A WEBINAR FOR DENTAL ASSOCIATIONS & LEGISLATORS

# Protecting the People Who Protect Our Smiles

Why self-referral changes everything — the two referral pathways, the five-tier ladder, and how every state can climb.

**2 of 50**

states currently have a dedicated dentist health program statute

# Dentistry's Well-Being Crisis, By the Numbers

**~2x**

the proportionate suicide mortality rate of dentists compared with the general U.S. population

*JADA / NIOSH-CDC, 2025*

**Majority**

of practicing dentists report moderate-to-severe work-related stress

*ADA 2021 Dentist Well-Being Survey*

**46%**

of dentists are even aware their state has a dentist well-being program

*ADA 2021 Dentist Well-Being Survey*

*Dentistry carries occupational stressors most professions don't: solo-practice isolation, financial ownership risk, malpractice exposure, and physically demanding, high-precision work — often with no colleague down the hall.*

THE BARRIER

# It Isn't Awareness Alone — It's Fear

## Licensing applications ask "have you ever..."

Historically, applications asked whether a dentist had ever received treatment for a mental health condition or substance use — treating help-seeking itself as a red flag.

## Self-reporting can trigger discipline, not support

Without a confidential, non-punitive pathway, coming forward can mean a board investigation instead of treatment — so dentists learn to stay silent.

## The result: crisis-stage intervention, not early care

Problems surface only after patient safety, a practice, or a family has already been damaged — the exact outcome a health program is meant to prevent.

THE KEY DISTINCTION

# Two Referral Pathways, Two Different Populations

| | Board Referral — The Discipline Side | Self-Referral — The Confidential Side |
|---|---|---|
| **Who initiates** | The licensing board, after a complaint or incident | **The dentist — or a concerned peer — voluntarily** |
| **When help arrives** | Late — after harm, a complaint, or an arrest | **Early — illness precedes impairment, often by years** |
| **What the dentist faces** | Investigation and possible discipline | **Confidential evaluation, treatment, and monitoring** |
| **What it takes to work** | A statute and board rules are enough | **Trust: independence from the board, plus dental peers** |
| **Share of the true caseload** | The small minority already caught | **The majority — but only if the program earns the call** |

THE ALTERNATIVE

# What a State Dentist Health Program Actually Does

### Confidential referral

Self-referral or peer referral — outside the disciplinary process

### Clinical evaluation

Independent assessment and connection to appropriate treatment

### Monitored recovery

A structured, documented agreement that protects patients

### Board advocacy

Support for a safe, accountable return to practice

### Family support

Resources for the families affected alongside the dentist

### Legal protection

Confidentiality safeguards written into the statute itself

MODEL ONE

# Maryland's Statutory Approach

**Health Occupations Article § 4-501.1 — "Dentist Well-Being Committee"**

- Codifies the Dentist Well-Being Committee in state law — not just association bylaws
- The State Board of Dental Examiners funds the Committee's budget (§4-207)
- The Legislative Auditor audits its accounts and transactions, like any public program
- Operated through the Maryland State Dental Association since 1980
- Evaluates and assists any dental provider needing treatment for alcoholism, drug abuse, chemical dependency, or other physical, emotional, or mental condition

## Since 1980

Maryland's program predates most physician health programs nationally — proof this model is durable across four decades of board and legislative turnover.

MODEL TWO

# North Carolina's Statutory Approach

**N.C.G.S. § 90-48.2 — "North Carolina Caring Dental Professionals"**

- Statute authorizes the Board to contract with a special impaired-dentist peer review organization
- Tripartite governance: NC Dental Society, State Board of Dental Examiners, and the UNC School of Dentistry
- Board rule 21 NCAC 16S operationalizes identification, intervention, treatment, referral, and follow-up
- Peer liaisons conduct interventions and monitor treatment compliance directly
- Running continuously since the legislation passed the General Assembly on April 1, 1994

## 3-Way Governance

Splitting oversight across the society, the board, and the dental school gives the program clinical credibility, regulatory legitimacy, and professional trust all at once.

THE CORE ARGUMENT

# Why a Statute Beats a Handshake

| | Voluntary / Association-Only | Independent Statutory Program (MD / NC) |
|---|---|---|
| **Funding** | Depends on annual association budget | **Board-funded / dedicated fee mechanism** |
| **Survives leadership turnover** | Fragile — tied to current volunteers | **Codified — outlives any one leader** |
| **Legal confidentiality protection** | Limited, informal | **Written into law** |
| **Relationship to licensing board** | Ad hoc, goodwill-based | **Defined by statute and board rule** |
| **Long-term durability** | Vulnerable to being deprioritized | **Proven over decades (MD, NC)** |

THE NATIONAL PICTURE

# 48 States Still Have No Program Statute

**2**

states with a dedicated dentist health program statute

Several states have passed statutes that name dentists — **Connecticut's HAVEN and Virginia's Safe Haven** extend wellness protections to health professionals generally, and some boards run alternative-to-discipline programs.
But most of these live on the board side. A program sponsored by a licensing board or health department can never be truly confidential — and it will never receive self-referrals, where most cases actually reside.

So “dentists included” on paper can still mean nothing on the confidential side. Only Maryland and North Carolina have independent, purpose-built dentist programs recognized in statute.

WHAT'S AT STAKE

# The Cost of Leaving This to Chance

## Patient safety

Unaddressed impairment goes undetected longer without a structured, confidential monitoring pathway.

## Delayed care

Dentists wait until crisis — or a board complaint — before getting help, when earlier treatment works better.

## Workforce attrition

Burnout-driven exits shrink an already-strained dental workforce, especially in rural and underserved areas.

## Inconsistent protection

A dentist's access to confidential help depends entirely on which state line they practice behind.

WHY NOW

# The Profession Is Already Moving

**2023**

## ADA House of Delegates resolution

Directs the ADA to help states develop legislation and regulations against licensure discrimination for dentists who sought mental health or substance-use treatment.

**2024**

## ADA pilot project launched

Florida, New Jersey, and Wisconsin selected as pilot states to test the licensure-reform playbook, with a toolkit built for other states to follow.

**2023–25**

## Licensure & Safe Haven reforms

Texas, Minnesota, Virginia, and North Dakota have reformed licensing questions or folded dentists into multi-profession wellness statutes.

*None of this yet replicates a purpose-built, dedicated dentist health program statute — which is exactly the opening your state can be first to fill.*

A REALISTIC STRATEGY

# Five Tiers: Where Does Your State Stand?

1. **Independent, statutory, dental-specific program —** the full model: safe to call, dental peers answering, protected in law, durably funded (MD, NC)
2. **Independent, statutory, multi-profession program —** self-referral is possible, but dental trust, peers, and outreach are diluted
3. **Association-run dental committee, no statute —** trusted peers do attract self-referrals, but with no legal protection, guaranteed funding, or durability
4. **Board- or health-department-based program —** limited to board cases by design; no dentist will call the entity that can take their license
5. **No program at all —** dentists are left to crisis, complaint, or chance

***A statute is necessary but not sufficient — sponsorship determines which referrals ever arrive.***

THE BLUEPRINT

# Core Elements of Effective Legislation

### Independent sponsorship

Housed outside the licensing board and health department — sponsorship determines which referrals ever arrive

### Confidential self-referral track

A non-punitive pathway kept fully separate from board discipline — where most cases actually enter

### Dental peers at the center

Trust comes before the call — dentists helping dentists, with society, board, and dental school in governance

### Statutory authorization & funding

Legal recognition plus a license-fee set-aside or board budget line — funded by the board, never run by it

### Confidentiality protections

Participant records shielded in the statute itself

### Oversight & accountability

Regular audit requirement to preserve public trust

YOUR PLAYBOOK

# From Idea to Statute: An Advocacy Roadmap

1. Find your state's rung — map what exists on the confidential side, not just the board side
2. Build a coalition — state dental society, licensing board, and dental school at the table together
3. Get sponsorship right — the program must live outside the licensing entity; this is the one drafting decision you cannot get wrong
4. Draft from proven templates — the AMA Physician Health Programs Act (2016) adapted for dentistry, plus MD §4-501.1 and NC §90-48.2
5. Engage legislators around patient safety and workforce retention — and pair the bill with licensure-application reform
6. Climb one rung — whatever your tier today, the next step up is a win worth passing

EVERY DENTIST DESERVES

# A Safe Path Back to Practice

Maryland and North Carolina sit at the top of the ladder — but the realistic goal isn't one bill for fifty states. It's knowing your state's tier and climbing one rung.

**This week: find out where a dentist in your state who self-refers can actually call — confidentially, outside the board. If the answer is nowhere, that is the gap to close.**