Crescent Road, Toronto, ON M4W 1T1 ■ IRWIN FEFERGRAD ■ DIRECT LINE: 416-934-5625

More information will follow after the FDI meetings in Buenos Aires.

Best wishes to all.

Yours truly,

Dr. Barry Dolman
President

AMS:821273

From: CCSA / CCDUS
To: Sherban, Angie
Subject: New Report on Treating Opioid Use Disorder / Nouveau rapport sur le traitement du trouble lié à l'usage d'opioïdes
Date: September 5, 2018 11:03:15 AM

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

New Report: Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder

The Canadian Centre on Substance Use and Addictions (CCSA) is pleased to announce the release of *Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder*. This report officially launched at the Opioid Symposium in Toronto (Sept. 5-6, 2018).

Developed to inform Health Canada's Federal, Provincial and Territorial Treatment Task Group, the report outlines the services that should be available to individuals seeking help for opioid use disorder, as well as considerations for how to deliver these services in a person-centred manner.

The report includes a summary of some of the actions taking place in Canada at multiple levels of government to respond to the opioid crisis and to stop deaths due to overdose.

People living with an opioid use disorder in Canada should have access to comprehensive treatment options that meet all their needs. This report provides a benchmark to ensure that services across Canada meet these needs. It is available for download on the CCSA website.

If you have any questions about the report, please contact Sheena Taha (staha@ccsa.ca).

Publication du rapport Pratiques exemplaires dans le continuum des soins pour le traitement du trouble lié à l'usage d'opioïdes

Le Centre canadien sur les dépendances et l'usage de substances (CCDUS) est fier d'annoncer la publication du rapport *Pratiques exemplaires dans le continuum des soins pour le traitement du trouble lié à l'usage d'opioïdes*, dont le lancement officiel se fera en marge du Symposium sur les opioïdes, à Toronto (5 et 6 sept., 2018).

Préparé à l'intention du Groupe de travail fédéral, provincial et territorial sur le traitement de Santé Canada, le rapport décrit les services à offrir aux personnes qui veulent faire traiter un trouble lié à l'usage d'opioïdes. Il présente aussi des facteurs à prendre en compte pour une prestation de services centrée sur la personne.

Le rapport résume certaines des mesures prises au Canada, par plusieurs ordres de gouvernement,

pour remédier à la crise des opioïdes et prévenir les décès par surdose.

Les personnes ayant un trouble lié à l'usage d'opioïdes au Canada devraient avoir accès à des options de traitement globales qui répondent à tous leurs besoins. Ce rapport fournit un point de repère pour s'assurer que les services offerts au pays répondent à ces besoins. Vous pouvez le télécharger sur le site Internet du CCDUS.

Si vous avez des questions sur le rapport, écrivez à Sheena Taha à staha@ccsa.ca.

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CCSA was created by Parliament to provide national leadership to address substance use in Canada. A trusted counsel, we provide national guidance to decision makers by harnessing the power of research, curating knowledge and bringing together diverse perspectives.

Le CCDUS a été créé par le Parlement afin de fournir un leadership national pour aborder la consommation de substances au Canada. À titre d'organisme digne de confiance, il offre des conseils aux décideurs partout au pays en profitant du pouvoir des recherches, en cultivant les connaissances et en rassemblant divers points de vue.

Canadian Centre on Substance Use and Addiction | Centre canadien sur les dépendances et l'usage de substances
500–75 rue Albert Street, Ottawa ON K1P 5E7
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Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder

August 2018

Sheena Taha, PhD
Knowledge Broker

Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder

This document was published by the Canadian Centre on Substance Use and Addiction (CCSA).

Suggested citation: Taha, S. (2018). *Best Practices across the Continuum of Care for Treatment of Opioid Use Disorder*. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.

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Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Ce document est également disponible en français sous le titre :

Pratiques exemplaires dans le continuum des soins pour le traitement du trouble lié à l'usage d'opioïdes

ISBN 978-1-77178-507-5

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Executive Summary

People living with an opioid use disorder in Canada should have access to comprehensive treatment options that meet all their needs. *Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder* presents services that should be available to individuals experiencing or at risk of experiencing harms from opioid use.

This report, developed to inform Health Canada's Federal, Provincial and Territorial Treatment Task Group, outlines the standard of service that should implemented to provide person-centred care to all people experiencing harms from opioids. The report includes a summary of actions taking place across Canada at multiple levels of government to help people experiencing harms from opioids and to stop the deaths occurring from opioid poisonings.

The Continuum of Care

Every person's pathway through the continuum of care may look different. The components can overlap and are most effective when used together. Some people may use all services in the continuum of care whereas others might not. There are also people who might revisit different components as needed. Detailed descriptions of each element are in the full report.

Continuum of Care								
Harm Reduction								
Screening	Assess-ment	Brief Interven-tions	Rapid Access Clinics	Community Outreach	Withdrawal Manage-ment	Pharmaco-logical Interven-tions	Psychosocial Interven-tions	Recovery, Sustaining Wellness & Ongoing Care

Key Findings

Throughout the treatment process, there are fundamental principles and best practices to take into consideration. The first principle is that the person living with an opioid use disorder should determine the goals of their treatment with support from an experienced care provider. Other principles include:

- Customize a treatment plan to meet the individual's' needs and goals.
- Continually assess the person's well being for any issues that could prevent successful outcomes, including physical and mental health, stress, housing concerns, financial barriers and so on.
- Provide services that are culturally competent and safe.
- Provide services that are trauma and gender informed.
- All efforts should be made to reduce stigma, which is a major barrier to seeking treatment and maintaining recovery.
- Peer-engaged and led services establish trust and help people sustain positive changes in their substance use.
- Make recovery the focus of policies and practices, which can enhance outcomes for people seeking treatment.

Introduction

Evidence-informed comprehensive treatment is known to improve the lives of those living with an opioid use disorder. This inventory was developed in response to a commitment to the Health Canada's Treatment Task Group to "develop a document that defines the continuum of outreach, interventions and treatment supports for opioid use disorder, including rapid access to addictions medicine and mild to moderate social supports (i.e., brief intervention and counselling), [and] make recommendations on best practices and drive policy development to improve quality care across the country."

Identification of best practices[i] across the continuum of care can provide a benchmark to ensure effective services are available in Canada to prevent and minimize the experience of harms.[ii] Responding to these harms requires a combination of both available services and quality implementation. This inventory includes best practices for certain services, but also overarching principles that should guide the way in which these services are delivered (i.e., in a patient-centred manner).

The continuum of care outlined below was developed to inform Health Canada's Treatment Task Group of the services to be considered for availability in all jurisdictions. It should be recognized that the settings and providers for the services outlined in the continuum might differ across and within jurisdictions. For example, a range of practitioners from nurses to pharmacists to community outreach and peer support workers can implement harm reduction services, whereas pharmacological interventions might require a specialized addiction physician. Additionally, pharmacological interventions might take place in a primary care provider's office or in a specialized opioid agonist treatment clinic. System planning is required to ensure that quality services are available and competent providers are engaged to meet the needs and intensity levels of those seeking help.

While reviewing the findings, the reader should consider that the evidence base related to substance use treatment is an evolving area of inquiry. Many components of practice are guided by expert opinion and even best practices are established based on varying strengths of evidence.

Method

Best practices for care and treatment of opioid use disorder among the general population were identified from peer-reviewed and grey literature. Peer-reviewed articles were found through searches using PubMed, PsycNet, Health Evidence and the Cochrane Library. Grey literature was retrieved by searching the Centre for Addiction and Mental Health's Google Custom page as well as individual websites such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Best Practices Portal, HealthEvidence.org, Public Health England and Portico. A search using Google was also performed to ensure that valid resources were not omitted. A limitation of this methodology is that 1) the quality assessment of the peer-reviewed literature was not within scope for this project and 2) that grey literature is not necessarily peer reviewed and can have varying levels of quality. Retrieving resources from only reputable, well-established organizations minimized this risk.

i Best practices are defined as initiatives, projects, policies, programs or procedures that are recognized or accepted, and have proven effective in achieving the desired outcomes or results.

ii Throughout this documents the term "harm" can refer to a variety of outcomes, including injury, contraction of illnesses such as hepatitis C or HIV, functional impairments, polysubstance use, dependency, overdose, poisoning, or risk of overdose with relapse following a period of abstinence.

To focus on best practices, as opposed to emerging ideas, only review papers, systematic reviews, meta-analysis and grey literature produced between 2007 and 2018 were included. Primary research and preclinical studies were excluded. The release by the Canadian Research Initiative in Substance Misuse of guidelines coincided with the development of this inventory. To avoid duplication of efforts, in-depth reviews of pharmacological or psychosocial interventions were not conducted. A detailed search strategy is available upon request.

Best practices that speak to specific populations (i.e., youth, women who are pregnant, First Nations, individuals living with chronic pain and individuals convicted of an offense) are highlighted in Appendix A, where studies with these populations appeared in general searches. Studies examining individuals living with cancer pain were excluded. While it is critical to tailor treatment to the needs of specific groups, a comprehensive search for each population was out of scope for this project. Additionally, interventions for individuals who use drugs occasionally requires a separate, in-depth review as the strategies that are effective for this population could differ from those that are best practices to treat individuals living with an opioid use disorder.

Best practices were synthesized in the inventory to highlight critical services across the continuum of care. External partners with expertise in addiction medicine, harm reduction, substance use, psychology and psychiatry reviewed and provided input to the inventory. (See Appendix B for details.)

The Continuum of Care for the Treatment of Opioid Use Disorder

The continuum of care represents a range of services that should be available to individuals experiencing or at risk for experiencing harms from opioid use. Although presented as discrete categories, many of the continuum components overlap in practice (e.g., screening and assessment) and are most effective when used together. Pathways through the continuum are not necessarily meant to be linear. Some individuals might use all components of the continuum whereas others might not, and some might revisit different components as needed.[1,2,3,4,5]

Continuum of Care								
Harm Reduction								
Screening	Assess-ment	Brief Interven-tions	*Rapid Access Clinics	*Community Outreach	Withdrawal Manage-ment	Pharmaco-logical Interven-tions	Psychosocial Interven-tions	Recovery, Sustaining Wellness & Ongoing Care

*Although there is insufficient evidence (i.e., no review papers) to categorize rapid access clinics or community outreach as best practices in the continuum of care, details about these components were included as a) these resources have shown promise in Ontario,[6] and b) to address the request from Health Canada to identify services that might be of value to individuals who use drugs occasionally or are not identified in health surveillance activities.

Best Practices for the Continuum of Care

This inventory outlines best practices for each component of the continuum; however, there are overarching principles to be considered in implementing any of the services in the continuum.

1. The individual experiencing harm from opioid use should determine the ultimate goal of treatment (i.e., safer use, abstinence, opioid maintenance, obtaining certain functional outcomes, etc.) with input from a care provider who is experienced in substance use management.[1]
2. The treatment plan and services used can be determined together with the individual, and customized to meet their needs and goals.[1,2,7,8,9,10,11] Stepped care, wherein the least intensive services are offered first, should be used.[5,12,13]
3. The continuum of care should assess and address in a coordinated manner all components of a person's wellbeing that might prevent successful outcomes, including physical and mental health, personal vulnerabilities, stressors, housing, recovery capital[iii] and so on.[1,2,3,4,7,9,11,12,13,14,15,16,17,18,19,20,21,22,23] Family of choice can also be included in treatment activities where desired by the individual seeking treatment.[2,9]
4. Services should be culturally competent and safe, and trauma and gender informed.[1,10,12,20,21]
5. Stigma is a major barrier to seeking treatment and maintaining recovery. All efforts to reduce stigma should be undertaken.[2,20]
6. Peer-engaged and peer-led services help establish trust[20,24] and help individuals sustain positive changes in substance use.[2]
7. A recovery-oriented system of care, wherein policies and practices that reflect recovery principles are integrated into treatment, can enhance outcomes for individuals seeking treatment.[2]

Harm Reduction

Efforts to minimize the negative outcomes experienced while an individual is using opioids and to prevent accidental death or poisoning should be integrated along the continuum of care.[5,12]

- Education and training on recognizing and responding to overdose, along with take-home naloxone, decreases mortality related to opioid overdose.[10,25,26,27,28,29] Take-home naloxone should be widely available,[7,8,16,19] particularly to individuals being treated for an opioid use disorder, as well as to those who frequently spend time with them as they may be present if an individual overdoses.[5,7,12,30]
- Supervised consumption services help prevent multiple harms, including overdose,[20,31,32] and provide an opportunity to connect with health and other support services, including primary care[32] and treatment.[31,33]
- Needle distribution and exchange programs are related to decreased incidences of HIV;[34,35,36] results related to incidences of hepatitis C have been mixed as sharing of other drug use

[iii] Recovery capital refers to the resources an individual can rely on to support them through their journey along the continuum. It may include personal, interpersonal and community resources.[2]

equipment such as swabs, cookers, water and filters, is also a factor of particular importance in the transmission of HCV.[34,37]

Resources

A Public Health Guide to Developing a Community Overdose Response Plan[20]

Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and Are At Risk for HIV, HCV, and Other Harms: Part 1[38]

Community Management of Opioid Overdose[26]

Supervised Consumption Services: Operational Guidance[31]

Screening

Identifying if an individual is currently at risk for experiencing harms from opioid use allows for the identification of those who may benefit from additional services and supports.[4]

- General dialogue for initial screening should be used with all individuals,[4] not just those at risk;[1,10] positive screens should be followed with an assessment.[4]
- Screening should address polysubstance use, and mental and physical health concerns.[7,9]
- Multiple screening tools are available, as listed below, but are general to all substances and do not provide comprehensive assessment (i.e., do not address mental health, physical concerns, etc.). There is no consensus on best practice.[39,40]
  - *Alcohol, Smoking and Substance Involvement Screening Test* (ASSIST): eight-item measure that can be used in primary care settings to identify risk related to the use of 10 different substances across all levels of severity[41]
  - *CAGE-Adapted to Include Drugs* (CAGE-AID): four-item measure to predict substance use disorders in primary care context[42]
  - *Drug Abuse Screening Test* (DAST): 10-, 20- and 28-item versions assess problematic drug use among multiple populations[43]
  - *Global Appraisal of Individual Needs—Short Screener* (GAIN-SS): 20-item measure that examines internalizing and externalizing disorders, substance abuse and criminal behaviour[44]
  - *Kreek-McHugh-Schluger-Kellogg Scale*: 28-item measure that considers the frequency, amount and duration of use of opiates, cocaine, alcohol and tobacco[45]
  - *Two-Item Conjoint Screen*: two-item measure that can be used in primary care to evaluate using substances more than intended to and feeling the need to cut down on substance use in the past year[46]

Assessment

Assessment allows for the identification of an opioid use disorder and co-occurring conditions, determines the severity and indicates the intensity of treatment to be considered.[4]

- The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) is the most recognized criteria to establish a diagnosis of opioid use disorder.[47]

- Assessment should include:
  - concurrent disorders and physical health concerns,[1,3,7,9] and
  - an examination of recovery capital, which are the resources an individual has to support them through their journey. Treatment should then be designed to build and strengthen recovery capital.[2]
- Assessment should also include collaborative care planning with the individual seeking treatment[4] repeated throughout treatment to ensure services are meeting individuals changing needs.[3,9]
- There are multiple assessment tools, including the *Addiction Severity Index* (ASI), a structured interview that assesses an individual's functioning or the severity of problems an individual with an opioid use disorder is experiencing in the medical, employment, legal, social, psychological and substance use components of their lives.[48]

Brief Interventions

Brief interventions provide non-judgmental information regarding the harms of substance use, and explore motivation to change opioid use.[49,50] The Screening, Brief Intervention and Referral to Treatment (SBIRT) framework allows for the identification of individuals who may be experiencing harms from substance use. Those who are not experiencing harms receive education and reinforcement for their behaviours. Those who are at moderate to high risk of harms receive a brief intervention, and those with severe risk or who are currently experiencing harms are referred to treatment.[50]

- Using motivational interviewing can encourage change towards healthier behaviours[1] and reduce substance use.[10]
- SBIRT typically involves two sessions that are 10–45 minutes in duration[49]

Rapid Access Addiction Medicine and Clinics

Rapid access clinics allow individuals experiencing harms from opioids to receive treatment from an addiction specialist (typically within a few days of referral) until they are stabilized. Individuals then receive ongoing treatment from community services and/or a primary care provider who may receive support, resources and training about addiction management from the addiction clinic staff.[6]

- Rapid access to addiction medicine services have resulted in reduced emergency department visits, reduced wait times and lessened stigma,[6] as well as greater retention in treatment.[51] However, there is insufficient data to determine if this is a best practice to be included in the continuum of care.

Community Outreach

These supports can take different forms, but are typically services provided in the community to individuals who use drugs. Activities can include education, harm reduction resources and referrals to services.[24]

- Examination of assertive community treatment[iv] revealed improvements in mental health, quality of life, housing stability[52] and treatment enrollment, but there is a need for further evaluation to determine long-term outcomes.[10]
- Best practices for substance use outreach programs: gain the trust of individuals who use drugs, go to where these individuals are, conduct outreach in evening and early morning (when risk is greatest), provide multiple means for behaviour change (e.g., information, equipment, referrals, etc.), provide training and supervision for employees, and supports to address burnout, relapse and other health issues.[24]

Withdrawal Management

Withdrawal management without subsequent treatment is strongly advised against and can put an individual at risk of serious harms, including death, if substance use resumes.[3,5,7,10,12,22,23] However, pharmacological and psychological supports can help an individual cope with the symptoms experienced when they stop using opioids.[4]

- If used, an agonist taper should occur slowly over a time period greater than one month.[5]
- Methadone,[16,23] buprenorphine,[5,16,23] and clonidine[7,12,23] are recommended to reduce physical symptoms of withdrawal.
- Clinical opiate withdrawal scale (COWS) is used to measure and monitor symptoms.[7,53]
- Contingency management and cognitive behavioural therapy were related to greater abstinence rates than control conditions over the short term.[54]

Resources

A Guideline for the Clinical Management of Opioid Use Disorder[12]

CRISM National Guideline for the Clinical Management of Opioid Use Disorder[5]

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence[23]

Medications for Opioid Use Disorder (Treatment Improvement Protocol 63)[4]

National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use[7]

The World Federation of Societies of Biological Psychiatry Guidelines for the Biological Treatment of Substance Use and Related Disorders. Part 2: Opioid Dependence[22]

Pharmacological Interventions

Medications, particularly opioid agonists, are effective in helping an individual achieve their desired recovery outcome.[4,5,12,23]

- Internationally, buprenorphine or methadone are the recommended opioid agonist treatments.[23]

[iv] Assertive community treatment is define as 'a service delivery framework characterized by service provision in the community, assertive engagement, high intensity of services, small caseloads, 24 h responsibility, team approach, multidisciplinary team, close work with support system, and staffing continuity'.[53]

- Within Canada, the Canadian Research Initiative in Substance Misuse developed *National Guidelines for the Clinical Management of Opioid Use Disorder*, which recommend:
  - Buprenorphine/naloxone (bup/nal)[v] is the recommended first-line medication for most individuals in Canada.[5,12]
  - Methadone can be used as a second-line treatment if bup/nal is not appropriate, or if treatment has limitations or is ineffective.[5,12]
  - Agonist treatment with slow-release oral morphine[vi] prescribed by an experienced addiction physician should be used if first- and second-line treatments are not successful or if there are contraindications.[5,12]
- For individuals who do not respond well to other pharmacological treatment, diacetylmorphine-assisted treatment (with or without flexible methadone doses) resulted in greater treatment retention and reductions in illicit drug use compared to methadone treatment or baseline substance use.[16,17,55,56,57,58,59,60] There is a risk of serious events, however, so this treatment should only be considered for individuals for whom other treatment options have not been successful, and with careful medical supervision.[55,59]
- Naltrexone (antagonist) should be considered for those wanting to abstain from opioids.[9,23]
- Injected or implanted extended release formulations (naltrexone and buprenorphine) can provide improvements to treatment adherence and continuation of care.[7,9,15]
- If individuals wish to discontinue medication after prolonged period of successful response to treatment (i.e., more than one year), use a slow taper,[5] and/or possible use of oral naltrexone.[12]

Resources

A Guideline for the Clinical Management of Opioid Use Disorder[12]

CRISM National Guideline for the Clinical Management of Opioid Use Disorder[5]

Federal Guidelines for Opioid Treatment Programs[9]

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence[23]

National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use[7]

Psychosocial Interventions

Therapies that can take place in individual, family or group formats can be provided alongside pharmacological therapy to help an individual achieve their desired recovery outcome.[4,23,49]

- Psychosocial interventions provided together with pharmacological treatment are effective approaches to treating opioid use disorder,[3,7,23,47,61,62] though it is unclear if certain psychosocial therapies are more effective than others,[62,63] and if certain modalities correspond better to particular medical-treatments.[62,64,65]

v The buprenorphine/naloxone formulation is commonly referred to by its brand name: Suboxone.

vi One external reviewer strongly recommends against this approach and believes there is an insufficient evidence base to support the use of oral morphine.

- Although some studies have shown psychosocial therapies to have no additional benefit over pharmacological therapies, authors have rationalized that this occurs because the control groups are often receiving some degree of management or support, and thus the question that should be examined is if extensive therapies provide benefit over minimal supports.[63,66]
    - Reviews of cognitive behavioural therapy (CBT; helping individuals reframe their thinking and actions[10]) have revealed mixed results.[54] Some mildly support the use of cognitive behavioural therapy among those on methadone maintenance treatment;[62] others do not reveal any reductions in substance use among those in methadone maintenance therapy;[49] and still others show no effect of CBT as compared to those receiving physician management of buprenorphine treatment.[62]
    - Contingency management (CM), where goods or services are provided for negative drug tests among those on methadone or naltrexone maintenance treatment,[49] have consistently demonstrated positive outcomes, including drug-free urine tests, longer involvement in treatment and greater functional improvements, as compared to control groups or treatment as usual.[10,16,23,49,54,62,66]
    - Behavioural couples therapy and family training have been associated with opioid abstinence and/or reduced illicit drug use.[49,62]
    - Motivational interviewing and relapse prevention counselling enhance effectiveness of pharmacological treatments[9] and has been related to decreased self-reported substance use as compared to those solely receiving methadone maintenance therapy.[62]
- At a minimum, psychosocial needs assessment, supportive counselling, links to existing family supports and referrals to community services should be provided to individuals seeking treatment.[7]
- Concurrent disorders (where an individual experiences both substance use and mental health disorders) are very common and evidence-based treatment should address both concerns.[3]

Resources

Federal Guidelines for Opioid Treatment Programs[9]

Drug Misuse: Psychosocial Interventions (National Clinical Practice Guideline Number 51)[49]

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence[23]

National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use[7]

Recovery, Sustaining Wellness and Ongoing Care

Recovery can be defined differently by each individual, but generally includes changes to lifestyle and behaviours by accessing formal (e.g., treatment programs) and/or informal (e.g., meditation) supports to manage or eliminate opioid use and improve multiple aspects of quality of life.[2]

- Participation in recovery support services leads to better outcomes than standard treatment alone.[10]
- The treatment system should be recovery oriented,[2,9] which includes recognizing and supporting that each individual's recovery journey might look different and is a personal venture.[2]

- Connections to support services following acute treatment increases recovery capital.[2,9] Assess recovery capital and aid individuals in strengthening it.[2]

Resources

Federal Guidelines for Opioid Treatment Programs[9]

Moving Toward a Recovery-Oriented System of Care: A Resource for Service Providers and Decision Makers[2]

Actions across Canada[vii]

The federal government has instituted a number of policy changes to ensure Canada is able to respond to the needs of those experiencing harms from opioid use. These actions include changes to Bill C-37, *An Act to Amend the Controlled Drugs and Substances Act and to Make Related Amendments to Other Acts*, permitting a significant reduction in the number of criteria required to apply for an exemption under section 56 of the *Act* to establish safe consumption sites. Bill C-37 also amends the *Customs Act* to allow border security agents to inspect packages less than 30 grams. Whereas previously the focus was on larger packages, the potency of fentanyl allows small volumes in transit to be of concern. It is also illegal now to bring unregistered pill presses into Canada, which will make it more difficult for illicit substances to be processed. Finally, amendments made by Bill C-37 allow new psychoactive substances to be scheduled and controlled quickly and also enables law enforcement to dispose of drugs expediently.

In the spring of 2017, the parliament of Canada passed the Good Samaritan Drug Overdose Act. This act protects individuals experiencing an overdose or present at the scene of an overdose from some charges related to the possession of controlled substances. The act is intended to encourage people to call emergency services if an overdose is occurring without fear of legal repercussion. Another measure to address opioid overdoses is the coverage of injectable and nasal forms of naloxone as open benefits for First Nations and Inuit people under the non-insured health benefits program. Correctional Services of Canada has developed a national project to provide individuals being released from incarceration with access to a take-home naloxone kit. Across Canada, naloxone can be obtained at pharmacies without a prescription (without a fee in some areas) for anyone concerned about the risk of overdose for themselves or others.

The Honourable Ginette Petitpas Taylor, Minister of Health, has announced additional actions to support an evidence-based response to the opioid crisis. These actions include streamlining the processes to set up temporary overdose prevention sites, allowing drug checking to occur at supervised consumption sites and researching drug checking further in pilot projects. Projects are also examining alternatives to pharmaceutical opioids, such as hydromorphone, to be provided as an uncontaminated source to individuals using illicit opioids.

Significant funding investments have been made in the 2018 budget to address border security, law enforcement and stigma, and to support advancements in the evidence base related to the opioid crisis, as well as the evaluation of actions taken in response to the crisis.

The Government of Canada has also amended regulations focusing on treatment for opioid use disorder which allow healthcare practitioners to prescribe methadone without a section 56 exemption and to increase access to diacetylmorphine (prescription-grade heroin) for prescription to individuals dependent on opioids. While the federal government is able to make policy changes to regulations and has provided $150 million to the provinces and territories to enhance evidence-based treatment, the individual jurisdictions are responsible for service delivery.

As the impact of opioid harms is being experienced differently across Canada,[67] responses vary in each province and territory. The jurisdictions represented on the Treatment Task Group have made efforts to prevent the loss of more lives to the opioid crisis. Many jurisdictions are increasing access to naloxone. British Columbia, Alberta and Ontario are opening more safe consumption and overdose

vii During the March 12, 2018, Treatment Task Group teleconference it was decided that a summary highlighting the actions taking place in each jurisdiction would comprise the second phase contract requirements as opposed to policy analysis.

prevention sites. British Columbia is expanding the use of fentanyl test strips to determine the contamination of substances and prevent harm to users.

Efforts have also been made to improve or expand treatment and service options. Almost all jurisdictions are working to improve physicians' knowledge of appropriate opioid prescribing, as well as their knowledge of treatments for opioid use disorder. British Columbia and Ontario have established clinics that provide rapid access to addiction treatment. Manitoba has made changes to its formulary to make access to bup/nal easier, and nurse practitioners in Ontario can now prescribe bup/nal. British Columbia and Alberta are initiating the use of hydromorphone as an agonist treatment option.

Public education campaigns are being conducted across the country to combat stigma, to increase awareness of the dangers of fentanyl and other opioids, and to educate individuals on how to avoid or respond to an overdose. Peer services and supports are being used in British Columbia and being considered for implementation in Newfoundland and Labrador. Provinces are also responding to the social determinants of health by increasing support for housing.

Together, these efforts will establish a comprehensive response that addresses the complexities and contextual differences of the opioid crisis across Canada. Additional details on the initiatives each jurisdiction represented on the Treatment Task Group is taking can be found in Appendix C.

Appendix A: Best Practices for Specific Populations

A literature review was not conducted on the populations identified below. This appendix highlights only that information encountered as part of a general search. To determine best practices for these populations, an in-depth, targeted literature search and synthesis would need to be completed.

Screening

Youth[viii]

- Multiple tools are available, but there is no consensus on best practice.
  - *Adolescent Alcohol and Drug Involvement Scale* (AADIS): interview to determine if assessment of alcohol or other drug use is needed[68]
  - *CRAFFT*: six-item measure to screen for substance use disorders and related problems[69]
  - *Drug Abuse Screen Test* (DAST)—*Adolescent*: 27-item scale that determines the presence and severity of problematic substance use among adolescents[43]
  - GAIN-SS: 20-item measure that examines internalizing and externalizing disorders, substance abuse and criminal behavior[44]
- Violence, abuse and risk of suicide should be considered.[11]

Individuals living with chronic pain

- Multiple scales exist to determine risk before initiating or during opioid therapy for chronic pain, but there is no consensus on best practice.[39,40,70,71,72,73,74]
  - *Addiction Behaviors Checklist (ABC)*: 20-item measure to track behaviours related to prescription drug addiction[75]
  - *Atluri Screening Tool*: 20-item checklist to determine which patients with chronic pain are at risk of prescription opioid misuse[76]
  - *Brief Risk Interview (BRI)*: questions about "past medication use, past discharge from treatment, concurrent mental health disorders, current and past substance abuse, family history of substance abuse and educational level" can be used by pain clinicians to determine risk of aberrant opioid use[77]
  - *Current Opioid Misuse Measure (COMM)*: 17-item self-report instrument used to measure possible opioid misuse among individuals receiving opioid treatment for chronic pain[78]
  - *Diagnosis, Intractability, Risk, Efficacy (DIRE) score*: rating scale developed for a primary care physician to predict effectiveness of pain medication and appropriate use of long-term opioid treatment[79]
  - *Opioid Risk Tool (ORT)*: self-administered instrument examining individual and family history of substance use disorders, personal history of preadolescent sexual abuse, and

viii The definition of youth varied across the studies included in this appendix. It should be noted that recommendations differ based on the chronological age and developmental stage of youth (i.e., youth, adolescents, transitional-aged youth, young adults, emerging adults, etc.).[11]

particular psychological illnesses to determine the level of risk a pain patient has for aberrant opioid use[80]

- *Prescription Drug Use Questionnaire (PDUQ)*: 42-item interview to be used by clinician to evaluate pain, opioid use, social and relationship factors, family and personal history of pain, substance use and mental health concerns. Results from the measure should be considered in conjunction with input from physicians and family members, and past medical charts.[81]
- *Prescription Opioid Misuse Index (POMI)*: six-item interview that identifies the risk misuse among of individuals using prescription opioids to treat pain[82]
- *Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)*: 24-item self-report questionnaire "to predict aberrant medication-related behaviors among chronic pain patient considered for long-term opioid therapy"[83]
- *Screening Instrument for Substance Abuse Potential (SISAP)*: five-item instrument to identify individuals at risk of opioid abuse among individuals living with chronic pain to be used in conjunction with clinical judgement[84]
- *Screening Tool for Addiction Risk (STAR)*: 14 self-administered true or false questions that identifies chronic pain patients at risk of problematic opioid use during treatment[85]

- Urine screening should be administered to individuals at high risk or who exhibit unexpected drug related behaviours.[13]

Assessment

Youth

- Assessment should be ongoing with movement across the continuum of care as needed.[21]

Individuals living with chronic pain

- Assessment should begin with a detailed history of prior pain and problematic substance use, provide weekly urine testing, and encourage reports of opioids prescribed by other practitioners.[13]
- *Pain Assessment and Documentation Tool* (PADT): assesses "analgesia, activities of daily living, adverse effects and aberrant drug related behaviours"[13]

Community Outreach

Youth

- Assertive community treatment resulted in improvements in psychiatric symptoms, general functioning and reduced duration and frequency of hospital admissions.[86]

Withdrawal Management

Women who are pregnant

- Detoxification should be avoided; methadone and buprenorphine are safe for treatment during pregnancy.[7,22]

Pharmacological Interventions

Youth

- Bup/nal should be the first-line opioid therapy for youth, and only opioid therapy for youth that live or frequently travel to communities where methadone is not available.[87,88]
- Buprenorphine, methadone and naltrexone can be considered for youth.[7]

Women who are pregnant

- Opioid agonist therapy should be initiated or maintained during pregnancy,[7,16,87] labour and post-natal care.[87]

First Nations

- Bup/nal should be the first line treatment.[87]
- Transition from methadone to bup/nal when clinically or geographically indicated.[87]

Individuals living with chronic pain

- Non-narcotic treatment should be considered first.[7] Opioid therapy can be considered if the benefits of treatment outweigh the potential risks. Treatment should be structured with check points to validate progress, and agreed upon actions in the event of non-compliance should be endorsed by the individual receiving treatment and all healthcare providers to ensure clarity of goals and the course of treatment.[13,89]
- Treatment must be comprehensive to address both opioid use disorder and chronic pain concerns.[13]

Individuals convicted of an offense

- Pharmacological treatment is recommended and should be accessible.[7,23]
- Methadone maintenance therapy initiated before, during or after release was related to greater treatment engagement after release, reduced risk of death from overdose, decreased relapse and reduced HIV drug-risk behaviours.[64]
- Monthly naltrexone injections resulted in lower rates of relapse and greater time to relapse, as compared to treatment as usual (brief counselling, referral to community treatment programs). However, results were not sustained after treatment ended.[90]

Psychosocial and Behavioural Interventions

Youth

- Behavioural therapies focusing on resistance skills, coping, problem-solving and interpersonal relationships can strengthen motivation to change and thus help adolescents remain abstinent from substance use.[11]
- Family (of choice) should be involved in treatment and receive education and counselling as needed, including with transitional-aged youth.[9,11,21]

First Nations

- Programs based in community, land and culture.[87]

Individuals living with chronic pain

- Cognitive behavioural therapy and graded exercise recommended.[13]
- Education regarding how to deal with pain syndromes without misusing opioids should be prioritized.[47]

Individuals convicted of an offense

- Access to psychosocial treatment options should be equivalent to those available in the community.[49]

Recovery, Sustaining Wellness and Ongoing Care

First Nations

- Culturally appropriate aftercare that supports individual, family and community healing from post-traumatic stress disorder and historical trauma transmission.[87]

Individuals living with chronic pain

- If relapse occurs, an examination of the factors leading up to the incident should take place, followed by a focus on developing coping strategies and supports to address these factors.[13]

Appendix B: External Reviewers

We would like to thank the following external reviewers for their contributions to this document.

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Appendix C: Jurisdictional Highlights

British Columbia

- In July 2017, the Ministry of Mental Health and Addictions was established with responsibility to lead the provincial response to the opioid emergency. An Overdose Emergency Response Centre, based on emergency management best practices, was established in December 2017 to bring together provincial, health authority, municipal, Indigenous and law enforcement resources to tackle the overdose crisis at a community level.
- The provincial response focuses on four key areas:
    1. Saving lives: Services for people who continue to use drugs that help reduce the risk of overdose, reduce the severity of overdose, or provide immediate lifesaving interventions when an overdose has happened.
    2. Ending the stigma around addictions and mental illness: Activities that reduce negative attitudes about people who use drugs that may keep people from seeking and receiving help for problematic substance use.
    3. Rebuilding the network of mental health and addiction treatment services: Services that support treatment of and recovery from addiction.
    4. Addressing the full range of supports and social factors: Activities and services that address social factors related to substance use such as housing, income, employment, intergenerational trauma and community development.

Saving Lives

- The province has broadened access to no-cost naloxone with an extensive publicly funded Take-Home Naloxone program that distributes naloxone kits and community organization facility response boxes to over a thousand distribution locations in British Columbia.
- The province is focusing on drug checking as a harm reduction intervention and has expanded drug-checking services through the use of fentanyl test strips to all overdose prevention and supervised consumption service locations in the province. The City of Vancouver purchased a Fourier-Transform Infrared Spectrometer to rapidly test drug samples at supervised consumption sites at Insite and Powell Street Getaway. There is a plan to build upon the City of Vancouver's experience and purchase more mass spectrometers for other health authorities. The BC Centre on Substance Use released an evidence review on drug checking services as a harm reduction intervention. The report can be found at http://www.bccsu.ca/wp-content/uploads/2017/12/Drug-Checking-Evidence-Review-Report.pdf
- The BC Centre for Disease Control has been funded by Health Canada to initiate a pilot project to support access to safer drugs. The pilot would dispense oral hydromorphone pills to people who use opioids obtained from the illegal drug supply. The pilot is slated to begin in the summer of 2018.

Ending Stigma

- The province launched an overdose awareness campaign with the Vancouver Canucks in January 2018. The campaign encourages people to strike up honest conversations about problematic substance use with friends, family members, and co-workers.
- A new website, www.stopoverdoseBC.ca, launched and will continue to expand.
- The BC Centre for Disease Control, peers and other partners have completed a three-year research project, Peer Engagement and Evaluation Project (PEEP). The goal of PEEP is to ensure everyone across the province has equal access to harm reduction services by visiting communities across B.C. to talk to people who use drugs and providers about peer engagement and harm reduction. A number of resources have been developed including a guide for health providers that outlines peer engagement principles and best practices. Resources can be found at http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction/peer-engagement-evaluation#Resources

Building a Network of Mental health and Addiction Treatment Services

- The BC Centre on Substance Use has released provincial Guidelines for the Clinical Management of Opioid Use Disorder. It is expected that a number of supplementals focusing on the treatment of opioid use disorder in pregnancy, in youth, and in correctional settings will be released over the next few months.
- For the small proportion of people who are living with an opioid use disorder and do not respond successfully to first line treatment with oral medications (i.e., methadone, buprenorphine/naloxone and slow-release oral morphine), the province is working with health authorities to expand access to injectable hydromorphone treatment.
- Regional health authorities are scaling up rapid access to medication treatment for opioid addictions by expanding hours of operation and opening new addictions clinics.
- Increased education and training in addictions treatment has been made available to healthcare providers through interdisciplinary addictions fellowships, rural fellowships through the Rural Education Action Plan initiative, online addiction medicine and opioid agonist treatment online training programs and preceptorships, and a range of clinical guidance documents, provider tools and fact sheets available from the BC Centre on Substance Use.
    - In particular, the BC Centre on Substance Use offers a free online certificate course targeted at healthcare professionals interested in learning more about providing care to patients with substance use disorders. Details can be found at https://www.bccsu.ca/about-the-online-addiction-medicine-diploma/
    - Working in partnership with the University of BC Continuing Professional Development Program, the BC Centre on Substance Use offers a Provincial Opioid Addiction Treatment Support Program to provide education and information for physicians, nurses, allied health professionals and other care providers involved in the treatment of individuals with opioid use disorder. The course is free and provides an overview of the provincial Opioid Use Disorder Guidelines. Details can be found at https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program

Addressing the Full Range of Supports and Social Factors

- In May 2017, a Mobile Response Team was established under Health Emergency Management BC's Disaster Psychosocial Support Program. The Mobile Response Team delivers services across all regions in the province to front-line providers, including volunteers and peers. Services include formal and drop-in sessions, assessments, psychosocial education and training, information on how to deal with grief and loss, outreach and referrals, team building and trauma responses.
- The province and regional health authorities are working together to expand access to services for inadequately housed youth and for people living with mental health and substance use issues who require supportive housing.

Alberta

- As of March 28, 2018, Alberta has opened four supervised consumption services across the province, with another five anticipated to open in 2018–2019. The Lethbridge service is the first supervised consumption service in Canada to offer supervised inhalation; the Royal Alexandra Hospital in Edmonton is the first in-patient hospital supervised consumption service model in North America.
- The Alberta naloxone program provides kits and overdose training distributed through harm reduction agencies, community-based organizations, pharmacies, emergency departments and Alberta Health Services facilities.
- Alberta is developing an overdose prevention site program for both a fixed-term and short-term basis, which may include festivals and other community events.
- Alberta has both launched a mainstream opioid awareness campaign by Alberta Health Service and provided grants to communities to increase awareness.
- The College of Physicians and Surgeons of Alberta continues to communicate with physicians and the public about appropriate prescribing of opioids.
- The College of Physicians and Surgeons of Alberta provides physicians who prescribe opioids and/or benzodiazepines with comparative prescribing pattern reports including a list of patients exceeding guidelines.
- Alberta has been expanding access by opening many new treatment spaces in areas that were previously underserved. In addition, an opioid dependency advice line is available for physicians and prescribers to consult with an opioid dependence specialist for advice regarding prescribing drugs such as Suboxone and methadone, as well as treating patients with existing opioid dependency.
- Alberta is implementing a supervised injectable opioid agonist therapy program in Edmonton and Calgary to support people with severe opioid use disorder. The program is planning to provide hydromorphone to clients.
- Health Professional colleges have been making regulatory changes and releasing standards of practice to support healthcare professionals in providing opioid agonist therapy (e.g., the removal of administrative barriers for physicians prescribing Suboxone).

- Addiction Recovery and Community Health (ARCH) Team, in the Royal Alexandra Hospital (Edmonton), provides patient-centred, evidence-based and holistic care for patients with an active substance use disorder and/or those dealing with social inequity. ARCH is being expanded to both increase supports available to Edmonton clients and be implemented in Calgary.
- A project to increase the role of primary care in the opioid response (i.e., improve access to opioid treatment in primary care) through a partnership of the College of Family Physicians, Alberta Medical Association, Alberta Health Services and the primary care networks.
- Alberta is implementing a project where patients will be able to be initiated on Suboxone in emergency departments in Edmonton and Calgary.
- Alberta is supporting Stimulus 2018, the national harm reduction and drug policy conference in Edmonton in October 2018.
- Indigenous communities and Indigenous serving organizations were supported to develop and implement interventions to address the opioid crisis.

Manitoba

- Manitoba's addiction services system offers a continuum of treatment services and support for youth and adults, including school-based intervention and prevention, medical and non-medical residential detoxification, a variety of community-based services, opiate replacement therapy clinics, short- and long-term specialized residential treatment, aftercare programming and outreach.
- To assist Manitobans with finding the right service, the Manitoba Addictions Helpline was established in November 2015 and is operated by the Addictions Foundation of Manitoba.
- Addictions services are provided by the Addictions Foundation of Manitoba, and a number of other organizations funded by Manitoba Health, Seniors and Active Living.
- The health response to opioid use and misuse in Manitoba is being coordinated through a Health System Opioid Response. Work is managed to provide a system response in an integrated, coordinated and effective manner.
- Accessibility to Suboxone has increased over the last year due to changes to the Manitoba Drug Formulary (removed coverage criteria for Suboxone to the Manitoba Pharmacare Program) and support of programs like the Manitoba Prescriber Education and Audit Program (MPEAP)
- Effective April 20, 2017, Suboxone was moved from a Part 3 (Exception Drug Status) to a Part 1 (open) listing on the Manitoba Drug Benefits Formulary making it easier for individuals to access coverage for this drug
- Funding through the MPEAP has contributed to the development of an inter-professional "Opioids 101" workshop, led by the College of Physicians and Surgeons of Manitoba.
- A provincial naloxone distribution program was launched in January 2017. People who are at risk of opioid overdose may access free take-home naloxone kits at designated distribution sites located throughout the province. In addition they can receive overdose recognition and response training at participating distribution sites.

- As of September 30, 2017, there are 64 registered naloxone distribution sites, with registered sites in all five regional health authorities and First Nations. In the first nine months of 2017, over 765 take-home naloxone kits were distributed to people at risk of opioid overdose and over 93 have been used in overdose events in the community.
- Data collection has been improved through the implementation of a robust opioid surveillance system, which collects data from a wide range of stakeholders and provides analyses on the data to inform public health programming and direct policy. The *Surveillance of Opioid Misuse and Overdose in Manitoba* report is produced on a quarterly basis. http://www.gov.mb.ca/health/publichealth/surveillance/opioid.html
- A social media awareness campaign was launched in November 2016 and a webpage created to provide information to the public and service providers about the dangers of fentanyl and how to get help. http://www.gov.mb.ca/health/mh/overdose/index.html
- Information packages were sent to all schools in Manitoba, including First Nations schools, in November 2016.
- A training manual was developed: *Overdose Prevention, Recognition and Response*. This manual provides education about the use of naloxone to address the morbidity and mortality associated with opioid overdoses. The manual is intended to prepare educators and trainers in provincial take-home naloxone distribution sites to prepare people to prevent, recognize and respond to overdose in a voluntary capacity. http://www.gov.mb.ca/health/publichealth/docs/training_manual_overdose.pdf
- Increased funding from the Public Health Agency of Canada was received to increase harm reduction efforts.

Ontario

- Ontario has a range of services and supports that align with the continuum of care for the treatment of opioid use disorder.
- The province has Assertive Community Treatment Teams that provide outreach and connections to treatment resources, and case management services that provide ongoing individual assessment and adjustment of treatment plans.
- Individuals can access short-term treatment through Rapid Access Addiction Medicine clinics, which offer opioid agonist therapy, counselling, harm reduction interventions (e.g., naloxone kits) and advice, until they can be connected to longer-term support in their community.
- Ontario has medical and non-medical withdrawal management services in residential and community-based settings, which offer additional supports such as discharge planning and early recovery education.
- Both buprenorphine/naloxone and methadone are available pharmacological interventions for treating opioid use disorder on the Ontario Drug Benefit Formulary, and in April of 2017, nurse practitioners were given the ability to prescribe buprenorphine/naloxone to improve access to treatment.
- The province offers psychosocial supports such as community-based lifestyle and personal counselling, including relapse prevention, which is available in individual, group and family formats, and individuals can access supportive housing services to aid in recovery.

- Ontario has addiction programs targeted to special populations, such as youth aged 12–24, Indigenous communities, and women, including pregnant women and mothers.
- Treatment services are supported by initiatives to improve provider treatment capacity, including targeted outreach, training, and opioid agonist therapy prescribing support to interdisciplinary care teams in communities of high need through the Centre for Addiction and Mental Health, mentorship opportunities for treating opioid use disorder through the Ontario College of Family Physicians, and quality standards on treating opioid use disorder developed by Health Quality Ontario, released March 2018.
- Ontario has various harm reduction initiatives such as needle exchange/syringe programs, naloxone distribution programs, supervised consumption services, and overdose prevention sites. Ontario's three main programs where naloxone is made available at no cost to Ontarians to prevent opioid overdoses are the Ontario Naloxone Program (ONP), the take-home naloxone program for at-risk inmates in collaboration with the Ministry of Community Safety and Correctional Services, and the Ontario Naloxone Program for Pharmacies (ONPP). The ministry maintains a list (in the form of a locator map) on its website that is available to the public and displays all of the organizations currently participating in the ONP and ONPP. This locator map can be found online at https://www.ontario.ca/page/get-naloxone-kits-free. The government has also strengthened the harm reduction workforce by providing new funding for the hiring of additional frontline harm reduction outreach workers and additional staff at public health units.
- In the fall of 2017, the Ministry of Health and Long-Term Care established the Opioid Emergency Task Force that brings together representatives from province-wide system partners, including front-line workers in harm reduction, emergency response and addiction medicine, community mental health and addiction, education, public health, municipalities, primary care, hospitals, people with lived experience, as well as other essential partners, to strengthen the province's coordinated response to the opioid crisis.
- In December of 2017, Ontario launched the first phase of a robust and targeted public education campaign to raise awareness about the risks associated with both prescribed and illicit opioid use, and how people can protect themselves and their loved ones against addiction and overdose.

New Brunswick

- New Brunswick, currently has methadone maintenance treatment programs, which are also referred to as opioid replacement therapy programs. They are offered in different forms such as publicly funded, privately operated physician offices or specialized clinics. These services are now offered in most areas of the province. Individuals receiving opioid replacement therapy are able to also participate in various programs such as individual counselling and residential rehabilitation programs.
- The accessibility to take-home naloxone kits is currently being rolled out in the province. The AIDS organizations through their needle exchange programs are able to provide take-home naloxone kits to those at risk. In addition, the residential withdrawal management programs (detox programs) will also be distributing the take-home naloxone kits to those most at risk.
- The province has also increased their capacity to report on opioid-related data to get a better understand of the New Brunswick reality. The following website offers information and tools related to opioids: http://www2.gnb.ca/content/gnb/en/corporate/promo/opioids.html

- In addition, the following link provides surveillance data for our province. Last surveillance report available on the site: http://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/MentalHealth/New-Brunswick_opioid-surveillance-report_2017-Q3.pdf

Newfoundland and Labrador

- Newfoundland and Labrador has an integrated system of delivery for mental health and addictions. The province has prevention and promotion services, a youth outreach worker program and youth case managers. The province is looking at peer-support programming.
- Under Towards Recovery Action Plan, Newfoundland and Labrador has an Action Plan for Mental Health and Addictions Services in the province. There are 54 recommendation to guide the re-design of mental health and addictions services. These recommendations cross all points of the continuum.
- In Newfoundland and Labrador, the four regional health authorities would offer mental health and addictions services. These services would differ from region to region; however, all regions would offer intake services, single-session counselling session (Doorways), and addictions counselling services (assessment and therapeutic counselling to individuals of all ages).
- There is a Provincial Navigator who provides information on services via telephone for all regions.
- There are three provincial inpatient addictions treatment programs:
    - Humberwood (Corner Brook) for 19+
    - Grace Centre (Harbour Grace) for 18+
    - Hope Valley (Grand Falls) inpatient addictions treatment for 12–18 year olds.
- Tuckamore: live in treatment program for 12–18 year olds with complex mental health needs
- Withdrawal services
    - The Recovery Centre in St. John's is open to anyone in the province who is 16+ and needs help while withdrawing from alcohol, drugs and/or gambling. This is a medical assisted withdrawal service.
- Harm reduction
    - Take-home naloxone kits: available at 91 sites in the province
    - Safe Works Access program: offered through the NL AIDS Committee
- Opioid Treatment Centre: St. John's site
- Methadone Clinic: Corner Brook
- Mental Health Crisis Line and Gambling Line

Yukon

- No update to provide at this time

Nunavut

Nunavut is currently not experiencing opioid-related harms to the same extent as other jurisdictions in Canada. As such, efforts are focused on naloxone availability and training sessions.

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APPENDIX F

Financial statements of
Canadian Dental Regulatory Authorities Federation

December 31, 2017

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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 statement of financial position as at December 31, 2017, 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.

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, 2017 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.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
February 8, 2018

Canadian Dental Regulatory Authorities Federation

Statement of financial position

As at December 31, 2017

	Notes	2017	2016
		$	$
Assets			
Cash		**254,813**	124,057
Prepaid expenses		**—**	1,734
Capital assets	3	**490**	980
		255,303	126,771
Liability			
Accounts payable and accrued liabilities		**3,609**	1,550
Fund balance			
Unrestricted		**251,694**	125,221
		255,303	126,771

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

Approved by the Board

Director

Director

Canadian Dental Regulatory Authorities Federation

Statement of operations and change in fund balance

Year ended December 31, 2017

	2017	2016
	$	$
Revenue		
Fees	**405,954**	395,946
Other income	**317**	118
	406,271	396,064
Expenses		
Bank charges	**927**	681
ISDR membership	**2,750**	2,750
Meetings	**38,795**	52,116
Operating	**233,917**	227,651
Translation services	**3,409**	4,197
	279,798	287,395
Excess of revenue over expenses	**126,473**	108,669
Fund balance, beginning of year	**125,221**	16,552
Fund balance, end of year	**251,694**	125,221

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

Canadian Dental Regulatory Authorities Federation

Statement of cash flows

Year ended December 31, 2017

	2017	2016
	$	$
Operating		
Excess of revenue over expenses	**126,473**	108,669
Items not affecting cash		
Amortization of capital assets	**490**	490
	126,963	109,159
Changes in non-cash operating items		
Prepaid expenses	**1,734**	1,016
Accounts payable and accrued liabilities	**2,059**	(2,935)
	130,756	107,240
Net cash inflow	**130,756**	107,240
Cash, beginning of year	**124,057**	16,817
Cash, end of year	**254,813**	124,057

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

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.

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. Capital assets

	Cost	Accumulated amortization	2017 Net book value	2016 Net book value
	$	$	$	$
Computer hardware	**1,470**	**980**	**490**	980

CDRAF
Canadian Dental Regulatory Authorities Federation

FCORD
Fédération canadienne des organismes de réglementation dentaire

POLICY ON INTERNALLY RESTRICTED NET ASSETS (RESERVE FUND)

The CDRAF must execute effectively, at a reasonable cost on a not for profit basis. The CDRAF Board maintains internally restricted net assets (reserve fund) in order to ensure ongoing financial stability and to provide funds for identified one time expenditures in the following areas:

General contingencies

Internal restricted assets designated in this area ensure continuous operations of the Board:

Maintenance of consistent cash flow including allowing optimal timing of purchases, providing for salary continuity and unforeseen overtime expenses	$100,000
Reserve required to meet obligations in the event of changes in government or regulatory policy that reduces of eliminates major responsibilities of the CDRAF. These obligations would include salary commitments.	$100,000

Initial Funding for Identified National Initiatives

From time to time, the CDRAF Board may authorize expenditure of funds to enable work to start on a national initiative. The expectation is that eventually DRAs will eventually fund the initiative.	$100,000
TOTAL	**$300,000**

Approved: _____

AMS:777127v2

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

	2016 Actual	2017 Actual	2017 Budget	2018 July 31st Actual	2018 Budget	2019 Draft Budget		Cost per dentist (23,056 - 2018 Base)	2020 1st draft	2021 1st draft	2022 1st draft
								23056			
FUND BALANCE @ BEGINNING OF YEAR											
Fee Rates	**$ 18.00**		**$ 18.00**		**$ 5.50**	**$ 6.00**			**$ 9.00**	**$ 12.00**	**$ 13.00**
REVENUES											
CDRAF Fees:	395,946	405,954	405,954	126,808	124,042	138,336			208,800	278,400	301,600
Gov't of Canada	118	317	-	2,625	-	-			-	-	-
Interest			-		-	-			-	-	-
Total Revenues	**$ 396,064**	**$ 406,271**	**$ 405,954**	**$ 129,433**	**$ 124,042**	**$ 138,336**			**$ 208,800**	**$ 278,400**	**$ 301,600**
EXPENSES							**Notes:**				
Meetings/Conferences											
Board & Members meetings	$ 40,992	$ 35,030	$ 35,210	$ 26,652	$ 25,900	$ 27,120	**1**		$ 28,000	$ 28,000	$ 28,000
Other meetings/Conferences - ED	7,134	10,306	20,068	4,781	15,000	12,000	**2**		12,000	12,000	12,000
Other meetings/Conferences - President (NA no Pres)	3,990		9,440		-	-			-	-	-
ISDR Conference	10,951		13,400		7,500	4,320	**3**		5,000	5,000	5,000
Operations:											
Salary (ED and Executive Assistant)	186,769	189,852	183,000	69,309	183,000	163,500	**4**		166,770	170,106	173,508
Financial consultant	4,000	8,400	8,400	4,200	8,400	8,400	**5**		9,000	9,000	9,000
External resources (policy, communications, translations, etc.)	4,197	5,122	25,000		15,000	3,000	**6**		3,000	3,000	3,000
Legal	3,359	3,449	10,000		7,500	3,500	**7**		3,500	3,500	3,500
Administrative fees (banking, etc.)	750	3,595	600	350	600	600			600	600	600
Audit	1,802	1,752	3,500	202	3,500	3,500	**8**		3,500	3,500	3,500
Equipment/Support/Maintenance		-	5,000		2,500	500	**9**		50	50	50
Postage/courier ($50/mth)	520	11	2,400		1,200	600			600	600	600
Printing/supplies ($50/mth)	106	1,256	2,400	446	1,200	600			600	600	600
Phone/internet ($175/mth)		2,019	2,100	816	2,100	1,560			1,560	1,560	1,560
Information technology (web hosting, conference calls, etc.)	6,599	6,050	8,288	3,366	8,060	7,808	**10**		7,000	7,000	7,000
ED Professional fees and conferences/PD		-	5,000	2,988	3,500	3,500			3,500	3,500	3,500
Insurance	1,998	3,629	2,400	1,678	3,700	3,700			3,700	3,700	3,700
Depreciation	490	490	1,500	286	1,157	667	**11**		600	600	600
Memberships											
CNNAR	848	1,413	850		850	850			850	850	850
ISDR	2,750	2,750	5,500		2,750	2,750			2,750	2,750	2,750
Working Groups	6,112	11,216	20,000		30,000		**12**				
Executive Search	4,028	-	-		-	-			-	-	-
Total Operations Disbursements	$ 287,395	$ 286,340	$ 364,056	$ 115,074	$ 323,417	$ 248,475			$ 252,580	$ 255,916	$ 259,318
Surplus/(Deficit)	$ 108,670	$ 119,931	$ 41,898	$ 14,359	$ (199,375)	$ (110,139)			$ (43,780)	$ 22,484	$ 42,282
Estimated Internally Restricted Net Assets (IRNA) at end of year				$195,000		$84,861			$41,081	$63,565	$105,847
Internally Restricted Net Assets (IRNA) as per policy approved September 2018				$300,000		$300,000			$300,000	$300,000	$300,000
Deficiency in IRNA				-$105,000		-$215,139			-$258,919	-$236,435	-$194,153
IRNA as per proposed policy September 2018						$ 300,000	**13**				
Estimated IRNA balance at end of 2018						$ 195,000					
Budgeted deficit for 2019 (6.00 per dentist) plus costs of working group ($5,000)						$ (115,139)					
Estimated INRA balance at end of 2019						$ 79,861					
Estimated Budget deficit for 2020 (7.50 per dentist) plus costs of specialty recognition and working group ($15,000)						$ (48,780)					
Estimated INRA balance at end of 2020						$ 31,081					
INRA deficit at end of 2020						$ (268,919)					
INRA deficit at end of 2021											

Notes:

1	Board meetings - Five (5) meetings locations to be determined ED+EA+Financial Consultant(	*Meeting 1*	*Meeting 2*	*Meeting 3*	*Meeting 4*	*Meeting 5*
	Catering (Snacks/Coffee - $30/person x 20)	600	600	600	600	600
	Travel ED/EA- $600/avg return flight + Fall meeting FC	1,200	1,200	1,800	1,200	1,200
	Hotel ED/EA x $300/night + Fall meeting FC	700	700	1,050	700	700
	Taxi ($60/person/trip)	240	240	360	240	240
	Meals ($30/breakfast + $70/dinner)	200	200	300	200	200
	Room Rental $2250/day includes AV	2,250	2,250	2,250	2,250	2,250
		5,190	5,190	6,360	5,190	5,190
2	Other meetings/conferences - ED					
	Other meetings - incld NDEB, CDA, CDAC, etc.	3,000				
	ACFD - 1 meeting	2,000				
	RCDC - 1 meeting	2,000				
	Continuing Education - ED	5,000				
		12,000				
3	Calculation based on one participant - San Francesco 2019					
	Conference Fee ($600USD/person)	780				
	Travel (1 individuals) $1500/avg return flight	1,500				
	Hotel (1 individuals x $500/night) @ 3 nights	1,500				
	Taxi ($60/person/trip)	240				
	Meals ($30/breakfast + $70/dinner)	300				
		4,320				
4	Salary (ED & Executive Assistant)					
	Executive Director	120,000				
	Executive Assistant - Approx 20 hours/week @ $31.73/hour = $33,000/year	35,000				
	CPP, EI, EHT	8,500				
		163,500				
5	Financial consultant - $100/hr x 7 hours/month x 12 months/year	8,400				
6	External resources - this is for services such as Policy					
	Translation, Communications, etc.	3,000				
7	Consistently have legal expenses - therefore included in budget	3,500				
8	Audit, by Deloitte LLP - for each fiscal year	3,500				
9	Equipment lease, repairs, service agreements, this would include photocopiers,					
	fax machines, computer software agreements, AV Rentals, Computer Maintenance,					
	Software service agreements, non-capital equip/furniture purchases, etc..	500				
10	Information technology:					
	Web Hosting - monthly cost $404/month plus tax	4,848				
	Conference calls ($80/month average)	960				
	Web Programming/Updates/Changes (20 hours @ $100/hour)	2,000				
		7,808				
11	Capital Expenditures - initial cash outlay $2000 + $490/year of current capital assets					
	Assume 5 year life on capital expenditures - computer equipment	Depreciation/Year				
	2019	667				
	2020	667				
		1,333				
12	Working Groups - WILL BE FUNDED THROUGH RESTRICTED NET ASSETS:					
	National Competency Standards for General Dentists in both 2018 & 2019	5,000				
	National Dental Specialty Recognition possibly in 2020	10,000				
		15,000				
13	IRNA as per propsed policy					
	Maintenance of consistent cash flow including allowing optimal timing of purchases,					
	providing for salary continuity and unforeseen overtime expenses	100,000				
	Reserve required to meet obligations in the event of changes in government or regulatory					
	policy that reduces of eliminates major responsibilities of the CDRAF. These obligations					
	would include salary commitments.	100,000				

Initial Funding for Identified National Initiatives. From time to time, the CDRAF Board may authorize expenditure of funds to enable work to start on a national initiative. The expectation is that eventually DRAs will eventually fund the initiative.	100,000
TOTAL	300,000

APPENDIX G

professional standards authority

Right-touch regulation in practice

international perspectives

Professional Standards Authority
for Health and Social Care
September 2018

About the Professional Standards Authority

We are an independent body, accountable to the UK Parliament. We exist to protect the public by improving regulation and registration of health and care professionals.

We ensure that our values are at the core of our work: they are at the heart of who we are and how we would like to be seen by our partners. We are committed to being:

- focused on pubilc interest
- independent
- fair
- transparent
- proportionate.

There are three main areas to our work:

- reviewing the work of the regulators of health and care professionals
- accrediting organisations that register health and care practitioners
- giving policy advice to ministers and others and encouraging research to improve regulation.

Find out more about our work at **www.professionalstandards.org.uk**.

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Right-touch regulation

Right-touch regulation means understanding the problem before jumping to the solution. It makes sure that the level of regulation is proportionate to the level of risk to the public. It builds upon the principles of good regulation, identified by the Better Regulation Executive to which we added 'agility'. This means looking forward to anticipate change.

The principles state that regulation should aim to be:

Proportionate: Regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.

Consistent: Rules and standards must be joined up and implemented fairly.

Targeted: Regulation should be focused on the problem, and minimise side effects.

Transparent: Regulators should be open, and keep regulations simple and user-friendly.

Accountable: Regulators must be able to justify decisions, and be subject to public scrutiny.

Agile: Regulation must look forward and be able to adapt to anticipate change.

There are eight elements that sit at the heart of **right-touch regulation**:

1. Identify the problem before the solution
2. Quantify and qualify the risks
3. Get as close to the problem as possible
4. Focus on the outcome
5. Use regulation only when necessary
6. Keep it simple
7. Check for unintended consequences
8. Review and respond to change.

Find out more details about right-touch regulation, including the Authority's publications, at:
www.professionalstandards.org.uk/right-touch-regulation

Introduction

Harry Cayton | Chief Executive
Professional Standards Authority

Harry Cayton CBE was formerly National Director for Patients and the Public at the Department of Health. From 1992 to 2003 he was Chief Executive of the Alzheimer's Society and from 1981-1992 Director of the National Deaf Children's Society. He has served on many public and voluntary committees and chaired independent reviews for the Department of Health.

One early morning in September 2009 I scribbled down on a single piece of paper the principles of what was to become right-touch regulation. It was after a discussion by our Board the day before about what good regulation should look like. Over the next few months, with our great staff team, we debated and expanded and refined our ideas. I've always liked clear thinking and clear language and apart from its genuine usefulness I think it's the clarity and simplicity of right-touch regulation that has contributed most to its success.

We published *Right-touch regulation* in 2010 without much of a fuss. Not making a fuss is part of our way of working. We think that the quality of our work should speak for itself; if it's good enough other people will read it and use it. If it's not good enough it's best forgotten. Quite quickly people did start referring to right-touch regulation, asking us about it and trying to apply it to their regulatory tasks. By 2015 it was widely influential and we revised our original paper to take account of what people had told us about their experience of putting the principles into practice.

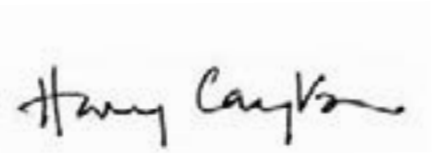
Now it seems timely to learn again from others' experiences of using right-touch regulation. The varied and interesting papers in this publication set out the interesting and varied ways in which different regulators in different sectors, in different jurisdictions have applied right-touch regulation to their particular problems and challenges.

A common theme in these papers is that it is an adaptable approach, flexible enough to be useful in different regulatory regimes, clear enough to provide a consistent framework for problem-solving. Another is that it has helped regulators think through the noise that surrounds them to achieve clarity of process and outcome and a third that recognising the unintended consequences of regulatory intervention helps us be more targeted and effective. Right-touch regulation is not a prescription but a way of thinking about regulatory problems, it requires us to challenge our assumptions, to identify the superfluous and to focus on the necessary.

We learn from our authors that right-touch regulation is complementary to other values-based approaches, such as a just culture and that it can act as a catalyst for organisational change within regulators. At the Professional Standards Authority, it has encouraged us to direct our research towards human behaviour, to what it means to be a member of a liberal profession, and to the moral basis of our role in society.

I should like to thank all the colleagues from around the world who so generously and enthusiastically responded to my invitation to contribute to this publication. My colleagues at the Authority over several years have enriched, challenged and improved our thinking about how regulation should contribute to the public good.

Finally, of course there are all the people at all the conferences, seminars and workshops from Brisbane to Barcelona, from Dublin to Vancouver who have debated, argued, questioned and embraced right-touch regulation. They too have contributed and helped to shape what is still a work in progress.



Health practitioner regulation in Australia: using the right touch

Martin Fletcher | AHPRA
Luisa Interligi | AHPRA
Chris Robertson | AHPRA

Martin Fletcher started with AHPRA in December 2009 as the inaugural Chief Executive. Before joining AHPRA, Martin was Chief Executive of the National Patient Safety Agency, the leading National Health Service body for patient safety in England and Wales. From 2004 to 2007 Martin worked with the World Health Organisation in Geneva to establish a global programme of work on patient safety.

Luisa Interligi is Strategic Policy Advisor for AHPRA. Before joining AHPRA, she was the Deputy Health Services Commissioner for Victoria. Luisa has over 15 years' experience in health workforce policy, planning and reform and also has experience in strategic policy and planning in the tertiary education sector.

Chris Robertson is AHPRA's Executive Director, Strategy and Policy. He has held senior leadership roles for over 15 years in health policy and regulatory reform, as well as workforce planning and innovation. He is an authority in the design and application of the National Law across 15 health profession boards, establishing a single national regulatory scheme for what is now over 670,000 registered health practitioners in Australia.

Background

In 2010 Australian state and territory governments passed legislation, the *Health Practitioner Regulation National Law* (the *National Law*), to establish a single National Registration and Accreditation Scheme (the Scheme) for registered health practitioners. As Australian state and territory governments have constitutional responsibilities for health, the legislation required national agreement between the states and territories. The Scheme's objectives are to:

- help keep the public safe by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered

- facilitate workforce mobility for health practitioners
- facilitate provision of high quality education and training for practitioners
- facilitate the assessment of overseas qualified practitioners
- facilitate access to services provided by health practitioners, and
- enable the continuous development of a flexible Australian health workforce.

The Scheme regulates 16 health profession groups across Australia[1] with more than 700,000 registered practitioners and 150,000 registered students. The 15 National Boards[2] work in partnership with the Australian Health Practitioner Regulation Agency (AHPRA) to implement the National Scheme. Scheme Accreditation Authorities work to accredit over 740 programmes of study delivered by over 330 education providers leading to registration.

Our primary role is public protection and we aim to do this through a risk-based approach to regulation, taking action proportionate to the identified risks to public health and safety.

Risk and the legislation

Our work is governed by the *National Law*. It seeks to reduce the risk of harm to the public associated with the practice of regulated health professions and ensure that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. Our work is organised around the following five core regulatory functions:

- establish accreditation and professional standards for entry to the profession, initial and continuing registration
- register health practitioners with the skills and qualifications to provide competent and ethical care
- ensure practitioners are safe to practise by managing complaints and concerns raised about the health, performance and conduct of individual health practitioners and using regulatory force where necessary
- through compliance we monitor and audit practitioners to make sure they are complying with Board requirements
- work with accreditation authorities and committees to ensure graduating students are suitably qualified and skilled to register as a health practitioner.

The Professional Standards Authority[3] published the first version of *Right-touch regulation*[4] in 2010, the same year the National Scheme was established. The concept of right-touch regulation has helped inform the Scheme's implementation since then, with

our governing legislation providing a regulatory framework consistent with the principles of best practice regulation. We are fortunate to benefit from modern legislation that is consistent with many of the ideas and innovations progressively proposed in *Regulation rethought*[5] and *Right-touch reform*[6] and provides a flexible platform for implementing risk-based approaches – it therefore inherently aligns with the approach that right-touch regulation advocates. One of the guiding principles in our legislation is that regulatory interventions through accreditation, registration, notifications or compliance are only imposed if necessary to ensure health services are provided safely and are of an appropriate quality. This sets a high threshold for regulatory intervention, applying regulatory force only where there is an unmanaged risk to public safety.

Implementing the scheme

The concept of right-touch regulation, in particular the Authority's eight elements at its heart, are embedded throughout the Scheme. They are reflected in our regulatory principles which are highly visible within the Scheme – in operations, policy and strategy. The decision-making process outlined by Harry Cayton when he presented 'Right-touch questions' to all Boards in 2011, helped us adopt the elements and integrate them in strategic policy-making and in operational decision-making.

Together with the right-touch questions, the elements have guided and informed Australia's approach to professional regulation since the Scheme's inception in 2010.

Our regulatory principles were developed with reference to the principles of right-touch regulation, early in the Scheme's implementation. They underpin our work and shape our thinking about regulatory decision-making to encourage a responsive, risk-based approach to regulation across all professions. They are (see page 9, overleaf):

Regulatory principles for the National Scheme

These regulatory principles underpin the work of the Boards and AHPRA in regulating Australia's health practitioners, in the public interest. They shape our thinking about regulatory decision-making and have been designed to encourage a responsive, risk-based approach to regulation across all professions.

1. The Boards and AHPRA **administer and comply with the Health Practitioner Regulation National Law**, as in force in each state and territory. The scope of our work is defined by the National Law.

2. We protect the **health and safety of the public** by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

3. While we balance all the objectives of the National Registration and Accreditation Scheme, **our primary consideration is to protect the public**.

4. When we are considering an application for registration, or when we become aware of concerns about a health practitioner, **we protect the public by taking timely and necessary action under the National Law**.

5. In all areas of our work we:
   - **identify the risks** that we are obliged to respond to
   - **assess the likelihood and possible consequences** of the risks, and
   - **respond in ways that are proportionate and manage risks** so we can adequately protect the public.

   This does not only apply to the way in which we manage individual practitioners but in all of our regulatory decision-making, including in the development of standards, policies, codes and guidelines.

6. When we take action about practitioners, **we use the minimum regulatory force appropriate to manage the risk** posed by their practice, to protect the public. Our **actions are designed to protect the public and not to punish practitioners**.

   While our actions are not intended to punish, we acknowledge that practitioners will sometimes feel that our actions are punitive.

7. Community confidence in health practitioner regulation is important. Our response to risk considers **the need to uphold professional standards and maintain public confidence in the regulated health professions**.

8. **We work with our stakeholders**, including the public and professional associations, to achieve good and protective outcomes. **We do not represent the health professions or health practitioners**. However, we will work with practitioners and their representatives to achieve outcomes that protect the public.

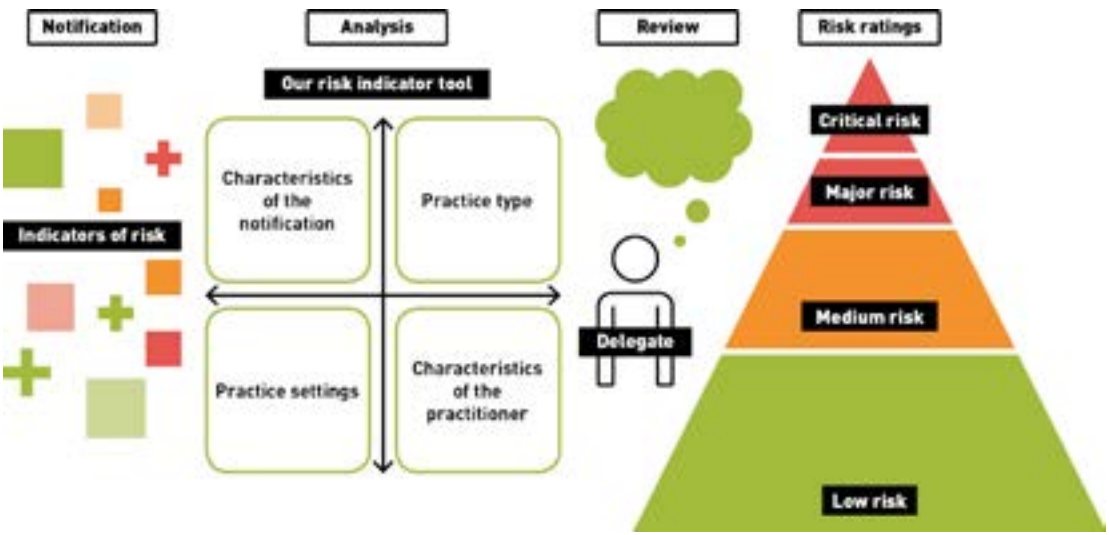
We identify the problem before the solution

Our legislation clearly provides for us to commence court proceedings when a breach of the advertising provisions has occurred. Initially, our approach was to consider all advertising breaches from a prosecution perspective. When this approach was challenged by the growing volume of low risk matters, not suitable for prosecution, we applied a right-touch regulatory lens and gained greater clarity about the problem – advertisers did not fully understand the law. We therefore considered a more targeted, proportionate approach and adopted a multifaceted strategy, focusing on support and education. This has been effective in achieving our goal.

We quantify and qualify the risks

Upon receipt of a notification about the health, performance or conduct of a registered health practitioner, we assess the likelihood and severity of future risk of harm to the public. This informs evidentiary requirements, resource allocation and whether any immediate regulatory action is necessary and whether the risk is currently unmanaged.

In the future, we want to improve the way we use risk assessments to further concentrate resources on the areas of greatest risk, having identified and defined the risks and harms. This is a priority for the Scheme's Research Framework. We will establish criteria for low, medium and high-risk issues and apply different regulatory approaches accordingly. This will enable us to expedite how we respond to lower risk issues, including through more delegated decision-making, and focus more attention on higher risk issues.



We look for solutions that are close to the problem

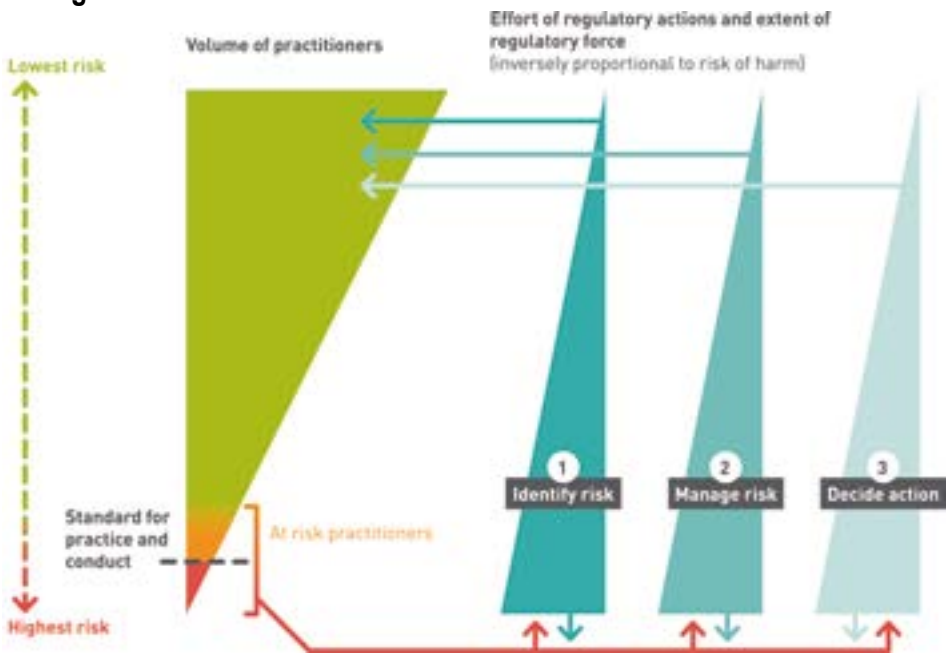
In 2013, soon after the Scheme was established, we engaged Professor Malcolm Sparrow to help us explore how to use available intelligence to identify problems causing significant harm, then to use the right solution to prevent harm. He encouraged us to think about how we might draw on the discipline of epidemiology to analyse data to identify concentrations of significant harm which might be amenable to regulatory action. Specifically, this led to the establishment in 2014 of our own Risk-based Regulation Unit (now the AHPRA Research Unit), with a specialised skill set including epidemiology and research methods to, amongst other things, access and analyse our regulatory data for the risks of harm.

We have since focused on maximising the use of internal and external data to identify, analyse and address significant harms to the public. Understanding when and where risk is more likely to present informs when and how we should intervene in a practitioner's professional life-cycle. It can enable more preventative approaches that identify the likelihood of risk before it eventuates (as a notification for example) so we can act proportionally to assess the future risk, and then support professional practice to prevent future harm, which may include using non-regulatory measures.

The Authority's further development and application of the concept of right-touch regulation in documents such as *Approach to assuring continuing fitness to practise based on right-touch principles*,[7] has also influenced our evolving model and approach to regulation. An important recent example is the Medical Board of Australia's (MBA) development of a Professional Performance Framework (PPF). The PPF, comprising five core pillars,[8] will support doctors to take responsibility for their own performance and encourage the profession collectively to raise professional standards and build a positive, respectful culture in medicine that benefits patients and doctors.

The MBA has used data to identify a number of risk factors for poor performance to inform where targeted screening of medical practitioners with these risk factors might occur. Screening will identify individuals who have markers of poor performance and will enable practical, proportionate and supportive interventions to keep patients safe, when and where these are needed. This work is designed to ensure that all doctors providing clinical care continue to provide safe care throughout their working lives. (See the diagram on page 12.)

A professional performance framework would assist to actively identify and manage risk



We focus on the outcome

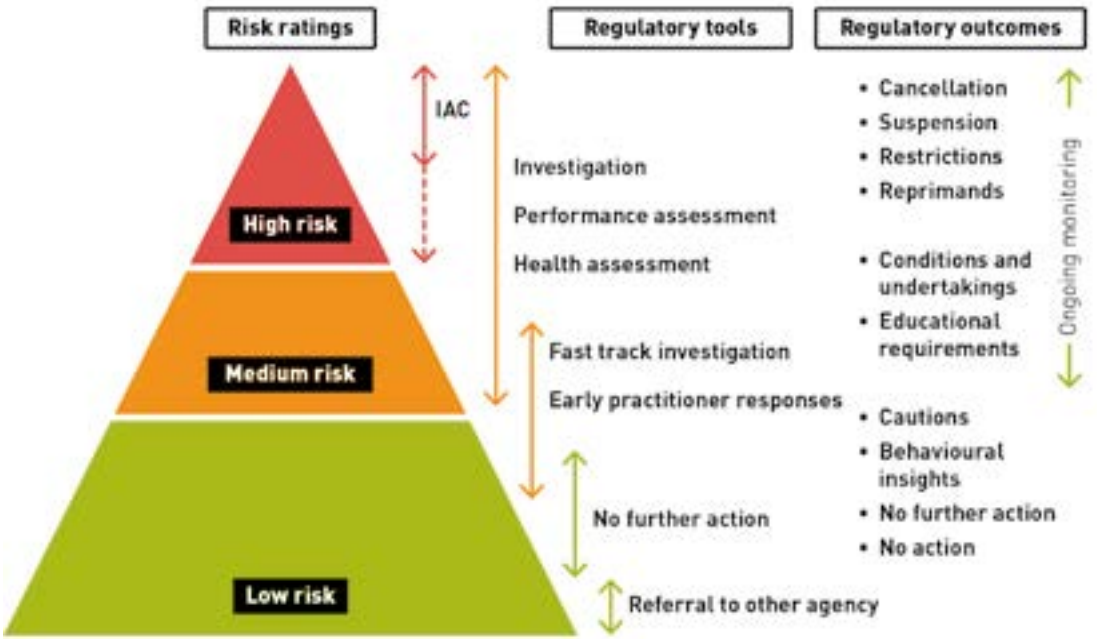
The Scheme's strategy is an outcome-focused plan. As a risk-based regulator, our strategic outcomes all align with our vision, which is to protect the public by regulating health practitioners effectively and efficiently in the public interest to facilitate access to safer healthcare. In support of our strategic outcome to reduce harm to the public we develop, implement and embed processes, infrastructure and capabilities that are informed by data driven evaluation, research and best practice initiatives. This supports risk-based regulation approaches across all Scheme entities and in everything we do and is often in contrast to our previous reliance on more time-based, compliance-focused activities.

We use regulatory force only where necessary

When we take action, we use the minimum regulatory force appropriate to manage the risk posed by practice, to protect the public. Informed by our regulatory principles, our regulatory responses are proportional to the assessed level of risk. Where risk is low, the extent of regulatory intervention used to minimise the harm and manage the future risk is also low. For example, a harmful event that may have been the result of a single error, with causative factors remedied, is unlikely to attract a restriction on practice, as future risk of harm is low.

AHPRA and the Boards are working together to explore how we can extend the concept of right-touch regulation further, and use preventative non-regulatory approaches, especially in notifications. Where future risk of harm to the public is assessed as low, responses might be less formal in nature and instead attempt to engage the practitioner in how to improve professional practice to reduce the risk of their practice falling below threshold standards in the future. We want to explore new approaches that could involve using behavioural insights to change behaviour and practice. These approaches may be helpful where a registrant's practice or behaviour is not so serious as to warrant formal regulatory action, but where an effective remedy would involve practitioner reflection on the concerns raised regarding their practice and enabling them to improve practice or conduct to prevent future harm. (See the diagram below.)

Aligning notifications management and outcomes to risk



We keep it simple

The notion that risk is core to effective regulation was foremost in the early days of the Scheme, with the development of a risk appetite statement to provide direction on the risk parameters within which the Scheme would operate. However, as a regulator embracing agile practices, we are reviewing our risk statement, and recalibrating it to move further toward decision-making that is differentiated by risk. We have followed the Authority's work about risk and the role it plays in regulation, particularly the development of risk ideas in public and regulatory policy and the benefits, challenges and limitations of designing regulatory regimes on the basis of risk.[9] This has informed our revised risk statement, which will be streamlined and provide a strong and clear foundation to articulate our risk capacity, profile and appetite – that is:

- the maximum level of risk at which we can operate
- the entire risk landscape – reflecting the nature and scale of risk exposure, aggregated across and within each category
- the risk we consider appropriate to take in achieving our core objective – public protection.

Our risk appetite statement will be more nuanced to differentiate between the type and level of risk and how we respond to different types and level of risk in a way that is sensitive to the risk assessed. We will subsequently communicate the change in the way we identify risk and manage risk and work with all our partners and stakeholders to explain how we will behave differently with new risk models so there is a clearer, simpler and shared understanding of risk types and approaches to manage them.

We check for unintended consequences

In 2017, we developed a multifaceted *Advertising Compliance and Enforcement Strategy* to enable a more differentiated, risk-based approach to compliance with the advertising provisions under the *National Law*. Central to the strategy was education and capacity-building through communications campaigns to educate practitioners about advertising requirements, evidence and the need to consider advertising from a consumer perspective. While this approach was focused on the outcome – preventing harm from false, misleading or deceptive advertising – we considered whether providing examples of acceptable advertising might drive advertisers to replicate the examples without undertaking the education and self-instruction necessary for understanding and ongoing compliance. This was mitigated by focusing on building practitioner understanding through self-assessment and other tools,

with rationale and explanations embedded in the tools.

We review and respond to change

The National Scheme is committed to continuously improving our regulatory processes and decision-making to more effectively contribute to assuring professional practice. Through our annual cycle of strategic planning, we monitor and review our performance and the external environment and adjust our priorities accordingly. Our continuous improvement occurs within a wider environment of constant change and challenge, which requires flexible, thoughtful and agile responses. For example, changing consumer expectations have prompted us to consider the future of the public register and how it can more effectively align with the objectives of practitioner regulation.

When first published, *Right-touch regulation* encouraged our early development as a risk-based regulator, where the resources used and the regulatory force we apply is proportionate to the quantified and qualified risk of harm to the public.

We have continued to draw on the principles of good regulation and the evolving work of the Authority, creating a collaborative environment for data exchange and collaboration in the public interest to deliver tangible public value. While the elements of right-touch regulation have been effective in helping to shape ourselves as an effective regulator, a future iteration of *Right-touch regulation* could reflect the growing focus on data and analytics. For example, a possible element could address how capacity in assessing data and information is becoming a key element of effective regulation.

The concept of right-touch regulation and the work that has since progressed has played a critical role in the development of the Scheme and will continue to do so as our approach further evolves, inspired and informed by our research, strategy and policy development alongside the work of other regulators, as well as the Professional Standards Authority.

About AHPRA

AHPRA is the Australian Health Practitioner Regulation Agency. It regulates Australia's health practitioners in partnership with 15 National Boards to regulate 700,000 health practitioners in Australia. It is governed by the *Health Practitioner Regulation National Law* which came into effect on 1 July 2010.

Find out more from: **www.ahpra.gov.au**

Banking standards and right-touch regulation

Rick Borges | BSB

Rick Borges is the Head of Assessment (UK and International) at the Banking Standards Board. Rick has a Masters in law and a postgraduate diploma in law in the United Kingdom.

One may wonder what the 2008 financial crisis, banking standards and the right-touch regulation approach, developed by the Professional Standards Authority for Health and Social Care in 2010, could have in common given that right-touch regulation is initially applied in the health and social care sector. This article discusses how some of the elements that the Authority identified at the heart of applying the concept of right-touch regulation in practice can be seen in some of the actions resulting from the 2008 financial crisis that had adverse effects on the UK's and the world's economy. It focuses on the establishment and some aspects of the work of the Banking Standards Board (BSB) in the UK and shows some parallels that demonstrate that right-touch regulation could be a concept applied in other sectors beyond health and social care. In addition, it illustrates how the work of the BSB is, in a different context, committed to using evidence 'to identify and understand issues, and to draw on the roles and responsibilities of different parts of the system to deliver the best solution' which is a key aspect of the right-touch regulation approach.[10]

Identify the problem before the solution

The financial crisis of 2008 exposed failures of competence, behaviour, management and leadership – as well as breaches of the law – in the banking sector. A succession of serious issues in both retail and investment banking (including, but not confined to, the manipulation of the London inter-bank lending rate and foreign exchange benchmark rates, and the mis-selling of Payment Protection Insurance and interest rate hedging products) have damaged trust and confidence in the banking sector. While some of

these practices stemmed from the period prior to the crisis, others occurred or continued well after it, notwithstanding conduct having risen up the agendas of bank boards and executive teams. The trust and confidence affected was that not only of customers, but also of taxpayers, regulators, public policy makers, investors and banking sector employees themselves.

The UK Parliamentary Commission on Banking Standards (PCBS) undertook an inquiry into the events that precipitated and exacerbated the crisis. While many reforms to regulation were proposed, the PCBS also identified the need to go beyond regulation if the underlying problems which led to such widespread misconduct were going to be addressed. At its root, the problem was not solely how the sector was regulated, but in the culture of banking institutions and the competence and behaviour of some individuals working within them.

Changing an organisation's culture is widely recognised as being one of the most difficult leadership tasks. Changing the culture of an entire sector is even more difficult and not a task that can be achieved without the genuine ownership of the challenge by the organisations within the sector. While acknowledging the importance of regulation, and the need for reform, the PCBS also recognised that the industry itself both had to want to change and needed help to do so. It recommended that the industry establish an independent body as a demonstration that 'commitment to high standards is expected throughout banking and that individuals are expected to abide by higher standards than those that can be enforced through regulation alone.'[11] Following a careful examination of the options in his 2014 review of banking standards, Sir Richard Lambert concluded that there was 'a strong case for a collective effort to raise standards of behaviour and competence in the banking sector, and that the best way to deliver this [was] by setting up a new and independent body to drive the process forward'.[12]

Regulation cannot solve every problem

The BSB was accordingly established as an independent, non-statutory, membership body in April 2015, with the aim of helping to raise standards of behaviour and competence across the UK banking sector in the interests of employees, customers and wider society.

The BSB is neither a trade association nor a regulator. It does not represent the industry, and it has no statutory powers. As a membership body, it takes the regulatory framework as a given and asks firms how they can not only meet the letter and the spirit of that framework, but also voluntarily go

beyond it with respect to the wider issues of organisational culture that regulation either cannot, or is not best placed to, address. As described by Dame Colette Bowe, BSB Chairman, 'the BSB existence reflects the recognition that, while effective regulation is vital for well-functioning markets, regulation is not – and cannot – be the answer to every question.'[13] Although not drawn from right-touch regulation, this approach illustrates the principle that 'there is usually more than one way to solve a problem and regulation is not always the best answer. It may be more proportionate and effective, for instance, to strengthen employment practices or to foster professionalism. New regulations should be introduced only as a last resort.'[14]

Getting as close to the problem as possible

According to right-touch regulation, 'problems are best solved near to where they occur' and 'the regulator is usually furthest removed from the harms it is trying to prevent and as such regulation is a blunt instrument for promoting behaviour change'.[15] The BSB annual assessment of culture, behaviour and competence across its member firms provides evidence to boards and executive teams to help them identify what needs to be done, prioritise competing demands, actions and timescales, and establish a baseline against which progress can be measured. Its aims are:

a) to help banks and building societies to gauge their performance with respect to culture, behaviour and competence, and thereby better serve their customers, employees and broader society;

b) to build an evidence-based picture of developments across the sector that will facilitate collective efforts to improve customer, employee and societal outcomes by raising standards and sharing good practice.

The BSB assesses how far its member firms demonstrate nine characteristics: honesty, respect, openness, accountability, competence, reliability, responsiveness, personal and organisational resilience and shared purpose. It would expect a firm that strongly exhibited the nine characteristics to be better equipped and more likely to serve its customers, employees and society well, than in one in which these characteristics were lacking.

The assessment contains qualitative and quantitative aspects: the BSB Employee Survey, interviews with Executives and Non-Executive Directors, focus groups with junior and middle ranking staff and questions to the firm's board. These methods allow the BSB, working with participating firms, to collect evidence from those who are closest to the issues that are relevant to gauge their performance with

respect to culture, behaviour and competence. The survey questions explore employees' perceptions, observations and beliefs about their firm's culture, drawing on personal experience. There are 36 core questions that enable firms to track progress year-on-year and to benchmark themselves against the group of BSB member firms participating in the Survey. Additional questions have been added to the survey in 2017 and 2018 to cast light on specific issues identified in the previous year. This allows the BSB to be agile in helping firms to understand these areas in more depth and make relevant changes if required.

This is the third year in which the BSB assessment has been undertaken. Evidence for 2018 is being analysed at the time of writing. The BSB received more than 36,000 responses for the Employee Survey in 2017 (28,000 in 2016).

Focus on the outcome

The BSB can then draw on the evidence gained from the BSB annual assessment of culture to identify themes and issues relevant to some or all firms. Where appropriate, it can work with firms in identifying what 'good' looks like and develop a common understanding of how to achieve it.

As an example of this, the BSB published a *Statement of Principles*[16] to help firms strengthen professionalism in February 2018. The principles were developed in partnership with several stakeholders that formed part of a Professionalism Forum established by the BSB in April 2017. The Forum brought together BSB member firms, professional bodies and qualification providers, other voluntary standards organisations, trade bodies, academics, regulators, trades unions and other relevant organisations from both within and outside the banking sector. This diversity of participation allowed ideas to be aired, challenged and improved from a variety of perspectives. The Forum was supported throughout by a working group drawn from member firms, professional bodies and academics.

Strengthening and promoting professionalism is another area where the work of the BSB interacts with the aims of right-touch regulation as defined by the Authority. According to the Authority, it 'creates a framework in which professionalism can flourish and organisations can be excellent and right-touch regulation supports professionalism by:

- discouraging the use of regulation if the risk can be addressed more effectively by the professionals themselves; and
- encouraging the use of regulatory measures that support positive behaviour change and the exercise of professional judgement, rather than seeking to be overly prescriptive.'[17]

The BSB Professionalism Principles are deliberately high level and provide a way for firms to structure a discussion internally about what they do to help their employees act professionally and how well they do it. They do not attempt to prescribe what firms should do and are intended to complement and support the principles or codes for individuals drawn up by professional bodies or, of course, the regulator.

Conclusion

Although not a product of right-touch thinking, the establishment of the BSB and its work to date illustrate how right-touch regulation could be practised or seen in a different sector and how non-regulatory solutions can complement regulatory objectives. The BSB is not a regulator, but it has a place working alongside firms, regulators, professional bodies, banking professionals, trades unions, investors and civil society organisations to improve behaviour and competence across the banking sector.

Banking is not, of course, unique in having suffered a loss of trust in recent years; examples of poor behaviour and competence are not confined to the banking sector. System-wide issues resulting from poor professional behaviour and competence have been brought to light in many sectors, including health and social care. Different sectors can and are willing to learn from each other to improve and promote high standards of professionalism in the best interest of the users of their services, that being customers, clients, patients or society overall. It would be interesting to see the outcomes if similar work to measure culture was delivered in the health sector. Finally, and consistent with the right-touch regulation principle of agility, the BSB aims in its work to anticipate change, and not solely look back at the issues of the previous crisis. Promoting professionalism and healthy cultures are an important part in doing this.

About the BSB

The Banking Standards Board is an independently led body that promotes high standards of behaviour and competence across the UK banking industry. The BSB began its work in April 2015. It is a private sector body funded by membership subscriptions and open to all banks and building societies operating in the UK. It is neither a regulator nor a trade association; it has no statutory powers, and it will not speak or lobby for the industry. It will, instead, provide challenge, support and scrutiny for firms committed to rebuilding the sector's reputation, and it will provide impartial and objective assessments of the industry's progress.

Find out more from: **www.bankingstandardsboard.org.uk**

Ros Foster | Browne Jacobson LLP

Right-touch regulation: the CIOB – a worked example

Ros Foster is a partner at Browne Jacobson LLP who specialises in regulatory law. Ros acts for a range of regulatory bodies including the Professional Standards Authority for Health and Social Care, the Human Fertilisation and Embryology Authority, NHS England, the Independent Parliamentary Standards Authority and the Royal Institution of Chartered Surveyors.

The Chartered Institute of Building (CIOB) was incorporated by Royal Charter in 1980, but it originates from the Builders' Society which was established in 1834. The CIOB describes itself[18] as the world's largest and most influential professional body for construction management and leadership. It has a Royal Charter to promote the science and practice of building and construction for the benefit of society. Its members work worldwide in the development, conservation and improvement of the built environment.

The CIOB accredits university degrees, educational courses and training. It considers that its professional and vocational qualifications are a mark of the highest levels of competence and professionalism, providing assurance to clients and other professionals procuring built assets. The Bye-laws that govern the CIOB require there to be a code or codes establishing standards of professional conduct and for there to be a disciplinary scheme to enforce those standards.

In 2015 the CIOB had three documents that contained professional rules: the *Rules and Regulations of Professional Competence and Conduct*, the *Code of Professional Conduct and Rules for Chartered Building Companies*, and the *Code of Professional Conduct and Rules for Chartered Building Consultancies*. All three documents began with a set of rules or core principles which were followed by detailed regulations. It was generally accepted that the three documents were in need of review to achieve a single, coherent and comprehensive set of rules that could apply across the membership of the CIOB. A 'right-touch' regulatory approach was taken to the review of

the standards, as explained below.

In establishing a new set of professional rules, the CIOB faced a number of challenges that it needed to fully understand. It was also keen to quantify and qualify the risks associated with a new, lighter[19] and outcome-focused approach to standards.

The challenges were:

- the diverse nature of the membership of the CIOB, which ranged from individual student members to sole trader local builders to multi-national construction corporations
- the international reach of the CIOB, giving rise to the need to take account of cultural norms in various jurisdictions
- the range of occupation/job types that would need to be able to apply the new rules, from site managers to quantity surveyors and directors of construction companies.

The risks were:

- over-simplification of the rules such that they ceased to be of universal relevance
- lack of buy-in from the membership, increasing the risk of non-compliance
- failure to capture all potential types of misconduct.

The CIOB took the following steps:

- Established a working group comprising members of the Professional Conduct Committee (PCC), the CIOB's governance lead and a longstanding legal advisor to the Committee;
- Undertook a consultation across the membership on the new draft rules. These sought to explore issues such as integrity while asking members what their areas of concern were and seeking an indication of members' views to regulation. For example, members were asked:
    - 'To what extent do you agree that 'integrity, honesty and trustworthiness' should be the guiding principles for a construction professional's conduct?'

      This question was designed to gain an understanding of what the membership wanted the focus of regulation to be: was it honesty or practical excellence, ethics or professional conduct?

    - 'Do the draft Rules include all of the main standards and levels of competence you believe should be expected from construction professionals?'

This question was included to address the risk that the new rules would miss their mark, by reason of over-generalisation, obsolescence or otherwise.

- ‘Do you think there are any barriers that would prevent a CIOB member from achieving the standards and levels of competence required by the draft Rules?’

  This question was included to address the risk that the rules would not be of practical application or relevance.

The consultation generated a significant and overwhelmingly positive response. The questions asked were devised by the Working Group, drawing on their PCC and industry experience.

This approach encapsulated a number of the practical steps envisaged by the Professional Standards Authority in *Right-touch regulation*,[20] namely:

1. Identify the problem before deciding upon a solution
2. Quantify and qualify the risks
3. Get as close to the problem as possible
4. Focus on the outcome.

The Working Group used the response to the consultation to inform further development of the draft rules. In establishing initial parameters for the draft rules, the Working Group had agreed to move away from an approach that involved detailed rules, in line with the ‘right-touch’ approach of keeping it simple. However, it was agreed that some rules required a degree of amplification/explanation, given members’ experience of the industry and knowledge of the cases that had come before the PCC.

So, it was agreed that a requirement simply to have written terms and conditions in place before commencing work was not sufficient; the CIOB needed to give an indication of what, as a minimum, those terms had to include (scope of work, payment terms, procedures to apply in the event of a dispute, complaints-handling procedures etc). Similarly, it had become apparent that there was considerable misunderstanding amongst the membership as to what would qualify as Continuing Professional Development (CPD), and as such the relevant rule did not simply require that CPD be undertaken. It explained what that meant.

The issue of cultural norms was an interesting one. It was accepted that, to be of relevance across the global construction landscape, the rules had to reflect the fact that in some cultures the giving and receiving of

gifts and hospitality was a recognised part of doing business and the awarding and delivery of construction contracts. The relevant rule was worded to apply only to improper activity, so as not to provoke offence nor to bring into the scope of regulation activity that would not be viewed as problematic when viewed in its local context. This met the 'right-touch' objective of checking for unintended consequences.

The principles of better regulation require that regulation is proportionate and properly targeted. Right-touch regulation reinforces that approach with its emphasis on using regulation only when necessary. As noted above, the CIOB's old approach had involved one set of rules for individual members and other sets for corporate members.

Having agreed that a single set of rules was to be developed, the challenge for the CIOB was to ensure that accountability was properly allocated: it would be unfair for an individual employee of a corporate member to be placed in breach of a rule of professional conduct on the part of his employer over which he had no control, but there would be a regulatory gap if the corporate entity itself or those in control of the employer who were themselves members of the CIOB were not required to ensure adherence to the rules within and by the corporate entity. Rules were therefore introduced that applied to corporate members (to inform their employees of the rules and monitor compliance with them, and to ensure all staff engaged in the construction process were working towards appropriate qualifications) and to the directors and partners of those entities as individuals (imposing individual responsibility for the corporate entities' compliance with the rules, as appropriate to the individual's role).

The new rules were adopted on 1 January 2018 and will be subject to regular review. They can be found on the CIOB's website.[21]

The objective of the CIOB in devising and promulgating the new rules was to introduce a framework that would minimise the risk of harm to clients and to those affected by the work undertaken by its members while enhancing the reputation of the construction profession by the maintenance of realistic professional standards that were of use and relevance across a broad geographical and professional landscape.

The old approach – of imposing diverse and detailed rules that had not been informed by the views of the membership and were not subject to regular review – was not achieving that objective, nor did they enable the CIOB when acting as a regulator to meet the principles identified by the Better Regulation Executive in 2000.[22] A 'right-touch' approach enabled the CIOB to establish a set of rules in collaboration with its

membership that are focused and relevant and that support targeted and proportionate regulation.

The CIOB is not a statutory regulator. It is, at heart, a membership organisation. But it is one that has a wider remit, by virtue of its Royal Charter and charitable status, and which has sought to put ethics at the heart of what it does: Paul Nash, President of the CIOB, at the Members' Forum Governance Review Workshop, July 2016, quoted from the CIOB's 2015 report *Understanding the value of professionals and professional bodies*:[23]

'Ethics and ethical behaviour is a central pillar of professionalism. It does not matter how skilled and experienced a person is or becomes: if they behave dishonestly and without regard for the rights of others, they are not a professional. The message applies both domestically and internationally, irrespective of cultural and behavioural differences.'

A 'right-touch' approach to regulation has assisted the CIOB in achieving its ethical and regulatory objectives, in the manner described above. The new rules meet the Authority's definition of right-touch regulation: they are based on a proper evaluation of risk, they are proportionate and outcome-focused, and they create a framework in which professionalism can flourish and individual and corporate members of the CIOB can achieve excellence.

About the CIOB

The Chartered Institute of Building is the world's largest and most influential professional body for construction management and leadership. It has a Royal Charter to promote the science and practice of building and construction for the benefit of society, and has been doing that since 1834. Its members work worldwide in the development, conservation and improvement of the built environment.

Find out more from: **www.ciob.org**

Right-touch regulation – our touchstone

Cynthia Johansen | CRNBC

Cynthia Johansen has served as the Registrar/ Chief Executive of the College of Registered Nurses of British Columbia. CRNBC is one of the three legacy nursing regulatory agencies that amalgamated to form the British Columbia College of Nursing Professionals (BCCNP). Cynthia has extensive experience in investigating and reporting on issues of public safety and access to care, and working with government, the public and stakeholders on improving professional practice standards and health profession regulation.

In writing this paper, I had a chance to reflect on how far my organisation, the College of Registered Nurses of British Columbia (CRNBC), has come in the past decade as it has adopted the persona of a right-touch regulator. We experience right-touch regulation as a concept that we are continuously putting to the test in our daily efforts to regulate nurses – our sole mandate being protection of the public.

Back in 2005, my organisation shed its professional association past, and evolved into a regulatory college in service of the public. This shift was significant, in itself: nurses were shocked by the change and grieved the loss of their professional association. It was also hard on the staff, board and committee members of the College who felt that in some way, we were letting the profession down. And over the last few years, it has been a significant uphill battle to shift our mental model away from advocating for the profession of nursing, to regulating focusing solely on protection of the public. The challenge isn't because we collectively resisted the change, in fact we embraced it! Rather, the challenge has been in shifting our philosophical approach from advocacy to regulatory and supporting our stakeholders and ourselves through this transition.

As a result of this evolution, there is no denying that CRNBC's strategic orientation (Burke et al, 2009)[24] has gone through a change in the past decade. CRNBC's core beliefs and values have altered, resulting in changes to the organisation's structures, the work of its employees and even the products and services we offer to our registrants and the public.

CRNBC's Board and management team recognised that to manage this change successfully, a new foundation of understanding would be required – a touchstone for ensuring that staff, the board and stakeholders could understand and recognise that its core function had changed. To support this, the Board asked that staff undertake an exercise to develop a regulatory philosophy. After months researching, analysing and discussing regulatory concepts, practices and approaches, staff recommended, and the Board agreed, to its own philosophy of 'relational regulation'.

Relational regulation is comprised of five key concepts:

- right-touch regulation
- a just culture
- collaborative self-regulation
- principle-based approach
- continuing professional development.

The concept of right-touch regulation – the use of regulatory forces proportionate to the desired outcome – is the bedrock of CRNBC's regulatory philosophy. The concept underscores everything we do – from our approach to investigating complaints about nurses, to how we have developed and launched our quality assurance programme. Right-touch regulation is now a part of our organisational culture and has provided a foundation for our evolution away from professional advocacy to regulatory practices that are modern and effective.

So, how has this shown up in our day-to-day practices? I will share a reflection on how I experienced CRNBC's approach to complaints when I joined the organisation in 2006.

At that time, complaints about nursing practice were not considered along a continuum of risk to the same sophisticated extent that they are today. In fact, most complaints were investigated by looking at a nurse's past practice and an employer's assessment of that practice. It was through this lens, mostly the nurses' lens, that we reviewed and considered concerns reported to the College. Most were therefore dismissed without due consideration.

Today, it is a very different story. Despite experiencing a marginal increase in the number of nurses registered in our province, (roughly 10 per cent over the past 12 years), we have increased our complaints staffing by seven-times (from four to 29 full-time equivalents). In doing so, we have better managed the complaints we receive, giving the right amount of attention (a lot) to issues of significant risk to the public, and triaging those complaints that are at the lower end of the risk continuum in new and more efficient ways. The result? A significant

increase in disciplinary hearings (the most serious of possible outcomes) – from zero in 2006 to 10 in 2018 (so far); more targeted remedial actions for nurses needing a course correction; and the expedient dismissal of frivolous and vexatious complaints deemed to be low-to-zero risk to the public.

In 2015, CRNBC invited the Professional Standards Authority to complete a review of the College.

This step opened the College up to an external third-party review which could, thanks to the Authority's expertise, assess how well CRNBC was meeting its public protection mandate. We were pleased with the outcome. We received feedback for improvement as well as confirmation that we were on the right trajectory.

Notably, the Authority recognised our efforts to adopt and integrate right-touch regulation into our work and products. The Authority singled out our Quality Assurance Program (My Professional Plan) for registrants.

The programme is the embodiment of a right-touch regulatory approach. Its purpose is to support good things happening (providing a programme for nurses to continuously develop), while identifying and then acting along a continuum of activities, when standards are not being met (from a self-administered learning plan for nurses to the delivery of concerns to our complaints process).

Although a new programme for our College, the concepts underpinning CRNBC's quality assurance programme are not novel. There is evidence in the literature that competence can be directly linked to an individual's engagement in their own ongoing development in their chosen profession (Austin & Gregory, 2018).[25]

As a regulator, CRNBC recognises its role in providing a framework to support nurses linking regulatory requirements to ongoing professional development. Finding the balance between enforcing a standard while at the same time encouraging and recommending engagement in a specific programme is challenging at the best of times.

The concept of right-touch regulation helps CRNBC to manage this balance – to know where we find the hard edges of regulatory requirements, versus the best or better practices for encouraging and supporting nurses to, on their own volition, engage in professional development activities that help them remain current, competent and engaged in ongoing learning.

CRNBC's journey to becoming a right-touch regulator has been important and valuable, and challenging. Like any shift in perspective, the heart often wins over the head. CRNBC's staff and Board have had to work hard to bring emotional attachment to the transition to assure ourselves that the concept will be more than a

theoretical construct – we have made right-touch regulation a key component of our organisational culture.

On 4 September 2018, CRNBC will cease to exist and will, along with two other nursing regulatory bodies (the College of Licensed Practical Nurses of BC and the College of Registered Psychiatric Nurses of BC) amalgamate to become the new British Columbia College of Nursing Professionals (BCCNP).

It is my great wish that the concept of right-touch regulation will live on in the new regulatory body and that much of the work borne by the Board and staff of CRNBC will be built upon by those taking on the next phase of nursing regulatory practice in British Columbia.

We have had a long and challenging journey. I believe that these efforts have made CRNBC a more effective and engaged regulator. It is my hope that BCCNP can carry that torch and contribute even more to the understanding of what it means to be a right-touch regulator in the 21st century.

About the CRNBC

Nursing in British Columbia has been a self-governing profession since 1918. Under provincial legislation (*Health Professions Act*), it is the duty of CRNBC to protect the public through regulation of registered nurses, nurse practitioners, and licensed graduate nurses. This includes registering nurses, setting standards of practice, assessing nursing education programs in British Columbia and addressing complaints about CRNBC registrants.

As of 4 September 2018, the CRNBC, together with the College of Licensed Practical Nurses of British Columbia and the College of Registered Psychiatric Nurses of British Columbia, came together to become the British Columbia College of Nursing Professionals (BCCNP).

Find out more from: **www.bccnp.ca**

Right-touch regulation: the art of simplicy

Jan Robinson | College of Veterinarians of Ontario

Jan Robinson is a leader in profession-based regulation in Ontario, Canada. She is a well-known teacher, advisor, and thought-influencer in regulatory communities internationally, and is currently the Registrar and Chief Executive of the College of Veterinarians of Ontario.

Regulation in Ontario, Canada has been the recipient of multiple spotlights over the years that of course have influenced legislation and organisational behavior. While initially reviews and resulting change were more locally focused, the impact of discourse on professional regulation around the globe has increasingly become important to understand as an influence of change.

In the 1980s healthcare regulation in Ontario faced a major review known as the *Health Professionals Legislative Review*. The driver was agility in public policy. The 1990s in Canada saw trade in services, both local and global, rise to the forefront. How are the skills of internationally educated professionals appropriately utilised? Why can licensed professionals not move easily across provincial borders? The driver was the economy and, for the first time, profession-based regulators viewed themselves in the middle of economic decision-making. The 2000s on a more global stage brought Enron and Nortel; disasters which shed a spotlight on governance and accountability, and the early days of the decline of the public trust of regulated professions gained momentum.

At home in Ontario, the pressure to demonstrate performance against metrics was also beginning. While certainly an increasing mainstay within the hospital system, this conversation on metrics related to regulators began with the licensing of international applicants. The result of this push was the Ontario Fairness Commission, an oversight agency of all profession-based regulators focused on registration practices that are fair, objective, impartial, and transparent.

I have had the privilege of leading three regulatory bodies for over 25 years. My thoughts in this

paper are shaped by Canadian and international debate and challenges in striving toward achieving regulatory excellence. My organisations were early adopters of audits and the use of various metrics to measure performance, inclusive of an adapted Balanced Scorecard.[26] Our view has always been a 'heads up' approach to a thoughtful analysis of broad regulatory trends:

- The Lisbon Convention (before it the Bologna Agreement)
- The Centre for Quality Assurance and International Education (Washington, DC)
- The work of the Organisation for Economic Cooperation and Development (the OECD)
- The interests of Canadian foreign affairs and trade (now provincial trade aspirations as well), and
- The developing field of regulatory research, and so on.

The formation of the Council for Healthcare Regulatory Excellence – now known as the Professional Standards Authority – one result of the Kennedy Inquiry and the Dame Janet Smith report – was a wake-up call to the international regulatory community. Its mandate, beyond oversight, to research and influence the practice of profession-based regulation – at least in healthcare – was something to pay attention to. With that in mind, the 2010 publication of the document discussing an approach called right-touch regulation had impact.

While fundamentally our community knows that regulation exists to manage risk, never before had this concept so simply and straightforwardly been placed before us. It gave words to existing processes and initiatives. It brought, at the very least, validity to our work in an increasingly challenging environment of criticism.

My organisation of the day snapped it up. The right-touch approach – what is the problem, what is the risk posed to the public, does the problem need a regulatory solution and if so, what is the least invasive level of tool in the tool-chest to use to mitigate the problem and risk – was enormously helpful. It strengthened policy-analysis activities, council debates, and orientation programmes to ensure organisation alignment (staff and volunteers) with the public interest mandate. And it was a wonderful tool to help a council with mid-course corrections on topics potentially fuelled by professional self-interest.

The advancements and ongoing iterative tweaking of the right-touch thinking and approach, published seemingly regularly by the Professional Standards Authority, have held significant and continued interest. The concept of agility in decision-making and in solutions was a value-added perspective. As was the analysis that right-touch alone was perhaps a too-funneled

approach. Broader thinking and questioning related to risks in professional practice and public safety was needed.

And so, for me, the right-touch platform launched further exploration and cast a wider net to other influencers:

- Malcolm Sparrow[27] – the concept of harm
- Simon Sinek[28] – explaining why we do what we do
- Onora O'Neill[29] – the concept of trustworthiness

as examples.

In my organisation, practical examples of bold moves forward linked to the right-touch regulation paradigm include:

- Utilising it as an underlying fundamental principle to a thorough review of existing legislation and resulting recommendations to the Minister to consider modernisation of the Act
- Setting a framework on regulatory effectiveness that better publicly explains why we do what we do as a profession-based regulator
- Establishing an iterative risk analysis and mitigation process based on identified leading risks and emerging strategic risks
- Linking our aim for governance excellence with the work of the OECD on regulatory risk and effectiveness[30]
- Focusing our complaints and discipline processes on at risk and reckless behavior, bolstering our remediation activities and setting the stage for the crafting of better outcomes-based decisions and reasons.

One of the challenges put forward for consideration in writing this article, was how the right-touch approach might be improved – a daunting question based on the excellence of the work. I would offer the following that may be of use in future thinking.

While the Professional Standards Authority does speak often in its writings of public confidence, I wonder if it might turn its mind to the links between the right-touch principles and the elements of trustworthiness as articulated by Onora O'Neill. She speaks of trustworthiness as broken into the components of competence, reliability and honesty. If competence in our role as a regulator is based on a strong focus on solving risk-based problems relevant to our role and in collaboration with other relevant stakeholders, how might steadfastness to this duty be extended to the concepts of reliability and honesty?

Further I ponder on the matter of who gets to decide the problem and the risk. While our community increasingly is mining its data better to facilitate informed discussions, how do we manage potential bias, discerning the right collaborations for harm mitigation, etc.

And then, how does all of this link to professionalism and professional identity? It is known that professions have different cultures or personas. Successful mitigation strategies are tied to understanding these more fully. Perhaps shining a light on this linkage would be helpful.

Lastly, the right-touch model is question – not answer – oriented. While this is helpful, these questions tend to be 'what' questions. Might the use of 'why' questions potentially change the value proposition for the right-touch approach into the future?

The right-touch regulation framework and its varied aspects have, in my opinion, done a great service to the regulatory community worldwide. The concept is widely known and understood.

I hear the words 'what is the problem we are trying to solve' or 'what is the risk that requires mitigating', regularly in policy conversations. And while fundamental, we also need to keep in mind, it is but one tool in an ever-evolving conversation on excellence, leadership and evidence in strong, public focused, profession-based regulation.

About the College of Veterinarians of Ontario

The College of Veterinarians of Ontario regulates the delivery of veterinary medicine in Ontario. All veterinarians who practise in Ontario must be licensed by the College. In serving the public interest, the College seeks to understand the risks involved in the practice of veterinary medicine and collaborates with partners to develop solutions which reduce the potential for harm to animals and people.The College licenses approximately 4,700 veterinarians and accredits over 2,300 veterinary facilities in Ontario. The role and authority of the College is set out in the *Veterinarians Act* and regulations made under this legislation. The veterinary profession in Ontario has been regulated since 1877.

Find out more from: **www.cvo.org**

Starting statutory regulation with the right-touch approach

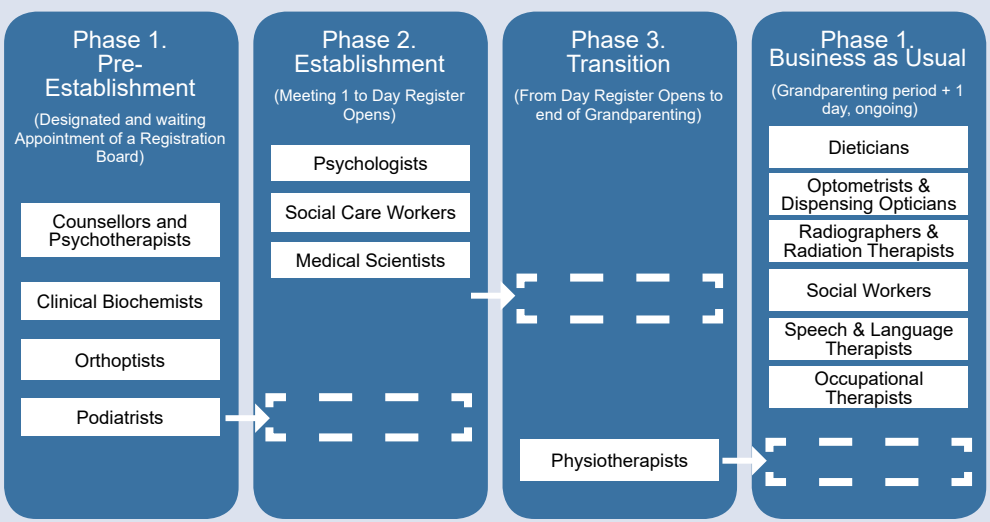
Ginny Hanrahan | CORU

Ginny Hanrahan, is the Inaugural Chief Executive/ Regulator of CORU (Council and Registration Boards), regulating health and social care professionals in Ireland since 2008 following 25 years working in health and social care services.

On 12 May 2008, I arrived in a borrowed office, with my own laptop and the *Health and Social Care Professionals Act 2005*[31] (the *Act*) under my arm, to implement statutory regulation for health and social care professionals in the Republic of Ireland for the first time.

We worked to establish statutory regulation for social workers, radiographers, radiation therapists, dietitians, speech and language therapists, occupational therapists, physiotherapists, psychologists, social care workers, medical scientists, podiatrists, orthoptists and clinical biochemists. Regulation of optometrists and dispensing opticians transferred to CORU in 2015. In July 2018, counsellors and psychotherapists were also designated under the legislation.

Progress on Registration of Professions in Ireland - September 2018



CORU's Health and Social Care Council (Council) has a lay/public majority of members on its governing body – more members representing the public than members of the professions to be regulated.

There is one representative of each of the regulated or to be regulated professions and a matching opposite number plus one, representing employers, educators, experts and service users. Our Council's Chairperson must be a member of the public. This does have an impact on the culture of the organisation, 'how is this protecting the public?' is asked at every meeting.

The *Act* states Council must

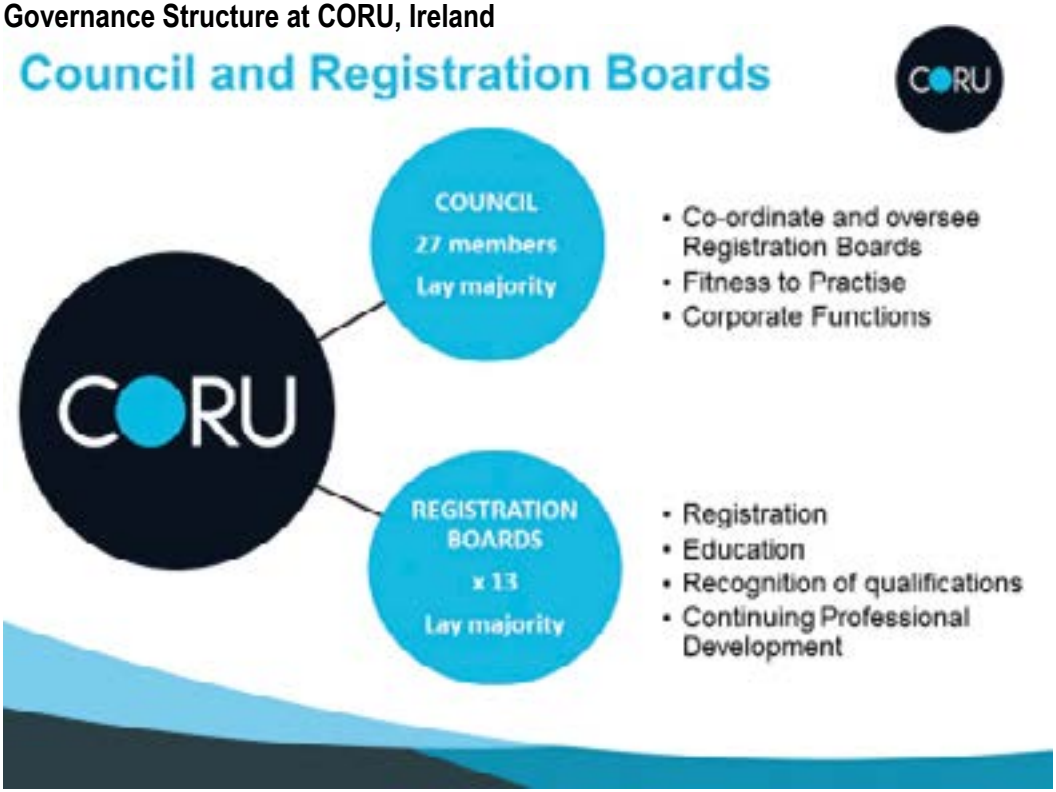
'Protect the public by promoting high standards of professional conduct and professional education, training and competence among registrants of the designated professions.' (*The Act, Part 2, Section 7*)[32]

and

'To oversee and co-ordinate the activities of registration boards.' (*The Act, Part 2, Section 8 (2) (a)*)[33]

Council also holds responsibility for setting strategy, corporate governance and managing fitness to practise requirements.

Governance Structure at CORU, Ireland



Consistency of approach in the implementation of Council frameworks and policies is something that we work hard to achieve.

The Social Workers Registration Board commenced its work in August 2010; opening its register on 31 May 2011. We subsequently opened nine registration boards, regulating 11 professions, with 10 registers open at the end of 2018.

The Registration Boards set the standards for registration, education, recognition of international qualifications and continuing professional development for the profession they regulate and advise on ethical issues.

Council sets framework guidelines, meaning that there has been more consistency in the work, with the Boards identifying and addressing the unique requirements for their profession – for social workers, social justice is at the centre of their work, for radiographers and radiation therapists, radiation safety is crucial, etc.

We looked internationally to see what we could learn from others regulating health and/or social care professions. The Health Professionals Council, UK[34] (now the Health and Care Professions Council, UK (HCPC)) regulates similar professions to CORU and kindly shared their learning and knowledge with us as novices.

This has been key to our success. The Northern Ireland Social Care Council (NISCC) regulates social workers and shared its learning and knowledge with us. These two agencies influenced our work in the early days, including their approach to right-touch regulation. Council for Licence, Enforcement and Regulation (CLEAR) an international body for regulators of professions also influenced our thinking.

The Better Regulation Task Force (UK) – *Principles of good Governance* (2003) (1)[35] states that the government must:

> 'Get the balance right, providing proper protection and making sure that the impact on those being regulated is proportionate'.

The principles were also supported by the European Commission in its *Action Plan on Better Regulation*.[36]

The principles were further explored and enhanced by the Council for Health Regulatory Excellence (CHRE), (now the Professional Standards Authority) in the UK at the time, describing them as 'right-touch regulation',[37] but adding a sixth dimension, which is critical for successful regulators – being agile.

- Proportionate – only intervene when necessary; appropriate remedies to risks posed; costs identified and minimised
- Accountable – justify decisions and be subject to public scrutiny

- Consistent – rules and standards are fair
- Transparent – be open, keep regulation simple and user friendly
- Targeted – focused on problems and minimise side effects
- Agile – must look forward and be able to adapt to anticipate change.

Throughout our work, we consider the Authority's right-touch regulation in practice:

1. Identify the problem before the solution
2. Quantify and qualify the risks
3. Get as close to the problem as possible
4. Focus on the outcome
5. Use regulation only when necessary
6. Keep it simple
7. Check for unintended consequences
8. Review and respond to change.

In all of this planning, we kept in mind, George Bernard Shaw's declaration about professions in 1906: 'All professions are conspiracies against the laity'.[38]

Whatever mechanisms we were using to implement this legislation, had to be cognisant of the principle of protecting the public, of ensuring that we set the correct threshold standards for education, a code of professional conduct and ethics, to advise registrants, but also used for fitness to practise complaints; giving clarity to the professions, and the public, as to what was expected of the future registrants.

Economic climate

The year 2008 could not have been a worse time to set up regulation of health and social care professionals in Ireland. Following the global financial downturn, the Irish economy went into meltdown and Ireland lost its financial independence for a number of years.

'Light-touch regulation' culture was evident in the banking culture, which was seen as a major contributing factor to Ireland's financial calamity. Ajai Chopra, Deputy Director of the European Department, in the International Monetary Fund team, who supervised Ireland's progress in dealing with the financial situation, stated in October 2011:

> 'Mechanisms of self-regulation and market discipline – such as corporate governance, internal risk management, private audits and discipline by creditors, failed to prevent the build-up of risk.'[39]

This background helped CORU to focus on what type and standard of regulation should be used with health and social care professions working in high risk situations. The Authority's 'right-touch regulation' approach made sense.

Proportionate – only intervene when necessary; appropriate remedies to risks posed; costs identified and minimised

Statutory registration delivering public safety, while giving professions clarity about what was require, was essential.

One example was setting the framework *Code of Professional Conduct and Ethics* (the *Code*) – a principle-based document, to be used as a guide to registrants, but also by the public to make complaints against registrants. We identified that there would be a problem, if there was too much variation in the codes for the different professions. Devising Council's framework *Code*, following extensive consultation with representatives of the professions to be regulated – unions, professional bodies and employers; allowed for proportionality and consistency and is the starting document for all of the registration boards.

This approach quantified the risks and focused on the outcome, thinking about how the *Code* would work in the future management of disciplinary cases. It also kept the process simple, and was a good way to get the individual registration boards to start their journey towards regulating their professions. The *Code* has recently been reviewed and continues to have the same approach with only unique requirements for the professions now set separately from the main *Code of conduct* which applies to all of our registrants.

Accountable – justify decisions and be subject to public scrutiny

CORU publishes an annual report every year and outlines what progress we have made and our costs, also how we review our work and respond to change. This has to go before the Houses of the Oireachtas (Irish Parliament) every year and is on the public record. We also emphasise the importance of giving reasons for the decisions being made.

CORU believes that every decision made, must be done so correctly and in an accountable manner. We are mindful that any of our decisions can be judicially reviewed and are keen to ensure that CORU is not found wanting in its work.

Consistent – rules and standards are fair

In setting the framework *Criteria and Standards of Proficiency* for all of the regulated courses, producing graduates who can apply to become registrants; we considered the challenges of having differing standards for professions.

By addressing the problem of a lack of consistency in the requirements for registrants, entering the workforce; the framework criteria and standards of proficiency, gave our educators a consistent approach

to our requirements, setting the threshold levels required, while allowing creativity in delivering the training.

Consistency in such important issues as confidentiality, communication was focusing on the outcome for the service users of our future registrants. The practice placement requirements and the profession specific skills are set by the relevant registration board.

Transparent – be open, keep regulation simple and user-friendly

Every student entering a course which results in potential registration has to aware that they may not be suitable for the profession. Under our criteria, each course is required to have a mechanism for assisting students, who may have met the requirements of the course academically, but in their practice, did not work well with the service users, or found it difficult to do the work required. Our criteria requires that this student has to complete the course with a different qualification, which would acknowledge the work they had done, but they would not be eligible to apply for registration.

In this approach, we initially thought of the problems and the risks that could arise, if these provisions were not in place and any potential unintended consequences. It is outlined at the beginning of the course for the potential students in a very clear and simple way.

Targeted – focused on problems and minimise side effects

We worked to refine the registration requirements details, based on a risk-based approach. In 2011, we asked anyone who had worked abroad for over six months to get police clearance, as part of the application process. In 2014, we reviewed the process having learned from the implementation and considered the limited information generated with the old requirements; we decided to change this to one year and one day, as many professionals do take a year out of work to travel. This worked within the risk boundaries that we could accept as a regulator and simplified the process, while responding to the issues that arose for applicants, but all the time keeping the impact on public protection in mind.

Agile – must look forward and be able to adapt to anticipate change

Since 2008, the world of regulation has changed, so that while we must have Fitness to Practise (discipline procedures) to deal with the small number who are not fit to practise; we make every effort to support registrants to be engaged in their work and to be resilient; serving the public in a better manner. This focus on supporting registrants to be the best they can, is working to lessen the problems that can arise for registrants, despite problems within a service – the registrant has to take responsibility for their own

actions. We want regulation to focus on the outcome of public safety by regulating to the correct level and ensuring registrants are fully aware of their responsibilities.

Research carried out by Bulbulia,[40] identified the need for registrants to be aware of when issues were creating a challenge for them – being aware of personal triggers – to take action. One social work registrant talked of seeing an old man in the park with a child at a weekend and immediately worrying that the child might be in danger as opposed to seeing a grandfather with his grandchild. This triggered a realisation that she needed a break from her work in the profession.

When meeting our registrants, we address this issue regularly; discussing the need for Continuing Professional Development to support a registrant's engagement in their work and being mindful of how their work/life balance is important to monitor over a career.

There is a need for the community to acknowledge that there are times when one may not be able to work at the top of their game, when life is challenging – death, birth, marriage, divorce; but equally to acknowledge that work standards cannot fall below acceptable levels during these times.

Conclusion

Right-touch regulation helps CORU to successfully regulate our professions. We constantly seek to improve our work – these principles and practices, are a sound basis on which to continue our journey.

About CORU

CORU is Ireland's multi-profession health regulator. Its role is to protect the public by promoting high standards of professional conduct, education, training and competence through statutory registration of health and social care professionals. CORU was set up under the *Health and Social Care Professionals Act* 2005 (as amended). It is made up of the Health and Social Care Professionals Council and the Registration Boards, one for each profession named in its Act.

Find out more from: **www.coru.ie**

Duncan Rudkin | GPhC

A framework in which professionalism can flourish

Duncan Rudkin was appointed by the Privy Council as the founding Chief Executive and Registrar of the General Pharmaceutical Council and has been with the organisation since its inception in 2010. Prior to that, Duncan had worked for the General Dental Council, including a period as Chief Executive there. His original professional background was as a commercial solicitor.

'A framework in which professionalism can flourish': how right-touch regulation can help in developing professional standards and revalidation

A woman walks into a pharmacy towards the end of the day on a Saturday afternoon. She asks to speak to the pharmacist and requests emergency hormonal contraception, explaining that she had unprotected sex the previous day. Supplying emergency hormonal contraception conflicts with the pharmacist's religious beliefs. But the pharmacist is aware that they are the only pharmacist working in the pharmacy that day, and the nearest pharmacy is over five miles away, and might be closed for the rest of the weekend by the time the woman gets there.

Is there a rulebook telling the health professional what they must do in a situation like this? No. But there are standards for professional practice that provide a framework for health professionals to help them navigate the challenging situations they face every day. The standards act as a tool to help the health professional use their professional judgement to decide what to do, rather than being a manual that tells them exactly what they must do.

All of the health professional regulators in the United Kingdom are responsible for setting standards for professional practice. These standards sit at the heart of regulating health professionals, as they set out what is expected of a health professional and have a bearing on every regulatory decision we make. Having the right standards in place is therefore vitally important.

There have been standards for health professionals since at least the time of the Hippocratic Oath, but just as healthcare doesn't stand still,

neither do professional standards. They need regular review and revision to make sure they continue to reflect what patients and the public expect from the people who care for them.

Reviewing our standards for pharmacy professionals

In 2014, we began a major programme of work to review and update our standards for pharmacists and pharmacy technicians, which had been in place for five years. And right-touch regulation provided a useful framework for the review of these standards. The principles that sit at the centre of right-touch regulation helped us to frame some of the questions we asked when developing the standards and to test and refine our approach.

The Professional Standards Authority has said of right-touch regulation that it 'creates a framework in which professionalism can flourish and organisations can be excellent.'[41] And this closely mirrors the purpose of the standards we set for pharmacy professionals; we want the standards we set to support professionalism and to help professionals to provide high-quality care for their patients.

When we began work on reviewing the standards, we weren't starting with an obvious 'problem'. There wasn't really any significant evidence to suggest the previous standards weren't working. But at the same time we knew that we wanted to radically change them, particularly in terms of reducing them in number, to make sure they were more focused on the outcomes we wanted to achieve for patients and the public.

'Keep it simple' was a key principle behind the new standards. We wanted to concentrate the minds of professionals on what really matters to patients and the public. These standards cover topics of crucial importance in upholding public confidence, such as patient confidentiality. But if you only talk about patient confidentiality once in 57 standards (as in the previous version) it loses its importance. In contrast, if you make it one of nine standards (as we did in the new standards for pharmacy professionals)[42] then its importance is emphasised.

We wanted to develop core standards that would apply to all pharmacy professionals wherever they worked. We know that pharmacy professionals are increasingly working in a diverse range of roles and these standards needed to work for everybody.

When you have such a diversity of practice as you see among pharmacy professionals, a prescriptive approach to standards wouldn't have worked. Prescriptive standards would take away professional autonomy and undermine decision-making. We wanted to empower professionals to use their professional judgement in the best interests of patients. And

agility was another key concept. You can't be agile with prescriptive standards; they quickly go out of date because of changes in practice, advances in technology and changes in what the public and other health professionals expect.

We wanted to get a better understanding of what these expectations might be, so we decided to hold a national conversation on patient-centred professionalism[43] with the public and with health professionals to 'get close to the problem' as such. We asked a range of questions during this conversation to help us identify what really mattered to people; what behaving professionally and providing person-centred care really meant to them.

What we learnt through this conversation, which we summarised in a report,[44] helped us to draft the new standards. One of the key things we heard is that it is the attitudes and behaviours of pharmacy professionals in their day-to-day work which make the most significant contributions to the quality and safety of care. We therefore drafted standards that describe how safe and effective care is delivered through 'person-centred' professionalism, and what attitudes and behaviours are part of that, and then held a major public consultation on the draft standards[45] to seek views on whether we had got them right.

The nine standards we developed cover person-centred care, partnership working, effective communication, professional knowledge and skills, professional judgement, professional behaviour, confidentiality and privacy, speaking up about concerns and leadership. We think these are fundamental elements of the relationship between patient and health professional; and so by focusing the standards on these essential elements we have as far as possible tried to 'future-proof' the standards.

The consultation was invaluable in helping us to check for unintended consequences of the new standards. One of the areas we had to consider was potential unintended consequences for decision-making in our fitness to practise processes. Part of the work we did was to revise our decision-making guidance for our committees, to align this with the new standards. As an example, candour and confidentiality are two key areas that are highlighted in the new standards, and so they have been emphasised within the new guidance for decision-makers.[46]

We also had to carefully consider the standards from the perspective of revalidation, as we knew we wanted the standards to sit at the heart of the new process we were developing for assuring that pharmacy professionals remained up-to-date and fit to practise throughout their careers.

We've designed revalidation so that it makes pharmacy professionals engage with the standards and reflect on them in relation to their own practice. This will be particularly helpful in evaluating the impact of the standards. It is notoriously difficult to evaluate the impact on standards on practice, but the way in which we have integrated the standards within revalidation enables us to evaluate their impact through our evaluation of revalidation.

Developing our framework for revalidation

The principles of right-touch regulation again proved a valuable framework in developing our approach to revalidation. With revalidation, we spent a long time working out what the problem was. What was revalidation being introduced to solve? Without developing this understanding of the problem, we could have introduced something that was disproportionate and burdensome.

A key challenge for us was considering how to deal with the significant variance in risk across the different roles and tasks within pharmacy. Some pharmacy professionals are working in incredibly high-risk roles; for many others the risk to patients is much less. We had to be careful not to treat the professions we regulate as homogenous in terms of risk; you can go too far in regulation by trying to regulate everyone at the level needed by the most high-risk group working in the most complex roles. We therefore decided to build a flexible model to take into account the different levels and types of risk in different roles.

And we wanted to make sure we developed an approach that worked for pharmacy and the approach we have gone for is very different to that developed for doctors or nurses. Our approach, set out in the revalidation framework,[47] doesn't intend to assess the personal competency of everyone on the register. This would be a disproportionate endeavour and its complexity would almost certainly mean it would be impossible for a regulator to achieve in reality. Instead it is about encouraging reflection, behavioural change and improvement in practice.

Enabling improvement

Through the work we do, we aim to promote professionalism, support continuous improvement and assure the quality and safety of pharmacy. We believe regulation is not just there to reduce risk of harm, but to encourage improvement.

When it comes to regulating individual pharmacy professionals, we want to help everybody to continuously improve; enabling and encouraging them to demonstrate the behaviours and attitudes that lead to excellent care.

The new standards and revalidation are not just there for the pharmacy professionals who may fall below the line and create a significant risk or problem. They are for everybody.

And what we've learnt in developing our new standards and our approach to revalidation is that the principles of right-touch regulation not only work when trying to reduce the risk of harm, but also work if you're trying to encourage and drive continuous improvement. They don't just help to deal with a problem, they can help you to avoid a problem in the first place and help to raise the standards of care for everyone.

About the GPhC

The General Pharmaceutical Council regulates pharmacists, pharmacy technicians and pharmacies in Great Britain. It works to assure and improve standards of care for people using pharmacy services. Its role is to protect the public and give them assurance that they will receive safe and effective care when using pharmacy services.

Find out more from: **www.pharmacyregulation.org**

Right-touch regulation: a New Zealand example

Andrew Charnock | Occupational Therary Board

Andrew Charnock is the Chief Executive and Registrar for the Occupational Therapy Board of New Zealand, a position he has held for the last eight years. Andrew originally trained as nurse in the UK where he was involved with regulation at the Nursing and Midwifery Council (formally the UKCC). He moved to New Zealand 16 years ago and held positions in the Nursing Council and Osteopathic Council.

Since reading and discussing the publications, *Right-touch regulation revised*,[48] *Rethinking regulation*,[49] and *Regulation rethought*,[50] the Board and its staff have slowly incorporated the language and philosophies outlined in the publications. It is now our practice to use the words 'right touch' in the office and around the board-table.

We would like to offer the following illustrations of how right-touch regulation is evident within our work.

Language and actions

When the Board and its staff receive a notification about conduct, competence or health, we apply a broad 'lens' to our assessment and triaging processes.

Our first approach is to fully understand the problem/s and identify the level of seriousness, or risk of harm. This part is crucial and will dictate the level and speed of our response. Added to this, we pose the following questions:

- What is the level of risk we are dealing with?
- Do we have enough information to understand the problem/s?
- Who is close to this problem/ situation?
- Where does the person work?
- What is the most appropriate action/s we need to take?
- Who is best placed to take the appropriate action/s?

These questions are posed from a position which is based on enquiry, while being non-confrontational and non-punitive in nature.

Knowing where the person works helps us to understand the nature of support or supervision that may be available to the practitioner.

A practitioner working in a large hospital could, arguably, have more supports than a practitioner working privately, or working for a small non-government organisation.

In the past we would turn directly to the legislation (*Health Practitioners Competence Assurance Act*),[51] to guide and often dictate our practice. We had two lawyers on staff to help us to do that.

Now we take a more enquiry-based approach and early engagement is sought with the complainant or employer, and practitioner. This approach takes into consideration the context and supporting structure that may be in place that are relevant to the problem. We still have work to do in this area as often people take a defensive attitude when discussing notifications. Contacting people by phone in the first instance is preferable. This is then followed by email confirmation of discussions and potential next steps.

We also consider who is best placed to deal with the issues. This may be the employer, who is local and can see, and potentially manage, the issues first hand.

For example, if the employer has a performance improvement plan in place for the practitioners, it would be counterproductive for the Board to place additional requirements on the practitioner just to satisfy our legislative requirements. We have, therefore, moved from a policing role to a facilitating, supportive role.

Our engagement with senior professional staff is important in facilitating good communications. We support and are present at the association's conferences each year. This allows us to meet practitioners face-to-face and explain our role and functions.

The language we use to describe what we are doing has also changed. The Board members now make reference to a 'right-touch' approach. To facilitate understanding of this, we have developed a flowchart to help us work through the stages of a 'right-touch' approach (see page 50).

We are also mindful of the notifications that require a swift and more authoritative response. In such cases we consider the proportion of the response to the level of risk. A maxim we often apply is 'what would the public think of our actions'? Or what does this look like from the outside, and could we present a reasoned argument for our actions?

All staff have undertaken a plain English course to reduce the complexity of the language used in our communications. This is perhaps another aspect of keeping it simple, described in one of the elements of 'right touch'.

Our plain English approach is still a work in progress as regulation and bureaucratic administration tends to lend itself to a more defensive practice in all forms of communication.

Like others, we have tended to rely on template letters which we tweak to match the circumstances. We need to move away from this and personalise our communications. It is a leap of faith when an organisation moves from the safety net of statutory requirements to the principles and processes described in the work of *Right-touch regulation*. We believe the 'leap' has been quick and successful for the Board. Some of the reasons for this are described in the next section.

The culture of occupational therapy practice

It has been suggested that the practice and philosophies of occupational therapy fit with the concept and principles of right-touch regulation. This may be part of the reason why the Board (six practitioners, two lay people) have accepted the concept so well.

The ideas of inclusion and social justice, a rehabilitative approach, and maintenance of occupation required in the practice of occupational therapy, enables the proportionality of actions, identified in *Right-touch regulation*, to be observed. The principles of social justice are also part of the ethics of occupational therapy practice in New Zealand.

Recently I had a discussion with a practitioner who felt our regulatory approach should mirror the philosophical approach of the profession. In essence, this would mean the importance of occupation, equity and social justice. This is an interesting observation and one which may encourage further engagement and understanding of our role by the profession.

The advent of a 'right-touch' approach to the work of the Board, has allowed the Board to move from a reactive position to a more proactive position. This in turn will change our Board meeting agendas. It will give us time to 'look out' (horizon-gazing) and so gain a deeper understanding of the profession and the issues of practice.

One mechanism the Board has used to identify the issues in practice, is to meet frequently with the profession. Face-to- face meetings help practitioners to understand the work of the Board, while allowing the Board to understand practice. The Board holds symposiums throughout the country to facilitate such meetings.

Understanding practice provides insight into the issues facing practitioners. This in turn provides an opportunity for the Board to develop guidelines and policies to support practice. This assists the Board to be seen as proactive and accessible in its work.

It also allows the Board to be agile in responding to changes in practice. At the same time, the Board obtains a view of practice which provides context and understanding when considering risk factors. Too often

regulation takes place in a vacuum without clear understanding of the practice context and the various support systems available to the practitioner. An area for future development will be discussions on the ability to offer welfare support for practitioners who are facing problems. Having a welfare service may provide support to practitioners and so avoid the development of problems.

Maori cultural connection and beliefs

Maori make up 15 per cent of the population of New Zealand. Just over 3 per cent of occupational therapists identify as Maori. New Zealand has a unique piece of legislation[52] which requires recognition of Maori.

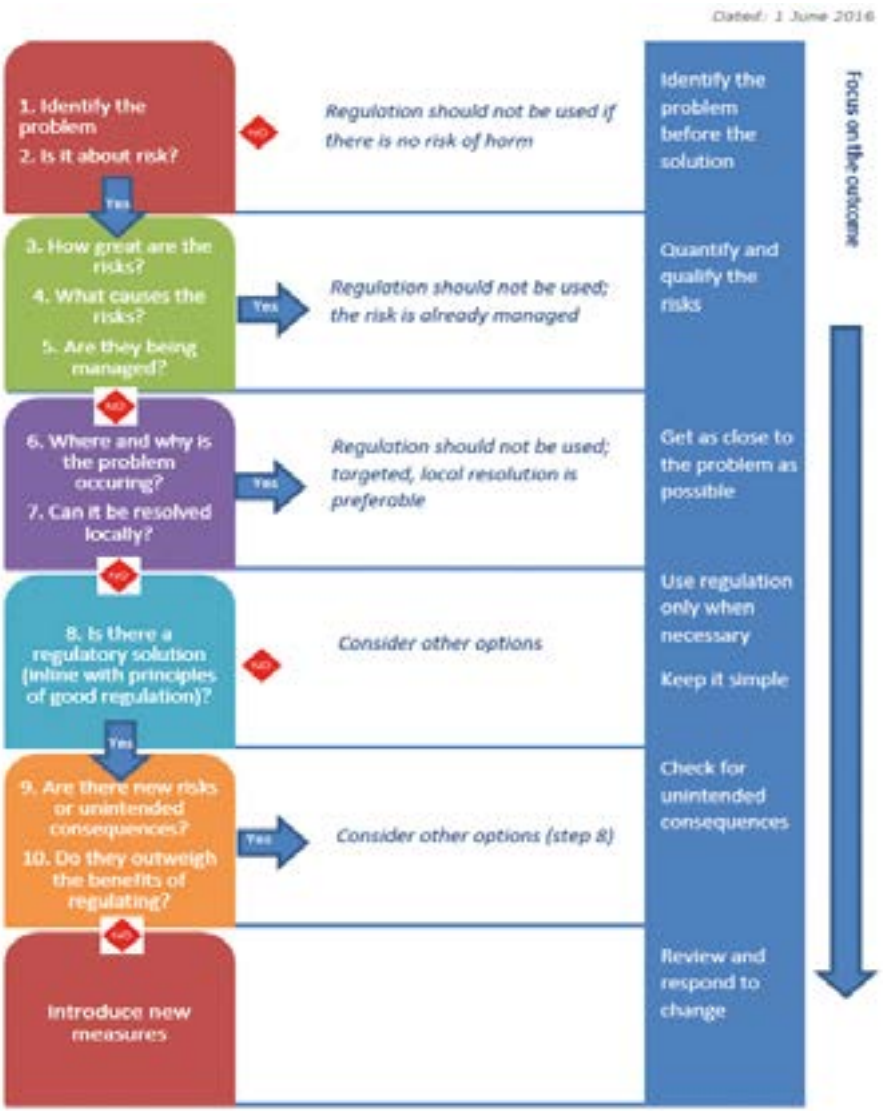
The approach Maori prefer to take on addressing issues is kanohi ke ti kanohi or face-to-face. We believe, from our experience, that this fits with the concept of right-touch regulation. Being able to get close to the practitioner and any problems that present, leads to a better understanding. It also cuts down on the formality of written legalese and jargon, and encourages meaningful and lasting engagement. A by-product of this approach is the learning that can take place.

Facilitated Resolution Policy

We have developed a *Facilitated Resolution Policy*.[53] We believe this policy supports many of the principles of right-touch regulation. It provides the Board with another mechanism to deal with concerns and complaints.

The purpose of the policy is to provide a facilitated resolution process for complaints and concerns brought to the attention of the Board. It involves the complainant, the health practitioner and other relevant stakeholders, without the need for a statutory response, unless required, under the provisions of the *Health Practitioners Competence Assurance Act* 2003 (HPCAA).

This policy allows for a variety of resolution processes to be used, depending on the circumstances. These include negotiation, mediation, tangata whenua tikanga and restorative resolution processes. It clarifies the procedures to be followed when the option is chosen. Our legislation is currently under review and we have promoted the inclusion of the policy.



About the OTBNZ

The Occupational Therapy Board of New Zealand is a health regulatory authority. It ensures the safety of consumers using occupational therapy services. It does this by making sure all occupational therapists meet the specifications of the *Health Practitioners Competence Assurance Act* 2003.

Find out more from: **www.otboard.org.nz**

Irwin Fefergrad | RCDSO

Right-touch regulation in practice

Irwin Fefergrad, CS, BA, BCL, LLB, is Registrar of the Royal College of Dental Surgeons of Ontario. Appointed in 2000, he is the first Ontario lawyer to receive a specialty in the practice of health law. He is also Executive Director of the International Society of Dental Regulators, Chair of the Advisory Group for Regulatory Excellence (AGRE) in Ontario, and Assistant Professor (adjunct) at the University of Toronto, Faculty of Dentistry.

Sometimes the very best ideas are the simple ones.

As a lawyer with a deep interest and history in health law, I know all too much about complexity and nuance in regulation. As the first-ever non-dentist Registrar for the dental regulator in Ontario, Canada, I have learned to ask, 'What is the problem we're trying to solve?' and 'How do we make this simpler?'.

After about 10 years in the Registrar's chair, I had an opportunity to start looking more closely at what was going on around the globe in regulation. The timing was good; there was much to learn, digest, see and hear.

In Ontario, our once-cherished model of profession-led 'self-regulation' was under tremendous scrutiny – and rightly so. At that point we were one of the few jurisdictions in the world still holding on to a 'pure' version of that regulatory model.

When our governing legislation, the *Regulated Health Professions Act*, became law in 1991, it was ground-breaking. Two decades later, the world was a completely different place. We began to hear stakeholders, consumers and governments around the world calling for more accountability, accessibility and transparency.

Our College supported (and still holds dear) those very same values. We made every effort to put them into action. And we believed that we were pretty successful at doing that within the framework of profession-led self-regulation.

Perhaps we were. But that had not been the experience of a significant number of major regulators in Australia, New Zealand, the UK and even elsewhere in Canada.

As we looked a little closer, we began to see countries where profession-elected governance models in

regulation had been modified and, in some cases, discarded, where governments had imposed a new way of doing business. Those governments decided that healthcare regulation was much too important to be left exclusively to the professionals who elect governing councils.

In Ontario, and at our College, we began to examine how we could assure greater competencies on committees and how we could have the majority on our Council not be elected.

The more I looked, the more it seemed that all forward-thinking in regulatory roads were leading to the Council for the Regulation of Health Professionals in the UK (soon to become the Professional Standards Authority). In 2011, I attended a conference with our then College president, Dr Peter Trainor, to hear Harry Cayton speak.

What we heard was simple – and a revelation. Here was a model that would help keep us on the path towards accountability, accessibility and transparency, but that also seemed to offer a lot more. We felt confident we were already doing many things well; the eight key elements at the heart of right-touch regulation would point to where and how we could improve and perhaps suggest how we might meet new challenges as they appeared.

Our Council thought it would be fabulous if we could engage Harry Cayton himself to measure our regulatory performance based on the international standards that he had developed. We approached him, and it was agreed that the Professional Standards Authority would conduct a full review of the Royal College of Dental Surgeons of Ontario (RCDSO) and measure us against the international standards that the Authority had created. There was one binding condition that, of course, exemplified the right-touch approach to transparency; we had to agree that the Authority's final report, good or bad, would be made public.

The review process started in early January 2013. College staff prepared volumes of material and shipped it off by air express to London. Meetings were held to consider detailed questions from the Authority and to review how the College did its work. In mid-April Harry Cayton and Douglas Bilton, the Authority's then Research and Knowledge Manager, came to observe and review our processes in practice. They met with external stakeholders, some Council members, and College staff.

When the report landed in June of that year, with great anticipation we read it carefully. Harry wrote to me to say, 'We consider that the College meets all the relevant standards of good regulation and that it demonstrates best practice in a number of areas. We make a small number of recommendations with the aim of assisting you in

improving some internal processes or enhancing the quality of the work you already do.'

For some, this would be the end of the story – standards reached, recommendations addressed, and a pat on the back – done.

For the RCDSO, it was the beginning of a new chapter.

The model of right-touch regulation genuinely spoke to all that we did (and continue to do). The impact of answering the questions, of looking more closely at our processes and approaches in general, was felt across the College. From our perspective, it began to change business behaviours. Here are but a few examples.

We asked important questions around transparency: what information does the public need to have to make informed choices of their healthcare providers and how can we facilitate the delivery of that information?

In 2014/15 our Council passed by-laws with sweeping changes on what was easily available on our website for all to see. We continue to evaluate how we can do better on transparency.

More focus came in early 2015 when the Government of Ontario launched a new phase in its plan for healthcare – *Patients First*. That mantra reflected our mandate and became, at one stroke, a rallying cry and a test for all our activities: 'does this activity/programme/policy put patients first?' If the answer was no, we knew we had work to do.

This period of self-assessment also helped us understand the need to approach all our work in a much more evidence-based and data-driven way.

For example, one of our keys duties at the College is to receive written complaints from members of the public regarding dental care. In 2016, the RCDSO received 712 letters of complaint or inquiry; 525 of those became formal complaints.

The complaints contain a lot of information, but we have not done much work looking at categories or themes in complaints. We had great data at the decision-making level, but we did not really appreciate what the public was telling us through the vehicle of the complaint. So, the College engaged an epidemiologist to study patterns and to understand what they reflect about public thinking, regardless of outcome.

The data analysis team did a pilot study to create a taxonomy and is applying those categories to a much broader sample of complaints data. We hope to gain insights on how to conduct better education and to drive more effective communications.

Similar data analysis was done on patterns of opioid prescribing in Ontario and brought us more useful information – and even some good news.

The College had requested and received narcotics monitoring system data for 2015 and 2016. This data, along with that received for 2014, was provided to an epidemiologist for analysis.

The results are encouraging. They strongly suggest that dental patients in Ontario are getting the right drug, in the right amount and only once. Even better – over a relatively short time span, the data shows a statistically significant decrease in opioid prescriptions and the number of drugs made available via dentists in Ontario since 2014 – about 4.4 per cent over two years.

We believe that this reflects a growing awareness on the part of prescribers, supported by the publication of the College's guidelines on the topic. Of course, we will continue to monitor opioid provider practices in the dental community and promote appropriate prescribing through the use of our guidelines. Further study of the data may suggest where more education is needed, and the College will work with others to help develop appropriate programmes across Ontario.

The point of these two examples is that more knowledge and analysis is critical to some of the elements of right-touch regulation:

- Identify the problem before the solution
- Quantify and qualify the risks
- Get as close to the problem as possible.

We even found, in the case of the opioid report, that there was an effective solution – education – that did not rely on regulation. As right touch says:

- Use regulation only when necessary.

'Focusing on the outcome' has led us to much more analysis and planning. Developing and using criteria in decision-making has been a huge step forward for us. For example, we built a new *Risk Assessment Framework* and Tool for use by our Inquiries, Complaints and Reports Committee, including a separate tool for interim orders. Assessing risk through a 'patients first' lens helps establish better priorities and assigns resources where they are most needed.

We also created a staff working group on Process Mapping to improve efficiency in the complaints process and to identify and reduce processes that do not actually add value. This is helping to streamline processes and move cases through the system more efficiently.

If the desired outcome is excellent patient safety and care, then helping our members maintain and improve their skills and protocols makes sense. Lately we have extensively revised our *Standards on Infection Prevention and Control* (IPAC), and our *Sedation and General Anesthesia*

Standard. Both documents benefitted from broadly-based working groups of experts, clinical and regulatory. Our IPAC work was further strengthened through a new collaborative relationship with local public health units. We helped them to understand how their principles could be best applied in the dental office; one result was new checklists for inspectors that also help dentists self-assess their IPAC protocols. Another staff working group does future-planning on issues related to IPAC. In all areas of dental practice, continuous education is in play through our quality assurance work.

While we do not control all aspects of our governance, we can make it better. Our Council spent a day brainstorming with staff, developing new ideas to bolster competencies and tighten eligibility requirements. Now, prospective Council and committee members must complete an online eligibility training course, so they understand their responsibilities before they throw their hat in the ring. Our statutory committees have their own competencies to ensure people with the rights skills are matched to the right jobs.

A critically important element of our governance is the role of public (non-dentist) members. Many of our committees are chaired by public members who bring the public interest to their decision-making. But more and more, we find that the need to put patients first is trumping self-interest among all governance groups.

Patients need the best information too. That is why we have completely revamped our website to make it more accessible, informative and engaging. We worked with other leading colleges in the health sector to improve shared transparency principles. That same group also focused on better consistency among regulators so patients can better navigate the system. We made more information available to the public through our by-laws before being required to do so by the government. We strengthened communications to the public and membership around sexual abuse prevention and dentist-patient boundaries, again anticipating legislative change and proving leadership across the sector.

We are trying to live the eight elements of right-touch regulation. Despite the temptations of legal and clinical nuance, we are trying to keep it simple. We are checking for unintended consequences with better metrics, more analysis and reaching out to a wider community to help us understand the ramifications of our actions.

And then, we do it all again. Review and responding to change is not the last step; it is the direction to renew and revitalise. We know that in the coming years there will be new statutory imperatives, new clinical information, new awareness among patients.

We are working now to be ready. Right-touch regulation is guiding our organisation in ways that we did not anticipate when I heard Harry Cayton speak in 2011. His work has helped take the long-practised strengths of our organisation and bring improved focus to all that we do. And where there is an 'unintended consequence' we did not foresee; we are happy to face that consequence.

About the RCDSO

The Royal College of Dental Surgeons of Ontario is the governing body for dentists in Ontario. Its mission is to protect the public's right to quality dental services by providing leadership to the dental profession in regulation.

Find out more from: **www.rcdso.org**

Jonathan Gorvin | RICS

Right-touch regulation at RICS

Jonathan Gorvin is RICS' Head of Regulatory Policy and Development. He is a trustee of the Science Council, and regularly provides advice to governments on approaches to professional regulation. Jonathan was previously Head of Regulatory Affairs at the Press Recognition Panel, where, following the Leveson Inquiry, he developed the regulatory approach to recognising and monitoring press self-regulators.

Introduction

The Royal Institution of Chartered Surveyors (RICS) is a global professional body, which sets and enforces international standards in the valuation, management and development of land, real estate, construction and infrastructure. Working in the public interest, we regulate over 125,000 individuals and 10,000 businesses across nearly 150 countries. As a non-statutory regulator, our regulatory powers are derived through contracts with those we regulate. Individuals and businesses choose to be part of our regulatory regime because the market, the profession and the public recognise the value of it.

Like many other sectors, the professional services sector is increasingly transboundary. Not only are the largest suppliers based in multiple markets, but the services they offer, and clients they work for, are also global in nature. This globalisation has led to market demand for the development of international standards, underpinned by regulation, to ensure key technical activities and behaviours are globally consistent.

When implemented correctly, international standards and regulation can play an important role in the development of economies and societies.[54] By increasing transparency and technical and behavioural consistency in professional services, particularly financial audit and asset valuation, regulation can help to build confidence in markets, which in turn helps promote inward investment and economic growth.[55] Implemented poorly, regulation can increase burdens on businesses, stifle innovation and ignore consumer detriment; leading to a lack of confidence and trust in the regulator, and the activities that it safeguards.[56]

This loss of confidence is particularly important for professional self-regulatory bodies like RICS, where there is no compulsion for the profession to join, and whose value is derived from the confidence its brand imparts. It is therefore imperative that RICS has an approach to regulation that effectively controls the key risks posed in a targeted and proportionate way.

For the past two years, we have been establishing right-touch regulation as the foundation of our regulatory approach. In this short paper, we share three examples of how we have used right-touch regulation in our work. Firstly, in our process for identifying regulatory risks[57] and appropriate controls; secondly, in how we use our direct connection to the market to engage with stakeholders and get as close to the problem as possible; and, thirdly, in focusing on the outcome by establishing alternative decision-making processes in our disciplinary function.

Example 1 - Identifying the problem before the solution

I once worked with a consultancy that described itself as solutions-focused. They were true to their word, providing multiple solutions to unclear problems. Given the number of solutions provided, some certainly helped mitigate the problem originally put forward in the brief, but this was by chance, rather than design, and the process lacked efficiency, as their bill showed.

Until two years ago, RICS operated in a similar way. Committees of professionals, along with other stakeholders, would consider the need for regulatory change, but the reason for this change – the problem – was not clearly defined or understood.[58] This led to a plethora of standards, rules, guidance documents and schemes being created, which required an enormous amount of resource to develop and maintain, were confusing for the profession to follow, and did not effectively target regulatory risks.

Using the principles of right-touch regulation, RICS changed this way of working to better target its resources. A new framework was established requiring standards and policy setters to profile and assess risks before proposing proportionate and targeted solutions (both regulatory or non-regulatory). The framework requires individuals to draw on internal and external information to substantiate the problem posed and consider a wide spectrum of tools to control that risk.

To set the baseline for this risk analysis, we commissioned Ipsos MORI to undertake a global review of risks in the surveying profession. Using a wide variety of sources and research techniques, including interviews with services users, members of the public and the profession, this review assisted us

in understanding key areas of focus and prioritisation for our activities.

While this approach is still new, we have already seen positive outcomes. The number of new controls being put forward has reduced considerably as people are now better at considering risks, allowing us to prioritise our resources in better ways.

This approach to standard and regulatory development has also increased engagement in consultations. The sheer number of activities taking place previously had led to consultation fatigue, but with fewer, well timed and better targeted activities, we are seeing increased engagement, leading to a better understanding of impacts and unintended consequences in proposed approaches.

Example 2 – Getting as close to the problem as possible

As a transnational regulator, covering a wide range of professional activities, we need to ensure we get as close to the problem as possible, in order to properly consider the geographical and sectoral scope of a particular risk. A risk in one market, may not be replicated in others, or globally.

In line with the principles of right-touch regulation, when identifying the risk using the framework discussed above, we require policy makers to work closely with, and involve, stakeholders that are closest to the risk identified; as insights gained from the market and/or sector allow us to better tackle a problem at its source. Similarly, when developing our approach to controlling a risk, we ensure that those closest to that problem are engaged with developing the control.

This process ensures that we, as regulators, do not become detached or distant from the problem in question, as solutions are developed with a clear understanding of the context and concerns of those most affected in mind. This understanding, and appreciation, also helps us in considering the impacts and unintended consequences of introducing new regulatory measures, where they are required.

A recent example of this approach is demonstrated in the development of RICS' requirements on conflicts of interest. A risk within the profession of not acting impartially, or in the best interest of a client, was identified and assessed by working closely with service users, the regulated population and other stakeholders. Following this assessment of risk, a control was proposed in the form of a new global mandatory requirement on conflicts of interest.

Through the process of consulting on this requirement, an additional risk was highlighted in the United Kingdom (UK), which was not dealt with as part of the global requirement. RICS got as close to this problem as possible, by working

with stakeholders in key markets, to assess whether this risk was isolated to the UK or replicated elsewhere.

Following this assessment, it was considered that the risk identified in the consultation was localised to the UK, and therefore the original wording in the proposed control did not need amending; instead, an additional requirement was put forward on those in the UK to manage that specific market risk.

The process we undertook in this example, using right-touch regulation, ensured our response to the problem identified was proportionate and targeted.

Example 3 - Focusing on the outcome

Professional disciplinary tribunals are costly, time-consuming, and not always in the best interests of the parties involved. Using right-touch regulation, RICS has reviewed alternative approaches to disciplinary decision-making, which focus on the outcome, rather than being concerned with the process.

RICS already has options to use consent orders in which to agree conditions and fines on less serious cases, we also have powers to hold disciplinary panel hearings solely on the papers. However, these are only available for certain types of allegation, or where the regulated individual or business makes full admissions. We therefore wanted to develop an additional decision-making option to allow us to take the most proportionate approach to cases.

Under our new approach to alternative disciplinary decision-making, we intend to allow for decisions on all but the most serious and contentious of cases to be made on the papers by a single decision-maker, drawn from RICS' independent disciplinary tribunal. The decision-maker will be able to make findings of fact and impose most of the sanctions available to the tribunal; however, the regulated individual or business will retain the right to have an oral hearing before a tribunal where they do not agree with the decision made by the single decision-maker.

We believe this proposal provides us, as the regulator, with greater flexibility to focus on a more goal-based outcome underpinned by a set of principles, rather than a prescriptive disciplinary approach, and gives us the ability to use the most proportionate decision-making option, without removing any rights from those being disciplined.

While this initiative has yet to be formally approved and implemented, we have received positive feedback during consultation and engagement on the approach.

Conclusion

I include a copy of *Right-touch regulation* as part of the induction pack for all new starters in my

team. Right-touch regulation provides an effective foundation in which to approach our work, and a useful tool in communicating this work. It is more accessible than similar frameworks produced by others, such as the OECD, and it is particularly useful for RICS, as a global body covering a disparate sector, because it encourages policy-makers to get as close to the problem as possible. A risk posed in one region or sector, is not always replicated in others.

I also believe that being a non-statutory regulator allows us to support right-touch regulation in more diverse ways than our peers, as we have greater flexibility, and a wider regulatory toolkit to use, than statutory regulators.

If there were to be a criticism, it would be less of right-touch regulation, and more of regulators. Right-touch regulation requires us to review and respond. However, while as regulators we have become better at understanding and assessing risks, and putting in place appropriate controls to manage these, we have a tendency – not to reflect on the effectiveness of those controls after implementation. As regulators, we need to reflect back, further down the line, on whether the intervention has been successful, and if not, how can it be developed in the future.

It would be valuable for right-touch regulation to consider the process of reflection in further iterations.

About RICS

The Royal Institution of Chartered Surveyors is the global professional body promoting and enforcing the highest international standards in the valuation, management and development of land, real estate, construction and infrastructure.

Find out more from: **www.rics.org**

Notes

1 The professions regulated are: Aboriginal and Torres Strait Islander health practice, Chinese medicine practice, chiropractic, dental, medical, medical radiation practice, nursing, midwifery, occupational therapy, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology. Paramedicine is scheduled to join the National Scheme as a regulated profession from late 2018.
2 One for each health profession group that is part of the National Scheme, except nursing and midwifery which are considered distinct professions, regulated by the one Board.
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8 Five pillars of the PPF are:

1. Strengthened continuing professional development (CPD) requirements.
2. Active assurance of safe practice.
3. Strengthened assessment and management of medical practitioners with multiple substantiated complaints.
4. Guidance to support practitioners – regularly updated professional standards that support good medical practice.
5. Collaborations to foster a culture of medicine that is focused on patient safety, based on respect and encourages doctors to take care of their own health and wellbeing.

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19 In the sense of being more agile and high level, not in the sense of imposing lesser standards on members.
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for Health and Social Care September 2018

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