BOARD OF HEALTH

GOVERNANCE STANDING COMMITTEE

SEPTEMBER 14, 2016

PRINCE MEETING ROOM, 3RD FLOOR

www.algomapublichealth.com

Meeting Book - Governance Standing Committee - September 14, 2016

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a. Adoption of In-Committee Mintues dated June 8, 2016

b. Labour Relations or Employee Negotiations

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10. **Items Identified to be brought forth to the Board**

11. **Next Meeting**

a. Wednesday, November 9, 2016 @ 5:30 PM

12. **Adjournment**

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH GOVERNANCE STANDING COMMITTEE
SEPTEMBER 14, 2016 @ 5:30 – 6:30 P.M.
PRINCE MEETING ROOM, 3RD FLOOR
A*G*E*N*D*A

1) Meeting Called to Order — Mr. Ian Frazier, Chair

2) Declaration of Conflict of Interest — Mr. Ian Frazier, Chair

3) Adoption of Agenda Items — Mr. Ian Frazier, Chair

RESOLUTION:
THAT the agenda items for the Governance Standing Committee meeting dated September 14, 2016 be adopted as circulated.

4) Adoption of Minutes — Mr. Ian Frazier, Chair

RESOLUTION:
THAT the minutes for the Governance Standing Committee meeting dated June 8, 2016 be adopted as circulated.

5) Business Arising from Minutes

a. Communication with Municipalities – Key messages — Mr. Justin Pino, CFO

b. Terms of Reference — Mr. Ian Frazier, Chair
   i. Governance Standing Committee – Draft
   ii. Governance Standing Committee – Clean
   iii. Finance and Audit Committee – Draft
   iv. Finance and Audit Committee – Clean

RESOLUTION:
That the Governance Standing Committee recommends and put forth to the Board of Health for approval the revised Terms of Reference for the Governance Standing Committee and the Finance and Audit Committee as presented.

c. Bylaw 95-1: To Regulate the Proceeding of the Board of Health — Mr. Ian Frazier, Chair

RESOLUTION:
That the Governance Standing Committee recommends and put forth to the Board of Health for approval the revisions to Bylaw 95-1: To Regulate the Proceeding of the Board of Health as presented.

6) New Business/General Business

a. Legalization of Cannabis – Provincial Collaboration — Mr. Justin Pino, CFO
   i. Briefing Note
   ii. Cannabis Collaborative Response to Public Input
   iii. Draft Board Resolution

RESOLUTION:
That the Governance Standing Committee supports and puts forth to the Board of Health a resolution on "A Public Health Approach to the Legalization of Cannabis" as presented.

b. **Board Orientation – Saturday, October 15, 2016**

7) Addendum

8) In-Committee Mr. Ian Frazier, Chair

RESOLUTION:
THAT the Governance Standing Committee goes in-committee.

a. Adoption of Minutes dated June 8, 2016
b. Labour Relations or Employee Negotiations
c. Personal Matter of an Identifiable Individual

9) Open Meeting Mr. Ian Frazier, Chair

RESOLUTION:
THAT the Governance Standing Committee goes into open meeting.

10) Items Identified to be brought forth to the Board Mr. Ian Frazier, Chair

11) Next Meeting: Wednesday, November 9, 2016 Mr. Ian Frazier, Chair

12) That The Meeting Adjourn Mr. Ian Frazier, Chair

RESOLUTION:
THAT the meeting of the Governance Standing Committee adjourns.

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE
TERMS OF REFERENCE

O: September 22, 2015

R: Sept 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	Board of Health Governance Standing Committee
~~Purpose/Goal~~Mandate:	To ~~fulfill the following functions on behalf of the Board:~~assist the Board in meeting its responsibilities, The Governance Standing Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • ~~Governance – To S~~support the Board in fulfilling its commitment to and responsibility for sound and effective governance of Algoma Public Health (subject to the requirements of the Health Protection and Promotion Act and Provincial Public Appointments Process) • ~~—~~ • ~~Nominations - To manage the process to identify potential provincial nominees for the Board to recommend for appointment to the Board (subject to the requirements of the Health Protection and Promotion Act and Provincial Public Appointments Process)~~ • From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience. • • ~~Orientation and Education – To support the Board by ensuring that new Directors receive adequate and appropriate orientation and that all Directors are provided ongoing education to assist them in fulfilling their duties effectively.~~ Ensure the adequacy and effectiveness of the Board policies and procedures. • ~~Performance accountability – To s~~Support the Board in overseeing key elements required to ~~achieve its vision and mission.~~ ensure accountability, transparency and effective performance.
Roles & Responsibilities:	These Governance functions are fulfilled through the following roles and responsibilities: • Enable the Board to meet its fiduciary obligations by defining APH's approach to governance and supporting processes and practices that promote a leading-edge governance culture; • Recommend, where appropriate, changes to the mandate of the Board of Directors and each of its Committees based on the needs of APH and evolving governance standards (subject to requirements of the HPPA and Municipal Acts) • Recommend, where appropriate, the development and oversee the

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	implementation of new governance structures, processes and protocols that enable the Board to fulfill its governance role effectively; • Support the Board of Directors in fostering a positive relationship with its key stakeholders; • Support a high standard of Board conduct and performance • Review Board policies on a regular basis, and at a minimum of every two years, and make recommendations to the Board to ensure currency and relevancy • Recommend and oversee the implementation of a governance review/ evaluation process regarding the performance of the Board, the Board Chair, committee chairs, committees and individual Directors; • Recommend procedures for the ongoing assessment of Board and Committee meeting effectiveness; • Recommend changes to address effectiveness issues arising out of these evaluations; • Assess the adequacy of the quality and timeliness of information provided to the Board of Directors and its Committees and make recommendations to the Board of Directors for change where appropriate. • Approve and monitor various measures of performance accountability on a regular basis. • Support the Chair of the Board of Health with MOH/CEO/CAO review as requested; • Oversee succession planning for the MOH/CEO/CAO, including development of a clear and transparent process to recruit and select a future MOH/CEO/CAO. • Ensure that there is an appropriate orientation and education program for new Directors and continuing education for all Directors including making recommendations on methods to improve Directors' knowledge of Algoma Public Health and their responsibilities as Directors; • Oversee the implementation of orientation and education programs for Directors to ensure these are undertaken effectively. • The Committee shall study and make recommendations to the Board on any matter as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Governance Standing Committee will also serve as the 2nd Vice-Chair of the Board of Health. ~~The Governance Standing Committee shall elect a chair amongst them. The Board Vice-Chair may be appointed as Committee chair.~~ The Committee chair is responsible in consultation with MOH/CEO/CAO for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The committee may elect a vice-chair.on an annual basis. ~~The Committee chair may be appointed for a term that is not longer than his or her term as a Director and may be reappointed for as many terms as the Board determines.~~

Recorder:	The secretary to the Board will act as recorder for the Governance Standing Committee.
~~**Delegation of Authority from the Board:**~~	~~No authority is delegated by the Board through these terms of reference. However, the Board may from time to time delegate specific responsibilities to the Committee by resolution of the Board.~~
Reporting and Accountability to the Board:	The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-chair or another Director member of the Committee or to staff.
Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Governance Standing Committee shall be comprised of: • Up to six (6)~~five (5)~~ members of the Board of Health plus the Board Chair and no less than three (3) voting members; • ~~Board Chair as an ex-officio, non-voting member~~ • MOH/CEO/CAO of Algoma Public Health, non-voting members • Director of HR and Corporate Services – non-voting member • Director of Promotion and Prevention~~Community Services~~ – non-voting member • Director of Protection and Prevention~~Clinical Services~~ – non-voting member ~~The Committee shall have a minimum of three and a maximum of five members, all of whom shall be Directors. The Board Vice-Chair normally shall be a member of the Committee. The Board Chair may member of the Committee. Chairs of other standing committees normally would not be appointed as members of the Committee.~~ Board Committee members will be appointed annually by the Board ~~for a term not exceeding their term as a Director and may be reappointed at the discretion of the Board~~
~~**Reporting to:**~~	~~Algoma Public Health Board of Health~~
Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity plan.~~workplan~~. Additional meetings can be held at the call of the Chair or at the request of the Board. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee. ~~The Committee will meet at least four times a year. Meetings may be more frequent in the first year.~~ ~~The Committee may meet on other occasions at the call of the Committee chair or at the request of the Board.~~
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board

	meetings as set out in By-Law No. 95-1 The Committee may, with the approval of the Board, establish sub-committees.
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendations for any amendments to the Board for its review and decision re: approval.
Distribution of Minutes:	Minutes shall be provided to the committee members and the Board of Health.~~Distribute to committee members and the Board of Health members.~~

Signature of Board of Health Chair

Date

TERMS OF REFERENCE MEMBERSHIP

	Name	Position
1	Ian Frazier	~~Board Member~~Committee Chair
2	~~Lee Mason~~Candace Martin	~~Board Chair~~Committe Vice-Chair
3	~~Candace Martin~~Sue Jensen	Board Member
4	~~Sue Jensen~~Vacant	Board Member
5	Vacant	Board Member
6	Vacant~~Ex- Officio~~	Board member
6	Lee Mason	Board Chair
~~5~~7	Ex-Officio Tony Hanlon or CA0	CEO or CAO
~~6~~8	Antoniette Tomie	Director of Human Resources and Corporate Services
9	Laurie Zeppa	Director of Promotion and prevention~~Community Services~~
10	Sherri Cleaves	Director of Protection and Prevention ~~Clinic Services~~
~~7~~11	Christina Luukkonen	Recording Secretary
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Guide for Completing Terms of Reference

- Please complete each section of the terms of reference (TOR) form.
- None of the sections should be blank.
- Ensure a copy of the previous TOR accompanies the newly edited TOR with the changes highlighted.

Name:	Indicate the name of the committee
Purpose/Goal:	Indicate the end result that the committee's plan is intended to achieve. Use round bullets to identify individual points.
Objectives:	Previously Goals/Responsibilities Indicate the activities, objectives, responsibilities that the plan will take in order to achieve the goal, e.g., To discuss…To review…To create…To facilitate, etc. Use round bullets to identify individual points.
Chair:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Recorder:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Membership:	Indicate position titles not specific names. If necessary, complete the Terms of Reference Membership and attach to the TOR. Include the Chair's title in this section. If the chair rotates, indicate: 'Chair rotates'
Reporting to:	Indicate position title or name of committee, e.g., Management Committee, to whom the committee reports and who will act on committee recommendations/ suggestions.
Frequency:	Indicate the number of times the committee will meet, e.g., once per month for one-hour session. Quorum is not required to hold a meeting.
Term:	Indicate the length of time members remain on the committee, e.g. membership will change every two years.
Decision-making Format:	Indicate consensus/ majority/ not applicable, etc. Consensus is preferred where possible. Quorum is required (50 percent participation plus 1 individual).
Distribution of Minutes:	Indicate the 'Reporting to' individual(s), committee, etc. along with who will benefit from the Committee. Membership will automatically appear.

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE
TERMS OF REFERENCE

Original: September 22, 2015

Revised: September 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	**Board of Health Governance Standing Committee**
Mandate:	To assist the Board in meeting its responsibilities, The Governance Standing Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • Support the Board in fulfilling its commitment to and responsibility for sound and effective governance of Algoma Public Health (subject to the requirements of the Health Protection and Promotion Act and Provincial Public Appointments Process) • From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience. • Ensure the adequacy and effectiveness of the Board policies and procedures. Support the Board in overseeing key elements required to ensure accountability, transparency and effective performance.
Roles & Responsibilities:	These Governance functions are fulfilled through the following roles and responsibilities: • Enable the Board to meet its fiduciary obligations by defining APH's approach to governance and supporting processes and practices that promote a leading-edge governance culture; • Recommend, where appropriate, changes to the mandate of the Board of Directors and each of its Committees based on the needs of APH and evolving governance standards (subject to requirements of the HPPA and Municipal Acts) • Recommend, where appropriate, the development and oversee the implementation of new governance structures, processes and protocols that enable the Board to fulfill its governance role effectively; • Support the Board of Directors in fostering a positive relationship with its key stakeholders; • Support a high standard of Board conduct and performance • Review Board policies on a regular basis, and at a minimum of every two years, and make recommendations to the Board to ensure currency and relevancy • Recommend and oversee the implementation of a governance review/ evaluation process regarding the performance of the Board, the Board Chair, committee chairs, committees and individual Directors;

	• Recommend procedures for the ongoing assessment of Board and Committee meeting effectiveness; • Recommend changes to address effectiveness issues arising out of these evaluations; • Assess the adequacy of the quality and timeliness of information provided to the Board of Directors and its Committees and make recommendations to the Board of Directors for change where appropriate. • Approve and monitor various measures of performance accountability on a regular basis. • Support the Chair of the Board of Health with MOH/CEO/CAO review as requested; • Oversee succession planning for the MOH/CEO/CAO, including development of a clear and transparent process to recruit and select a future MOH/CEO/CAO. • Ensure that there is an appropriate orientation and education program for new Directors and continuing education for all Directors including making recommendations on methods to improve Directors' knowledge of Algoma Public Health and their responsibilities as Directors; • Oversee the implementation of orientation and education programs for Directors to ensure these are undertaken effectively. • The Committee shall study and make recommendations to the Board on any matter as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Governance Standing Committee will also serve as the 2nd Vice-Chair of the Board of Health. The Committee chair is responsible in consultation with MOH/CEO/CAO for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The committee may elect a vice-chair on an annual basis.
Recorder:	The secretary to the Board will act as recorder for the Governance Standing Committee.
Reporting and Accountability to the Board:	The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-chair or another Director member of the Committee or to staff.
Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Governance Standing Committee shall be comprised of: • Up to six (6) members of the Board of Health plus the Board Chair and no less than three (3) voting members; • MOH/CEO/CAO of Algoma Public Health, non-voting members

	• Director of HR and Corporate Services – non-voting member • Director of Promotion and Prevention – non-voting member • Director of Protection and Prevention – non-voting member Board Committee members will be appointed annually by the Board .
Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity plan. Additional meetings can be held at the call of the Chair or at the request of the Board. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee.
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1. The Committee may, with the approval of the Board, establish sub-committees.
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendations for any amendments to the Board for its review and decision re: approval.
Distribution of Minutes:	Minutes shall be provided to the committee members and the Board of Health.

Signature of Board of Health Chair _____ Date _____

TERMS OF REFERENCE MEMBERSHIP

	Name	Position
1	Ian Frazier	Committee Chair
2	Candace Martin	Committee Vice-Chair
3	Sue Jensen	Board Member
4	Vacant	Board Member
5	Vacant	Board Member
6	Vacant	Board member
7	Lee Mason	Board Chair
	Ex-Officio	
8	Tony Hanlon or CA0	CEO or CAO
9	Antoniette Tomie	Director of Human Resources and Corporate Services
10	Laurie Zeppa	Director of Promotion and Prevention
11	Sherri Cleaves	Director of Protection and Prevention
12	Christina Luukkonen	Recording Secretary

Guide for Completing Terms of Reference

- Please complete each section of the terms of reference (TOR) form.
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- Ensure a copy of the previous TOR accompanies the newly edited TOR with the changes highlighted.

Name:	Indicate the name of the committee
Purpose/Goal:	Indicate the end result that the committee's plan is intended to achieve. Use round bullets to identify individual points.
Objectives:	Previously Goals/Responsibilities Indicate the activities, objectives, responsibilities that the plan will take in order to achieve the goal, e.g., To discuss…To review…To create…To facilitate, etc. Use round bullets to identify individual points.
Chair:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Recorder:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Membership:	Indicate position titles not specific names. If necessary, complete the Terms of Reference Membership and attach to the TOR. Include the Chair's title in this section. If the chair rotates, indicate: 'Chair rotates'
Reporting to:	Indicate position title or name of committee, e.g., Management Committee, to whom the committee reports and who will act on committee recommendations/ suggestions.
Frequency:	Indicate the number of times the committee will meet, e.g., once per month for one-hour session. Quorum is not required to hold a meeting.
Term:	Indicate the length of time members remain on the committee, e.g. membership will change every two years.
Decision-making Format:	Indicate consensus/ majority/ not applicable, etc. Consensus is preferred where possible. Quorum is required (50 percent participation plus 1 individual).
Distribution of Minutes:	Indicate the 'Reporting to' individual(s), committee, etc. along with who will benefit from the Committee. Membership will automatically appear.

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE
TERMS OF REFERENCE

O: May 22, 2015

R Date: September 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	Finance and Audit Committee
Mandate:	To assist the Board in meeting its responsibilities, the Finance and Audit Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • Ensure the adequacy and effectiveness of financial reporting by reviewing and recommending approval to the Board of ~~all~~ financial statements, accounting policies, internal and external audits, internal controls, management plans and information. ~~The Committee shall assist with fulfillment of the Board's mandate and those specific responsibilities and duties assigned to the Committee; however, unless specifically stated otherwise, the Committee shall act in advisory capacity only, recommending decisions to the Board for approval.~~From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience.
~~Scope/Duties:~~Roles and Responsibilities	These Finance and Audit Committee functions are fulfilled through the following roles and responsibilities: ~~shall have the following specific functions, duties and responsibilities and where necessary recommend for approval to the Board:~~ Review and make recommendations to the Board regarding monthly financial statements and other monthly/quarterly financial reporting being presented to the Board; • Review and make recommendations to the Board regarding the annual Operating and Capital Plan; • Review and make recommendations to the Board regarding the annual audited financial statements; • Review and recommend the annual audit plan, audit fees, and scope of audit services (engagement letter); • Meet with external auditors to review the findings of the audit including but not limited to the auditor's Management Letter, any weaknesses in internal controls and the Executive Management's response to such letter;

	• Review and report to the Board any changes in accounting policies or significant transactions which impact the financial statements in a significant manner as per the annual financial statements; • Periodically review the need for an internal audit and if required make such recommendation to the Board; • Monitor the internal audit process, ensure all items from the internal auditor's reports are resolved and assess the internal audit performance; • Monitor the effectiveness of internal controls to ensure compliance with Board policies and standard accounting principles; • Review and ensure that all risk management is complete with respect to all insurance coverage for the Board; • Review and make recommendations to the Board regarding long-term financial goals and long-term revenue and expense projections; • Review and make recommendation to the Board concerning any material asset acquisitions; • Review and make recommendations to the Board regarding financial, Investing and banking transactions, providers and signing officers; and • Review other projects or developments as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan~~Develop an Committee Annual Work Plan for approval by the Board.~~
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Finance and Audit Committee will also serve as the 1st Vice-Chair of the Board of Health. The Committee chair in consultation with the MOH/CEO/CAO is responsible for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The Committee may elect a vice-chair on an annual basis.
Recorder:	The secretary to the Board will act as recorder for the Finance and Audit Committee.
Reporting and Accountability to the Board:~~Reporting Relationship:~~	~~Finance and Audit Committee shall report on significant issues and year end progress of the Annual Work Plan through the Committee Chair or other Committee Designate to the Board.~~ The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-Chair or another Director member of the Committee or to staff.

Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Finance and Audit Committee shall be comprised of: • Up to six (6) ~~five (5)~~ members of the Board of Health plus the Board Chair and no less than three (3) voting members; • ~~Board Chair as an ex-officio, non-voting member~~ • CFO or designate of Algoma Public Health, non-voting member • MOH/CEO/CAO of Algoma Public Health, non-voting members ~~Committee members will be appointed for a term not exceeding their term as a Director and may be reappointed at the discretion of the Board~~
Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity ~~work~~plan. Additional meetings can be held at the call of the Chair or at the request of the Board. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee.
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:~~Quorum:~~	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1 The Committee may, with the approval of the Board, establish sub-committees. ~~A Quorum shall be the majority of the members on the committee~~
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendation~~(s)~~ for any amendments~~. Any amendments are made by the Board.~~ to the Board for its review and decision re: approval.
Distribution of Minutes:~~Minutes:~~	Minutes shall be provided to the committee members and the Board of Health.

Signature of Board of Health Chair _____ Date _____

TERMS OF REFERENCE MEMBERSHIP

	Name	Position
1	Ian Frazier	~~Chair, Finance Committee~~Committee Chair
2	~~Candace Martin~~Dennis Thompson	~~Board Member~~Committee Vice-Chair
3	~~Lee Mason~~Candace Martin	Board Member
4	Vacant	Board Member
~~4~~5	~~Dennis Thompson~~Vacant	Board Member
	~~Ex-Officio~~	
6	Lee Mason	Board Chair
7~~5~~	Tony Hanlon or CAO	Chief Executive Officer or CAO
8~~6~~	Justin Pino	Chief Financial Officer
9~~7~~	Christina Luukkonen	Recording Secretary
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Guide for Completing Terms of Reference

- Please complete each section of the terms of reference (TOR) form.
- None of the sections should be blank.
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Purpose/Goal:	Indicate the end result that the committee's plan is intended to achieve. Use round bullets to identify individual points.
Objectives:	Previously Goals/Responsibilities Indicate the activities, objectives, responsibilities that the plan will take in order to achieve the goal, e.g., To discuss…To review…To create…To facilitate, etc. Use round bullets to identify individual points.
Chair:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Recorder:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Membership:	Indicate position titles not specific names. If necessary, complete the Terms of Reference Membership and attach to the TOR. Include the Chair's title in this section. If the chair rotates, indicate: 'Chair rotates'
Reporting to:	Indicate position title or name of committee, e.g., Management Committee, to whom the committee reports and who will act on committee recommendations/ suggestions.
Frequency:	Indicate the number of times the committee will meet, e.g., once per month for one-hour session. Quorum is not required to hold a meeting.
Term:	Indicate the length of time members remain on the committee, e.g. membership will change every two years.
Decision-making Format:	Indicate consensus/ majority/ not applicable, etc. Consensus is preferred where possible. Quorum is required (50 percent participation plus 1 individual).
Distribution of Minutes:	Indicate the 'Reporting to' individual(s), committee, etc. along with who will benefit from the Committee. Membership will automatically appear.

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE
TERMS OF REFERENCE

O: May 22, 2015

R Date: September 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	**Finance and Audit Committee**
Mandate:	To assist the Board in meeting its responsibilities, the Finance and Audit Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • Ensure the adequacy and effectiveness of financial reporting by reviewing and recommending approval to the Board of financial statements, accounting policies, internal and external audits, internal controls, management plans and information. From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience.
Roles and Responsibilities	These Finance and Audit Committee functions are fulfilled through the following roles and responsibilities: Review and make recommendations to the Board regarding monthly financial statements and other monthly/quarterly financial reporting being presented to the Board; • Review and make recommendations to the Board regarding the annual Operating and Capital Plan; • Review and make recommendations to the Board regarding the annual audited financial statements; • Review and recommend the annual audit plan, audit fees, and scope of audit services (engagement letter); • Meet with external auditors to review the findings of the audit including but not limited to the auditor's Management Letter, any weaknesses in internal controls and the Executive Management's response to such letter; • Review and report to the Board any changes in accounting policies or significant transactions which impact the financial statements in a significant manner as per the annual financial statements; • Periodically review the need for an internal audit and if required make such recommendation to the Board; • Monitor the internal audit process, ensure all items from the internal

	auditor's reports are resolved and assess the internal audit performance; • Monitor the effectiveness of internal controls to ensure compliance with Board policies and standard accounting principles; • Review and ensure that all risk management is complete with respect to all insurance coverage for the Board; • Review and make recommendations to the Board regarding long-term financial goals and long-term revenue and expense projections; • Review and make recommendation to the Board concerning any material asset acquisitions; • Review and make recommendations to the Board regarding financial, Investing and banking transactions, providers and signing officers; and • Review other projects or developments as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Finance and Audit Committee will also serve as the 1st Vice-Chair of the Board of Health. The Committee chair in consultation with the MOH/CEO/CAO is responsible for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The Committee may elect a vice-chair on an annual basis.
Recorder:	The secretary to the Board will act as recorder for the Finance and Audit Committee.
Reporting and Accountability to the Board:	The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-Chair or another Director member of the Committee or to staff.
Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Finance and Audit Committee shall be comprised of: • Up to six (6) members of the Board of Health plus the Board Chair and no less than three (3) voting members; • CFO or designate of Algoma Public Health, non-voting member • MOH/CEO/CAO of Algoma Public Health, non-voting members
Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity plan. Additional meetings can be held at the call of the Chair or

	at the request of the Board. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee.
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1 The Committee may, with the approval of the Board, establish sub-committees.
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendations for any amendments to the Board for its review and decision re: approval.
Distribution of Minutes:	Minutes shall be provided to the committee members and the Board of Health.

Signature of Board of Health Chair

Date

TERMS OF REFERENCE MEMBERSHIP

	Name	Position
1	Ian Frazier	Committee Chair
2	Dennis Thompson	Committee Vice-Chair
3	Candace Martin	Board Member
4	Vacant	Board Member
5	Vacant	Board Member
6	Lee Mason	Board Chair
7	Tony Hanlon or CAO	Chief Executive Officer or CAO
8	Justin Pino	Chief Financial Officer
9	Christina Luukkonen	Recording Secretary
8		
9		
10		
11		
12		
13		
14		
18		
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Guide for Completing Terms of Reference

- Please complete each section of the terms of reference (TOR) form.
- None of the sections should be blank.
- Ensure a copy of the previous TOR accompanies the newly edited TOR with the changes highlighted.

Name:	Indicate the name of the committee
Purpose/Goal:	Indicate the end result that the committee's plan is intended to achieve. Use round bullets to identify individual points.
Objectives:	Previously Goals/Responsibilities Indicate the activities, objectives, responsibilities that the plan will take in order to achieve the goal, e.g., To discuss…To review…To create…To facilitate, etc. Use round bullets to identify individual points.
Chair:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Recorder:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Membership:	Indicate position titles not specific names. If necessary, complete the Terms of Reference Membership and attach to the TOR. Include the Chair's title in this section. If the chair rotates, indicate: 'Chair rotates'
Reporting to:	Indicate position title or name of committee, e.g., Management Committee, to whom the committee reports and who will act on committee recommendations/ suggestions.
Frequency:	Indicate the number of times the committee will meet, e.g., once per month for one-hour session. Quorum is not required to hold a meeting.
Term:	Indicate the length of time members remain on the committee, e.g. membership will change every two years.
Decision-making Format:	Indicate consensus/ majority/ not applicable, etc. Consensus is preferred where possible. Quorum is required (50 percent participation plus 1 individual).
Distribution of Minutes:	Indicate the 'Reporting to' individual(s), committee, etc. along with who will benefit from the Committee. Membership will automatically appear.

Algoma Public Health - GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	O: December 13, 1995 Revised: September 28 ~~June 22~~, 2016	**SECTION:**	Board
PAGE:	1 of 9	**SUBJECT:**	To Regulate the Proceedings of the Board of Health

The Board enacts as follows:

Interpretation

1. In this By-law:

a) "Act" means the Health Protection and Promotion Act. ~~S.D. Ontario 1983, Chapter 10~~ R.S.O. 1990, Chapter H.7 as amended;

b) "Board" means THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT, as prescribed;

c) "Chair" means the person presiding at the meeting of the Board;

d) "Chair of the Board" means the Chair elected under Section 5~~7~~6 of the Act which reads:

i) A Board of Health shall hold its first meeting of each year not later than the 1st day of February
ii) At the first meeting of the Board of Health in each year, the members of the Board shall elect one of the members to be Chairman and one to be Vice-chairman of the Board for the year;

e) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

f) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

g) "Meeting" means a meeting of the Board;

h) "Member" means a member of the Board;

i) "Quorum" means a majority of the voting positions on ~~members of~~ the Board with no less than ~~less than~~ five of the positions being filled;(models alPHa by-law amendment)

~~i)~~j) or " Quorum means a majority of the current members of the Board (MOHLTC interpretation) and that there must be at least five current members of the Board

~~j)~~k) "Secretary" means the Secretary of the Board of Health;

~~k)~~l) Words that indicate singular masculine gender only shall include plural and/or feminine

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gender.

General

2. The Board shall hold the first meeting of each year not later than the first day of February. At the first meeting of the Board in each year, members of the Board shall elect one member to be Chair~~-~~, one member to be First Vice- chair and one member to be Second Vice-chair of the Board for the year. The First Vice-chair shall chair the Finance and Audit Committee and the Second Vice-chair shall chair the Governance Committee. ~~at least one of the standing committees of the Board~~.

3. The Board shall consist of the members as prescribed under the Act;

    a) Where a vacancy occurs in the Board by death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

4. In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee (s) thereof.

5. Except as herein provided, *Robert's Rules of Order* shall be followed for governing the proceedings of the Board and the conduct of its members.

6. A person who is not a member of the Board shall not be permitted to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

7. In unusual circumstances persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board's members are ~~are~~ in agreement.

Meetings

8. Regular Meetings:

    a) The regular meetings shall be held at a date and time as stated in the Board's Activity Plan determined by the Board annually at its June meeting. ~~first regular meeting of the year~~;

    b) The Board may, by resolution, alter the time, day or place of any meeting;

    c) It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members;

    d) Three consecutive absences from regular Board meetings by a member of the Board will be reviewed by the Chair of the Board with the member in question; following which, notification may be forwarded to the appropriate municipality, council or the province.

9. Special Meetings:

    a) A special meeting of the Board shall not be called for a time which conflicts with a regular meeting previously called of (participating) council(s) or municipality(s).

b) A special meeting may be called by the Chair of the Board of Health.

c) The Secretary shall call a special meeting upon receipt of a petition signed by the majority of Board members, for the purpose and at the time mentioned in the petition.

10. Notice of Meetings:

a) The Secretary shall give notice of each regular and special meeting of the Board and of each committee to the members thereof and to the heads of departments concerned with such meeting.

b) The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

c) The notice for a regular meeting shall be delivered or sent by electronic means or courier to the residence or place of business of each member so as to be received not later than three working days prior to the day of the meeting.

d) The notice for a special meeting may be sent by telephone or by electronic means with the Secretary confirming receipt.

e) No errors or omissions in giving such notice for the meeting shall invalidate it or any action taken.

f) The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

11. Preparation of the Agenda:

a) The Secretary shall have prepared for the use of members at the regular meetings, the Agenda as follows:

i. Call to Order
ii. Declaration of Conflict of Interest
iii. Adoption of Agenda
iv. Adoption of Minutes of Previous Meeting
v. Business Arising from Minutes
vi. Delegations/Presentations
vii. Reports of Committees
viii. Reports of Officers/Program Managers
ix. Correspondence/Items for Information
x. Addendum
xi. Announcements
xii. New Business/General Business
xiii. In-Committee Session
xiv. Return to Open Meeting
xv. Adjournment

b) For special meetings, the Agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

c) The business for each meeting shall be taken up in the order in which it stands upon the Agenda, unless otherwise decided by the Board.

12. Commencement of Meetings:

a) As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board or First Vice-chair of the Board, if the Chair is not present or the Second Vice-chair if the First Vice-chair is not present shall take the chair and call the members to order.

b) If the Chair or Vice-chairs are~~is~~ not present, or their duly appointed representative, but a quorum is otherwise achieved, the Secretary shall call the members to order and a presiding officer shall be appointed by the Secretary to preside during the meeting or until the arrival of the person who ought to preside.

c) If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present. If an absence of an expected Quorum occurs due to a health emergency or to weather conditions and business must be expedited, the Board shall have the privilege of designating items of business as essential to be expedited at that meeting. Under these conditions the Board shall have the privilege of conducting the necessary items of business but such items shall be confirmed at the next meeting of the Board

Rules of Debate and Conduct of Members of the Board

13. The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on point of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

14. Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

a) The Board shall render its decision in each case within five (5) working days after deputations have been heard.

15. If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall ~~call on~~ vacate the chair to one of the Vice-chairs during the debate ~~another member,~~ prior to the beginning of the debate, to fill his place until he resumes the chair.

16. Every member, prior to speaking to any question or motion, shall be acknowledged by the Chair.

17. When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak. The Chair shall develop a speakers list when more than one member wishes to address each item.

18. A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

19. A motion for introducing new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

20. Every motion presented to the Board shall be written.

21. Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

22. When a matter is under debate, no motion shall be received other than a motion:

    a) to adopt,
    b) to amend,
    c) to defer action,
    d) to refer,
    e) to receive,
    f) to adjourn the meeting, or
    g) that the vote be now taken.

23. a) A motion to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.
    b) A motion to refer shall require direction as to the body to which it is being referred and is not debatable.
    c) A motion to defer must include a reason and a time period for the deferral and is not debatable.

24. When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

25. Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the chair to one of the ~~the~~ Vice-chairs during debate on the motion and reassume the chair following the vote.

Duties of the Secretary for the Board

26. It shall be the duty of the Secretary:

    a) to attend or cause an assistant to attend all meetings of the Board;

    b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of By-laws and Resolutions passed by it; and

    c) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

    d) to give all notices required to be given to the members.

Appointment and Organization of Committees

27. At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees(s) (Finance and Audit Committee, Governance Committee). When a new member(s) join the Board after the first meeting of the year the Board shall appoint the new member(s) to one of the standing committees.

28. The Board may appoint committees from time to time to consider such matters as specified by the Board.

Conduct of Business in Committees

29. The rules governing the procedure of the Board shall be observed in the Committees insofar as applicable.

30. It shall be the duty of the Committee:

    a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

    b) to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and

    c) to forward to the incoming Committee for the following year any matter undisposed of.

Procedures of the Board Covered by other By-laws

31. The procedures of the Board with respect to:

    a) incurring of liabilities and paying of accounts;

b) authority for expenditures;
c) audits;
d) budgets and settlements;

Shall be in accordance with the By-laws #95-2 and #95-3.

Corporate Seal

32. The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Chief Executive Officer/Chief Administrative Officer- or the Chief Financial Officer.

Short Name

33. The Board will use the short name Algoma Public Health for signage, communications and promotional messaging and other matters as warranted.

Execution of Documents

34. The Board may at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the Board and when required affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

35. In general, unless changed by a resolution of the Board under clause 34 of this By-law, the following applies:

a) Budgets and Settlement Forms will be signed by the combination of Board member(s) and staff of the agency as required by Ministry specifications;

b) Leases for real estate, mortgages or other loan documents -will be signed by the Chair of the Board and by the Medical Officer of Health or Chief Executive Officer/Chief Administrative Officer;

c) Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the Director/Chief Financial Officer and/or the Medical Officer of Health or Chief Executive Officer /Chief Administrative Officer (should two signatures be necessary);

d) Purchase of service agreements with service providers for programs will be signed by the Medical Officer of Health or/CEO/CAO and by the appropriate program Director.

e) Purchase of service agreements with service providers for financial, building and corporate services will be signed by the Medical Officer of Health or Chief Executive Officer/ Chief Administrative Officer and by the appropriate administrative manager or Director/Chief Financial Officer.

Duties of Officers

36. The Chair of the Board shall:

a) preside at all meetings of the Board;

b) represent the Board at public or official functions or designate another Board member to do so;

c) be ex-officio a member of all Committees to which he has not been named a member;

d) complete an annual performance appraisal of the Medical Officer of Health/CEO/CAO using input from the Medical Officer of Health/CEO/CAO as well as the members of the Board, with the results of this appraisal being shared with the Board members in camera;

e) perform such other duties as may from time to time be determined by the Board.

37. The First Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board. The Second Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of both the Chair of the Board and the First Vice-chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

Amendments

38. Any provision contained herein may be repealed, amended or varied, and additions may be made to this By-law by a majority vote of members present at the meeting at which such motion is considered to give effect to any recommendation contained in a Report to the Board and such report has been transmitted to members of the Board prior to the meeting at which the report is to be considered. No motion for that purpose may be considered, unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived and in any event no bill to amend this By-law shall be introduced at the same meeting as that at which such report or motion is considered.

Dismissal of Medical Officer(s) of Health/CEO/CAO

39. A decision by the Board of Health to dismiss a Medical Officer of Health/CEO/CAO from office is not effective unless:

a) the decision is carried by the vote of two-thirds of the members of the Board; and

b) in situations where the Medical Officer of Health is a separate position from the CEO/CAO position the Minister consents in writing to the dismissal of the MOH.

40. The Board of Health shall not vote on the dismissal of a Medical Officer of Health/CEO/CAO unless the Board has given to the Medical Officer of Health/CEO/CAO:

a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;

b) a written statement of the reason for the proposal to dismiss the Medical Officer of Health/CEO/CAO; and

c) an opportunity to attend and to make representation to the Board at the meeting.

Reporting of Medical Officer of Health to the Board of Health/CEO/CAO

1. The Medical Officer of Health/CEO/CAO of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The Medical Officer of Health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

2. The Medical Officer of Health/CEO/CAO of a board of health is entitled to notice of and to attend each meeting of the Board and every committee of the Board, but the Board may require the Medical Officer of Health/CEO/CAO to withdraw from any part of a meeting at which the Board or a Committee of the Board intends to consider a matter related to the remuneration or the performance of the duties of the Medical Officer of Health/CEO/CAO. (HPPA, s70)

Enacted and passed by the Algoma Health Unit Board this 13th day of December, 1995.

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Algoma Public Health Board February 2011
Revised and passed by the Algoma Public Health Board on this 28th day of October 2015
Revised and passed by the Algoma Public Health Board on this 28th day of September 2016

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APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	O: December 13, 1995 Revised: September 28 , 2016	**SECTION:**	Board
PAGE:	1 of 9	**SUBJECT:**	To Regulate the Proceedings of the Board of Health

---

The Board enacts as follows:

Interpretation

1. In this By-law:

a) "Act" means the Health Protection and Promotion Act. R.S.O. 1990, Chapter H.7 as amended;

b) "Board" means THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT, as prescribed;

c) "Chair" means the person presiding at the meeting of the Board;

d) "Chair of the Board" means the Chair elected under Section 57 of the Act which reads:

i) A Board of Health shall hold its first meeting of each year not later than the 1st day of February
ii) At the first meeting of the Board of Health in each year, the members of the Board shall elect one of the members to be Chairman and one to be Vice-chairman of the Board for the year;

e) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

f) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

g) "Meeting" means a meeting of the Board;

h) "Member" means a member of the Board;

i) "Quorum" means a majority of the voting positions on the Board with no less than five of the positions being filled;(models alPHa by-law amendment)

j) or " Quorum means a majority of the current members of the Board (MOHLTC interpretation) and that there must be at least five current members of the Board

k) "Secretary" means the Secretary of the Board of Health;

l) Words that indicate singular masculine gender only shall include plural and/or feminine gender.

General

2. The Board shall hold the first meeting of each year not later than the first day of February. At the first meeting of the Board in each year, members of the Board shall elect one member to be Chair, one member to be First Vice- chair and one member to be Second Vice-chair of the Board for the year. The First Vice-chair shall chair the Finance and Audit Committee and the Second Vice-chair shall chair the Governance Committee. .

3. The Board shall consist of the members as prescribed under the Act;

    a) Where a vacancy occurs in the Board by death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

4. In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee (s) thereof.

5. Except as herein provided, *Robert's Rules of Order* shall be followed for governing the proceedings of the Board and the conduct of its members.

6. A person who is not a member of the Board shall not be permitted to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

7. In unusual circumstances persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board's members arein agreement.

Meetings

8. Regular Meetings:

    a) The regular meetings shall be held at a date and time as stated in the Board's Activity Plan determined by the Board annually at its June meeting.;

    b) The Board may, by resolution, alter the time, day or place of any meeting;

    c) It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members;

    d) Three consecutive absences from regular Board meetings by a member of the Board will be reviewed by the Chair of the Board with the member in question; following which, notification may be forwarded to the appropriate municipality, council or the province.

9. Special Meetings:

    a) A special meeting of the Board shall not be called for a time which conflicts with a regular meeting previously called of (participating) council(s) or municipality(s).

    b) A special meeting may be called by the Chair of the Board of Health.

c) The Secretary shall call a special meeting upon receipt of a petition signed by the majority of Board members, for the purpose and at the time mentioned in the petition.

10. Notice of Meetings:

a) The Secretary shall give notice of each regular and special meeting of the Board and of each committee to the members thereof and to the heads of departments concerned with such meeting.

b) The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

c) The notice for a regular meeting shall be delivered or sent by electronic means or courier to the residence or place of business of each member so as to be received not later than three working days prior to the day of the meeting.

d) The notice for a special meeting may be sent by telephone or by electronic means with the Secretary confirming receipt.

e) No errors or omissions in giving such notice for the meeting shall invalidate it or any action taken.

f) The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

11. Preparation of the Agenda:

a) The Secretary shall have prepared for the use of members at the regular meetings, the Agenda as follows:

i. Call to Order
ii. Declaration of Conflict of Interest
iii. Adoption of Agenda
iv. Adoption of Minutes of Previous Meeting
v. Business Arising from Minutes
vi. Delegations/Presentations
vii. Reports of Committees
viii. Reports of Officers/Program Managers
ix. Correspondence/Items for Information
x. Addendum
xi. Announcements
xii. New Business/General Business
xiii. In-Committee Session
xiv. Return to Open Meeting
xv. Adjournment

b) For special meetings, the Agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

c) The business for each meeting shall be taken up in the order in which it stands upon the Agenda, unless otherwise decided by the Board.

12. Commencement of Meetings:

a) As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board or First Vice-chair of the Board, if the Chair is not present or the Second Vice-chair if the First Vice-chair is not present shall take the chair and call the members to order.

b) If the Chair or Vice-chairs are not present, or their duly appointed representative, but a quorum is otherwise achieved, the Secretary shall call the members to order and a presiding officer shall be appointed by the Secretary to preside during the meeting or until the arrival of the person who ought to preside.

c) If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present. If an absence of an expected Quorum occurs due to a health emergency or to weather conditions and business must be expedited, the Board shall have the privilege of designating items of business as essential to be expedited at that meeting. Under these conditions the Board shall have the privilege of conducting the necessary items of business but such items shall be confirmed at the next meeting of the Board

Rules of Debate and Conduct of Members of the Board

13. The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on point of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

14. Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

a) The Board shall render its decision in each case within five (5) working days after deputations have been heard.

15. If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall vacate the chair to one of the Vice-chairs during the debate prior to the beginning of the debate, to fill his place until he resumes the chair.

16. Every member, prior to speaking to any question or motion, shall be acknowledged by the Chair.

17. When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak. The Chair shall develop a speakers list when more than one member wishes to address each item.

18. A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

19. A motion for introducing new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

20. Every motion presented to the Board shall be written.

21. Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

22. When a matter is under debate, no motion shall be received other than a motion:

    a) to adopt,
    b) to amend,
    c) to defer action,
    d) to refer,
    e) to receive,
    f) to adjourn the meeting, or
    g) that the vote be now taken.

23. a) A motion to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.
    b) A motion to refer shall require direction as to the body to which it is being referred and is not debatable.
    c) A motion to defer must include a reason and a time period for the deferral and is not debatable.

24. When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

25. Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the chair to one of the Vice-chairs during debate on the motion and reassume the chair following the vote.

Duties of the Secretary for the Board

26. It shall be the duty of the Secretary:

    a) to attend or cause an assistant to attend all meetings of the Board;

    b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of By-laws and Resolutions passed by it; and

    c) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

    d) to give all notices required to be given to the members.

Appointment and Organization of Committees

27. At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees(s) (Finance and Audit Committee, Governance Committee). When a new member(s) join the Board after the first meeting of the year the Board shall appoint the new member(s) to one of the standing committees.

28. The Board may appoint committees from time to time to consider such matters as specified by the Board.

Conduct of Business in Committees

29. The rules governing the procedure of the Board shall be observed in the Committees insofar as applicable.

30. It shall be the duty of the Committee:

    a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

    b) to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and

    c) to forward to the incoming Committee for the following year any matter undisposed of.

Procedures of the Board Covered by other By-laws

31. The procedures of the Board with respect to:

    a) incurring of liabilities and paying of accounts;
    b) authority for expenditures;
    c) audits;

d) budgets and settlements;

Shall be in accordance with the By-laws #95-2 and #95-3.

Corporate Seal

32. The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Chief Executive Officer/Chief Administrative Officer or the Chief Financial Officer.

Short Name

33. The Board will use the short name Algoma Public Health for signage, communications and promotional messaging and other matters as warranted.

Execution of Documents

34. The Board may at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the Board and when required affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

35. In general, unless changed by a resolution of the Board under clause 34 of this By-law, the following applies:

a) Budgets and Settlement Forms will be signed by the combination of Board member(s) and staff of the agency as required by Ministry specifications;

b) Leases for real estate, mortgages or other loan documents will be signed by the Chair of the Board and by the Medical Officer of Health or Chief Executive Officer/Chief Administrative Officer;

c) Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the Director/Chief Financial Officer and/or the Medical Officer of Health or Chief Executive Officer /Chief Administrative Officer (should two signatures be necessary);

d) Purchase of service agreements with service providers for programs will be signed by the Medical Officer of Health orCEO/CAO and by the appropriate program Director.

e) Purchase of service agreements with service providers for financial, building and corporate services will be signed by the Medical Officer of Health or Chief Executive Officer/ Chief Administrative Officer and by the appropriate administrative manager or Director/Chief Financial Officer.

Duties of Officers

36. The Chair of the Board shall:

    a) preside at all meetings of the Board;

    b) represent the Board at public or official functions or designate another Board member to do so;

    c) be ex-officio a member of all Committees to which he has not been named a member;

    d) complete an annual performance appraisal of the Medical Officer of Health/CEO/CAO using input from the Medical Officer of Health/CEO/CAO as well as the members of the Board, with the results of this appraisal being shared with the Board members in camera;

    e) perform such other duties as may from time to time be determined by the Board.

37. The First Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board. The Second Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of both the Chair of the Board and the First Vice-chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

Amendments

38. Any provision contained herein may be repealed, amended or varied, and additions may be made to this By-law by a majority vote of members present at the meeting at which such motion is considered to give effect to any recommendation contained in a Report to the Board and such report has been transmitted to members of the Board prior to the meeting at which the report is to be considered. No motion for that purpose may be considered, unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived and in any event no bill to amend this By-law shall be introduced at the same meeting as that at which such report or motion is considered.

Dismissal of Medical Officer(s) of Health/CEO/CAO

39. A decision by the Board of Health to dismiss a Medical Officer of Health/CEO/CAO from office is not effective unless:

    a) the decision is carried by the vote of two-thirds of the members of the Board; and

    b) in situations where the Medical Officer of Health is a separate position from the CEO/CAO position the Minister consents in writing to the dismissal of the MOH.

40. The Board of Health shall not vote on the dismissal of a Medical Officer of Health/CEO/CAO unless the Board has given to the Medical Officer of Health/CEO/CAO:

    a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;

    b) a written statement of the reason for the proposal to dismiss the Medical Officer of Health/CEO/CAO; and

    c) an opportunity to attend and to make representation to the Board at the meeting.

Reporting of Medical Officer of Health to the Board of Health/CEO/CAO

1. The Medical Officer of Health/CEO/CAO of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The Medical Officer of Health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

2. The Medical Officer of Health/CEO/CAO of a board of health is entitled to notice of and to attend each meeting of the Board and every committee of the Board, but the Board may require the Medical Officer of Health/CEO/CAO to withdraw from any part of a meeting at which the Board or a Committee of the Board intends to consider a matter related to the remuneration or the performance of the duties of the Medical Officer of Health/CEO/CAO. (HPPA, s70)

Enacted and passed by the Algoma Health Unit Board this 13th day of December, 1995.

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Algoma Public Health Board February 2011
Revised and passed by the Algoma Public Health Board on this 28th day of October 2015
Revised and passed by the Algoma Public Health Board on this 28th day of September 2016

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Briefing Note

To: The Board of Health

From: Dr. Alex Hukowich, Associate Medical Officer of Health

Date: August 19, 2016

Re: Legalization of Cannabis – Provincial Collaboration

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Canada has one of the highest rates of cannabis use in the world. In Algoma, 49.12 % of individuals indicated that they have used cannabis in their lifetime compared to 40.22% in Ontario (2011-2012 CCHS Share Files). Cannabis also ranks 3rd on the list of top drugs presented at intake in both North and East Algoma according to Algoma Public Health's Community Alcohol/Drug Assessment Program.

RECOMMENDED ACTION:

It is recommended that the Board of Health for the District of Algoma Health Unit consider a Board Resolution regarding the legalization of cannabis. And further, that the Board of Health for the District of Algoma Health Unit continue to support staff in their continued alignment with the "Provincial Marijuana Collaborative" of public health units on cannabis.

BACKGROUND:

The Government of Canada has announced that it has committed to the legalization, regulation and restriction of access to marijuana in the spring of 2017. A call for a provincial collaboration on cannabis was issued in order to discuss areas of concern with the recent announcement. A total of 27 health unit managers and staff participated in the initial meeting in June and discussed areas of:

- Adolescent brain development/mental health
- Cannabis impaired driving
- Medical marijuana
- Dependence

- Cannabis use during pregnancy/lactation
- Environmental issues – second hand smoke
- E-cigarettes/vaporizers

Unanimously, all health units agreed to continue to meet in order to build capacity, share resources, develop common messaging and discuss provincial/local policy work. A next meeting will be planned in September 2016.

Recently, an announcement was made indicating that a Task Force on cannabis legalization and regulation was developed. A discussion paper was produced noting that legalization will focus on:

1. Minimizing harms of use
2. Establishing a safe and responsible production system
3. Designing an appropriate distribution system
4. Enforcing public safety and protection
5. Accessing marijuana for medical purposes

In the announcement, the Task Force stated multiple times that this legislation will have a public health focus. Algoma Public Health supported a provincial health unit public response providing a public health perspective on the legislation, regulation and restriction regarding access to marijuana.

While noting that this will be a complex task, the Task Force has promised that they will take all viewpoints into consideration, but that the protection of youth, concern for social and health harms and the production, distribution and consumption of marijuana will take precedent.

ASSESSMENT OF RISKS AND MITIGATION:

Not applicable.

FINANCIAL IMPLICATIONS:

Supporting APH staff costs are estimated at 50 hours which would include meeting times, organization and preparation for upcoming meetings.

OPHS STANDARD:

Prevention of Injury and Substance Misuse Requirement #2. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive environments that address the following: Alcohol and other substances

Prevention of Injury and Substance Misuse Requirement #5. The board of health shall use a comprehensive health promotion approach in collaboration with community partners, including enforcement agencies, to increase public awareness of and adoption of behaviours that are in accordance with current legislation related to the prevention of injury and substance misuse in the following areas: Alcohol and other substances

STRATEGIC DIRECTION:

Collaborate Effectively
Be Accountable

CONTACT:

Jennifer Flood, Acting Program Manager
Chronic Disease Prevention, Injury Prevention, Genetics, Smoke Free Ontario, and Youth Engagement

References:

Provincial Marijuana Collaborative – Draft (attached)

Canadian Community Health Survey (2011-2012). Statistics Canada, Share File, Ontario MOHLTC

Cannabis: A Public Health Approach (2016). Middlesex-London Health Unit. Report No. 003-16.

Cannabis Policy Framework (2014). Centre for Addiction and Mental Health. Retrieved August 3, 2016 from https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force

Ontario Public Health Unit Collaboration on Cannabis

The Ontario Public Health Unit Collaboration on Cannabis is a group of substance misuse professionals from 27 public health units who have joined together to promote a comprehensive public health approach to marijuana legalization.

This feedback was developed by a working group of the Collaborative:

Algoma Public Health, Durham Public Health, Elgin St. Thomas Public Health, Grey Bruce Health Unit, Haliburton, Kawartha, Pine Ridge District Health Unit, Huron County Health Unit, KFL&A Public Health, Middlesex-London Health Unit, Niagara Region Public Health, Northwestern Health Unit, Ottawa Public Health, Perth District Health Unit, Peterborough Public Health, Peel Public Health, Sudbury & District Health Unit, Thunder Bay District Health Unit, Timiskaming Health Unit, Wellington-Dufferin-Guelph Public Health Unit, York Region Public Health

Discussion Issues: Elements of a New System
Section One: Minimizing harms of use

1(a). Do you believe that these measures are appropriate to achieve the overarching objectives to minimize harms, and in particular to protect children and youth?

(1) Minimum age for legal purchase.

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be 21.**
- **The minimum age for purchasing and possessing marijuana should be consistent across Canada in order to provide clear policy direction and eliminate cross-border variations which limit the effectiveness of minimum legal age regulations to protect young people.**
- **Regulations must be coupled with rigorous enforcement and penalties for violations in order to be effective.**

See responses to question 2 (a) and (b) for further detail.

(2) Advertising and marketing restrictions.

Recommendation:

- **Prohibit all forms of marijuana advertising, marketing, and sponsorship through federal legislation, similar to that of the Tobacco Act and include language that addresses volume and content restrictions**
- **Adopt plain packaging regulations that restrict or prohibit the use of logos, colors, brand images, or other promotional information on packaging other than brand and product names displayed in a standard color and font style. Also require that packaging include health warnings.**
- **In the case that marketing, advertising and promotion of marijuana is made allowable within strict limitations, it is crucial that an effective advertising regulatory system be put in place. This system must apply to all forms of marketing and have the flexibility to adjust restrictions as needed.**

- **Given that there is strong evidence from tobacco research that promotion at the point of sale, increases the likelihood that children and adolescents will start to smoke, it is recommended that federal legislation is enacted to prohibit youth under the minimum age for purchase of marijuana from entering marijuana retail outlets.**
- **Develop a supporting infrastructure to ensure accountability for these restrictions.**

Rationale:

There is strong evidence from tobacco research that advertising and promotion, including promotion at the point of sale, increases the likelihood that children and adolescents will start to smoke. (1) Furthermore a growing body of research identifies that exposure to alcohol advertising and marketing increases the likelihood of underage drinking. (2)

Given that lessons learned from tobacco and alcohol show partial restrictions on marketing, advertising and promotion are ineffective, and difficult to enforce, it is strongly recommended that a comprehensive ban on all forms of marijuana marketing be put in place. A substantial opportunity exists currently as a ban would likely appear very restrictive if put in place retrospectively but would be lessened for a new product, such as marijuana, because of its first chance to be legally traded. (3) A comprehensive ban should address all forms of advertising (e.g., print, television, radio, transit, billboards, point-of-sale including retail displays, Internet, and social media outlets), promotion (e.g., price discounting, coupons, free sample distribution), sponsorships, and other indirect forms of marketing (e.g., brand stretching, branded merchandise). (4) Such a ban would be in keeping with the Government of Canada's intention to legalize marijuana for the purposes of reducing its social and health harms, and not for the purpose of promoting its use.

In light of the fact that Health Canada recognizes that tobacco packages have become powerful promotional vehicles for the tobacco industry and has stated that it is committed to introducing plain packaging as part of its continued efforts to protect Canadians against the dangers of tobacco use, it is prudent the same regulations be put in place for marijuana products. (5)

Plain packaging of marijuana will be a useful tool for minimizing harms from use for this new product in an emerging industry, as there are no standards set as yet, and the government has the advantage in setting these standards. The 2013 Guidelines for

Implementation of the WHO Framework Convention on Tobacco Control recommends plain packaging measures that restrict or prohibit the use of logos, colors, brand images, or other promotional information on packaging other than brand and product names displayed in a standard color and font style. [4] Plain packaging of tobacco products has been adopted in Australia and has been shown to reduce the appeal of tobacco products among youth, increase the effectiveness of health warnings, and reduces the ability of the packaging to mislead the consumer. [6, 7]

If, as proposed by the discussion paper, marketing, advertising and promotion of marijuana was to be allowed within strict limitations, it would be crucial that an effective advertising regulatory system be put in place. Best practice evidence from Canadian alcohol advertising research identifies that an effective advertising regulatory system must include content restrictions, volume restrictions and an overall supporting infrastructure. This requires a supporting legal context, a commitment of all stakeholders, transparency of the decision-making process, a mandatory pre-screening system, an effective complaint system, an independent advertising committee, effective sanctions, and a monitoring system. This infrastructure should apply to all forms of marketing and have the flexibility to adjust restrictions as needed. [8]

The State of Washington has adopted some specific advertising content and volume restrictions in order to reduce expose to young people. For example, Washington State Legislature prohibits advertising through any medium within 1,000 feet (300 metres) of the perimeter of a school, playground, recreation center or facility; child care center, public park or library; or any game arcade, admission to which is not restricted to people over 21. State law also prohibits marijuana advertising from including any depiction designed in any manner to be especially appealing to children or other persons under legal age to consume marijuana. [9]

Colorado has placed strict requirements on advertising, including outright bans on Internet pop-up advertisements and any type of advertisement that targets minors. Advertising is only allowed via television, radio, print, Internet, or event sponsorship when it can be documented that less than 30% of the audience is younger than 21 years. Outdoor advertising is prohibited other than signs that identify the location of a licensed retail marijuana store. Additionally, Colorado's Marijuana Enforcement Division rules ban the presence of anyone younger than 21 years in marijuana retail stores. [10]

(3) Taxation and pricing

Recommendations:

- **Index marijuana prices to inflation to ensure prices do not decrease relative to other goods over time.**
- **Further regulate marijuana prices through tax increases, while giving consideration to the level at which minimum prices should be set to curb demand and reduce consumption (especially among youth) , while minimizing the opportunity for continuation of lucrative illicit markets.**
- **Base prices (including minimum prices) on THC content so that higher strength products are more expensive than lower strength products in order to create incentives for the production and consumption of safer, lower strength products.**

Rationale:

As identified in the Centre for Addiction and Mental Health's 2014 Cannabis Policy Framework document, it is important that marijuana pricing policy be designed to curb demand while minimizing the opportunity for continuation of lucrative illicit markets. In addition, it is strongly recommended that pricing encourage use of lower-harm products over higher-harm products. (11)

Alcohol research has shown that it is important to index prices to inflation to ensure prices do not decrease relative to other goods over time. The same research identifies that young people are particularly price-sensitive because of lower average disposable incomes as well as the fact that regular heavy drinking is most common among this age group. In order to reduce harm associated with the use of products with higher alcohol content, research recommends that prices (including minimum prices) need to be based on alcohol content as this creates price incentives for lower strength, less hazardous products and price disincentives for higher strength products. (12)

With regards to tobacco, there is strong and unequivocal evidence that increases in the price of cigarettes result in decreased demand and consumption as well as increased intentions to quit smoking. (13) Research also shows that higher taxes are an effective way to prevent young people from progressing from experimentation with tobacco to regular use. (14)

There is also some evidence that pricing strategies can reduce health-related inequities from tobacco use as well as having a greater impact on reducing tobacco use rates among individuals with lower incomes. The evidence highlights that while low income smokers are more likely to quit smoking in response to tax rate increases those who do not quit pay higher prices and bear a greater cost burden associated with price

increases. It is recommended that these distributional concerns be addressed by coupling tax increases with publically financed smoking cessation initiatives that are structured to particularly target low-income populations. [13]

(4) Limits of allowable THC potency in marijuana

Recommendation:

- **Determine maximum THC limit, which balances the risk for harm against the need to minimize the attractiveness of illegal production and trafficking of higher potency products.**
- **Set regulations that mandate clear and visible labelling of THC content in products, accompanied by evidence-based health warnings.**
- **Establish government right to impose regulations related to marijuana from the beginning, since lessons from tobacco demonstrate how challenging it can be to expand regulatory scope after the fact. As research reveals better evidence about the harms and therapeutic uses related to marijuana, regulations should be adjusted.**
- **Conduct further research into the short and long term health effects associated with the use of higher potency marijuana products.**

Rationale:

Young people are at a higher level of risk for experiencing negative impacts from marijuana use and evidence from Washington and Colorado shows that there are indications that youth are more likely to use products in concentrated format with higher levels of THC. [15] While further research is needed to confirm these issues, consumption of higher THC levels may be associated with a greater chance of a harmful reaction and explain the rise in emergency room visits involving marijuana use. Additionally, regular exposure to higher THC levels may be associated with an increased risk for addiction. [16]

(5) Restrictions on marijuana products:

Recommendation:

- **Set a maximum THC limit for all marijuana products, including specifying what constitutes a single serving size of edible product (e.g. 10 milligrams of THC) regulating the maximum number of serving to be allowed in a single packaged food item.**

- **Require that edible products have clearly marked serving sizes that are appropriate to the food being consumed. (For example a cookie should be one or two servings not ten)**
- **Prohibit production and sale of products that are attractive to youth (e.g., products which mimic popular brand-name snacks and candies (such as gummy bears), additives, flavorings and combinations with other substances (e.g., nicotine, caffeine, alcohol).**
- **Require that marijuana products be sold a child-resistant container that conform to federal consumer product safety regulations and include specific warning statements (e.g., Keep all marijuana products away from children.)**
- **Require that products be sold in plain packaging and be marked with a universal symbol indicating the container holds marijuana.**
- **Require that edible products be labeled with all ingredients, if refrigeration is required, standard serving limit and expiration date (for edibles).**
- **Offer producers of edible products access to its food safety training to help reduce the risk of foodborne illness.**
- **Ensure that a reliable system is put in place for product monitoring and testing to ensure production consistency and consumer safety.**

Rationale:

With regards to marijuana derivative products, such as edibles, salves and creams, it is agreed that regulations be put in place in order to limit the appeal to children and youth as well as to reduce the risk of unintended consumption. Edibles pose a particular risk of accidental expose and overdose, especially to children. Colorado experienced an increase incidence of childhood exposure to marijuana infused edibles following the legalization of medical marijuana in the state in 2000. Following legalization, Colorado also made national news related to residents' and tourists' overconsumption of edible marijuana products. Although initial regulations for edible marijuana sold on the recreational market specified a single serving size of 10 milligrams of THC and a maximum of 100 milligrams of THC per single packaged food item, it was sometimes difficult for consumers to identify serving size portions in a single edible or drinkable product. For example, early regulations allowed up to 10 servings in a single cookie. The resulting fact that 1 serving could only be one tenth of a product that would normally be consumed in one sitting, combined with the delayed onset of the effects of THC after eating, contributed to overconsumption. [(10)]

(6) Limitations on quantities for personal possession.

Recommendation:

- **Set limitations on quantities for personal possession that align with current practice in other jurisdictions, and with current definitions of quantities for personal possession under the criminal law in Canada.**
- **Limitations should include all types of marijuana products, including edibles.**
- **Consideration should be given to having lower limits for products containing higher levels of THC.**

Rationale:

Given that setting limits on quantities of marijuana may serve to minimize opportunities for resale on the illicit market, particularly to youth, it makes good sense that restrictions be put in place. Given that there is currently a lack of evidence to support specific best-practice limitations, restrictions for dried product should minimally align what is currently considered possession for personal use under Canada's current criminal law (30 grams), as possession of more than 30 grams is considered possession for the purpose of trafficking. However, at the outset it would be wise to have tighter limits and to study its impact over time prior to increasing allowable amounts.

Since products such as edibles and concentrates have a much higher level of THC in relation to marijuana in flower form, consideration should be given to having lower limits for these products. For example, in August 2015 the Marijuana Enforcement Division (MED) in Colorado conducted a study to determine the THC equivalent of concentrates and edibles as compared to marijuana in flower form. [(17)] As a result of this study, the MED has issued 'Marijuana Equivalency' guidelines and have updated their recreational marijuana purchasing laws accordingly. These new regulations will take effect as of October 1, 2016. [(18)]

(7) Limitation on where marijuana can be sold.

See comments on "Designing an Appropriate Distribution System."

1(b): Are there other actions which the Government should consider enacting alongside these measures?

We urge the task force to consider the following recommendations:

1) Develop a comprehensive strategy to clearly communicate the risks and harms associated with marijuana use, particularly for youth as well as conveying details of the regulations prior to implementation, so that the public and other stakeholders understand what is permitted, and so that individuals can make informed choices. [15]

2) Invest in evidence-based health promotion, prevention, awareness and education, targeted at both youth and parents, [15] with a secondary focus on other vulnerable groups (pregnant and lactating women, people with personal or family history of mental illness, and individuals experiencing issues with substance abuse) as well as harm-reduction messaging for those who choose to use marijuana.

3) Invest proactively in a collaborative public health approach that prioritizes investment in a continuum of evidence-informed prevention and treatment services to prevent and respond to problematic use. [15]

4) Invest in research to address gaps in knowledge in order to better understand short and longer-term health impacts of both non-therapeutic and medical marijuana use and to guide best-practice policy development. [15] The criminal status of marijuana has limited research opportunities up until now, leaving many gaps in knowledge, such as the full range of risks and therapeutic uses. Many recommendations for a regulatory framework have been made based on evidence borrowed from alcohol and tobacco research, and these should be substantiated by ongoing research specific to marijuana.

5) Conduct ongoing surveillance and monitoring on the patterns and trends associated with use, including the collection of baseline data prior to legalization. Stakeholders from Colorado and Washington expressed that they encountered challenges in monitoring impacts because no baseline data existed, particularly because marijuana was not reported separately from other illegal substances in many data systems. [15] Canada is in a position whereby we can put systems in place beforehand to confidently measure impact moving forward. This data will be extremely valuable in making evidence based decisions, regarding the impact of this new legislation and in making adjustments of this new system in years to come.

6) Restrict the sale of drug paraphernalia (e.g., pipes, bongs) in places where children and youth frequent and prohibit the sale of these products to minors. As experience with tobacco shows that the presence and availability of these products can

undermine other regulations by serving to normalize or increase the social acceptability of marijuana use among youth.

2(a): What are your views on the minimum age for purchasing and possessing marijuana?

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be 21.**
- **Regulations must be coupled with penalties for violations and be strictly and consistently enforced in all situations in order to be effective.**

Rationale:

A wealth of evidence exists to support the importance of delaying onset of drug use, including marijuana use, among youth. Current evidence confirms brain development is not complete until approximately age 25. [(19)] And further evidence demonstrates that both early and frequent marijuana use can alter the structure of the developing brain, and that some of these adverse effects may be irreversible, with the potential to seriously limit a young person's educational, occupational and social development. [(20)]

With regards to setting a minimum age for purchasing and possessing marijuana, a precedent has been set given that the legal age for tobacco consumption is 18 and varies between 18 and 19 across the provinces for alcohol. Given that both alcohol and tobacco are dependence–inducing substances that are legal for adults but subject to legal and social constraints on underage use, lessons can be learned for marijuana policy from the Canadian and U.S. experience with regards to the public health impact associated with enacting and raising the minimum age of legal access to tobacco products as well as the minimum legal drinking age.

The U.S. Institute of Medicine recently conducted a comprehensive review of the public health impact of raising the minimum age for purchasing tobacco products. A committee of public health, medical and other experts reviewed the, U.S. and international experience with enacting and raising the minimum age of legal access to tobacco products as well as the minimum legal drinking age. Results of the review were released in the 2015 report, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products. [(21)]

With regards to alcohol, the review found that that raising the minimum legal drinking age to 21, together with strict enforcement and penalties for violations, has been associated with lowered rates of alcohol consumption among adolescents and adults as

well as with reduced rates of alcohol-related adverse events (e.g., traffic crashes and hospitalizations). [21]

In terms of tobacco, the review concluded that increasing the minimum age of legal access to tobacco products will likely prevent or delay initiation of tobacco use by adolescents and young adults. The review also noted that while these legislative changes would directly pertain to individuals who are age 18 and older, the greatest impact would be on adolescents 15-17 years old. Furthermore, the report states that "The impact on initiation of tobacco use of raising the minimum age of legal access to tobacco products to 21 will likely be substantially higher than raising it to 19, but the added effect of raising the MLA beyond age 21 to age 25 will likely be considerably smaller" (p. 202). [21]

In Canada, an expert panel of scientists and researchers recently compared the effectiveness of provincial strategies to reduce alcohol related harms and costs in Canada. The resulting report, Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Comparison of Provincial Policies (2013), also highlights that a higher minimum legal drinking age is more effective in decreasing alcohol consumption and related harms among youth with a minimum legal drinking age of 21 years representing the best practice. [22]

The Canadian report also recommended that the legal drinking age be supported by legislation that prohibits not only the purchase of alcohol by those below the minimum legal drinking age but also prohibits the sale of alcohol to these individuals. In doing so, the drinker and alcohol retailers share the responsibility of upholding the legal drinking age. Finally, it is important to consider policies that permit individuals under the legal drinking age to drink under specific circumstances (i.e. social hosting policies) due to the permissive attitude towards alcohol they may promote. [22]

2(b): Should the minimum age be consistent across Canada, or is it acceptable that there be variation amongst provinces and territories?

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be consistent across Canada in order to provide clear policy direction and eliminate cross-border variations which limit the effectiveness of minimum legal age regulations to protect young people.**

Rationale:

Both experience from Ontario communities located near inter-provincial borders with Quebec and evidence from Canadian alcohol research demonstrate that cross-border variations in legal drinking age limit the effectiveness of a minimum age to protect young people.

The 2007 National Alcohol-Related Harm in Canada: Toward a Culture of Moderation report proposed that harmonizing minimum purchase ages across jurisdictions would help to reduce certain risky drinking behaviours. An example of this is where youth cross provincial/ territorial borders to take advantage of less restrictive regulations in neighbouring jurisdictions. [23]

Given alcohol, tobacco and marijuana are all clearly linked with varying levels of youth related harm, our recommendation ideally would be that tobacco, alcohol and marijuana all have a legal access age of 21. Given however the complexities involved in altering the legal access age for alcohol and tobacco in order to attain consistency, we are addressing our recommendation from the context of marijuana access only. Consistent age restrictions will provide clear policy direction and eliminate cross-border variations which limit the effectiveness of a legal drinking age to protect young people.

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Section Two: Establishing a safe and responsible Production system

1. ***What are your views on the most appropriate production model? Which production model would best meet consumer demand while ensuring that***

public health and safety objectives are achievable? What level and type of regulation is needed for producers?

Recommendation:

- **A government controlled monopoly on marijuana production.**
- **Marijuana should not be regulated or treated as a food product in the context of the agricultural industry**. This is especially important because it will likely be included as an ingredient in various types of food products (edibles), however marijuana is a psychoactive drug and not an ordinary commodity. This concern stems from the current representation of beer and wine as 'local food' and a 'farming crop' in Ontario's agricultural industry. This representation has been very detrimental to societal perceptions about alcohol and has contributed to its normalization. As lessons learned from alcohol show that normalization results in increased use and associated harms, (3) it is important that this recommendation be followed from the outset of legalization of recreational marijuana.

Rationale:

A government controlled monopoly has been used in different parts of the world on the production of various regulated substances to limit the influence of for-profit businesses. [(1)] Considerable evidence from alcohol literature indicates that government monopolies are better for public health than less regulated options. [(1, 2)] A government controlled monopoly on marijuana production controls diversion, eludes advertising, slows product innovation, maximizes tax revenue, decreases market competition and increases retail price. [(1)] Product innovation is projected to be slower within a government controlled monopoly. This is important from a public health perspective as product innovation will likely decrease production costs, which leads to decreased retail pricing in a competitive market. [(1)] While decreased pricing may appear to benefit consumers, strong evidence from alcohol literature suggests that a decrease in price is associated with an increase in consumption and harm. [(3, 4)] Higher pricing strategies are particularly effective in reducing consumption, especially among high-risk populations, such as youth. [(3)]

A government controlled monopoly also has the benefit of reversibility. [(1)] The health, social and economic implications of legalization are largely unknown. Following legalization, if a government monopoly on marijuana production proves to be the most effective model for reducing consumption and harms, this model will be easiest to retain from the outset. If governments initially choose a commercialized market, change to a more restrictive model will be difficult.

Having said this, a commercialized model (similar to that of alcohol regulation) is **not** recommended. Commercialization aims to "maximize the efficiency of production, the appeal of products to consumers, and the size, scale and scope of the market" (Caulkins et al., 2015, p. 53). While the trajectory of a commercialized model is far from certain, some potential outcomes include:

- decreased production costs resulting from increased production scales, a shift in cultivation from indoor to greenhouse or outdoor spaces, and an increase in production of extract-based products. [1] This has negative health implications as evidence from alcohol literature suggests that a decrease in price is associated with an increase in consumption and harm; [3, 4]
- increased product innovation toward concentrates, edibles and high potency products, and alarmingly, new and unknown products from extraction and blending of psychoactive chemicals in the marijuana plant;
- increased marketing; and
- increased competition and therefore decreased costs. [1]

The following chart was adapted from Caulkins et al. (2015) and highlights the attributes of government monopoly and commercial models.

Attributes	Strategy	
	Government monopoly	**Commercial model**
Production costs (without fees, taxes, regulation)	Low or medium	Very low
Product quality assurance and labelling	Very good	Good
Incentive for producers to promote use that is harmful to public health	Low	Very high
Government's ability to restrain suppliers promotion of harmful use	Very good	Low
Likelihood of promoting harmful use	Low or medium	Very high
Cost or effort for government control efforts	High	Low
Ability to generate government revenue	Very high	Fair

It is clear that a government monopoly on production is the best model for public health and safety.

2. *To what extent, if any, should home cultivation be allowed in a legalized system? What if any government oversight should be put in place?*

Recommendation:

- **Home cultivation is not recommended.**

Rationale:

From a public health perspective, home cultivation presents the following challenges:

- potential for increased access among children and youth;
- significant challenges in regulating potency, quality and labelling; [1]
- high cost and effort for governments to control and regulate marijuana production; [1]
- increased challenges in regulating commercial production and preventing diversion; [5]
- inability to generate government revenue to support health promotion initiatives.
- lack of authority to inspect homes to ensure safe production; and
- potential health impacts in the surrounding environment and risks to property from home growth, including fire and mould.

3. *Should a system of licensing or other fees be introduced?*

Recommendation:

- **Licensing should be required and a licensing fee enacted to increase revenue to enhance public health and safety through increased producer compliance with regulatory standards, and to** offset t**he health and social costs associated with legalization.**

Rationale:

Licensing will ensure all producers meet standards of regulations for ongoing safe production and storage to protect public health and safety. Licensing also enables governments to geographically track the number of producers to determine community trends and density.

If a commercialized model is considered, incentives are required to ensure production companies comply with regulations rather than opting to violate regulations and take the

chance of being caught. Restricting the number and size of licensed producers and establishing strict penalties to discourage violations creates a sense of value to the license and is a possible strategy to increase compliance. Producers would have a strong incentive to follow regulations. Without restrictions, the value of a license decreases, as does the fear of losing a license for a violation.

In addition, monitoring regulatory compliance is more efficient and less costly within a limited number of firms. [(1)]

4. *The MMPR* (ACMPR as of Aug. 24, 2016) *sets out rigorous requirements over the production, packaging, storage and distribution of marijuana. Are these types of requirements appropriate for the new system? Are there features that you would add or remove?*

Production

Recommendation:

- **Strengthen requirements set out in the ACMPR to develop a more comprehensive regulatory system, including: Development of national standards for production, packaging, storage, distribution and testing of marijuana products. This is an important strategy for public health and safety.**
- **Expansion to include regulation of a wider variety of marijuana products (e.g., edibles, concentrates, and tinctures).**
- **Provision of government resources for inspection and other accountability functions.**
- **Mandating food safety training for producers of edible marijuana products.**
- **Aligning marijuana production with public policy goals related to climate change.**

Rationale:

- The ACMPR sets out strict conditions for the production of medical marijuana in Canada, including batch testing for contaminants. These requirements form a good basis for the new regulatory system for non-medical marijuana.

- Other jurisdictions have measures in place that can inform Canada's system. In Colorado, one department provides key monitoring and accountability functions, including:
    - inspecting all growers, infused product manufacturers and retail outlets; and
    - inspecting and certifying marijuana testing facilities that perform potency and contamination testing on plants, concentrates and edibles. [6]

- In other jurisdictions, governments offer producers of edible marijuana products access to its food safety training to reduce the risk of food-borne illness (e.g., risk of contamination with certain viruses and bacteria). [6]

- There is an opportunity to align marijuana production with public policy goals related to climate change. The indoor production of marijuana has been shown to have a significant carbon footprint. Indoor cultivation uses significant energy resources, including intensive lighting and climate control. For example, one marijuana 'cigarette' represents 1.5 kg of CO2 emissions. This is equal to driving a hybrid car 35 kilometres. [7] Regulation and licensing options worth considering include mandating carbon-free electricity generation. Boulder, Colorado requires marijuana businesses to offset 100% of their electricity consumption with renewable energy. [8]

Product Packaging

Recommendations:

- **Develop and enforce product design requirements, including plain and standardized packaging regulations that prohibit branding and promotion of all marijuana products.**
- **Develop and enforce labelling requirements, including marijuana strain, dosage, and THC levels. Lessons can be learned from regulating product packaging of tobacco and alcohol and from other jurisdictions that have legalized marijuana.**
- **Commission research on the effectiveness of health warning labels on marijuana products and update labelling requirements as necessary.**

Rationale:

- Colorado has rules on packaging, labelling and product safety equal to or exceeding those for tobacco that should be considered in the development of Canadian standards. These include:
    - prohibiting appeal to children or youth under age 21;

- restricting use of cartoon characters in the design;
- mandating child-resistant packaging. [6]

- Strategies that prevent the promotion and marketing of marijuana will help reduce consumption and related harms. Health experts recommend the use of plain packaging as a means of reducing promotion and marketing of marijuana. [9, 10] The World Health Organization also recommends plain packaging as one measure to decrease tobacco smoking initiation and cessation. [11]

- There is limited research on the effectiveness of health warning labels on marijuana products to reduce marijuana-related harm. While further research is currently underway to evaluate the effectiveness of warning labels on alcohol products, there is evidence to suggest that consumers support the inclusion of more health/nutrition information on alcohol products. [12] Where evidence supports, health warning labels on marijuana products should advise against frequent use, use prior to age 25, use in combination with alcohol or other drugs, use prior to driving or operating heavy machinery, use during pregnancy, use with a family history of psychosis or with cardiovascular problems, use above recommended dosage, and about the risk for respiratory issues and of second hand smoke.

Distribution

Recommendations for regulations related to the distribution of marijuana are provided in section 3.

5. What role, if any, should existing licensed producers under the MMPR (ACMPR) have in the new system (either in the interim or the long-term)?

- *Out of public health scope. No response.*

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Section 3: Designing an appropriate distribution system

1. Which distribution model makes the most sense and why?

Recommendation:

A government owned and controlled store front system is the best model to emphasize health and safety over customer and profit generation and to prevent youth access, through:

- **controlling availability and accessibility of marijuana;**
- **providing adequate staff training;**
- **providing evidence-based information on the potential health effects of using cannabis to consumers;**
- **restricting and enforcing limitations on marketing and advertising;**
- **establishing and maintaining a minimum price; and**
- **ensuring marijuana is not sold alongside other products that can have synergistic effects when combined with marijuana (e.g., alcohol and tobacco).**

Rationale:

Experience from alcohol demonstrates that government ownership of alcohol outlets can regulate alcohol availability in a comprehensive way. There is strong evidence that off-premise monopoly systems limit alcohol consumption and alcohol-related problems if alcohol control is a central goal, and that elimination of those monopolies can increase total alcohol consumption, especially when privatization leads to increased outlets, expanded hours of sale and reductions in the enforcement of policies such as not selling to underage customers. (1)

We can infer that government ownership is the most effective way to achieve the overall government goals of reducing harm related to marijuana consumption. Research on state run alcohol monopolies have shown that monopolies help keep the price of a product higher through reduced competition and help reduce access to alcohol by youth and overall levels of use. (2)

It is difficult to change a policy to make it more restrictive once the use of a substance and its regulations have been socially embedded and accepted. Policies and regulations regarding recreational marijuana should be more restrictive rather than less restrictive in the beginning. The policies and regulations could be loosened if the evidence and experience collected over time is evaluated and supports changes.

Retail outlets

There are several safeguards that protect the health and safety of the public. Some of these regulations include:

- Limiting the number and type of retail outlets
- Restricting hours and days of operation
- Restricting locations of retail outlets
- Restricting density of retail outlets (geographic density or population density)
- Allowing for broad Zoning powers at the municipal level
- Restricting the type of products that can be sold through outlets along with cannabis
- Restricting marketing, promotion and displays
- Training of staff/education of consumers at point of sale
- Training of staff/promotion of health risks through educational material at point of sale

This is supported by evidence:

- The widespread availability of tobacco and alcohol products for purchase helps to normalize their use and to undermine health risk messaging. Contextual cues play a significant role in shaping understanding of the magnitude of a hazard. There is a discord between the risk information provided by health authorities and the contextual cues that tobacco (and alcohol are) commonplace. (3)
- Easy access to tobacco reduces the total cost (price plus time, distance and transportation) to use. Frequent cues (i.e. seeing products in many outlets) prompts impulse buys among experimental and occasional smokers and smokers trying to quit. For former smokers receiving cues to smoke in places where they regularly shop also contributes to high levels of recidivism. (3)
- More than one third of smokers and a higher proportion of young smokers said they would smoke less if they had to travel further to buy cigarettes. (3)

Free Enterprise (Business) Market

There are several public health and safety concerns regarding a free enterprise market for cannabis distribution, including**:**

- Commercial interest and profits take priority over public health interests.
- Lack of control over staff training to prevent youth access to marijuana.
- Decreased accountability to provide health education regarding potential risks of using cannabis for consumers.
- Economic burden on the government to prevent or delay use by youth. More costly and less efficient enforcement of regulations.

These concerns are supported by evidence:

- Research strongly indicates that as alcohol becomes more available through commercial or social sources, consumption and alcohol-related problems rise. Conversely, when availability is restricted, alcohol use and associated problems

decrease. The best evidence comes from studies of changes in retail availability, including reductions in the hours and days of sale, limits on the number of alcohol outlets and restrictions on retail access to alcohol. (1)

- Evidence from privatization experiments in the USA and abroad has shown that privatization leads to more outlets, longer hours of operation, increased promotions and increased sales and use. (4)
- Research suggests that roughly 80% of marijuana purchases in the USA are made by 20% of the users (heavy users who use daily or near daily). (5) To maximize profits, companies would benefit from creating and maintaining heavy users.

2. To what extent is variation across provinces in terms of distribution models acceptable?

Recommendation:

- **A uniform distribution model consistent across Canada is important for public health.**

Rationale:

Cross border variations can present many complexities and challenges, as is seen now between Ontario bordering Quebec and Manitoba, where the legal age to drink alcohol is different.

When it is left to each province to add additional policies and regulations, local health units and our partners are burdened with the challenging task of demonstrating the need for additional safeguards at the local level.

Even within a strict health-focused federal regulatory system, provinces and municipalities will require the jurisdiction to strengthen the regulations and policies in order to further safeguard the health and safety of their residents. For example, municipalities should be able to use zoning bylaws when determining locations of outlets.

3. Are there other models worthy of consideration?

Recommendation:

- **A government monopoly with cross-border consistency is the preferred model for Ontario health units.**

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Section 4: Enforcing public safety and protection

1. *How should governments approach designing laws that will reduce, eliminate and punish those who operate outside the boundaries of the new legal system for marijuana?*

Recommendation:

- **A federal legislative framework that sets out clear minimum standards that all provinces and territories must follow, including a minimum age for sale or provision, restrictions on labelling and promotion, and clear enforcement infrastructure**, will result in a strong foundation upon which more restrictive provincial and municipal laws can be built, if required.

- **Youth possession of marijuana should not be considered a criminal offense.** The onus of compliance with the laws should be placed on the commercial supplier with increasing penalty with each infraction, and include prohibition of any sale or storage of product. This recommendation, however, should not preclude criminal charges of youth related to impaired-driving. Offences regarding youth access should be aligned with those in alcohol and tobacco control.

- **Develop an enforcement infrastructure that prevents the diversion of marijuana products from the legal supply chain**. This will require collaboration at all levels of government and enforcement bodies.

- **Provide mandatory labelling or markings that easily identify permitted products thereby facilitating the removal of prohibited products from the supply chain. Ensure penalties are aligned with alcohol and tobacco contraband offences.**

- **Creating a new role of 'marijuana control officer' (similar to tobacco control officers) to help enforce regulations.**

Rationale:

It is important that the federal government take a public health approach that focuses on preventing youth access to marijuana through the legal and illegal supply chains. Existing alcohol and tobacco control policies provide structures that could support marijuana legislation.

The commercial model of marijuana legalization adopted in Washington, Colorado, Alaska and Oregon State performs well in terms of consumer access and reducing street level illicit marijuana trade. However, like alcohol, tobacco, and gambling, the goal of the commercial for-profit model is to attract new customers, keep existing customers and convert moderate users into consistent users. The preferred approach from a public health standpoint is a regulatory approach similar to alcohol that makes the sale of marijuana a provincially controlled state monopoly similar to the LCBO. This approach, provides an effective means of controlling the quality, cost and availability of the product, promotes responsible use amongst adults while restricting access to minors. [(1)]

Evidence suggests that a regulatory approach can reduce the burden on the criminal justice system and provide a platform for government or health care professionals to effectively address and help prevent problematic use. [(1)] If a regulatory controlled system for the legal purchase and use of marijuana is adopted, criminal sanctions should be strengthened for those who sell to minors or act outside the boundaries of the new regulatory system and civil violations punishable by a small fine to enforce regulatory non-compliance.

For example, a federal regulated legal system for marijuana should set out clear minimum standards that all provinces and territories should follow. At a minimum all provinces and territories should be required to ensure:

- That all sales of marijuana are done through provincially controlled outlets/dispensaries.
- No criminal sanctions for anyone who is the minimum age for purchasing and possessing marijuana or over and in possession of what is deemed to be within the limit for persona possession.
- Provincially appointed enforcement staff (non-criminal) should be given the option to issue Provincial Offences Act (POA) tickets plus tax assessment penalties similar to the taxation powers given to enforcement staff under the Ontario Tobacco Tax Act for all marijuana possession that exceeds the limit for personal possession and/or that was not purchased from a state or provincially controlled outlet/dispensary.
- Criminal charges under the Control Drug and Substances Act should be laid for all sales to persons less than the minimum age for purchasing and possessing marijuana and for distribution or sales without federal or provincial marijuana sales permit.

2. What specific tools, training and guidelines will be most effective in supporting enforcement measures to protect public health and safety, particularly for impaired driving?

Recommendation:

- **Develop a comprehensive framework which includes prevention, education, and enforcement to address and prevent marijuana-impaired driving with a focus on groups at higher risk of harm, such as youth.**
- **Continue with public health support for local law enforcement activities through education and awareness raising efforts on the dangers of marijuana-impaired driving.**
- **Direct provincial education ministries to work with public health to update and provide supports for health and physical education curriculums, embedding key evidence-based messages about risky use.**
- **Additional provincial funding to allow for the expansion of the role of public health inspectors by creating 'marijuana control officer positions (similar to tobacco control officers) to help enforce regulations.**

Rationale:

As highlighted in the discussion paper, it will be important to develop a comprehensive framework to address and prevent marijuana-impaired driving. Such a framework should include prevention, education, and enforcement. [(1)] This strategy should focus on groups at higher risk of harm, such as youth, and should emphasize the risk associated with marijuana use and drug-impaired driving. Targeted campaigns via the use of radio ads, news outlets, TV commercials, or movie stills could be an effective method used to inform the public of the new legislative requirements.

There is a recognized need for research on and the development of reliable technologies that can be used at road-side check points to detect impairment due to marijuana use. The use of these technologies, including training and guidelines, would fall to local, provincial and federal law enforcement agencies, depending upon the jurisdiction. Additional training opportunities could assist enforcement staff to further enhance their ability to combat difficult situations such as dealing with drug-impaired driver or managing conflict with individuals who may be impaired due to the use of marijuana.

Public health can play a role in supporting local police agencies through education and awareness raising efforts. Traditional public health communication channels could be used to help make the public aware of the dangers of marijuana-impaired driving, similar to efforts currently being done around drinking and driving.

Public health staff currently partner with school boards as well as school staff, school councils and students of elementary, secondary and post-secondary educational settings

to raise awareness of the health and safety risks to youth posed by alcohol, tobacco and marijuana use. [2] These efforts can be expanded to include greater emphasis on marijuana and youth-related health effects as well as marijuana-impaired driving. The communication of risk to the wider population can be undertaken using existing social media channels and providing support to relevant local partners, as needed.

3. Should consumption of marijuana be allowed in any publicly-accessible spaces outside the home? Under what conditions and circumstances?

Recommendation:

- **A comprehensive ban of the consumption of marijuana in workplaces and in shared indoor and outdoor spaces at the federal level would prevent a patchwork approach similar to what is observed in tobacco control across Canada. A federal level ban positions marijuana use as having risk, and provides a minimum standard upon which provinces and municipalities can build. Enforcement of these regulations must be jointly shared at the federal, provincial and local levels.**

Rationale:

The prohibition of alcohol consumption in public spaces has its roots in federal and provincial temperance laws and the prohibition movement with the misdirected aim to maintain social order. Currently, alcohol consumption is limited for the most part to private residences or licensed premises. On the other hand, the prohibition of smoking in workplaces, public indoor and outdoor spaces have been implemented to varying degrees across Canada over the last 30 years. The implementation of these policies was in response to the body of evidence that identified the link between tobacco use and chronic diseases. [3]

According to the World Health Organization, 100% smoke-free environments are the only effective way to protect the population from the harmful effects of second hand smoke (SHS). SHS can disperse quickly through a building traveling between adjacent units through cracks in walls and ceiling, windows, heating and ventilations systems. According to the American Society of Heating, Refrigerating & Air-Conditioning Engineers (ASHRAE) there is currently no available or reasonably anticipated ventilation or air cleaning system that can adequately control or significantly reduce the health risks of SHS. ASHRAE also says the only effective means of eliminating the health risk associated with indoor exposure to SHS is to ban smoking altogether. [4]

Studies have shown that smoke-free policies can reduce smoking rates, youth initiation rates and increase quit attempts. Smoking bans have also been associated with improved health outcomes, such as reductions in heart disease and respiratory illness. [4] Tobacco and other combustible smoking products should be the highest priority for no-smoking provisions. Exposure to all smoke, including tobacco, marijuana and herbal products such as shisha water pipe smoke, can trigger cardiovascular events, severe asthma attacks and can aggravate existing chronic obstructive pulmonary disease and other respiratory conditions. [5, 6, 7]

In March 2016, the Ontario government announced plans to further strengthen the smoking and vaping laws by proposing six additional changes to the regulations made under the Smoke-Free Ontario Act (SFOA) and ECA. The Province tabled Bill 178 that would amend the SFOA to prohibit the smoking of any substance or product prescribed by regulation. Bill 178 was carried on third reading in June. The Government would next promulgate the regulations that would stipulate what products/substances (other than tobacco) are not to be smoked in the same places where smoking of tobacco is prohibited. The Province to date has only formally proposed that medical marijuana be prescribed under the regulations but it is recommended that they extend this to recreational use of marijuana as well.

It is evident that the Task Force on Marijuana Legalization and Regulations seeks to protect young Canadians and protect the health of all. In the case of smoking or vaping of marijuana, a prohibition of its consumption in workplaces and public spaces, both indoor and outdoor, ensures the same reasonable and precautionary safeguards to employees, customers and bystanders from exposure to second-hand smoke. Further still, lessons from tobacco control suggest that a prohibition of consumption in public spaces, in conjunction with sufficient taxation and banning advertising, promotion and sponsorship, would prevent the normalization of consumption among youth. [1]

Section Four References:

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Section Five: Accessing marijuana for medical purposes

1. ***What factors should the government consider in determining if appropriate access to medically authorized persons is provided once a system for legal access to marijuana is in place?***

   Recommendation:

   - **Utilizing a health equity lens, the government needs to provide regulations including price and accessibility to suit the needs of all Canadians who require medical marijuana while maintaining effective controls to reduce potential harm.**

   Rationale:

   Ontario public health units focus on the issue of health equity.

   The legalization of marijuana will impact the current system of medical marijuana. If it is anticipated that there will be a continuation of access to marijuana for medical reasons, the proper measures need to be put in place to allow for enforcement.

   Affordability and accessibility have been identified as reasons for the commercial medical marijuana system not meeting the needs of all. Utilizing a health equity lens, the government needs to provide regulations including price and accessibility to suit the needs of all Canadians who require medical marijuana while maintaining effective controls to reduce potential harm. Regardless if the marijuana is medical or recreational, there is a need for strong regulation and control the methods by which people are accessing it.

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

Date:	RESOLUTION NO.: 2016 -
MOVED:	SECONDED:
SUBJECT: A PUBLIC HEALTH APPROACH TO THE LEGALIZATION OF CANNABIS	

Resolution:

WHEREAS Algoma Public Health is committed to prevent disease and promote the health of individuals and communities in the Algoma District; and

WHEREAS the Government of Canada has indicated the intention to legalize, regulate, and restrict access to marijuana; and

WHEREAS within the current criminalization context, 49.12 % of individuals in Algoma indicated that they have used cannabis in their lifetime compared to 40.22% in Ontario; and

WHEREAS cannabis also ranks 3rd on the list of top drugs presented at intake in both North and East Algoma according to Algoma Public Health's Community Alcohol/Drug Assessment Program; and

THEREFORE BE IT RESOLVED THAT the Board of Health for the District of Algoma Health Unit continue to support staff in their alignment with the "Provincial Marijuana Collaborative" on cannabis, with the purpose of forwarding public health recommendations to the Federal Task Force reviewing the legalization, enforcement and regulation of cannabis; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

CARRIED: Chair's Signature _____

☐ **Lee Mason - Chair**	☐ **Ian Frazier – Vice Chair**	☐ **Patricia Avery**
☐ **Lucas Castellani**	☐ **Deborah Graystone**	☐ **Sue Jensen**
☐ **Candace Martin**	☐ **Heather O'Brien**	☐ **Dennis Thompson**

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