ALGOMA PUBLIC HEALTH

BOARD OF HEALTH MEETING

4:00 - 6:00 PM

ELNOS BOARDROOM

302-31 NOVA SCOTIA WALK, ELLIOT LAKE, ON

www.algomapublichealth.com

May 25, 2016 - Board of Health Meeting

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ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
May 25, 2016 @ 4:00 pm
ELLIOT LAKE BOARDROOM, ELLIOT LAKE
A*G*E*N*D*A

1.0 Meeting Called to Order — Lee Mason, Board Chair

- **a. Welcome New Board Members**
- **b. Declaration of Conflict of Interest**

2.0 Adoption of Agenda Items — Lee Mason, Board Chair

Resolution
THAT the agenda items dated May 25, 2016 be adopted as circulated; and
THAT the Board accepts the items on the addendum.

3.0 Adoption of Minutes of Previous Meeting — Lee Mason, Board Chair

a. April 27, 2016

Resolution
THAT the Board of Health minutes for the meeting dated April 27, 2016 be adopted as circulated.

4.0 Delegations/Presentations.

a. Safe Water – Environmental Health Beach Sampling Program — Chris Spooney, Program Manager

5.0 Business Arising from Minutes

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Report — Tony Hanlon, Chief Executive Officer

Resolution
THAT the report of the Medical Officer of Health and CEO for the month of April 2016 be adopted as presented.

b. Finance and Audit Committee Report — Ian Frazier, Committee Chair

i. Committee Chair Report for May 2016

Resolution
THAT the Finance and Audit Committee report for the month of May 2016 be adopted as presented.

ii. Draft Financial Statements for the Period Ending March 31, 2016

Resolution
THAT the Finance and Audit Committee report for the month of May 2016 be adopted as presented; and

THAT the Financial Statements for the Period Ending February 29, 2016 be approved as presented.

iii. Approved minutes ***– for information only***

c. Governance Standing Committee Report — Ian Frazier, Committee Chair

i. Committee Chair Report for April 2016

Resolution
THAT the Governance Standing Committee report for the month of May 2016 be adopted as presented.

ii. Policy Review — Ian Frazier, Committee Chair

Resolution
THAT the Board of Health approves the changes to the following policies as presented:
02-05-000 – Board of Directors Membership
02-05-035 – Continuing Education for Board members
02-05-040 – Retirement – Board Recognition
02-05-045 – Attendance at Meetings using Electronic Means
02-05-050 – Retirement Benefits for Employees

iii. HPV Immunization Program — Ian Frazier, Committee Chair

Resolution:
WHEREAS Ontario is expanding the publicly funded human papillomavirus (HPV) vaccination program to include boys in Grade 7; and

WHEREAS Algoma Public Health supports the immunization of boys to help prevent the spread of HPV and prevent cancer; and

WHEREAS the HPV vaccine will continue to be provided to girls in Grade 8 for the transition year until all grade 7 students receive the vaccination; and

WHEREAS the Ministry estimates about 154,000 students will be eligible to receive the vaccine each year; and

WHEREAS APH, similar to other PHUs, plans to deliver the vaccination program over the course of three school visits in order to avoid giving more than two doses of vaccine per student per visit, which will increase the number of school clinics by approximately 33% (previously two visits per year); and

WHEREAS the Ministry of Health and Long-Term Care's (MOHLTC) Immunization 2020 Strategy strives to "reduce health risks related to vaccine-preventable diseases in the province"; and

WHEREAS the MOHLTC has not increased funding to the Vaccine Preventable Disease (VPD) program despite adding responsibilities and new vaccines to the program,

THEREFORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health commends the Ministry of Health and Long- Term Care for its commitment to expand its HPV vaccination program to young males

who are starting grade 7 this September; and

FURTHERMORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health urges the MOHLTC to consider increasing the annual funding for the VPD program in order to provide the staff resources to meet the above mandate.

FURTHERMORE BE IT RESOLVED that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.

iv. Environmental Health Program Funding — Ian Frazier, Committee Chair

v. 2015 APH Program Performance Report: A Quantitative Report to the Board — Tony Hanlon, Chief Executive Officer

Resolution
THAT the Board of Health accepts the 2015 APH Program Performance Report as presented.

vi. Approved Minutes April 13, 2016 – ***for information only***

7.0 New Business/General Business

8.0 Correspondence — Lee Mason, Board Chair

a. Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws
   i. Letter to alPHa and all Boards of Health from Middlesex-London Health Unit dated May 13, 2016

b. Environmental Health Program Funding
   i. Letter to Minister Hoskins from Peterborough Health Unit dated April 28, 2016

c. Herpes Zoster Vaccine
   i. Letter to Minister Hoskins from Algoma Public Health dated May 3, 2016

d. International Code of Marketing of Breastmilk Substitute
   i. Letter to Minister Philpott from Peterborough County-City Health Unit dated April 27, 2016

e. Invasive Personal Service Settings
   i. Letter to Premier Wynne from Durham Region dated April 29, 2016

f. Patients First: A Proposal to Strengthen Patient-Centred Health Care
   i. Letter to Minister Hoskins from alPHa dated April 28, 2016
   ii. Letter to Minister Hoskins from Middlesex-London Health Unit dated May 13, 2016

g. Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act

i. Letter to Minister Hoskins from Middlesex-London Health Unit dated May 13, 2016

h. Public Health Approach to Cannabis Legalization

i. Letter to Prime Minister Trudeau from Simcoe Muskoka District Health Unit dated April 20, 2016

ii. Letter to Prime Minister Trudeau from Elgin St. Thomas Public Health dated March 23, 2016

i. Response to Food Insecurity

i. Letter to Ontario Society of Nutrition Professionals in Public Health Food Security Workgroup from Northwestern Health Unit dated April 2016

j. Smoke-Free Schools Act Bill 139

i. Letter to Premier Wynne from Durham Region dated April 29, 2016

k. Water Fluoridation

i. Letter to Minister Hoskins from Porcupine Health Unit dated May 2, 2016

9.0 Items for Information

10.0 Addendum — Lee Mason, Board Chair

11.0 That The Board Go Into Committee — Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated March 30, 2016
b. Litigation or Potential Litigation

12.0 That The Board Go Into Open Meeting — Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into open meeting

13.0 Resolution(s) Resulting from In-Committee Session — Lee Mason, Board Chair

14.0 Announcements: — Lee Mason, Board Chair

Next Board Meeting:
June 22, 2016, 2016 at 5:00pm
Sault Ste. Marie, Room A&B, Sault Ste. Marie

15.0 That The Meeting Adjourn — Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns

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Safe Water – Environmental Health Beach Sampling Program

Chris Spooney
East Algoma District Program Manager

Ontario Public Health Standards

- The board of health shall report Safe Water Program data elements in accordance with the Beach Management Protocol, 2008 (or as current); the Drinking Water Protocol, 2008 (or as current).

- The board of health shall conduct surveillance of public beaches and public beach water illnesses of public health importance, their associated risk factors, and emerging trends in accordance with the Beach Management

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Indicator/Process

Escherichia coli (E.Coli) >100mL

- are bacteria that are commonly found in the intestines of humans and animals and is the key indicator used to determine water safety.

Algoma District Wawa – Elliot Lake

- 24 beaches – weekly sampling June to September
- 5 Samples collected from each location (geometric mean)

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Factors that affect beach water quality

- Human Activity
- Water Temperature
- Rainfall (occurrence/intensity)
- Wave Height
- Topography
- Water Clarity
- Birds
- Animals

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How Does APH notify the public if adverse results are detected?

- Posting signs at beach entrances
- Posting information on the Algoma Public Health website
- Issuing media releases to local new sources including the APH facebook
- Informing the affected municipal offices or individuals responsible for maintaining the safety of the location

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Does APH close the beach to the public?

- Is the beach closed? Or posted?
- During 2015, there were a total of 9 beaches posted within the Algoma District due to adverse results
- (4 SSM – 5 District)

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Questions?

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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER BOARD REPORT

May 2016

Prepared by Tony Hanlon Ph.D., CEO and Dr. Penny Sutcliffe, MOH

On May 10, 2016 APH staff participated in the City of Sault Ste. Marie's 5th Annual 20-Minute Makeover

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APH AT-A-GLANCE

We welcome Dr. Heather O'Brien and Dr. Lucas Castellani to the APH Board. They were appointed by the City of Sault Ste. Marie council at its May 16, 2016 council meeting. The two appointees will serve until the end of 2016, at which time the city will notify the APH Board of its three appointees to serve the next two-year term (2017/18).

April 23-30, 2016 was National Immunization Awareness Week. National Immunization Awareness Week highlights the importance of vaccination throughout the lifespan.

The First World Maternal Mental Health Day was recognized on May 4, 2016. The theme for this event is "Maternal Mental Health Matters" and the date was purposely chosen because it was close to Mother's Day and Mental Health Week. Maternal Mental Health problems like anxiety and depression impact 20% of pregnant and postpartum women. Increasing awareness will help improve the quality of care for women experiencing all types of Perinatal Mood and Anxiety Disorders, and reducing the stigma of maternal mental illness. To celebrate within the agency we encouraged all staff to wear GREEN on Wednesday May 4′ 2016. Green ribbons were provided to show support and a wellness basket set up on each floor.

On May 5, 2016 Algoma Public Health employees participated in the annual alPHa Fitness Challenge. Health Units across Ontario competed to get the highest percentage of staff participation for 30 minutes of physical activity. APH had 57% staff participation. The Employee Wellness Committee organized activities for staff over the lunch hour with lunch being provided. Activities included a 2-3 km Walk, Ball Hockey, Fitness Circuit and Laughing Yoga.

National Nursing Week took place from May 9-15, 2016 alongside International Nurses Day on May 12th. This week's theme, "Nurses: with you every step of the way" emphasizes how important nurses are in our lives - at every age and all health situations. We recognize the profession (406, 000 regulated nurses in Canada) for the dedication and commitment to making us healthier. APH staff joined our nursing staff on Wednesday, May 11, 2016 for cake in celebration.

On May 10, 2016 the City of Sault Ste. Marie held its 5th Annual 20-Minute Makeover. Staff in the Sault Ste. Marie office joined members of the Executive Team in cleaning up garbage outside around our building for 20 minutes. The intent of the community clean-up is to promote civic pride, city beautification, and acknowledge Earth Day. Last year, over 600 people participated in the city-wide initiative. In addition it promotes physical activity, environmental stewardship, teamwork, agency pride and showcases community partnership.

Once again APH staff participated in the annual Soo Sings for Kids charity event. Team Encore competed against eight other teams from various organizations to raise money for the charity of their choice. This year the event raised $20,000 at its sold-out show on May 11, 2016 at the Kiwanis Community Theatre Centre.

Regarding the MOH/CEO recruitment Dr. Sutcliffe has worked through a Quebec colleague to ensure our position is shared within the Quebec public health community. T. Hanlon and Dr. Sutcliffe are planning a visit to the University of Toronto in June to speak with 4th and 5th year residents about the MOH/CEO opportunity at APH.

PROGRAM HIGHLIGHTS

CHRONIC DISEASE PREVENTION

Director: Laurie Zeppa
Acting Manager, Chronic Disease Prevention and Injury Prevention: Jennifer Flood

Topic: Northern Fruits and Vegetable Program (NFVP)

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: Chronic Disease Prevention Requirement #3: Coordinate the Northern Fruit and Vegetable Program for Algoma district elementary/intermediate schools in 2016

This report addresses the following Strategic Directions:

- Improve Health Equity
- Collaborate Effectively

Algoma Public Health (APH) is currently in its ninth year of implementation of the Northern Fruit and Vegetable Program (NFVP), providing fresh Ontario-grown fruits and vegetables to all students in grades JK – 8 across the Algoma District, reaching over 10, 000 students. This program is funded by the Ministry of Health and Long-Term Care, in partnership with the Ontario Fruit and Vegetable Growers Association. This year Pic Mobert First Nation was incorporated into APH's implementation, and students at their elementary school are now also benefiting from the program. Students and school staff love the NFVP and are very grateful for the opportunity to participate.

With the lens of the Social Determinants of Health, the NFVP helps to provide children essential personal health and coping skills that will enhance their health now, and in the future. This is accomplished by educating children on the importance of vegetables and fruit, providing all children the opportunity to try new foods amidst the comfort of peers, and increasing fruit and vegetable consumption in children. This program can also provide opportunities to learn and practice important life skills, such as food safety and food preparation.

Ontario's Healthy Kids Strategy re-emphasizes the importance of creating healthy environments where children live, learn and play as one of the key strategies to addressing childhood obesity. The NFVP contributes to this strategy by offering many benefits, such as:

- opportunities for student involvement in program delivery,
- increased opportunities for student leadership,
- ability to practice numeracy and literacy outside of the traditional classroom setting,
- helping to create healthy school nutrition environments, where schools not only teach healthy eating in the classroom but students are able to practice healthy eating habits within their school environment,
- no cost to schools, and
- all students within participating schools are able to participate.

Porcupine Health Unit and Sudbury District Health Unit also participate in the NFVP, and together, with the leadership of a researcher with the University of Windsor, we are completing a three-year evaluation of the program. This three-year evaluation was included in our current three-year funding agreement. This year will be our third and final year of data collection. Although hopeful, we are unsure if the program will continue to be funded for next year. A work plan has been submitted to the Ministry for the 2016-2017 fiscal year, and we are currently waiting on approval.

COMMUNICABLE DISEASE CONTROL

Director: Sherri Cleaves
Manager, Environmental Health and Communicable Disease Control: Jonathon Bouma,

Topic: Pertussis Outbreak in Blind River

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/Deliverables: Requirement #8 in the Infectious Disease Prevention and Control Protocol. The Board of Health shall provide public health management of cases and outbreaks to minimize the public health risk in accordance with the Infectious Diseases Protocol, 2008.

This report addresses the following Strategic Directions: Collaborate Effectively

Algoma Public Health has been working with the community of Blind River and Blind River District Health Centre in response to over 50 cases of pertussis (whooping cough) in the last three weeks. Public Health Ontario and the Ministry of Health and Long Term Care have been offering scientific/technical expertise as well as helping with media and epidemiological analysis. Pertussis is a contagious bacterial disease which affects the respiratory system. The symptoms start with an irritating cough which gets progressively worse. The cough may be characterized by a high-pitched whoop or vomiting may follow a coughing episode. The cough tends to be worse at night. Routine immunization helps to protect children and adults from pertussis. Children should be up to date with their routine immunizations, including pertussis. Additionally, all adults are recommended to receive a one-time booster for pertussis (Tdap) during their adult years, especially those having contact with infants or pregnant women.

Immunization is the best way to prevent pertussis. Those who are not immunized have a greater chance of getting sick with pertussis. Despite early immunization, infants under one year of age are at the greatest risk from pertussis. Vaccination of pregnant women in their third trimester is strongly encouraged to help provide immediate protection to the newborn, and to prevent the mother from getting pertussis and spreading it to their newborn.

Algoma Public Health has offered an additional weekend clinic as well as three extra immunization clinics to the Blind River area. Uptake has been moderate and communications have gone out to emphasize the need for updated status to protect against this preventable disease. Schools and daycares were some of the early areas of identified cases and letters were issued to parents advising of the need to watch for symptoms and check immunization status. Several physician advisories were sent across Algoma notifying the physicians of the outbreak and information on signs and symptoms and to report any suspect cases to APH. A media release was also issued to keep the public informed of disease activity and the need for vaccination.

Pertussis outbreaks are often cyclical (3-5 years) and last several months. We will continue to work with the community partners in this outbreak to mitigate transmission through case management and offering vaccine to help prevent infection.

COMMUNITY ALCOHOL/DRUG ASSESSMENT PROGRAM (CADAP)

Director: Laurie Zeppa,
Manager, Community Alcohol/Drug Assessment Program: Sandra Byrne

Topic: The Addictions Treatment – Substance Abuse Counseling Program

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: MSAA agreement

This report addresses the following Strategic Directions:

- Collaborate Effectively
- Be Accountable

CADAP delivers a number of programs with the goal to help support healthy communities by providing a continuum of quality health care services. These services assist residences of Algoma to achieve a life free from alcohol and/or drugs. Services are provided to individuals age 16 and up (12+ in Wawa) who are interested in attending individual and group counseling to reach their substance use goals. One of the CADAP programs- The Addictions Treatment – Substance Abuse Counseling program has 4 indicators that are reported to the Ministry of Health and Long Term Care. The counseling program and groups are developed and delivered to assist in individuals attaining their goals.

This report summarizes the statistics related to the indicators for the Substance Abuse Counseling program and other related trends. The following statistics are based on the Ministry targets and indicators.

Indicator	Target	Goals/Target Results
1. # of Visits	900 visits	979 visits were completed
2. # of Individuals Serviced	725 individuals served	725 individuals were serviced, 64 of those were anonymous contacts (51 were individuals seen through the Walk-in Counseling program)
3. # of Group Session	66 group sessions	75 group sessions were completed
4. # of Group Participants	300 group participants	282 clients attended groups. (The variance resulted from a staff reduction and client drop out numbers)

Service delivery for this program is fairly consistent throughout the district with some difference in the delivery of groups. Due to lower client numbers, services in the district are delivered in individual sessions instead of group settings or, partnerships are developed to have a mixed group of addiction and mental health clients. In Wawa, APH is the only program providing addiction services as a result a culturally sensitive aftercare group was developed in partnership with Michipicoten First Nations. Wawa also partners with North Algoma Counseling Services to deliver the Anger Solutions Group. In Elliot Lake, the Anger Solutions group is co-facilitated with Community Mental Health.

Other program data:

Drug Use Trends:

For the 2015-16 reporting year the drug trends were tobacco, alcohol, cannabis, cocaine, prescription opioids, crack (ecstasy, hallucinogens, heroin, methamphetamines, over the counter codeine, and other stimulants were also noted). Most clients are polysubstance users meaning that they use 2 or more different drugs.

District Variances:
The drug trends are fairly similar in the north and east districts in Algoma.

Top drugs presented at intake (in order of ranking) are:

East Algoma	**North Algoma**
Tobacco	Alcohol
Alcohol	Tobacco
Cannabis	Cannabis
Prescription	Cocaine
Opioids	Prescription
Cocaine	Opioids

Age and Gender Differences:

- Males present with alcohol more often than females.
- Young female clients present more often with cocaine and crack cocaine, heroin, prescription opioids.
- Younger clients (age 16-24) report more often varied use of poly substances including alcohol, cocaine/crack, cannabis, tobacco, heroin, and prescription opioids.

For the 2016-17 reporting year, there will be continued monitoring of the trend of young adult clients accessing services, to evaluate the need for a different service approach or partnership in the community.

INFANT CHILD DEVELOMENT PROGRAM (ICDP)

Director: Sherri Cleaves
Manager, Infant Child Development Program: Leslie Wright

Topic: Infant Mental Health

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: Child Health Requirement #4 "the BOH shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies" along with The Ministry of Children and Youth Services program.

This report addresses the following Strategic Directions: Collaborate Effectively

On March 21-22, 2016 members from community agencies met with the Infant Mental Health (IMHP) Promotion Team from Toronto Sick Kids to discuss services that Algoma provides to support Infant Mental Health. IMHP has received funding from the Public Health Agency of Canada to engage communities across Canada to discuss current infant mental health practices and initiatives and identify opportunities to strengthen and improve knowledge and services specific to infant-early mental health. Community members from agencies/sectors that work with children 0-6 and their families (e.g. public health, child protection, early intervention, mental health services, etc.) were invited to collaborate with us during these discussions. The consultations addressed three areas of infant mental health: Core Prevention and Intervention, Competencies, and Organizational Policies and Practices.

During the consultations it was noted that APH already supports infant mental health within their programs. Our staff have been attending a 15 part series from IMHP which aims to raise awareness and understanding of the unique needs of infants and toddlers in order reduce the likelihood of poor mental and physical health. Also, staff working with children 0-6 will be attending a one day seminar entitled *"101 Infant Mental Health The Basics"* developed by IMHP and this seminar will become part of our program orientation. As well, we provide education to families about infant mental health during our parenting programs, prenatal classes and our home visits.

Based on these community consultations a report will be developed which will highlight what the community currently provides in relation to infant mental health and it will also identify potential short term and long term opportunities focusing on infant mental health. APH staff and community members that attended the consultations are working together to develop the report which will be made available to the community upon its completion.

RISK MANAGEMENT

APH MOHs and staff managed a pertussis (whooping cough) outbreak in Blind River and Elliot Lake and a norovirus outbreak at the Sault Area Hospital. Under the direction of the MOH, staff worked with the local health care providers, schools and hospitals to contain the outbreaks. Interventions included vaccination clinics, media messaging, communication with health care providers and provincial consultation through the Ministry of Health and Long-Term Care and Public Health Ontario.

PARTNERSHIPS

In addition to the partnerships mentioned above APH is also a member of the Algoma Leadership Table which met May 18. Topic discussed includes Syrian refugee settlement in SSM, a poverty initiative, children's special needs strategy coordination and the Healthy Kids Community Challenge.

Respectfully submitted,
Tony Hanon, Ph.D., CEO and Dr. Penny Sutcliffe, Acting MOH

ALGOMA PUBLIC HEALTH

FINANCE AND AUDIT COMMITTEE REPORT

FOR THE MAY 25, 2016 BOARD MEETING

Meeting held on: May 11, 2016 – Started at 4:58 pm

In attendance:

Tony Hanlon, Justin Pino, Ian Frazier, Lee Mason, Candace Martin

Secretary – Christina Luukkonen

Absent – Dennis Thompson (with regrets)

Justin provided a review of the financial statements for the period ended March 31, 2016. A few questions were asked with acceptable answers provided. A few of the areas discussed were the levies variance, the salaries and benefit variance, fees and insurance variance and the genetics program variance. It is going to be the recommendation of the Committee that the Board approve the statements for the period ended March 31, 2016.

The Committee had detailed discussions on the term loan renewals that are required by the end of August. It is the intent of APH to issue an RFP. Justin presented a draft template to be used to evaluate proposals from accredited financial institutions. The Committee will be asking for the Board's authorization to allow the Committee to assess and approve a successful bidder for APH's long-term debt. Planned timeframe to review RFPs would at the next Finance and Audit meeting.

The Committee discussed the need for a capital fund for the upkeep of capital assets. It is customary to have a detailed analysis of the capital assets that provides a benchmark of timelines of capital requirements. The Committee agreed that this would provide a basis to substantiate to the Municipalities if and when the Board requires to ask for additional funds for this purpose. Justin is to present a draft RFP for the Committee's consideration to have the analysis completed.

Next meeting is scheduled for June 8, 2016.

Meeting was adjourned at 5:40 pm.

Chair, Finance and Audit Committee
Algoma Public Health

5/18/16
Date

Algoma Public Health
Financial Statements
For the period ending: March 31, 2016

Algoma Public Health
Statement of Operations and Fund Balances
For the period ending: **March 2016**

	Actual YTD 2016	Budget YTD 2016	Variance Bgt to Actual 2016	Annual Budget 2016	2016 YTD Actual/ YTD Budget %
Revenue					
Municipal Levy -public health	$ 1,704,230	$ 849,948	$ 854,282	$ 3,399,791	201%
Provincial Grants -public health	$ 2,450,114	$ 2,441,825	$ 8,289	$ 9,767,300	100%
Grants/Levies - Capital	$ -	-	$ -	-	
Provincial Grants - community health	6,990,712	6,631,299	$ 359,414	7,606,547	105%
Fees, other grants and recovery of expenditures	124,470	206,051	$ (81,581)	824,204	60%
	$ 11,269,527	$ 10,129,122	$ 1,140,404	$ 21,597,842	111%
Expenditures					
Public Health Programs					
Public Health	$ 3,319,237	$ 3,494,824	$ 175,587	$ 13,991,298	95%
Public Health (Capital)	0	-	-	-	
Community Health Programs					
Healthy Babies and Children	259,324	$ 267,003	7,678	1,068,011	97%
Child Benefits Ontario Works	5,000	$ 5,000	-	20,000	100%
Dental Benefits Ontario Works	89,452	$ -	(89,452)	-	
Misc Calendar	23	$ -	(23)	-	
Northern Ontario Fruit & Vegetable Program	117,400	$ 117,400	-	117,400	100%
Brighter Futures for Children	98,300	$ 126,887	28,587	126,887	77%
Infant Development	675,986	$ 675,986	0	675,986	100%
Preschool Speech and Languages	611,355	$ 614,256	2,901	1	100%
Nurse Practitioner	122,853	$ 122,853	-	122,853	100%
Genetics Counseling	314,648	$ 367,806	53,159	367,806	86%
Community Mental Health	3,038,878	$ 3,164,598	125,720	3,164,598	96%
Community Alcohol and Drug Assessment	669,512	$ 683,210	13,698	683,210	98%
Remedial Measures	66,961	$ 53,080	(13,881)	122,320	126%
Diabetes	137,676	$ 150,000	12,324	150,000	92%
Healthy Kids Community Challenge	164,924	$ 169,669	4,745	169,669	97%
Stay on Your Feet	100,000	$ 113,550	13,550	113,550	88%
Misc Fiscal	62,593	$ -	(62,593)	-	
	$ 9,854,179	$ 10,126,122	$ 271,943	$ 20,893,589	97%
Excess of revenues over expenses - CH	455,770				
Excess of revenues over exp. - Public Health	959,577				
Operating fund balance, beginning of year	3,009,266				
Operating fund & capital, end of month (Note 1)	$ 4,412,453				

Note 1:
The operating fund balance consists of a public health reserve and amounts owed to the Gov't of Ontario as of the report date.

Algoma Public Health
Revenue Statement
For the Three Months Ending March 31, 2016

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget	Comparison Prior Year: YTD Actual 2015	YTD BGT 2015	Variance 2015
MOH Public Health Funding	1,859,276	1,874,450	(15,174)	25%	7,497,800	1,879,029	1,921,311	(42,282)
MOH One Time Funding	12,675	12,675	-	25%	50,700	11,200	12,674	(1,474)
MOH Funding Haines Food Safety	6,150	6,150	-	25%	24,600	6,133	6,133	(0)
MOH Funding CINOT/Healthy Smiles	102,650	102,650	(0)	25%	410,600	106,886	102,641	4,245
MOH Funding - Social Determinants of Health	45,125	45,125	(0)	25%	180,500	45,112	45,112	0
MOH Funding Vector Bourne Disease	27,175	27,175	0	25%	108,700	27,153	27,153	0
MOH Funding Chief Nursing Officer	30,375	30,375	-	25%	121,500	30,354	30,353	1
MOH Funding Safe Water	17,400	17,400	-	25%	69,600	17,391	17,391	0
MOH Enhanced Funding Safe Water	3,875	3,875	(0)	25%	15,500	3,875	3,875	(0)
MOH Funding Unorganized	125,075	125,075	(0)	25%	500,300	108,973	108,973	0
MOH One Time Funding Dental Health	27,967	8,500	19,467	82%	34,000	4,219	8,438	(4,219)
MOH Funding Infection Control	78,100	78,100	0	25%	312,400	78,075	78,075	0
Levies Sault Ste Marie	1,202,522	590,711	611,811	51%	2,362,846	486,510	477,427	9,083
Levies Sault Ste Marie Capital	0	0	-	0%	0	72,371	72,371	(0)
Levies Vector Bourne Disease	0	14,858	(14,858)	0%	59,433	16,488	16,488	(0)
Levies District	501,708	244,378	257,330	51%	977,512	216,422	216,279	143
Levies District Capital	0	0	-	0%	0	29,000	31,016	(2,016)
Recoveries from Programs	2,984	2,515	469	30%	10,061	2,515	2,515	0
Program Fees	53,069	61,786	(8,717)	21%	247,143	11,289	61,786	(50,497)
Land Control Fees	5,785	40,000	(34,215)	4%	160,000	4,440	40,000	(35,560)
Program Fees Immunization	57,831	40,000	17,831	36%	160,000	44,057	40,000	4,057
HPV Vaccine Program	306	2,500	(2,194)	3%	10,000	0	2,500	(2,500)
Influenza Program	1,285	15,000	(13,715)	2%	60,000	0	15,000	(15,000)
Meningococcal C Program	289	2,500	(2,211)	3%	10,000	0	2,500	(2,500)
Interest Revenue	2,921	500	2,421	146%	2,000	2,171	500	1,671
Other Revenues	0	41,250	(41,250)	0%	165,000	19,977	41,250	(21,273)
Funding Holding	0	0	-	0%	0	0	0	0
Funding Ontario Tobacco Strategy	128,305	110,275	18,030	29%	441,100	112,400	104,400	8,000
Elliot Lake Office Relocation	0	0	-	0%	0	0	0	0
Panorama	(14,034)	0	(14,034)	100%	0	0	0	0
First Nations Inititative -One Time	0	0	-	0%	0	112,214	0	112,214
	$ 4,278,814	$ 3,497,824	$ 780,991		$ 13,991,295	$ 3,448,254	$ 3,486,162	$ (37,908)
Summary								
Levies	1,704,230	849,948	854,282	201%	3,399,791	820,791	813,581	7,210
Funding Grants	2,450,114	2,441,825	8,289	100%	9,767,300	2,543,014	2,466,529	76,485
Fees & Recoveries	124,470	206,051	(81,581)	60%	824,204	84,449	206,051	(121,602)
	$ 4,278,814	$ 3,497,824	780,991	122%	$ 13,991,295	$ 3,448,254	$ 3,486,162	$ (37,908)

Algoma Public Health

Expense Statement- Public Health

For the Three Months Ending March 31, 2016

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget	Comparison Prior Year: YTD Actual 2015	YTD BGT 2015	Variance 2015	
Salaries & Wages	$ 1,958,247	$ 2,076,662	118,415	24%	$ 8,306,647	$ 2,033,925	$ 2,044,762	$ 10,837	1
Benefits	458,161	519,166	61,004	22%	2,076,662	480,596	511,191	30,595	2
Travel - Car Allowances	0	0	-	0%		18,537	15,490	(3,047)	3
Travel - Mileage	17,499	36,415	18,916	12%	145,659	29,922	31,362	1,440	3
Travel - Other	10,243	23,450	13,207	11%	93,801	14,479	31,577	17,098	3
Program	153,569	140,451	(13,117)	27%	569,806	142,117	183,538	41,420	4
Program Equipment Purchase	0	0	-	0%	0	0	0	0	
Office	23,662	23,000	(662)	26%	92,000	8,537	32,987	24,451	4
Computer Services	199,576	223,977	24,401	22%	895,908	278,796	189,607	(89,189)	4
Telephone Charges	(2,902)	9,750	12,652	-7%	39,000	3,178	12,066	8,888	5
Telecommunications	39,830	45,871	6,040	21%	187,483	29,761	42,740	12,979	5
Program Promotion	25,479	53,521	28,042	12%	214,085	21,800	52,896	31,095	4
Facilities Expenses	184,082	203,481	19,399	23%	813,924	142,723	189,775	47,052	6
Fees & Insurance	158,936	60,301	(98,635)	66%	241,205	111,232	69,873	(41,360)	7
Special Projects	0	0	-	0%	0	0	0	0	
Debt Management	116,756	114,000	(2,756)	26%	456,000	0	(35,702)	(35,702)	8
Recoveries	(23,902)	(35,221)	(11,319)	17%	(140,883)	0	0	0	9
	$ 3,319,237	$ 3,494,824	$ 175,587		$ 13,991,297	$ 3,429,568	$ 3,486,162	$ 56,594	

	Current YTD	2015	Total	Total % Spent	Total Budget
Elliot Lake Renovations	373,628	277,890	651,518	90%	724,960

Notes to Financial Statements – March 2016

Reporting Period

The March 2016 financial reports include three months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, and Child & Dental Benefits Ontario Works. All other programs are reporting twelve month results from operations year ended March 2016.

Public Health – Statement of Operations (see page 1)

General Comments

As of March 31st, 2016, Public Health programs are reporting a surplus of approximately $959k. On the Revenue side, $854k positive variance is attributable to the timing of receipts of municipal levies from the City of Sault Ste. Marie and the District. Provincial Grants are operating relatively within budget. Program Fees & Recoveries are indicating a negative $81k variance as a result of timing of fees recovered by APH.

There is a positive variance of $175k related to Public Health Expenses being less than budgeted. This is a result of two vacant positions which have been gapped and yet to be filled. In addition, the vacant permanent Medical Officer of Health (MOH) position is impacting the noted positive variance. The inherent time lag in filling positions within the agency is also contributing to this variance.

Community Health programs are reporting a surplus of $455k. There is a $125k positive variance associated with the Community Mental Health Program. The program received additional funding for positions related to transitional case management. The lag in time to fill these positions drove the noted variance.

Brighter Futures for Children is indicating a positive $28k variance as a result of additional funding provided in Q4. The Infant Development Program operated within budget. Preschool Speech and Language Program and the Diabetes Program operated relatively within budget.

There is a positive variance of $53k associated with the Genetics Program. This is a result of the inherent time lag in filling positions within the agency.

Notes Continued...

Revenue (see page 2 for details)

Public Health funding revenues are indicating a positive variance of $780k. Driving this is an $854k positive variance related to the timing of the municipal levy receipts from the City of Sault Ste. Marie and the District. Funding Grants is within budget. There is a negative variance of $81k associated with Fees & Recoveries. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses Budget (see page 3)

Note1 & 2– Salaries/Benefits

The positive variance of $118k is a result of two vacant positions which have been gapped and yet to be filled. In addition, the vacant permanent Medical Officer of Health (MOH) position is impacting the noted positive variance. The inherent time lag in filling positions within the agency is also contributing to this variance.

Benefits are indicating a positive variance of $61k. The two vacant positions which have been gapped and the vacant permanent MOH position are contributing to the positive variance noted.

Note 3 –Travel (Mileage, Other)

Mileage is showing a positive $18k variance due to timing of employee claim submissions.

Travel - Other is showing a positive $13k variance. Staff travel typically occurs between the spring and fall months.

Note 4 - Program, Office, Computer Services, Program Promotion

Program expense is operating relatively within budget.

Office expense is operating relatively within budget.

Computer Services is showing a positive variance of $24k. Relative to last month, this variance has decreased as a result of expenditures related to software licensing renewals being incurred. As the year progresses, it is anticipated that this positive variance will continue to reduce.

Program Promotion is showing a positive variance of $28k due to timing of expenditures not yet incurred.

Note 5 – Telephone Charges/Telecommunications

Telephone Charges are indicating a positive variance of $12k. This is due to timing of expenditures not yet incurred.

Notes Continued...

Telecommunications is indicating a positive variance of $6k. This is due to timing of expenditures not yet incurred.

Note 6 – Facilities Expenses/Renovations

Facilities Expenses is showing a positive variance of $19k. This is a result of the timing of expenditures not yet incurred. As the year progresses, this positive variance is anticipated to reduce.

Note 7 – Fees & Insurance

Fees & Insurance is indicating a negative variance of $98k. This is due to the $83k payment of the annual insurance premium paid in full during the month of February. In addition, APH has incurred legal expenses regarding a Public Health policy matter. APH has submitted a one-time funding request to the MOHLTC with the intention of recouping these costs.

Note 8 – Debt Management

Debt Management is indicating a negative variance of $3k. This is a result of interest charges on the short-term debt related to Elliot Lake renovations. These interest charges were not budgeted.

Note 9 – Recoveries

Recoveries are indicating a negative variance of $11k. This is a result of recoveries being less than budgeted.

Community Programs (see page 1)

All community programs operated without budget issues.

Financial Position - Balance Sheet (see page 7)

Our cash flow position continues to be stable and the bank has been reconciled as of March 31st, 2016. Cash includes $.324 million in short-term investments.

APH has secured a $350,000 loan with interest only payments until September 1, 2016 to help with the financing of the Elliot Lake office renovations. The loan is open and can be repaid at any time without penalty.

Long term debt of $5.700 million is held by the Royal Bank @ 2.76% for a 20 year term. The loan matures on September 1, 2016. There are no collection concerns for accounts receivable.

Algoma Public Health
Statement of Financial Position

Date: As of March 2016	March 2016	December 2015
Assets		
Current		
Cash & Investments	$ **2,184,903**	$ 2,368,709
Accounts receivable	**606,559**	658,510
Receivable from municipalities	**206,520**	5,134
Receivable from Province of Ontario	**-**	
Subtotal Current Assets	***2,997,982***	*3,032,353*
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,215,479**	1,490,132
Payable to Gov't of Ont/Municipalities	**123,946**	641,766
Deferred Revenue	**661,475**	664,615
Employee Future Benefit Obligations	**2,453,960**	2,453,960
Capital Lease Obligation	**107,264**	107,264
Term Loan	**6,173,490**	6,173,490
Subtotal Current Liabilities	**10,735,613**	11,531,227
Net Debt	**(7,737,631)**	(8,498,874)
Non-Financial Assets:		
Building Construction in Progress	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,169,635**	1,169,635
IT	**3,029,040**	3,029,040
Automobile	**40,113**	40,113
Accumulated Depreciation	**(6,880,999)**	(6,880,999)
Subtotal Non-Financial Assets	**22,004,981**	22,004,981
Accumulated Surplus	**14,267,349**	13,506,107

ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE MEETING
APRIL 19, 2016
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Lee Mason	Dennis Thompson
REGRETS	Candace Martin		
APH STAFF PRESENT:	Tony Hanlon, Ph.D.	Chief Executive Officer	
	Justin Pino	Chief Financial Officer	
	Joel Merrylees	Manager of Accounting and Budgeting	
	Christina Luukkonen	Recording Secretary	
GUESTS	Michael Marinovich, KPMG		

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:31pm and welcomed Mr. Marinovich from KPMG and Mr. Merrylees.

2) DECLARATION OF CONFLICT OF INTEREST
Mr. Frazier called for any conflict of interests; none were reported.

3) ADOPTION OF AGENDA ITEMS
5d) Litigation or Potential Litigation added.

FC2016-16 Moved: L. Mason
Seconded: D. Thompson

THAT the agenda items for the Finance and Audit Committee dated April 19, 2016 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES
Correction to committee member attendance. Remove Sue Jensen and add Dennis Thompson.

FC2016-17 Moved: D. Thompson
Seconded: L. Mason

THAT the minutes for the Finance and Audit Committee dated February 10, 2016 be adopted as amended.
CARRIED.

5) IN-COMMITTEE

FC2016-18 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee goes in-committee at 4:35pm.
Agenda items:

a. Adoption of in-committee minutes: February 10, 2016
b. Security of property of the Board of Health
c. Personal matters about an identifiable individual, including municipal employees

d. Litigation or Potential Litigation

CARRIED.

6) OPEN MEETING

FC2016-20 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee goes into open meeting at 5:15pm.

CARRIED.

Mr. Pino, Mr. Merrylees and Mr. Marinovich rejoined the meeting.

7) FINANCIAL STATEMENTS

a. 2015 Draft Audited Financial Statements

Mr. Pino spoke to the 2015 draft audited financial statements that were included in the meeting package. A number of questions were asked and answered to the satisfaction of the Committee. This resulted in amendments to the draft audited financial statements. Mr. Pino to ensure an updated copy is provided to Mrs. Luukkonen to be put forth to the Board.

Mr. Marinovich expressed appreciation for the Board's commitment to completing the audited financial statements earlier than in the past. This not only benefits APH but all the municipalities as well. Once the draft audited financial statements are approved by the Board a copy will be placed on our website and all municipalities are notified.

Mr. Pino to provide a more in-depth explanation on the reduction of Operating Surplus from 2014 to 2015 to the Committee members.

A question arose regarding when the process for loan renewal would begin. Loan renewal to be added as an agenda item for the May Finance and Audit Committee meeting.

FC2016-21 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee recommends the draft 2015 Audited Financial Statements as amended and puts forward to the Board for approval.

CARRIED.

b. Financial Statements for the Period ending February 29, 2016

Mr. Pino presented the draft financial statements for the period ending February 29, 2016 that were provided in the meeting package. Due to the timing of the statements still being early in the year most of the surplus funds is attributed to funds still to be used. This will decrease as the year progresses.

FC2016-22 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee recommends the draft Financial Statements for the Period ending February 29, 2016 and puts forward to the Board for approval.

CARRIED.

8) BUSINESS ARISING FROM MINUTES

a. ELNOS Renovation Budget Update

Mr. Pino directed Committee member to page 3 of the Financial Statements for the period ending February 29, 2016. The ELNOS renovation budget has been included in these statements. The renovation costs are expected to be under budget.

9) NEW BUSINESS/GENERAL BUSINESS

a) Capital Fund for Upkeep of Capital Assets

Mr. Pino discussed the need for a policy as per the Organizational Standards. Mr. Pino has already reached out to other health units to see what their policies entail. Mr. Pino will report back at the May Finance and Audit Committee meeting.

b) Revamping of Financial Report Structure: Public Health vs Non-Public Health

Mr. Pino informed the Committee that he will be looking at creating a more comprehensive and organized report structure based on the feedback he has received from Committee members. He is looking at simplifying to make it easier to read. The Public Health and Non-Public Health programs will be segregated.

Mr. Pino welcomed feedback from Committee members and asked them to send any ideas or suggestions to him and cc the whole committee.

Mr. Pino expressed his appreciation to Mr. Merrylees for all his work on compiling the audited financial statements.

10) Addendum

11) NEXT MEETING: Wednesday, May 11, 2016

12) THAT THE MEETING ADJOURN: 6:19pm

FC2016-23 Moved: D. Thompson
Seconded: L. Mason

THAT the meeting of the Finance and Audit Committee adjourns at 5:24pm.

CARRIED.

ALGOMA PUBLIC HEALTH

GOVERNANCE COMMITTEE REPORT

FOR THE MAY 25, 2016 BOARD MEETING

Meeting held on: May 11, 2016 – Started at 5:49 pm

In attendance:

Tony Hanlon, Antoniette Tomie, Ian Frazier, Candace Martin, Lee Mason, Sue Jensen (teleconference)

Secretary – Christina Luukkonen

Mr. Hanlon updated the Committee on the revised Performance Monitoring Plan timeline. Due to a number of other reporting requirements of APH the quantitative report will be moved to June starting in 2017 and will provide a dashboard to help the Committee and Board evaluate the report. A number of other additions will be made to the report.

Communication with the Municipalities is a continued point of follow-up and it is anticipated that by fall time that APH staff will have materials ready that can be presented to each municipality along with the applicable Board representative.

The Committee reviewed five (5) policies this month that contained minor modifications or clarifications. It is going to be the Committee's recommendation that the Board approve the modified policies. These policies are:

02-05-000	Board of Directors
02-05-035	Professional Development for Board Members
02-05-040	Employee Retirement – Board Recognition
02-05-045	Attendance at Meetings Using Electronic Means
02-05-050	Retirement – Benefits for Employees

The Committee reviewed the Environmental Health Program Funding Briefing Note presented by Mr. Hanlon. A few questions were asked and answered satisfactorily. It is going to be the Committee's recommendation that the Board to approve the Environmental Health Program Funding resolution.

The Committee reviewed the New HPV Immunization Program for Grade 7 Boys presented by Mr. Hanlon. A number of questions were asked and answered regarding the additional cost and scheduling of this now expanded program being offered. It is going to be the Committee's recommendation that the Board approve the resolution being presented that the MOHLTC increase the annual funding for this program in order to the meet the mandate.

Next meeting is scheduled for May 8, 2016.

Meeting was adjourned at 6:49 pm.

Dan M Brangel

Chair, Governance Committee
Algoma Public Health

5/18/16

Date

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-000
DATE:	O: May 4, 1995 Reviewed: March 17, 2010 Reviewed: May 16, 2012 Revised: June 17, 2014 Revised: May 25, 2016	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Board of Directors

KNOWLEDGE:

The Board of Health for the District of Algoma Health Unit is the governing body of Algoma Public Health and is established by the provincial public health legislation, the Health Protection and Promotion Act, RSO 1990, (HPPA) and regulations.

Boards of Health are the governing body and policy maker of public health units. Boards of Health monitor all operations within their health unit and are accountable to the community and to the Ministry of Health and Long-Term Care.

All Boards of Health have a legislated duty to ensure that the public health programs and services required by the HPPA are provided to people who live in the health unit jurisdiction. Public health programs and services are intended to prevent the spread of disease and to promote and protect health.

The Mandatory Health Programs and Services Guidelines (2008), published by the Ministry of Health and Long-Term Care, set out the minimum requirements for fundamental public health programs and services for boards of health.

Section 1 of Regulation 559 to the HPPA states that the Board of Health for the District of Algoma Health Unit shall have eight municipal members. Section 49 (3) of the HPPA states that the Lieutenant Governor in Council ***may*** appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the Board of Health. Therefore the maximum size of the Board **may be 15 members** (8 municipal members + 7 provincial members).

The distribution of board membership for the Board of Health for the District of Algoma Unit is as follows:

Zero (0) to Seven (7) Members:	appointed by the Lieutenant Governor to represent the Province of Ontario (currently 3 provincial members);
Three (3) Members:	appointed by the Council to represent the City of Sault Ste. Marie;
One (1) Member:	appointed by the Municipal Councils representing the Municipality of Wawa, Township of White River and Dubreuilville;
One (1) Member:	appointed by the Municipal Councils representing the Town of Blind River and the Townships of North Shore and Shedden;
One (1) Member:	appointed by the Municipal Councils representing the Town of Thessalon and Municipality of Huron Shores.

One (1) Member:	appointed by the Municipal Councils representing the Town of Bruce Mines, Village of Hilton Beach and the Townships of Hilton, Jocelyn, Johnson, Laird, Macdonald, Meredith and Aberdeen Additional, Plummer Additional, Prince, St. Joseph and Tarbutt and Tarbutt Additional;
One (1) Member:	appointed by the Municipal Council representing Elliot Lake.
Current membership:	Eleven (11) members
Maximum membership:	Fifteen (15) members

The appointments for municipal council members are for a four year term but may end sooner with the ending of the term of office of the council.

Provincial appointees are for a three year term that may be renewed.

Note: The City of Sault Ste. Marie has an internal policy that appointments for municipal council members representing the City of Sault Ste. Marie are for a two year term but may end sooner with the ending of the term of office of the council.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-035
DATE:	O: January 20, 2010 Reviewed: May 16, 2012 Reviewed: June 17, 2014 Revised: May 25, 2016	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Professional Development for Board Members

POLICY:

Algoma Public Health encourages Board Members to become involved in workshops, seminars, meetings and conferences related to public health and governance issues.

The Medical Officer of Health/Chief Executive Officer shall bring programs, seminars or conferences relevant to the work of the Board to the attention of the Board. These may include seminars or workshops sponsored by other community service groups or those sponsored by health associations or government departments.

Board members attending a professional development activity shall submit a short written report to the Board highlighting the information/knowledge/skills presented.

Board Members, approved by the Board Chair for a professional development activity, shall be reimbursed for all expenses incurred as per policy 02-05-025 Board Member Remuneration. The Board Chair's professional development activities shall be approved by the Chair of the Governance Standing Committee.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-040
DATE:	O: April 18, 1990 Revised: March 18, 2009 Reviewed: May 16, 2012 Revised: June 17, 2014 Revised: May 25, 2016	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Employee Retirement – Board Recognition

POLICY:

Assuming availability of funds, the Board will recognize the length of service, if 10 years or greater, of the employee by the presentation of a gift upon retirement.

The value of the gift to be presented will be:

Length of Continuous Service	Value
10 – 14 Years	$250.00
15 – 19 Years	$350.00
20 – 24 Years	$425.00
25 Years +	$500.00

PROCEDURES:

Retiree: Receive gift from the Board on their last day of work.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-045
DATE:	O: April 17, 2013 Reviewed: June 17, 2014 Revised: May 25, 2016	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Attendance at Meetings Using Electronic Means

POLICY:

The Health Protection and Promotion Act allows Boards of Health any means to effectively manage a health unit.

Board of Health members are expected to attend Board of Health meetings and Board Committee meetings when they are members of a committee.

A Board member, when circumstances do not permit attendance in person, can participate in a Board of Health meeting by means of conference call, video conference call or any other electronic communication facility.

The Board member has the responsibility to ensure their attendance via an electronic method is done so in a private manner. For In-Committee meetings the Board member shall ensure confidentiality of the materials and the discussion.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-050
DATE:	O: May 15, 2013 Reviewed: June 17, 2014 Revised: May 25, 2016	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Retirement – Benefits for Employees

POLICY:

The Board of Health will provide select employment benefits to retired management and administrative staff in recognition of dedicated service to Algoma Public Health based on certain qualifications.

Qualifications:

To qualify, an employee must be a manager, director, medical officer of health, chief executive officer or administrative assistant (an employee) employed by Algoma Public Health (the agency).

An employee must be retiring on an unreduced pension as defined by OMERS, the agency pension fund.

An employee must elect to receive the benefits as described at the retirement date. An election cannot be made past the retirement date.

The retirement date is the date an employee ceases to receive employment income from the agency.

Benefits excluded are life insurance and long-term disability. An employee can elect to receive dental care benefits provided 100% of the cost of the premium is paid by the employee.

If an employee retires on an unreduced pension prior to the age of 65, the agency will pay for benefit premiums authorized except for the exclusion conditions as listed above.

After the age of 65, an employee may elect to receive agency benefits as authorized provided the employee pays 100% of the cost of the premiums for all benefits offered. After the age of 65, private duty nursing care is excluded.

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: The Board of Health

From: T. Hanlon, C.E.O.

Date: May 25, 2016

Re: New HPV Immunization Program for Grade 7 boys

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Excerpt from the MOHLTC website: http://www.health.gov.on.ca/en/ms/hpv/

Ontario's HPV Immunization Program, New for the 2016-2017 school year

"Ontario is expanding its publicly funded immunization program to help protect youth from Human Papillomavirus (HPV) infection and related cancers. Beginning in the 2016-2017 school year, Ontario will offer the cancer-fighting HPV vaccine to all boys and girls in Grade 7 as part of its routine school-based HPV immunization program. If you have a son or daughter entering Grade 7 in September 2016, they will be offered the vaccine through school-based clinics run by the local public health unit."

BACKGROUND

Why the expansion to boys
Expanding the school-based HPV immunization program to include boys aligns with current scientific and expert recommendations, including from the National Advisory Committee on Immunization.

HPV is a very common virus worldwide, and can lead to different kinds of cancer in females and males. The HPV vaccine can best prevent HPV-related diseases and cancers if received at a young age.

Why the move from Grade 8 to Grade 7

The HPV school-based immunization program will be shifted from Grade 8 to Grade 7. This aligns with expert recommendations to immunize girls and boys between 9 and 13 years of age when the vaccine is most effective.

The shift also brings Ontario more in line with other provinces and territories which provide the school-based HPV vaccine to children in earlier grades.

Catch-up program

Girls who were eligible for the HPV vaccine in Grade 8 in 2015-2016, but missed their immunization, continue to be eligible for the publicly funded vaccine until the end of Grade 12. Contact your local public health unit to find out how to get them vaccinated. Similarly, starting in 2016-2017, boys and girls who do not complete the HPV vaccine series in Grade 7 continue to be eligible to catch up missed doses until the end of Grade 12. Boys who are in Grades 8 to 12 during the 2016-17 school year are **not** eligible to receive the publicly funded HPV vaccine. For non-eligible boys and girls, the vaccine can be purchased privately. Speak with your doctor or nurse practitioner for more information.

The HPV immunization schedule

For the majority of students who are eligible for the HPV vaccine, the vaccine is given in a series of two injections, six months apart.

For those who receive their first dose after the age of 14 years, or who are immunocompromised (have a weakened immune system), the HPV vaccine is given in a series of three injections over a six-month period"

APH STAFFING IMPLICATIONS

The HPV initiative will increase the number of visits to each school from 2 visits to 3 visits across the District of Algoma per year representing a 33% increase in activity.

OPHS STANDARD

Infectious Diseases Program Standard, Vaccine Preventable Diseases

CONTACT PERSON

Sherri Cleaves, Director of Clinical Services

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

Date: May 25, 2016	**RESOLUTION NO.: 2016 -**
MOVED:	**SECONDED:**
SUBJECT: Human Papillomavirus Immunization for Grade 7 boys	

Resolution:

WHEREAS Ontario is expanding the publicly funded human papillomavirus (HPV) vaccination program to include boys in Grade 7; and

WHEREAS Algoma Public Health supports the immunization of boys to help prevent the spread of HPV and prevent cancer; and

WHEREAS the HPV vaccine will continue to be provided to girls in Grade 8 for the transition year until all grade 7 students receive the vaccination; and

WHEREAS the Ministry estimates about 154,000 students will be eligible to receive the vaccine each year; and

WHEREAS APH, similar to other PHUs, plans to deliver the vaccination program over the course of three school visits in order to avoid giving more than two doses of vaccine per student per visit, which will increase the number of school clinics by approximately 33% (previously two visits per year); and

WHEREAS the Ministry of Health and Long-Term Care's (MOHLTC) Immunization 2020 Strategy strives to "reduce health risks related to vaccine-preventable diseases in the province"; and

WHEREAS the MOHLTC has not increased funding to the Vaccine Preventable Disease (VPD) program despite adding responsibilities and new vaccines to the program.

THEREFORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health commends the Ministry of Health and Long- Term Care for its commitment to expand its HPV vaccination program to young males who are starting grade 7 this September; and

FURTHERMORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health urges the MOHLTC to consider increasing the annual funding for the VPD program in order to provide the staff resources to meet the above mandate.

FURTHERMORE BE IT RESOLVED THAT a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.

CARRIED: Chair's Signature

☐ **Lee Mason - Chair**	☐ **Ian Frazier – Vice Chair**
☐ **Sue Jensen**	☐ **Candace Martin**
☐ **Heather O'Brien**	☐ **Dennis Thompson**

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Fax: 705-848-1911

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Tel: 705-856-7208
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Fax: 705-856-1752

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: The Board of Health

From: T. Hanlon C.E.O.

Date: May 25, 2016

Re: Environmental Health Program Funding (Public Health Inspectors)

For Information | x☐ For Discussion | ☒ For a Decision

ISSUE:

In the last few years the role of Public Health Inspectors (PHIs) has been expanding within the MOHLTC Program Standards, Protocols and Guidance Documents without additional funding.

PHIs are required to:

- Enforce nutrition labelling under Bill 45, Making Healthier Choices Act, 2015– http://www.ontla.on.ca/web/bills/bills_detail.do?BillID=3080 and Healthy Menu Choices Act, 2015– https://www.ontario.ca/laws/statute/15h07.
- Inspect tanning salons under the Skin Cancer Prevention Act (Tanning Beds), 2013, *(we did receive some one time funding)*– http://www.health.gov.on.ca/en/public/programs/tanning/.
- Work on weekends to ensure rabies reports are responded to within 24 hours of receipt according to the Rabies Prevention and Control Program Standard– http://health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/rabies_prevention.pdf.
- Complete annual food categorization template as per MOHLTC guidance document, *"Guidance document for the Risk Categorization of Food Premises,"* supporting the Food Safety Protocol, 2013, made under the Ontario Public Health Standards– http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/risk_categorization_of_food_premises_gd.pdf.
- Investigate IPAC lapses and complete MOHLTC documentation and reports– http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/ipac_lapse_disclosure_gd.pdf.

BACKGROUND:

The work of Public Health Inspectors (PHIs) is governed by numerous, diverse MOHLTC Program Standards, Requirements under the Health Protection and Promotion Act including Regulations, the Ontario Building Code Act, and the Clean Water Act to mention a few. The PHI role includes but is not limited to:

- Food Safety
- Safe Water (including small drinking water risk assessments, beach management, pool and spa inspections)
- Health Hazard Prevention and Management
- Public Health Emergency Preparedness
- Rabies Prevention and Control
- Vectorborne Prevention
- Infectious Disease Prevention and Control
- Infection Control Inspections
- Outbreak Management including IPAC Lapse Investigations
- Ontario Building Code for Part VIII (for northern health units)
- Outbreak Management
- Emergency Preparedness and Events

With the added responsibility of:

- 9 MOHLTC Accountability Agreements
- 14 /26 Ontario Public Health Standards Guidance Documents
- 14/27 Ontario Public Health Standards Protocols

PHIs are already working beyond full capacity and are challenged to meet all the requirements under the Program Standards. The additional workload is not able to be absorbed into their regular work schedule.

RECOMMENDED ACTION:

Support the North Bay Parry Sound District Health Unit and the Board of Health for the Peterborough County-City Health Unit's correspondence and request for the Honourable Eric Hoskins to provide funding to support the expanded role of Public Health Inspectors.

CONTACT:

Sherri Cleaves, Director of Clinical Services

Algoma
PUBLIC HEALTH
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www.algomapublichealth.com

May 26, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
ehoskins.mpp@liberal.ola.org

Dear Minister Hoskins,

Re: Environmental Health Program Funding

At its meeting held on May 25, 2016, the Board of Health for the District of Algoma Public Health Unit considered correspondence from the North Bay Parry Sound District Health Unit and the Board of Health for the Peterborough County-City Health Unit regarding the above noted matter.

We agree unequivocally with our colleagues that there are significant challenges in implementing new environmental health policy and legislation as our current Environmental Health program staff is already working at full capacity and without additional resources it will be extremely difficult to meet the demands resulting from new regulations.

We strongly support the recommendations outlined in North Bay Parry Sound resolution (attached), and appreciate your attention to this important public health issue.

Sincerely,

Lee Mason
Board of Health Chair
Algoma Public Health

Attachment

cc: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Hon. David Orazietti, MPP Sault Ste. Marie
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities

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North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
in your community . . . here for your health
681 Commercial Street, North Bay, ON P1B 4E7 TEL 705.474.1400 FAX 705.474.8252
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
myhealthunit.ca TOLL FREE 1 800 563 2808

February 22, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, *the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and*

Whereas, *the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and*

Whereas, *the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and*

Whereas, *recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and*

Whereas, *in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and*

Whereas, *the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and*

Whereas, *in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and*

Whereas, *in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and*

Whereas, *recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any support for staff training,*

Now Therefore Be It Resolved, *that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:*

1) *Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;*

2) *Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;*

3) *Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and*

4) *Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.*

Furthermore Be It Resolved, *that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.*

Sincerely,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)

2015 APH PROGRAM PERFORMANCE

A Quantitative Report to the Board

Abstract

An overview of key performance measures associated with select programs from Algoma Public Health for the most recent reporting period

Table of Contents

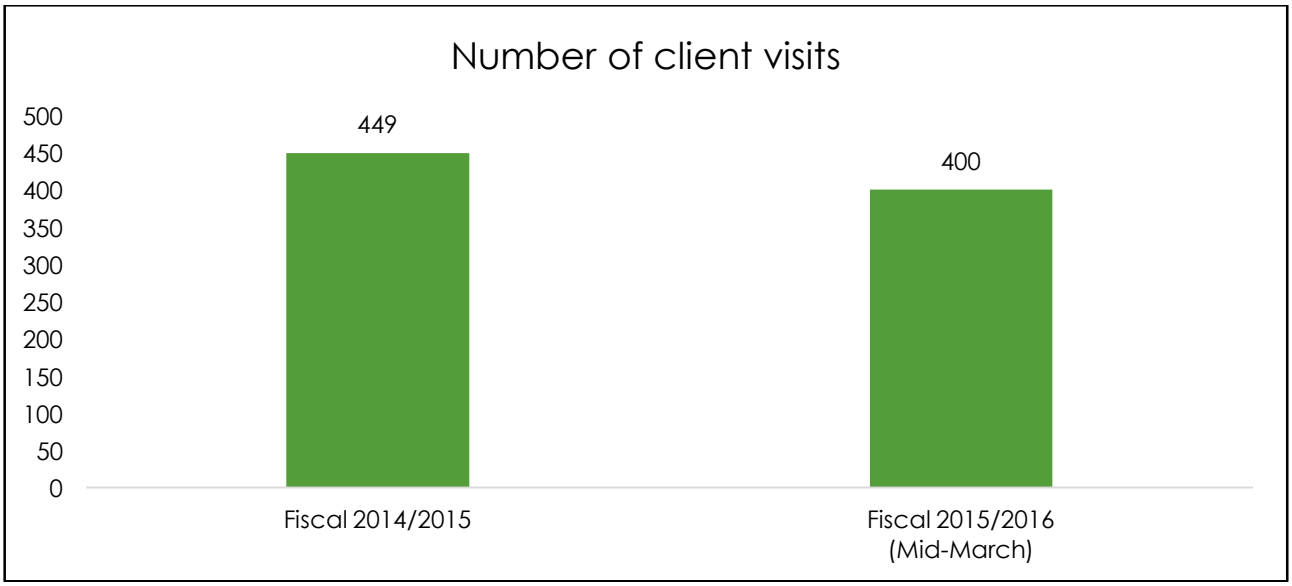
Introduction

The following report provides an update about select programs and their performance by comparing the two most recent reporting periods available, typically calendar 2014 and 2015. Each program manager was asked to provide statistics for two performance measures to represent programs they are responsible for. In addition, a brief summary to help provide context to accompany the measures and offer explanations for any trends is also included.

Addiction Supportive Housing

Number of client visits in Addiction Supportive Housing

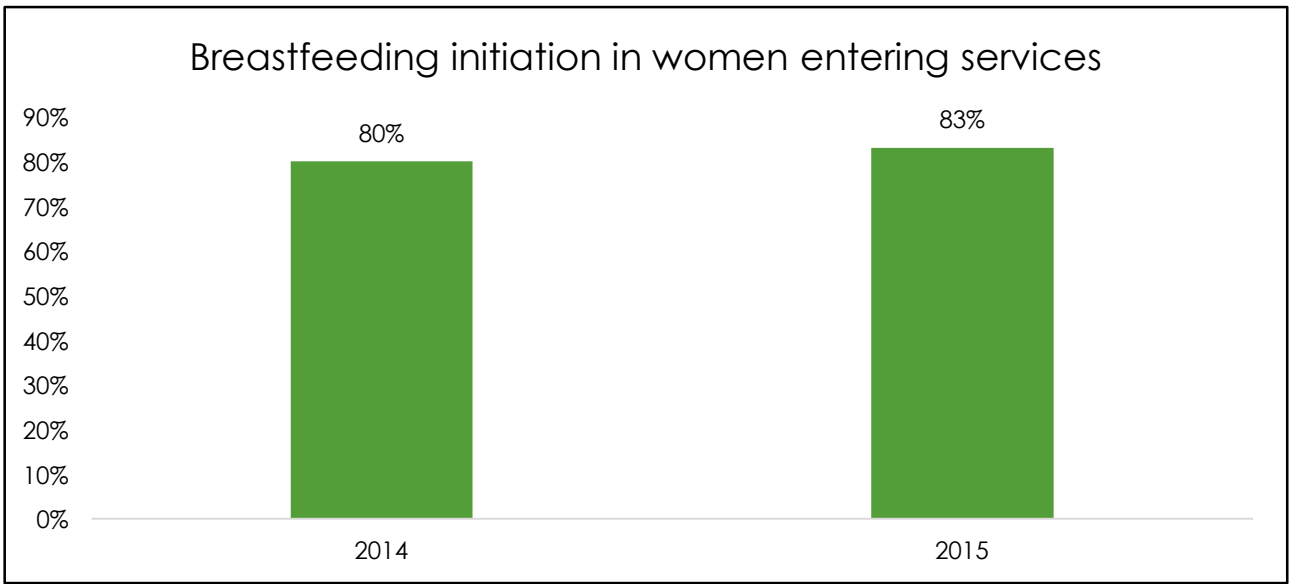
The number of client visits in the Addiction Supportive Housing program decreased approximately 10.9% to 400 in fiscal 2015/2016 from 449 in fiscal 2014/2015. However, since fiscal 2015/2016 was not complete at the time of reporting, the final percent decrease will be slightly less than 10.9%. The observed decrease between fiscal 2014/2015 and fiscal 2015/2016 can be partially attributed to the passing away of some clients receiving subsidies and transition to new clients. Additionally, staffing challenges in fiscal 2015/2016 limited the capacity of the program to conduct visits. Despite the decline in fiscal 2015/2016, the program is still on pace to meet its target.



Child Health

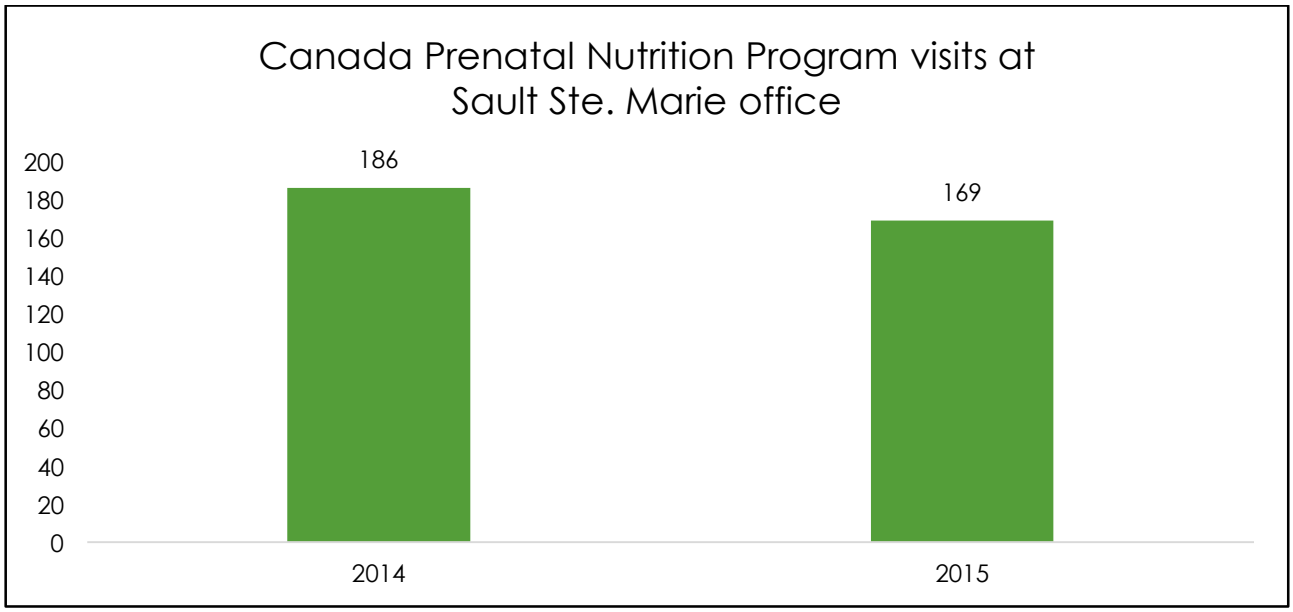
Mothers initiating breastfeeding

Breastfeeding initiation in women entering services at Algoma Public Health increased from 80% in 2014 to 83% in 2015. As a reference, in 2014 and 2015 respectively, 64.6% and 66.9% of the women who gave birth in the district of Algoma entered services at Algoma Public Health. Factors that may have accounted for this slight increase in breastfeeding initiation rates include support received from the Parent Child Information Line, the Parent Child Information Centre and lactation consultant appointments available at Algoma Public Health. Other contributing factors include ongoing district wide health promotion initiatives and bedside breastfeeding support from public health nurses for new mothers at the Sault Area Hospital.



Canada Prenatal Nutrition Program usage for Sault Ste. Marie

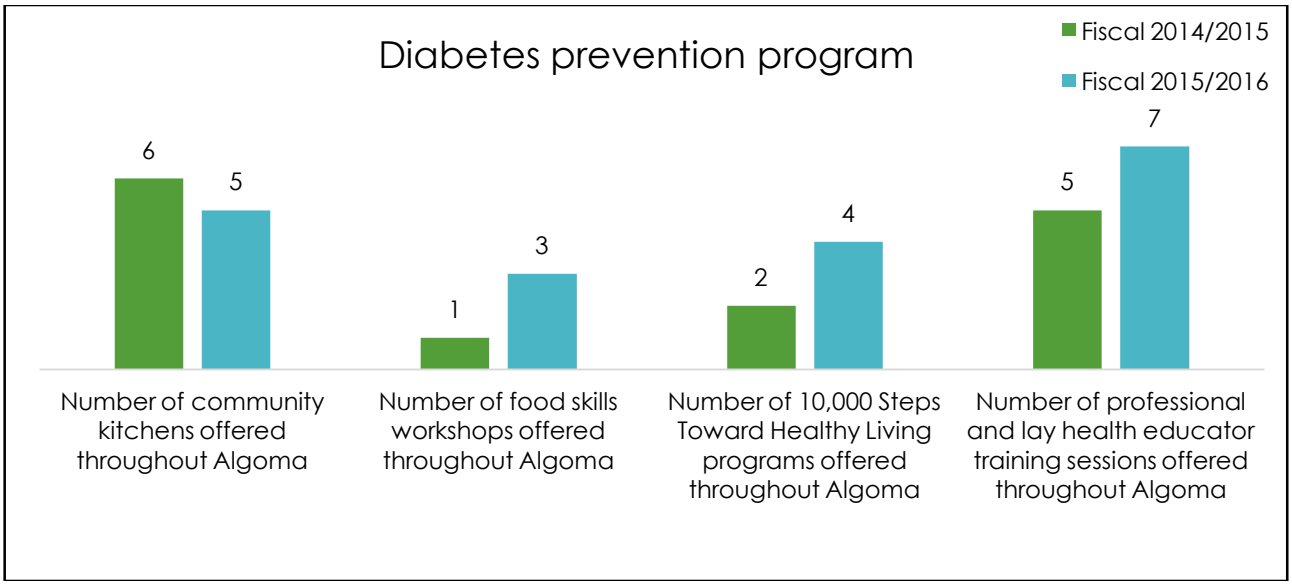
Visits for the Canada Prenatal Nutrition Program, which provides food, vitamins and support to pregnant women in financial need, decreased 9.1% to 169 in 2015 from 186 in 2014. This decrease is in line with the trend observed since 2010 when the Canada Prenatal Nutrition Program in Sault Ste. Marie moved from 126 Queen Street East, adjacent to the city bus terminal, to 294 Willow Avenue. Since this move, there has been a decline in visits for the program, from 265 in 2010 to 169 in 2015 as clients have indicated to staff that they find it difficult to get to the Willow Avenue location. Efforts are being made on several fronts to improve participation, including: offering monthly participation instead of the traditional biweekly participation, offering bus passes worth 20 rides when need is expressed, delivering milk coupons and food bags to Healthy Babies Healthy Children clients at home visits and promotion of the program to improve awareness for community partners and pregnant women.



Chronic Disease Prevention

Diabetes prevention program offerings

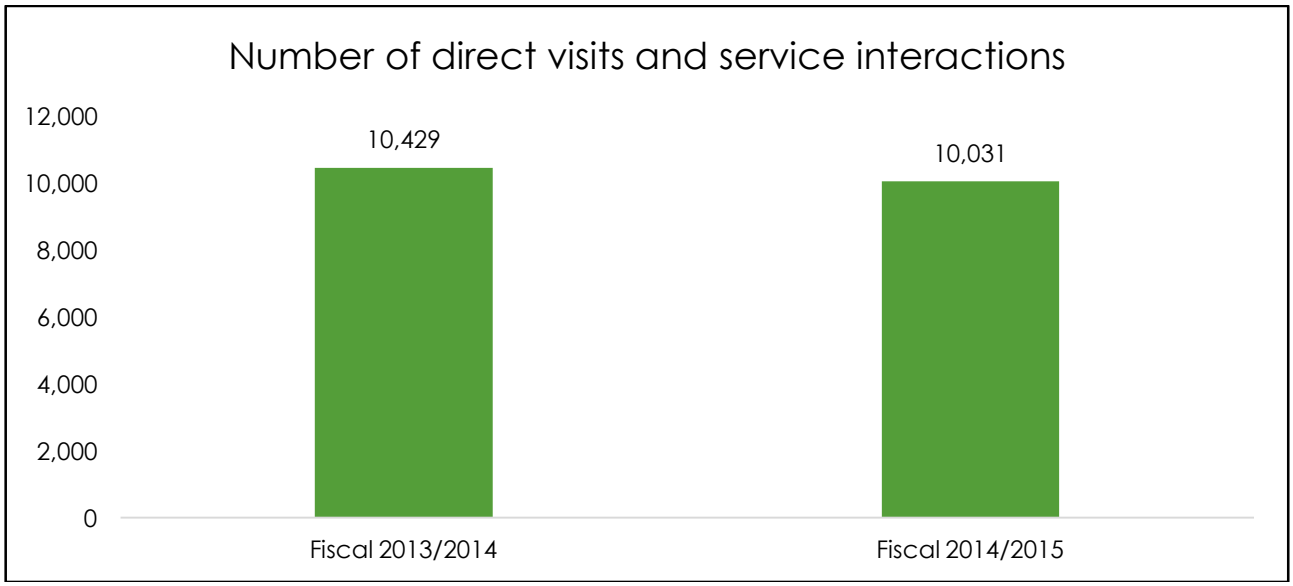
Overall in 2015, the number of workshops, programs and training sessions related to diabetes prevention has increased since 2014. Algoma Public Health works with community partners to increase awareness and provide skill building opportunities to groups and individuals related to diabetes prevention and modifiable health behaviours. Over the past three years, we have been able to continue to build on the successes and partnerships to extend programming and the reach in the district of Algoma.



Community Mental Health

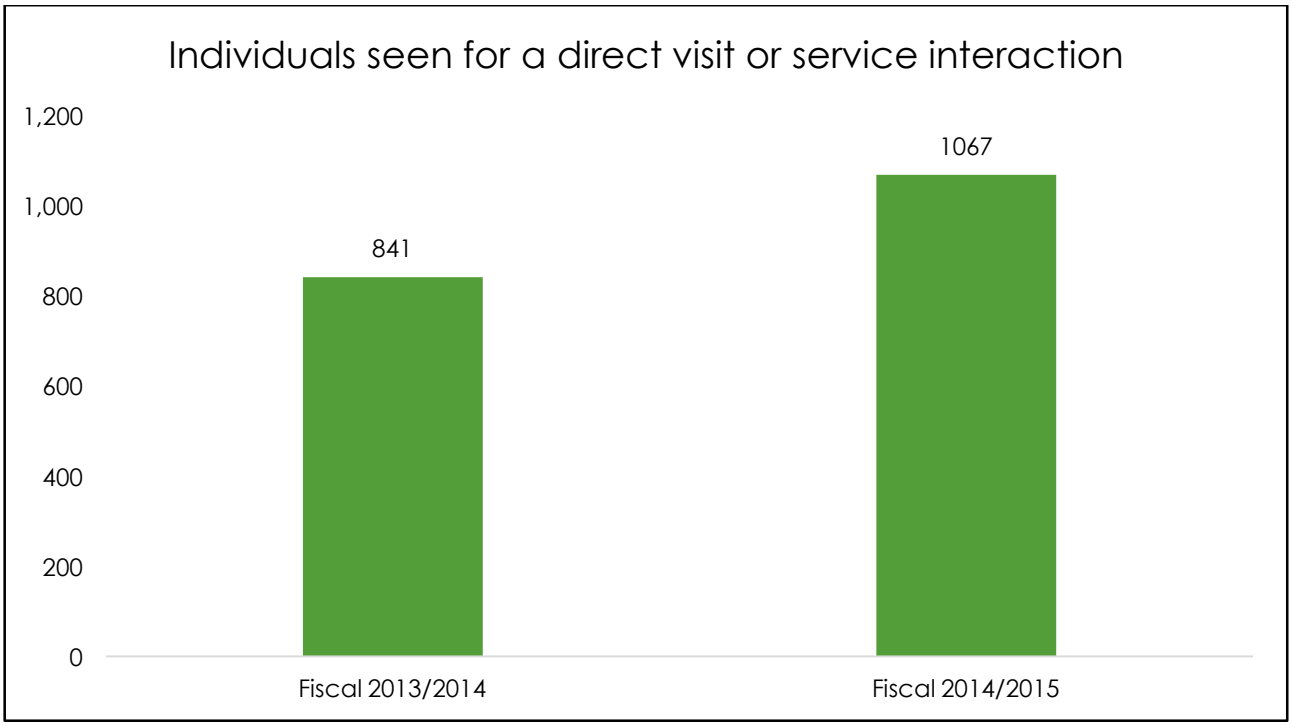
Direct case management and brief service contact visits

Direct visits from case managers declined 3.8% to 10,031 in fiscal 2014/2015 from 10,429 in fiscal 2013/2014. This decline is representative of a shift towards offering more group interactions where possible instead of multiple individual visits. Group interactions are only counted as one direct case management visit which lowers the number of visits and service interactions, but provides the benefit of an environment for mutual support between clients.



Individuals served by case management and brief service contact

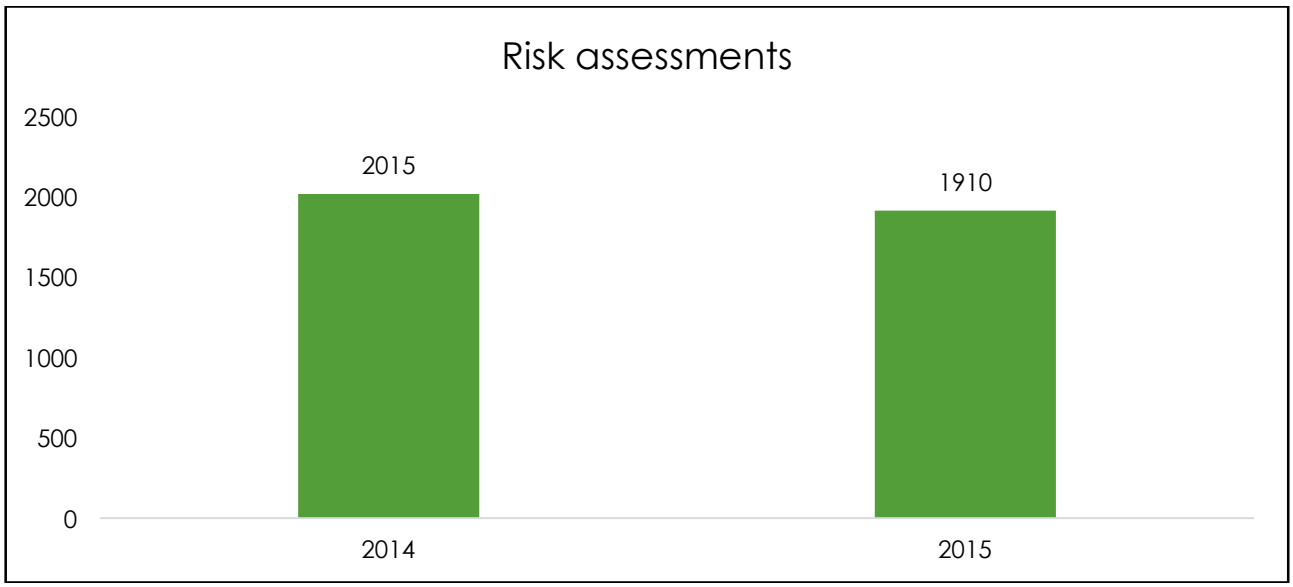
The number of individuals served by case management and brief service contact increased 26.9% from 841 in fiscal 2013/2014 to 1,067 in fiscal 2014/2015. This substantial increase is likely attributable to the alignment of one additional staff person at Sault Area Hospital and improved outreach at the Neighbourhood Resource Centre.



Food Safety

Food premise risk assessments and inspection frequency

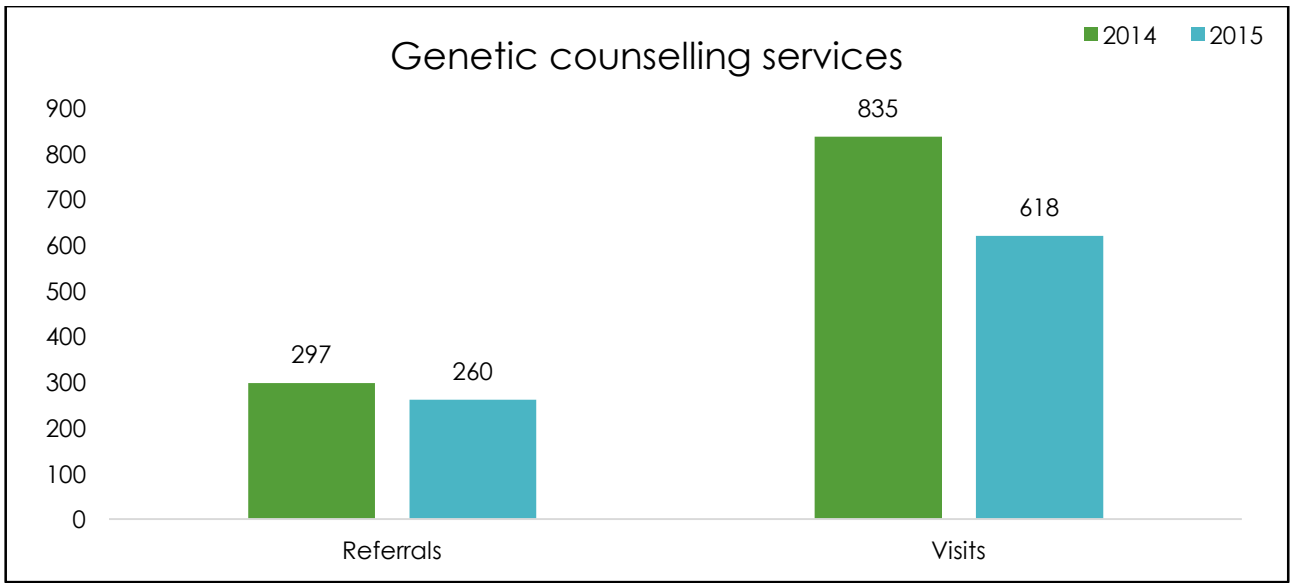
Annually, food premise risk assessments are completed by public health inspectors to determine the frequency that an establishment is inspected. The required number of inspections decreased 5.2% from 2,015 in 2014 to 1,910 in 2015. This decrease in frequency can be attributed in part to the implementation of a new food risk assessment tool for assessing the annual frequency of food premise inspections. The new food risk assessment tool has allowed for a reduction in inspections at premises with multiple processing locations, such as a hot handling food section, a deli, and a grocery store.



Genetics

Genetic counselling program usage

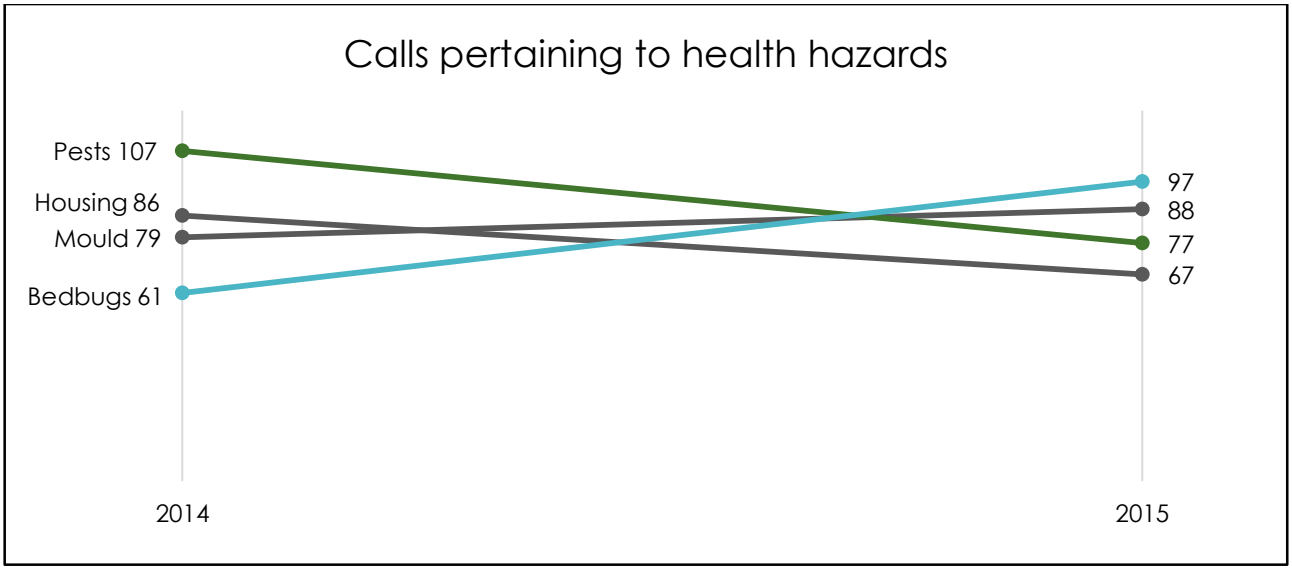
The number of physician referrals processed by the Algoma Public Health genetics program decreased 12.5% to 260 in 2015 from 297 in 2014. Additionally, the number of client visits decreased 26% to 618 in 2015 from 835 in 2014. This decrease in processing is attributable to program staffing changes and vacancies, which due to the small number of staff working in the program had a large impact on capacity. While a new public health nurse was hired, due to the significant orientation period of program they were limited in their ability to conduct genetic counselling sessions independently. By fall 2016, the program should return to a full complement of trained staff through the continued development of the new public health nurse.



Health Hazards

Complaints and requests for service

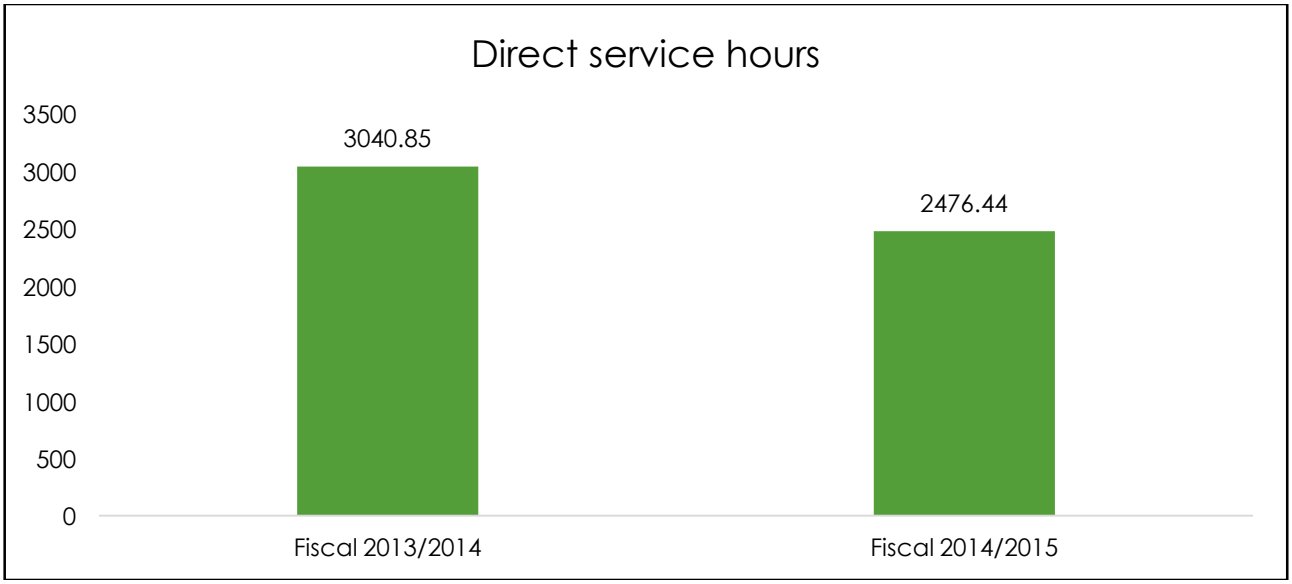
The total number of calls related to health hazard complaints were almost identical in 2014 and 2015 with 333 and 329 respectively. Differences were observed however when comparing call types. Most notably, calls related to bedbugs increased 59.0% to 97 in 2015 from 61 in 2014, while calls related to pests dropped 37.4% from 107 in 2014 to 67 in 2015. It is hard to attribute differences in call volume year-over-year to any singular cause; however, one major factor is the degree to which any given topic receives media attention. As an example, one national news story about bedbugs can prompt a noticeable increase in the amount of calls received.



Infant Child Development Program

Service hours provided

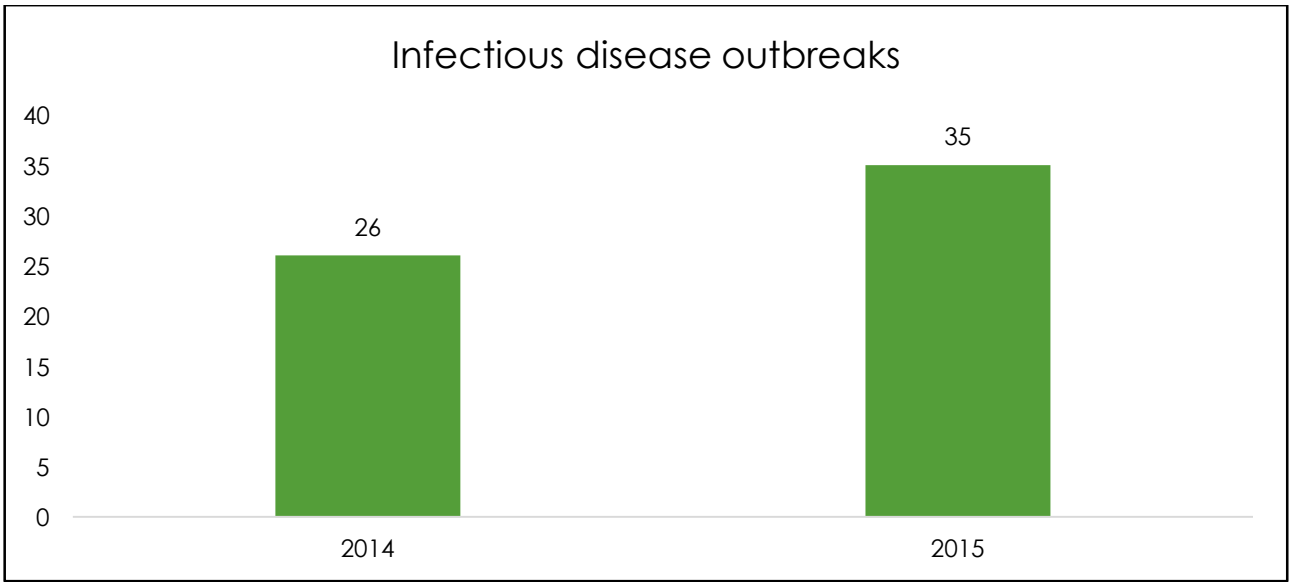
The Infant Child Development Program works with children who have or are at risk of developmental delays that may result from a large range of causes (i.e. low birth weight, genetic conditions, prenatal drug or alcohol exposure and autism). The number of service hours provided by the Infant Child Development Program decreased 18.6% from 3,040.85 in fiscal 2013/2014 to 2,476.44 in fiscal 2014/2015. While the internal target (3000) for hours was met in fiscal 2013/2014, the target for fiscal 2014/2015 (3220) was not. The observed decrease can be attributed in large part due to staffing challenges and turnover. As newly hired staff have recently completed their orientation and are now taking on a full case load, the number of service hours should rise.



Infectious Disease Control

Number of outbreaks

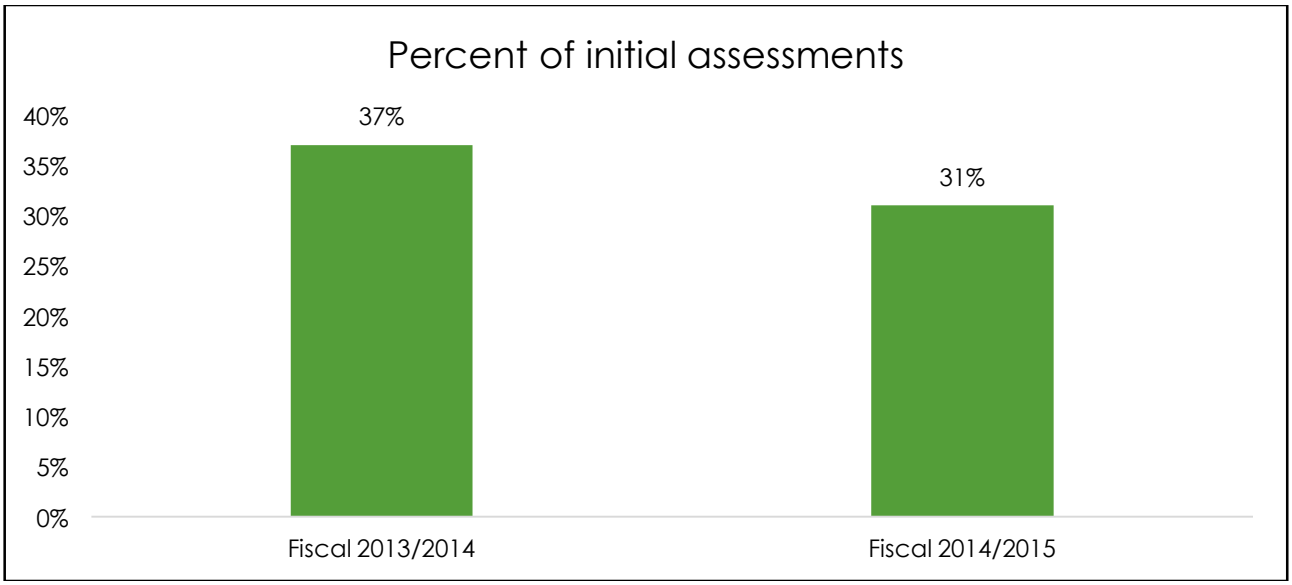
The number of infectious disease outbreaks that Algoma Public Health has investigated increased from 26 in 2014 to 35 in 2015. Infectious disease outbreaks are most commonly due to respiratory illnesses; however, outbreaks related to antimicrobial resistant organisms, enteric illnesses, and vaccine preventable diseases, such as mumps or measles are also investigated. The number of outbreaks year-over-year is highly variable, and affected by many causes including: flu strain type and vaccine effectiveness, vaccination prevalence, efficacy of antivirals, weather season severity and variable reporting by health care institutions. Algoma Public Health works closely with community partners for Infection Prevention and Control at the institutional level to effectively lead outbreak response plan and provide guidance for implementing infection control measures.



Preschool Speech and Language

Percent of initial assessments provided to children under 30-months old

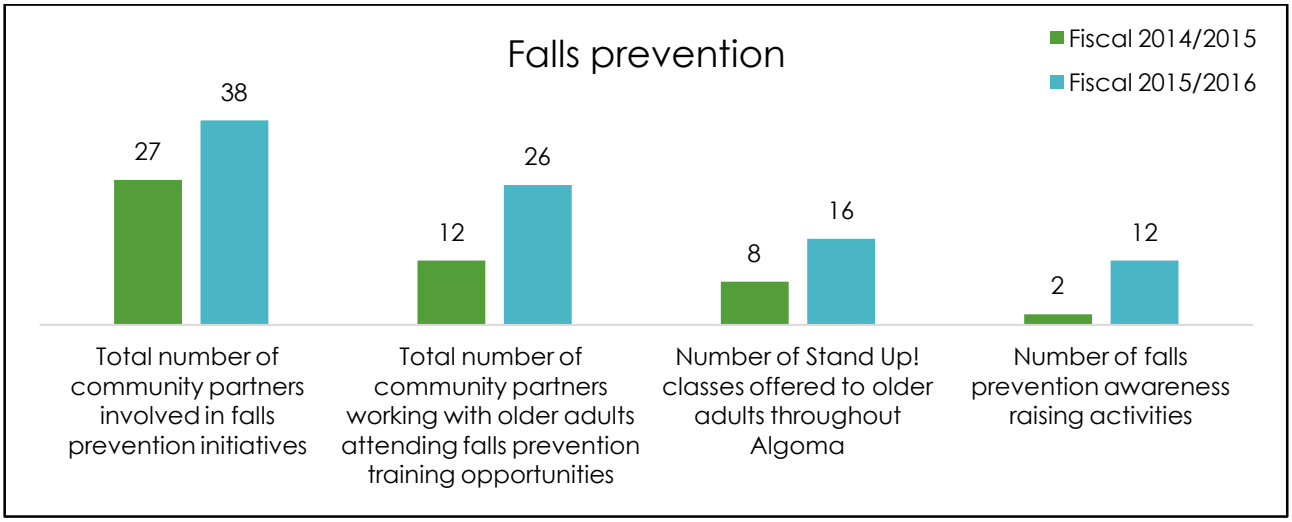
The percent of initial assessments provided to children under 30-months old has decreased from 37% in fiscal 2013/2014, to 31% in fiscal 2014/2015. During these last two fiscal years, the average age for a child being assessed was 32 and 33 months respectively, indicating that it has been a struggle to complete the assessments before the 30-month age time designated by the ministry. The difference between the last two periods may be the result of staffing changes at Algoma Public Health and an important partner agency as well as changes in how the reporting system works. As staff hired in 2015 are now at or approaching a full case load after their orientation, progress towards assessing more children under 30-months old should be seen.



Prevention of Injury and Substance Misuse

Falls across the lifespan prevention efforts

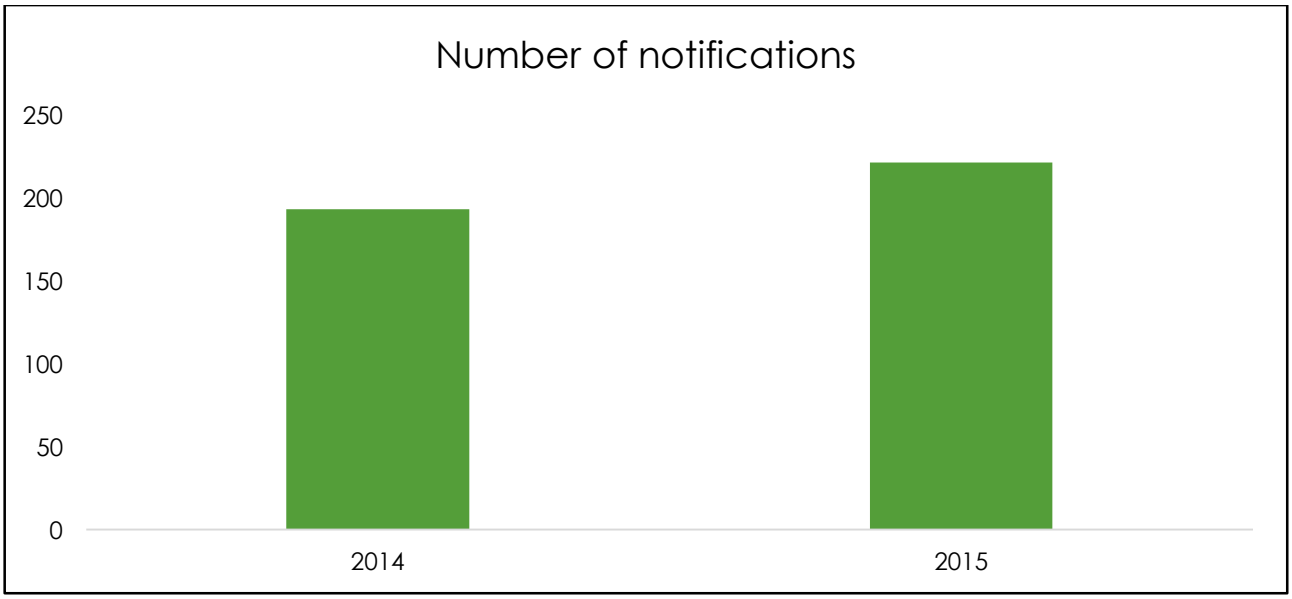
In the fall of 2014, APH became involved with a regional falls prevention strategy: Stay On Your Feet. Stay On Your Feet is a multi-faceted, collaborative strategy between the North East Local Health Integration Network and five public health units in Northeastern Ontario. The goal of the strategy is to improve the quality of life for older adults by reducing the rate and severity of falls. Overall in 2015, there was an increase in the number of community partners engaged and fall prevention/awareness activities offered in the district of Algoma compared to 2014. In order to influence this goal, multiple approaches have been included in the strategy and has provided opportunities for Algoma Public Health to greatly enhance efforts in the area of falls prevention.



Rabies

Number of notifications of potential rabies exposure

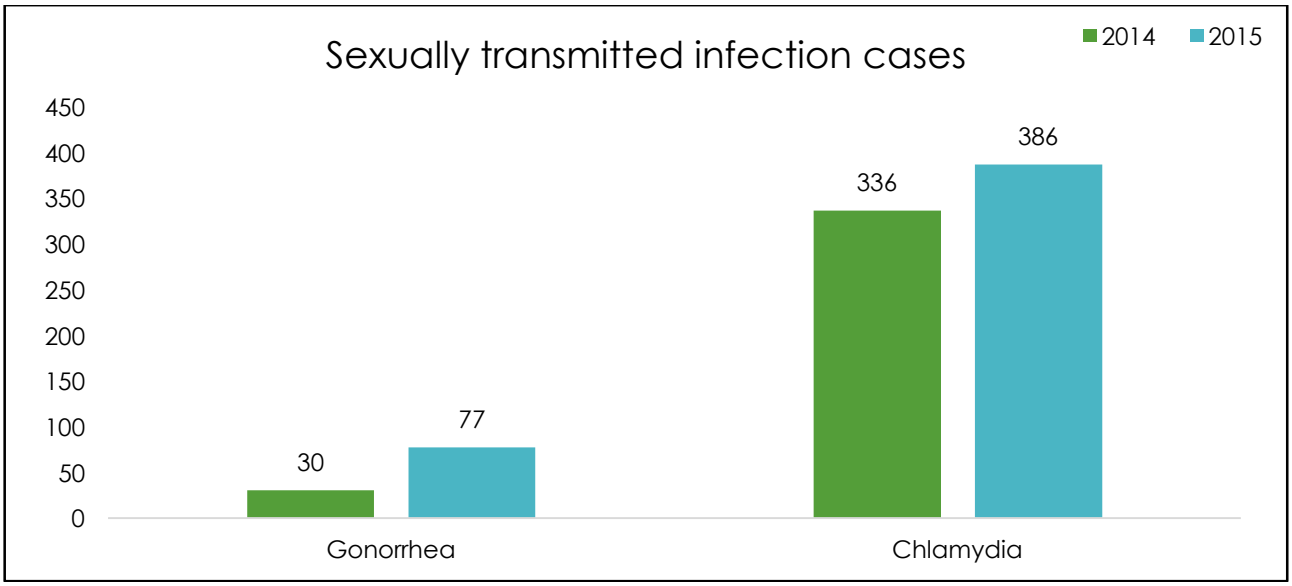
The number of notifications of potential exposure to animals carrying rabies increased 14.5% to 221 in 2015 from 193 in 2014. This is not a reflection of the number of human cases of rabies, which is extremely rare, but of the exposure of people to an animal that may or may not have rabies. The majority of notifications received have pertained to exposures from canines, accounting for 77.2% and 77.4% of the notifications in 2014 and 2015 respectively. The observed increase in potential exposures to rabies represents common fluctuation that is influenced heavily by the frequency of self-reporting from citizens and required reporting from agencies (i.e. hospitals and veterinarians) to Algoma Public Health.



Sexual Health

Sexually transmitted infections

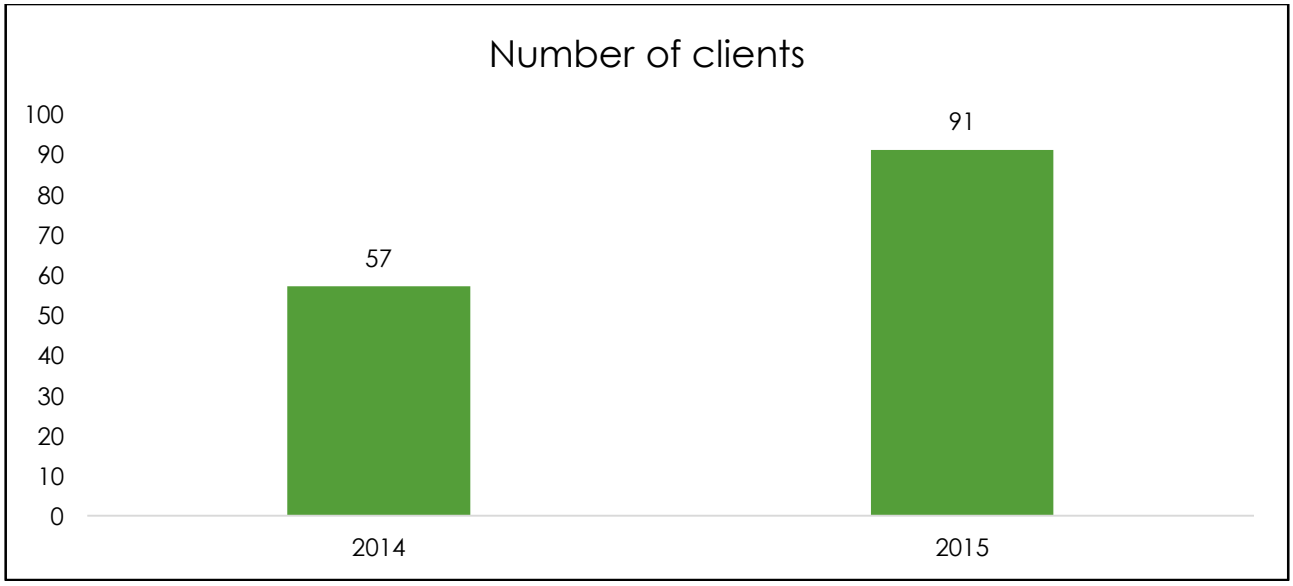
The number of sexually transmitted infections has increased between 2014 and 2015. Most notably, cases of gonorrhea have increased by 157% to 77 in 2015 from 30 in 2014, and cases of chlamydia by 14.9% to 386 in 2015 from 336 in 2014. Reasons for the observed rise for these two sexually transmitted infections are complex and not attributable to any single cause. The Sexual Health program continues to diligently conduct case management work to identify and treat cases and contacts of those infected. Additionally, efforts are being made to deliver outreach services to increase the availability of testing for high risk populations. Lastly, health promotion work continues. Most recently was a messaging campaign during Sexual and Reproductive Health Awareness Week in February 2016 that generated significant media attention and interest.



Smoke Free Ontario

Number of clients provided intensive smoking cessation counselling

The number of clients provided intensive smoking cessation counselling in scheduled clinics or as part of their existing home supports increased by 59.6% from 57 in 2014 to 91 in 2015. The observed increase is reflective of more staff from additional Algoma Public Health programs receiving specialized training and delivering the counseling. This increase is also a result of enhancements to the nicotine replacement therapy discount voucher supports and the expanded option of direct dispensing for clients in need. This positive expansion in quitting smoking support services were possible due to the receipt of Ministry one-time funding.



ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
APRIL 13, 2016 @ 4:30PM
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Sue Jensen
	Candace Martin	Lee Mason
APH STAFF PRESENT:	Tony Hanlon, Ph.D.	Chief Executive Officer
	Sheri Cleaves	Director of Clinical Services
	Christina Luukkonen	Recording Secretary

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:38pm and welcomed Mayor Jensen to the committee.

2) DECLARATION OF CONFLICT OF INTEREST
Mr. Frazier called for any conflict of interests; none were reported.

3) ADOPTION OF AGENDA ITEMS
Approved with changes. Item 6a) is moved to in-committee under 8b) Personal matters about an identifiable individual and addition of 8c) Litigation or Potential Litigation.

GC2016-16 Moved: L. Mason
Seconded: S. Jensen

THAT the agenda items for the Governance Standing Committee dated April 13, 2016 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES

GC2016-17 Moved: L. Mason
Seconded: C. Martin

THAT the minutes for the Governance Standing Committee dated January 13, 2016 be adopted as amended.
CARRIED.

5) BUSINESS ARISING FROM MINUTES
No Business arising from minutes.

6) NEW BUSINESS/GENERAL BUSINESS

a. Institute of Governance
Moved to 8b) Personal matters about an identifiable individual.

b. Elliot Lake Grand Opening Celebration
Dr. Hanlon presented a draft agenda for the grand opening celebration on May 25, 2016. The celebration will start at 2:30pm followed by the Board of Health meeting at 4:00pm. Invitation list was discussed and invitations will be sent out shortly.

c. Marketing to Children

Dr. Hanlon spoke to the draft briefing note and resolution that was included in the Committee's package regarding restrictions on food and beverage marketing to children. Discussion took place.

GC2016-18 Moved: L. Mason
Seconded: S. Jensen

THAT the Governance Standing Committee recommends the briefing note and resolution "Marketing to Children" and puts forth to the Board of Health for approval.
CARRIED.

d. Basic Income Guarantee

Dr. Hanlon spoke to the draft briefing note and resolution that was included in the Committee's package on the concept of basic income guarantee. Discussion took place and amendments were made to the draft resolution.

GC2016-19 Moved: L. Mason
Seconded: S. Jensen

THAT the Governance Standing Committee recommends the briefing note and resolution "Basic Income Guarantee" as amended and puts forth to the Board of Health for approval.
CARRIED.

e. Meeting Evaluations – Results for February 2016

Board of Health Meeting evaluations results were shared with committee members for February and March 2016. Evaluations can now be completed through the BoardEffect platform. It was noted that not all Board members are completing the monthly evaluations in a timely manner and/or not at all.

f. alPHa Conference

The date for the annual alPHa Conference has been confirmed for June 5-7, 2016 at the Novotel Toronto Centre Hotel. The agenda has not been released yet but will be shared as soon as possible. This item will go forth to the Board meeting for Board member consideration.

g. Accountability Agreement Review

Dr. Hanlon discussed with the committee the option of combining the accountability agreement review with the Quantitative Report. Dr. Hanlon also suggested revising our Performance Management Plan dates to align with program reporting.

h. Governance Training

Dr. Hanlon discussed a draft Board professional development plan for 2016. A full day orientation will be planned once the remaining vacant seats have been filled with more orientation in the fall. Mrs. Luukkonen will resend the information on governance on-line training modules to Board members.

i. Communications with Municipalities and the Public

The Committee discussed increased communication with Algoma municipalities on APH programs and services. Suggestions included presenting at council meetings for each municipality, developing key messages that are significant to each municipality and an annual summary. Dr. Hanlon will devise key messages for each municipality.

j. Communication with Board of Health Members
Dr. Hanlon will continue to proactively keep all Board members up to date as needed.

k. 2015 APH Program Performance Quantitative Report
Dr. Hanlon provided an overview of the Quantitative Report that was included in the meeting package. Dr. Hanlon proposed changes to the reporting time lines and report format. The Board of Health report on Board governance to be completed in June. A revised time line for the Performance Monitoring Plan will be presented at the next Governance Standing Committee meeting on May 11, 2016.

Committee members expressed appreciation for the report as it provided valuable insight into APH services.

Dr. Hanlon to follow-up and report back to the committee on a few items:

- can the surplus funding for CMH be used to increase staffing
- will the decrease in individual visits vs increased group sessions effect our budget

GC2016-20 Moved: C. Martin
Seconded: L. Mason
THAT the Governance Standing Committee recommends the 2015 APH Program Performance Quantitative Report as presented and puts forth to the Board of Health for approval.
CARRIED.

7) ADDENDUM

8) IN COMMITTEE

GC2016-21 Moved: L. Mason
Seconded: S. Jensen
THAT the Governance Standing Committee goes in-committee at 5:57pm.
Agenda items:

a. Adoption of Minutes dated February 10, 2016
b. Personal matters about an identifiable individual, including municipal employees
c. Litigation or Potential Litigation

CARRIED.

9) OPEN MEETING

GC2016-23 Moved: L. Mason
Seconded: S. Jensen

THAT the Governance Standing Committee goes into open meeting at 6:20pm.
CARRIED.

10) NEXT MEETING: May 11, 2016 @ 5:30pm

11) THAT THE MEETING ADJOURN: 6:21pm

GC2016-24 Moved: S. Jensen
Seconded: C. Martin

THAT the Governance Standing Committee meeting adjourns.
CARRIED.

May 13, 2016

Attention: Association of Local Public Health Agencies, all Boards of Health

Please find attached the Middlesex-London Board of Health Report No. 024-16 titled "*Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws*".

At their April 21st 2016 meeting, the Middlesex-London Board of Health passed the following motion to endorse this report:

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that the Board of Health*:

1. *Endorse Report No. 024-16 re: "Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws" and*
2. *Direct Health Unit staff to submit Appendix B and corresponding references to the Regulatory Registry for Ministry of Health and Long-Term Care consideration.*

Carried

Following the Board's endorsement, a copy of this report, Appendix B and corresponding references were submitted to the Regulatory Registry for consideration by the Ministry of Health and Long-Term Care.

Yours sincerely,

Jesse Helmer
Chair, Middlesex-London Board of Health

cc: Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies
All Ontario Boards of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 024-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016, April 21

COMMENTS ON THE MINISTRY OF HEALTH AND LONG-TERM CARE'S PROPOSAL TO STRENGTHEN ONTARIO'S SMOKING AND VAPING LAWS

Recommendation

It is recommended that the Board of Health

1. ***Endorse Report No. 024-16 re: "Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws" and***
2. ***Direct Health Unit staff to submit Appendix B and corresponding references to the Regulatory Registry for Ministry of Health and Long-Term Care consideration.***

Key Points

- In May 2015, the *Making Healthier Choices Act, 2015 (MHCA)* received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, increasing the maximum fines for youth-related sales offences, and increasing smoking restrictions on hospital property.
- The *MHCA* also created new legislation, the *Electronic Cigarettes Act, 2015* (*ECA*), to regulate the sale, use, display, and promotion of e-cigarettes. On January 1, 2016, provisions in the *ECA* came into effect, prohibiting the sale or supply of e-cigarettes to people less than 19 years of age.
- The Ministry is proposing further legislative and regulatory amendments to strengthen smoking and e-cigarettes laws in Ontario, outlined in Appendix A.
- The Middlesex-London Health Unit is in support of the proposed amendments with some suggested revisions, attached as Appendix B, to enhance public protection. Ongoing, dedicated funding with inflationary increases is required from the Ministry to support this work.

Background

The Ministry of Health and Long-Term Care is committed to improving the health and wellness of Ontarians. In May 2015, the *Making Healthier Choices Act, 2015* received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, increasing the maximum fines for youth-related sales offences, and increasing smoking restrictions on hospital property. These provisions came into effect January 1st, 2016. The *Act* also created new legislation - the *Electronic Cigarettes Act, 2015 (ECA)* – to regulate the sale, use, display, and promotion of e-cigarettes. On January 1, 2016, particular sections of the *ECA* came into force, prohibiting the sale or supply of e-cigarettes to people less than 19 years of age.

The ministry is proposing further legislative and regulatory amendments that would strengthen smoking and e-cigarettes (vaping) laws in Ontario. In summary, the Ministry's proposed amendments, if approved would:

1. Expand the *Smoke-Free Ontario Act's* "no smoking rules" to apply to medical marijuana;
2. Prohibit the use of e-cigarettes – including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of "e-cigarette" to include "e-substance";
5. Expand the list of places where e-cigarettes are prohibited for sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

The Ministry proposal is outlined in greater detail in their public consultation paper, attached as Appendix A.

Opportunity for Public and Stakeholder Input

The Health Unit has a vested interest in ensuring that the proposal will meet local public health needs, will contribute to a strengthened provincial tobacco control strategy, and is enforceable by the Health Unit's Tobacco Enforcement Officers. The Health Unit's comments on the Ministry's proposal and suggested revisions Ministry's approach are attached as Appendix B, and summarized as follows:

- The prohibition on the smoking or holding of lit tobacco should be expanded to include ***the smoking or holding of lit marijuana***, and not limit the prohibition to medical marijuana only
- The prohibition on the smoking or holding of lit tobacco should be expanded to include smoking hookah or water pipe devices, regardless of whether or not the substance smoked contains tobacco
- The proposed approach to prohibit the use of e-cigarettes in places where smoking is prohibited, including the e-cigarette retail environment is applauded. The exemption for the use of e-cigarettes in theatrical stage productions should not be permitted, and the definition of "electronic cigarette" should be amended to remove the requirement that the device contain a power or heating source.
- Parents, guardians or caregivers that supply an e-cigarette to a minor to consume medical marijuana can only do so if the device is purchased from a pharmacy or directly from the authorized licensed producers of medical marijuana under the Marihuana for Medical Purposes Regulations.
- Tobacco products should not permitted to be sold at retailers that choose to operate under the display, promotion and handling exemption outlined in the Ministry's proposal. The promotion and marketing of e-cigarettes and e-substances should also be strictly prohibited at places of entertainment, including bars, restaurants, special events, casinos, concerts and racetracks.

Health Unit staff shared the Ministry's announcement, the consultation paper and information on how to submit comments on the legislation with community and municipal partners to solicit community input.

This report was prepared by Ms. Linda Stobo, Program Manager, Chronic Disease Prevention & Tobacco Control.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the Chronic Disease and Injuries Program Standards of the Ontario Public Health Standards #1, 3, 4, 6, 11, 12 and 13"

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Comments on the Proposed Amendments to Ontario Regulation 48/06 made under the *Smoke-Free Ontario Act* and Ontario Regulation 337/15 made under the *Electronic Cigarettes Act, 2015*

Middlesex-London Health Unit
Dr. Christopher Mackie, CEO and Medical Officer of Health

Date: Friday April 22nd, 2016

To: Roselle Martino, Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care

The following comments are from the Middlesex-London Health Unit concerning the proposed amendments to Ontario Regulation 48/06 under the *Smoke-Free Ontario Act* and Ontario Regulation 337/15 made under the *Electronic Cigarettes Act*. Our comments are based on our review of the Ministry of Health and Long-Term Care's Public Consultation Paper "Strengthening Ontario's Smoking and Vaping Laws".

Re: Expand Smoking Prohibitions to Apply to Medical Marijuana

While the possession of marijuana is a criminal offence under the *Federal Controlled Drugs and Substances Act,* the federal government provides access to legal sources of marijuana for medical purposes under the *Marihuana for Medical Purposes Regulations* made under the *Controlled Drugs and Substances Act.* The *Liquor Licence Act* and driving laws restrict the ingesting, smoking or vaping of medical marijuana; however, there is a lack of regulation regarding the smoking or vaping of medical marijuana in public places. The proposed approach to amend the *Smoke-Free Ontario Act* and Ontario Regulation 48/06 to prohibit the smoking of medical marijuana in all places where smoking or holding lit tobacco is currently banned and in noted additional locations (e.g. designated guest rooms in hotels, motels and inns, and controlled smoking areas in residential care facilities), with the noted exemption (scientific research and testing facilities) will help to ensure that Ontarians are protected from the harmful effects of second-hand smoke. Regular marijuana smoking has been associated with chronic bronchitis and reduced lung function. The combustion of marijuana creates a smoke that contains many of the same carcinogens as tobacco smoke. While there is some evidence that marijuana smoking can be a risk factor for lung, head, neck and throat cancers, the association is unclear because of dual use of marijuana and tobacco smoking. Exposure to second-hand marijuana smoke has been studied less than second-hand tobacco smoke; however, due to the similarities in composition between tobacco and marijuana smoke, marijuana smoke is likely to be a similar public health concern. Exposure in an unventilated room or enclosed vehicle can cause non-smokers to experience drug effects, including minor problems with memory and coordination, and in some cases, testing positive for the drug in a urinalysis. There are additional concerns regarding exposure to second-hand marijuana smoke that warrant public health consideration.

The proposed approach will be fraught with enforcement challenges. Individuals caught smoking marijuana in a prohibited place can claim that the consumption is for recreational, not medicinal purposes. Enforcement Officers do not have the legislative authority to compel individuals to provide the documents that authorize the individuals involved as medical marijuana users. The Enforcement Officer can advise the individuals to smoke elsewhere in the absence of the required documentation; however, cooperation may be difficult to obtain, especially in public areas like playgrounds, sports fields and spectator areas, and hospital grounds.

Recommended Revision to the Proposed Approach:

The prohibition on the smoking or holding of lit tobacco should be expanded to include ***the smoking or holding of lit marijuana***, and not limit the prohibition to medical marijuana only.

Public health approaches to tobacco and alcohol provide supporting evidence of the effective strategies that could be applied towards a public health approach to marijuana. The harmful health effects from exposure to second-hand marijuana smoke, regardless of whether or not the marijuana smoked is for medical purposes, warrants health protective legislation. The prohibition on smoking or holding lit tobacco in outdoor public places, including playgrounds, sports fields and spectator areas, patios, and hospital grounds under the *Smoke-Free Ontario Act* was enacted to protect people from exposure to outdoor second-hand smoke and to limit youth and young adult exposure to tobacco use. The application of the Social Norms Theory and the Social Learning Theory has been invaluable to explain tobacco initiation in young people. Tobacco use is increasingly influenced by social norms and what is viewed as acceptable, routine or "normal" behaviour. Children and young adults are likely to copy the behaviours they see; the less exposure they have to tobacco use due to protective environmental factors, like healthy public policy, the less likely they are to initiate tobacco use. The application of these theories to explain the initiation of marijuana use by young people has also been extremely important. In fact, Colorado lawmakers and voters prevent the modelling of substance use for children and youth by applying existing smoke-free policies and public consumption bans to the use of marijuana. The opportunity exists for Ontario to take a leadership role in protecting people from the harmful effects of second-hand tobacco and marijuana smoke exposure, and to make marijuana use less visible within our cultural landscape. This public health approach to the prohibition of marijuana use would also address the enforcement challenges that the specificity of the "medical marijuana" language will create.

Please refer to the Middlesex- London Board of Health Report #003-16 and Appendix A, "Cannabis: A Public Health Approach" , included within our submission, for a more detailed analysis on the public health considerations regarding exposure to second-hand marijuana smoke and exposure to marijuana use.

Re: Definition of Smoking Prohibition to Include the Use of Hookah/Shisha, whether or not the Substance Contains Tobacco

A hookah or water pipe is a device that is used to smoke a moist concoction of tobacco or non-tobacco (herbal) products known as shisha. Hookah and shisha use is becoming increasingly popular as it is often considered to be healthier than cigarette smoking; however, both tobacco and non-tobacco shisha smoke pose serious health risks to those who use the device and to the individuals exposed to second-hand smoke that the device and its users create. Under the *Smoke-Free Ontario Act* and its current definition, the prohibition on smoking applies to hookah use if the shisha contains tobacco. The *Smoke-Free Ontario Act* does not prohibit smoking of shisha that does not contain tobacco.

Water pipe smoking of shisha that does not contain tobacco undermines the success of the *Smoke-Free Ontario Act* because it creates an unsafe work environment, contributes to the social acceptability of smoking in public places and is difficult and expensive for Tobacco Enforcement Officers to ensure that shisha product being smoked in public places, including playgrounds, patios and water pipe cafes does

not contain tobacco. Studies of both tobacco-based shisha and "herbal" shisha show that the smoke from both preparations contains carbon monoxide and other toxic agents known to increase the risks for smoking-related cancers, heart disease and lung disease. A study of second-hand smoke exposure in Toronto water pipe cafes showed that indoor air quality values for $PM_{2.5}$, ambient carbon monoxide and air nicotine are hazardous for human health. Outdoor water pipe cafes showed less harmful levels than indoors; however, the $PM_{2.5}$ levels were still poor. Water pipe usage is increasing in Canada. According to the Canadian Tobacco Use Monitoring Survey, 10% or approximately 2.8 million Canadians aged 15 years and older reported having ever tried a water pipe in 2012, which is higher than the results from 2011 (8%) and 2006 (4%). Water pipe use was higher among youth and young adults, with 13% of Canadian youth aged 15 to 19 and 28% of young adults aged 20 to 24 reporting having tried a water pipe. The 2015 Ontario Student Drug Use and Health Survey indicated that approximately 14% of students in grades 7 to 12 had ever used a water pipe in the last year, with use significantly increasing with grade, peaking at 26% in grade 12. Public health concerns of greater risk of contracting tuberculosis, meningitis, hepatitis and herpes because of shared hoses and mouthpieces during a smoking session must also be considered.

Recommended Revision to the Proposed Approach:

The prohibition on the smoking or holding of lit tobacco should be expanded to include the smoking of hookah or water pipe devices, regardless of whether or not the shisha or substance smoked contains tobacco. This approach was adopted by New Brunswick (effective July 1, 2015), Nova Scotia (effective May 31, 2015) and Prince Edward Island (introduced June 9, 2015). The City of Toronto enacted a bylaw that came into effect on April 1st, 2016, that prohibits hookah smoking, regardless of whether or not the shisha contains tobacco, in all city-licensed businesses. The expansion of the *Smoke-Free Ontario Act* would: provide a level playing field for all businesses and municipalities across Ontario; provide consistent protection to all employees and patrons in all Ontario municipalities; and, provide a consistent message that smoking and exposure to smoke is harmful to one's health, normalizing a smoke-free culture. A restrictive approach to hookah prohibitions would also help to curb the growing perception among high-school-aged youth that shisha smoking is safe; 40% of Canadian high-school students believe that shisha smoking is not as harmful as tobacco, and that while tobacco use among this age cohort is decreasing, hookah use is increasing. There is an opportunity to create a healthy, smoke-free environment by prohibiting hookah use in all places where smoking is currently banned.

For a more detailed analysis on the need for health protective legislation to govern the use of hookah, please refer to the City of Toronto Board of Health Report, "Health Risks of Indoor Waterpipe Smoking."

For more information on hookah use prevalence and perceptions among Canadian youth, please refer to the article "Hookah use Prevalence, Predictors, and Perceptions among Canadian Youth: Findings from the 2012/2013 Youth Smoking Survey".

Re: The Prohibition of the Use of E-Cigarettes in All Enclosed Public Places and Enclosed Workplaces – including E-Cigarette Retail Establishments - and other Specified Outdoor Areas

E-cigarettes have been growing in popularity in North America since their patent in 2004, and are heavily marketed, using television, print, retail promotions and online, as: healthier alternatives to tobacco cigarettes; possible tobacco cessation aids; and, products that can be used to circumvent smoke-free legislation. According to a 2014 study (CAMH Monitor), past-year use of electronic cigarettes was 10% among adults 18 years and over. Young adults aged 18 to 24 were more than twice as likely to have used in the past year compared to 25 to 44 year olds (31% vs. 15%) and more than three times as likely than adults aged 45 to 65 (31% vs. 9%). The growing popularity and social acceptability of e-cigarette use, especially among young adults is concerning given the lack of regulations and the volume of sophisticated marketing by the e-cigarette industry to recruit new users.

There is a lack of public health consensus around the health benefits and risks of e-cigarettes. The evidence on the efficacy of e-cigarettes as a cessation aid are mixed and while many former smokers have reported that e-cigarettes helped them quit smoking, most report dual use, and the long-term health effects of single and dual use are unknown. There are many safety concerns associated with e-cigarettes and their use, due to the lack of manufacturing standards and packaging and labelling requirements. Therefore, there is little to no consistency in the composition and quality of the individual e-cigarette delivery systems, the substances added to the device, the levels of nicotine, the chemical makeup of the e-juice or e-substance, and the facilities where they are made. For example, some e-juice may be manufactured in laboratories, whereas some may be manufactured in residential basements or kitchens. In Canada, electronic smoking devices that contain nicotine are regulated under the federal *Food and Drugs Act*. E-cigarettes that contain nicotine have not been approved for sale in Canada, and it is illegal for e-cigarette packaging or promotion to make health claims. In 2009, Health Canada issued a statement cautioning Canadians that e-cigarettes have not been fully evaluated for safety, quality and efficacy, and that electronic smoking devices and e-juice should not be purchased due to unknown health risks. Despite this statement, nicotine e-juice is widely available in most communities across Ontario.

There is documented evidence that e-cigarette use has caused mouth and throat irritation, nausea, headaches and dry cough. E-liquids containing nicotine may have harmful effects on young people and during fetal development because of the negative impacts of nicotine exposure on brain development. Other recent studies have focused on the chemical composition of e-liquids, with researchers concluding that users of e-cigarettes are exposed to carbonyl compounds, aldehydes, fine particulate matter, metals, formaldehyde, volatile organic compounds, glycerol and propylene glycol. Health risks associated with chronic inhalation of the chemical vapour remain poorly understood because of the variability of the products in market due to lack of regulation within the e-cigarette industry; however, there is emerging evidence calling into question the safety of inhalation of the flavouring agents used in e-juice. Toxicological studies have confirmed that in occupational settings, the inhalation of diacetyl and 2,3-pentanedione, used in the creation of the "butter flavour" for microwave popcorn, and many other flavourings used in the creation of flavoured e-juice, has caused bronchiolitis obliterans, and other severe lung diseases, often referred to as "popcorn lung". The heating, vaporization and subsequent inhalation of the chemicals used in flavoured e-liquids are similar to the route of exposure that workers at microwave popcorn facilities experience, supporting the need for precautionary, health protective legislation to limit the inhalation of vapour in enclosed public places and workplaces.

Under the *Electronic Cigarettes Act*, an "electronic cigarette" is defined as:

1. A vaporizer or inhalant-type device, whether called an electronic cigarette or any other name, that contains a power source and heating element designed to heat a substance and produce a vapour intended to be inhaled by the user of the device directly through the mouth, whether or not the vapour contains nicotine.

2. A component of a device described in paragraph 1.

3. Any other prescribed device or product;

This definition will create enforcement challenges when attempting to enforce Section 10 of the *Act*; the prohibitions on the use of e-cigarettes in public places and workplaces. When a Tobacco Enforcement Officer observes someone using an e-cigarette in a prohibited place, the Officer must be able to prove all elements of the offence. The Officer would have to take the device from the person using it and take it apart to ensure that the device being used meets all requirements outlined in the definition, including the power source and heating element. An additional complicating factor is that the first generation products do not come apart; therefore, an Officer would not be able to make a determination that there is a battery or heating element. In addition, newer products on the market do not contain a battery or heat source, as they are ignited by a flame.

Recommended Revision to the Proposed Approach:

The proposed approach to limit exposure to the vapour is required due to the current state of evidence. Patrons, employees of e-cigarette retailers and enforcement personnel mandated to inspect e-cigarette retail establishments, including Public Health Unit enforcement officers and youth test shoppers, and Fire and Building Code Inspectors, should not be exposed to the vapour due to the emerging evidence of the health risks, and the unknown health impacts of inhalation of the chemical vapour.

The use of e-cigarettes in places where smoking is prohibited, combined with their growing availability and the savvy marketing strategies used by the e-cigarette industry, including candy- and fruit-flavoured e-juice, adjustable vapour cloud volume, personalized tanks and mouthpieces, and the hosting of events to promote the "vaping culture", undermine the current tobacco control policies in place. Those who have quit smoking or are trying to quit may be tempted to smoke by seeing others use e-cigarettes. Prohibiting e-cigarette use in all places where smoking is currently prohibited protects people from the unknown health effects of exposure to vapour and helps to prevent the initiation of e-cigarette use by decreasing the social acceptability of e-cigarette use. **To this end, the exemption for the use of e-cigarettes in theatrical stage productions should not be permitted**. Until e-cigarettes are regulated and confirmed to be safe for use, this precautionary approach is required.

To increase the enforceability of the prohibitions on the use of e-cigarettes, the definition of an e-cigarette needs to be prescribed further by Regulation 337/15 under the *Electronic Cigarettes Act*. The definition of e-cigarette under the *Act* works well for enforcement of the sales provisions prescribed within the *Act*; however, the definition does not suffice for enforcement of Section 10. Amending the definition of e-cigarette as follows would increase Enforcement Officers' ability to prove all elements of the offence:

- ☐ A vaporizer or inhalant-type device, whether called an electronic cigarette or any other name, ***that may or may not*** contain a power source and heating element, that heats a substance and

produces a vapour intended to be inhaled by the user of the device directly through the mouth, whether or not the vapour contains nicotine.

Re: Permit Parents, Guardians and Caregivers to Supply E-cigarettes to Minors for Medical Marijuana Purposes

The Ministry proposal to specify that a parent, guardian or caregiver would be permitted to supply (but not sell) an e-cigarette to a minor to consume medical marijuana, if the minor is authorized to possess medical marijuana under federal law is reasonable; however, the *Electronic Cigarettes Act* should specify that for these unique circumstances, the source of device should be prescribed.

Recommended Revision to the Proposed Approach:

Regulation 377/15 under the *Electronic Cigarettes Act* should specify that parents, guardians or caregivers are permitted to supply an e-cigarette to a minor to consume medical marijuana, if the minor is authorized to possess medical marijuana under federal law, only if the device is purchased from a pharmacy or directly from the authorized licensed producers of medical marijuana under the *Marihuana for Medical Purposes* Regulations.

Re: Expand the Definition of "E-Cigarette" to include "E-Substance"

Worldwide, there are now over 450 brands being marketed in over 7000 flavours. E-juice is manufactured predominantly in China and bottles are not subject to any legal safety standards for labelling or packaging such as those imposed on the pharmaceutical industry in the production of medication. In 2009, Health Canada's Public Notice Advisory to Canadians and Notice to Stakeholders instructing persons importing, advertising or selling e-cigarette products in Canada to stop doing so immediately as such activity was in contravention with the *Food and Drugs Act* has been unsuccessful in its attempt to curb the distribution and promotion of these products. Despite these warnings by Health Canada, every premise within the Middlesex-London jurisdiction that was reported to Health Canada for selling e-juice containing nicotine continues to do so without penalty or consequence. In fact, there has been an increase in the number of retailers selling e-cigarettes and e-juice containing nicotine in Middlesex-London over the last few years.

With an estimated median lethal dose between 1 and 13 mg per kilogram of body weight, 1 teaspoon (5 ml) of a 1.8% nicotine solution could be lethal to a 90-kg person. A 20ml bottle of e-juice contains on average 360 mg of nicotine - several times the lethal dose. Incidents of nicotine poisoning have risen substantially, especially in the United States. In Canada, the risks associated with unregulated nicotine e-juice compositions include variable concentrations of chemicals and nicotine, dangerous nicotine dose levels or undisclosed ingredients. According to laboratory testing commissioned by Health Canada, approximately one-half of all products labelled as nicotine-free contained nicotine. In addition, unsealed, leaky or non-child proof bottles containing a potent poison is a concern. In 2015, among all students in grades 7 to 12, 23% reported ever using an e-cigarette. In lieu of federal action, health protective regulation is required at the provincial level.

Recommendation Regarding the Proposed Approach:

For the reasons outlined above, and the health concerns regarding the safety of the devices and the chemical cocktail that is inhaled when an e-cigarette is activated, the expansion of the definition of "e-cigarette" to include "e-substance" is required to limit youth access.

Re: Establish Rules for the Display and Promotion of E-cigarettes at Places Where They are Sold

The Ministry's proposal to prohibit the display of e-cigarettes in a way that would permit a consumer to view or handle an e-cigarette before purchasing it in a store and to prohibit the promotion of e-cigarette at places where e-cigarettes or tobacco products are sold or offered for sale would protect the health and well-being of children and youth by limiting their exposure to e-cigarette products, and would also help to curtail that point-of-sale promotions at convenience stores, gas stations, grocery stores, and head shops currently bombarding the marketplace. Display bans have been extensively documented in the literature as an effective tobacco control policy which helps to reduce tobacco sales, prevent the promotion and marketing to children and youth, and supports those who have recently quit from impulse purchases of tobacco. The evidence regarding the potential risks and benefits of e-cigarettes remains mixed and inconclusive; therefore, a precautionary approach is required.

Recommended Revision to the Proposed Approach:

E-cigarettes are being heavily marketed as healthier alternatives to tobacco cigarettes and as an effective tool to support tobacco cessation. Under Regulation 337/15, the *Electronic Cigarettes Act* should prescribe that the allowable signs shall not make health claims, shall not promote the devices as a tobacco cessation device and/or shall not state or imply that e-cigarettes are a healthier alternative to tobacco products. The documents that are allowed inside the store to adults 19 years and older must be prescribed by regulation and limit the content to brands, specifications, and instructions for use; documents shall not make health claims, shall not promote the devices as a tobacco cessation device and/or shall not state or imply that e-cigarettes are a healthier alternative to tobacco products.

The proposed approach to permit the display and promotion of e-cigarette products (but not the testing or sampling of e-cigarettes) in places where they are sold is recommended and endorsed by the Middlesex-London Health Unit as long as there is an added condition:

- ☐ Tobacco products are not permitted to be sold at premises that are operating under this exemption.

In addition, the promotion and marketing of e-cigarettes and e-substances should be strictly prohibited at places of entertainment, including bars, restaurants, special events, casinos, concerts and racetracks to curb the savvy marketing practices that the industry are currently employing to market their product to new users.

If you wish to discuss any of the recommended revisions provided, please do not hesitate to contact the Middlesex-London Health Unit by calling Linda Stobo, Program Manager for Chronic Disease Prevention and Tobacco Control, at (519) 663-5317 ext. 2388 or linda.stobo@mlhu.on.ca.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

CANNABIS: A PUBLIC HEALTH APPROACH

Recommendation

It is recommended that the Board of Health:

1. ***authorize staff to advocate for an evidence-based public health approach to Cannabis in the context of legalization, including strict regulation for the non-medical use of cannabis, as well as its production, distribution, product promotion and sale; and***
2. ***establish baseline data and mechanisms to monitor local use of cannabis in the coming years; and***
3. ***forward this report and appendices to the Association of Local Public Health Agencies, the Ontario Public Health Association, Ontario Boards of Health, the Ontario Minister of Health and Long-Term Care, the federal Minister of Health, and other elected officials as appropriate.***

Key Points

- Canada has one of the highest rates of cannabis use in the world.
- Police associations and public health organizations have expressed support for a new approach, and the federal government has indicated that they will legalize cannabis in their current mandate.
- Cannabis use is associated with a variety of health harms. The most concerning occur among youth and chronic heavy users.
- A public health approach to cannabis policy is recommended, including a strong policy framework of strict regulations to minimize health and social harms.

Background

In July 2015, staff reported to the Board of Health on work being undertaken to develop an evidence-based position on cannabis policy (see Report No. 047-15 from July).

Canada has one of the highest rates of cannabis use in the world with over 40% of Canadian adults having used cannabis in their lifetime. In Ontario, it is the most widely consumed illicit drug, with youth and young adults having the highest rates of use. The debate about the regulation of cannabis for non-medical use has been ongoing for decades in Canada and has gained interest with the election of the new Liberal government. Despite decades of legislation and international conventions aimed at eliminating cannabis, use has continued to increase globally. In response, various countries have adjusted or are in the process of adjusting their approach to cannabis legislation and control.

Portugal decriminalized the possession of all drugs for personal use in 2001 while implementing a national drug strategy at the same time. In 2013, Uruguay became the first country to legalize the personal use and sale of cannabis. In the United States, 15 states have decriminalized the possession of small amounts for personal use and in 2012 Colorado and Washington State became the first two states to legalize recreational use of cannabis, followed by Alaska, Washington DC and Oregon.

A comprehensive review of what cannabis is, prevalence of use, history of law related to cannabis, cannabis associated harms, synopsis of trends away from prohibition and positions of other Canadian agencies can be found in the attached report, Cannabis: A Public Health Approach (see Appendix A).

Public Health Approach

While the scientific evidence suggests that cannabis has a smaller public health impact than alcohol and tobacco, cannabis is associated with health risks which generally increase with frequent heavy consumption and use at an early age. Public health considerations include cannabis impaired driving, effects on youth brain development and mental health, respiratory system effects, use during pregnancy and risk of dependence. Criminalization of cannabis possession and use has not reduced use and has paradoxically resulted in increased health and social harms.

A public health approach addresses the public health concerns of cannabis use while aiming to eliminate or reduce the health and social harms resulting from its criminal prohibition. The Canadian Public Health Association (CPHA) asserts that a public health approach based on principles of social justice, attention to human rights and equity, evidence informed policy and practice and addressing the underlying determinants of health is the preferred approach to criminalization.

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in its field. In 2014, following extensive review of the research, CAMH scientific staff released the report "Cannabis Policy Framework" concluding that Canada requires a strong policy framework for cannabis, recommending legalization with strict regulations.

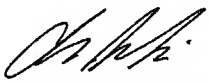
The policy framework by CAMH is consistent with the views of other agencies such as Canadian Public Health Association (CPHA) and the Canadian Centre on Substance Abuse (CCSA). Middlesex London Health Unit recommends an approach to cannabis policy that is consistent with CAMH. This recommended approach is also consistent with the Colorado Department of Public Health and Environment's public health framework for legal recreational marijuana. The federal government's approach to changing the legal framework around cannabis has also received support from such policing organizations as the Canadian Association of Chiefs of Police.

Conclusion

While there are recognized and important health harms to cannabis use, these are modest in comparison to the health impacts of other drugs such as alcohol and tobacco. Despite prohibition, prevalence of the recreational use of cannabis has increased, and moreover, criminal prohibition has resulted in well documented health and social harms. The Ontario Public Health Standards mandates boards of health to reduce the frequency, severity and impact of substance misuse; with regards to cannabis, criminal prohibition is a barrier to effectively meet these objectives.

In the context of coming legalization, strict regulation for the non-medical use of cannabis, i.e. a public health approach to cannabis production, distribution, product promotion and sale, is recommended to best prevent and reduce health and social harms associated with cannabis use. This approach acknowledges that cannabis is not a benign substance and that policy built upon evidence-based regulations and controls is the recommended best approach to minimize the risks and harms associated with use.

The report was prepared by Ms. Mary Lou Albanese, Manager and Ms. Rhonda Brittan, Public Health Nurse, Healthy Communities and Injury Prevention Team.



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Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Prevention of Injury and Substance Misuse Standard Requirement #2.

Appendix A to Report # 003-16

Cannabis: A Public Health Approach

MIDDLESEX-LONDON HEALTH UNIT

January 8, 2016

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Table of Contents

1.0 Introduction

A public health approach to cannabis policy is needed in Canada. Despite prohibition, Canada has one of the highest rates of cannabis use in the world with over 40 % of Canadian adults having used cannabis in their lifetime. In Ontario, it is the most widely consumed illicit drug, with youth and young adults having the highest rates of use. While it is known that cannabis use has the potential for adverse health consequences, most notably for those who begin use at an early age and use it frequently, the current approach of criminalization has been shown to increase these harms while also causing significant social harm. Furthermore, data shows that Canada's possession laws are not enforced consistently across jurisdictions or populations, making criminal prohibition of cannabis possession an issue of health equity.

The debate about the regulation of cannabis has been ongoing for decades. Most recently the issue has gained momentum with the election of a Liberal government that made cannabis legalization part of its election platform. The December 4th, 2015 Throne Speech included a pledge to "legalize, regulate and restrict access to marijuana". Canadian public support for change to cannabis control has been growing, and internationally, the landscape of cannabis policy is changing at a rapid pace.

This report builds upon the report: *Cannabis – Health Implications of Decriminalization, Legalization, and Regulation*, which was provided to the MLHU Board of Health in July, 2015. This report will provide background information about cannabis and trends in use; provide an overview of the current evidence related to the health harms of cannabis and the harms stemming from the criminalization approach; briefly describe current law and the historic progression of Canadian law related to cannabis control, including how medical marijuana fits into the current regulatory landscape in Canada; and provide an overview of regulatory models that have moved away from prohibition and the lessons learned.

While taking into consideration the positions of leading Canadian organizations, this report will conclude with a recommendation for a regulatory approach to cannabis control that will reduce the risks of health and social harms.

2.0 Cannabis: What Is It?

Cannabis, more commonly called marijuana, is the dried flowers, fruiting tops and leaves of the cannabis plant, most frequently, *Cannabis sativa.* The cannabis plant contains several different *cannabinoids*, the psychoactive component being delta-9-tetrahydrocannabinol (THC). The level of THC varies depending on the part of the plant used, plant breeding, and product processing. Cannabis can be consumed by smoking, such as a "joint" or in a pipe or bong, ingested as an edible, or consumed in a liquid infusion (CCSA, 2015; Room et al., 2010).

Psychoactive substance is a name given to a classification of substances that affect mental processes such as mood, sensations of pain and pleasure, motivation, cognition and other mental functions. Cannabis can be considered in the context of other psychoactive substances which include alcohol, tobacco, some prescription medications, and even caffeine. Psychoactive substances, including cannabis, have been used both medically and non-medically by humans for thousands of years (CPHA, 2014; Health Officers Council of BC, 2011). People use cannabis for various reasons and it affects people in different ways. Typically it produces a state of relaxation, happiness and changes in perception. The level of THC in the product, the amount of product consumed, the user's previous experience with the drug, and mode of consumption will impact its effects. When smoked, effects will typically be felt by the user in about 10 minutes and rapidly dissipate; while when ingested, the effects of cannabis can take anywhere from 30 minutes to 2 hours to be felt, and can last several hours. (Monte, Zane & Heard, 2015).

3.0 Prevalence of Use

Globally: Cannabis is the most widely used illegal drug in the world. According to the United Nations Office of Drugs and Crime (UNODC) an estimated 160 million people - 4% of the global adult population used marijuana in 2005 (Room et al., 2010). Cannabis became popular in Western countries in the 1960's. While prevalence has shifted over years and decades, rates are highest among youth and young adults. Common patterns of use across countries suggest that penalties for personal use do not affect prevalence of use (Room et al., 2010).

Canada: Canada has one of the highest rates of cannabis use in the world, with more than 40% of Canadian adults having used cannabis in their lifetime and 10% reporting past year use. Youth have the highest prevalence of use, with 2012 data indicating that over 20.3% of youth aged 15-24 used marijuana in the previous year (Health Canada, 2014)

Ontario: Ontario use is consistent with Canada as a whole, with population surveys indicating that 14% of adults and 23% of secondary school students have used cannabis in the past year. While cannabis use is most common in youth and young adults, Ontarians aged 30 and over account for half of all use (CAMH, 2014).

The Ontario Student Drug Use and Health Survey (OSDUHS) is a population survey of Ontario students in grades 7 through 12. According to the 2015 OSDUHS, cannabis is the third most commonly used substance after alcohol and energy drinks. Cannabis use increases with each grade level, with 10.3% of 9th graders compared to 37.2% of 12th graders reporting past year use. Males and female rates of use are similar. While cannabis use has shown a gradual decline since 1999, about 2 % of students report using cannabis daily, which equals approximately 20,000 Ontario students. Age at first use has shown an increase over past decades. In 2015, the average age at first cannabis use reported among 12th-grade users was 15.3 years. For grade 7 students, less than 0.5% used cannabis for the first time before the end of grade 6, compared with 5% in 2003, and 7% in 1981 (Boak et al., 2015).

Middlesex-London: London and Middlesex data regarding prevalence of cannabis use is limited. Although the Ontario Student Drug Use and Health Survey (OSDUHS) does not analyse data at the county level, it does analyse data down the level of a Local Health Integration Network. Across regions, the OSDUHS did not find significant difference in student cannabis use (Boak et al., 2015).

4.0 History of Law Related to Cannabis

The laws and systems that have been put in place to manage substances, including cannabis, reflect the dominant social norms, beliefs and political stances of the times when they were created, rather than current scientific knowledge and evidence (CPHA, 2014).

Cannabis was added to the schedule of prohibited drugs under Canada's *Opium and Narcotic Drug Act* in 1923. While the first charge for cannabis possession was not laid until the 1930's, cannabis became a primary drug enforcement focus in the 1960's. By 1972 there were more than 10,000 arrests for possession and use, with many young Canadians receiving criminal convictions (Ontario Public Health Working Group, 2004). The *Controlled Drugs and Substances Act* was introduced during the 1990's and is the legislation that currently governs cannabis and other psychoactive drugs in Canada.

Globally, cannabis was widely used for medical purposes from the end of the 19th century continuing into the 1950's. In 1961 it was added to the strictest prohibition category of the 1961 Single Convention on Narcotic Drugs specifying that 'use of cannabis should be prohibited for all purposes medical and non-medical alike'. International prohibition of cannabis was further solidified in the 1988 Convention, making even possession a criminal offence under each signatory country's domestic law. Many countries, including Canada, are signatories to these international drug control Conventions, criminalizing the production, distribution, use and possession of cannabis (Room et. al., 2010).

Despite legislation and international conventions aimed at eliminating use of cannabis, by the early 1970's there was a growing realization that prohibition was not achieving its intended effect. Public inquiries and commissions occurred in several

countries, including Canada, concluding that the effects of criminalization were excessive and counterproductive and calling on lawmakers to eliminate or reduce criminal penalties for personal use (Room et al., 2010).

In Canada alone, the ineffectiveness and high cost of criminalization has been described, and a call to move away from absolute prohibition made, in several reports: the Le Dain Commission (1972); the Senate (1974); the Canadian Bar Association (1994); the Canadian Centre for Substance Abuse (1998); Centre for Addiction and Mental Health (CAMH) (2000); the Frasier Institute (2001); the Senate Special Committee on Illegal Drugs (2002); The Health Officers Council of British Columbia (2011); the Canadian Drug Policy Coalition (2013); the Canadian Public Health Association (2014) and CAMH (2014).

5.0 Current Canadian Law Related to Cannabis

Marijuana is classified as a Schedule II drug under the *Controlled Drugs and Substances Act* (CDSA). This means that it is illegal to grow, possess, distribute and sell marijuana. Convictions under the CDSA will result in a criminal record and may result in penalties ranging from fines to life imprisonment depending on the nature of the offence (CCSA, 2014).

In Canada in 2013, 58,965 incidents involving possession of cannabis were reported to police. Over 600,000 Canadians currently hold a criminal record related to cannabis possession (Canadian Drug Policy Coalition, 2015).

Marijuana is also regulated through international treaties to which Canada is a signatory (CCSA, 2014).

Drug-impaired driving is an offence under the Criminal Code of Canada (Beirness & Porath-Waller, 2015).

5.1 Medical Marijuana in Canada

The human body has naturally occurring endocannabinoids that act on the brain and nervous system. When the body's own endocannabinoids bind to specific receptors, symptoms, such as anxiety, convulsive activity, hypertension and nausea which can be caused by over-activity of the nervous system are reduced. When marijuana is consumed, these same cannabinoid receptors are activated. Although there are claims that marijuana can benefit a wide range of symptoms and diseases, more research is needed. Current evidence supports the medical use of cannabis for nausea, vomiting and chronic pain (Kalant & Porath-Waller, 2014).

Cannabis for medical use has been legal in Canada since 2001, initially under the *Marihuana Medical Access Regulations* (MMARs). Under the MMARs, legal access to marijuana for medical purposes could be granted to Canadians meeting certain requirements. Health Canada was responsible for issuing authorizations and approved individuals had the option of obtaining their medical marijuana through Health Canada, a designated grower, or growing their own (Kalant & Porath-Waller, 2014).

Effective 2014, the MMARs were replaced with the *Marihuana for Medical Purposes Regulations* (MMPRs). Individuals now must receive a prescription from a medical practitioner versus Health Canada, and users of medical marijuana no longer have the legal option of growing their own product (Kalant & Porath-Waller, 2014). There are limits to how much cannabis that an individual can possess at one time (Health Canada, 2015).

As of September 30, 2015 there were 26 Health Canada authorized, licensed producers in Canada under the MMPR, 14 located in Ontario. While some are licensed only to produce, others can both produce and sell. Licensed producers are highly regulated and routinely inspected by Health Canada. Licensing requirements are strict and include quality control standards, physical and personnel security measures, inventory management and stringent record keeping. Products must be shipped in child resistant packaging and meet labelling requirements with health warning messages as well as THC content (Health Canada, 2015).

6.0 Harms

While the scientific evidence suggests that cannabis has a smaller public health impact than alcohol and tobacco, cannabis, like other drugs, is associated with health risks. Evidence has shown that these health risks generally increase with frequent consumption (daily or nearly-daily) and when used at an early age.

6.1 Direct Health Harms

Cannabis-Impaired Driving: Research has shown that driving while impaired by cannabis is associated with performance deficits in tracking, reaction time, visual function, concentration, short-term memory, and divided attention which increases the risk of motor vehicle crashes (Beirness & Porath-Waller, 2015). Epidemiologic data suggests that cannabis users that drive while intoxicated have 2 to3 times the risk of motor vehicle crashes over a non-drug intoxicated driver and the higher the level of THC in the blood, the higher the risk of crash (Hall, 2014 & Colorado Department of Public Health and Environment [CDPHE], 2015). In comparison, intoxication with alcohol has been found to increase motor vehicle crash risk by 6 to15 times. The combination of cannabis with alcohol increases the risk of collision more than either substance on its own (Hall, 2014). CAMH currently has a study underway to determine the extent of relationship between cannabis consumption and driving ability.

The 2012 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) found that 2.6% of drivers admitted to driving within two hours of cannabis consumption at least once in the previous year (Beirness & Porath-Waller, 2015). Among young drivers, driving after using cannabis is more prevalent than driving after drinking alcohol; with 1 in 10 drivers in grades 10 -12 reporting driving within an hour of cannabis use at least once in the past year (Boak et al., 2015). The issue of cannabis impaired driving is particularly of concern for youth, as data indicates that young adults are at highest risk of injury and death from motor vehicle crashes while are also the highest users of cannabis.

In contrast to alcohol, testing for drugged driving is more complicated, inconsistent, and there is not a specific level of cannabis consumption that leads to intoxication. A very real policy challenge therefore is to define a THC level in blood that can define impairment (Room et. al., 2010). Detection of cannabis–impaired driving is further complicated by the fact that cannabis can remain detectable in the blood and urine for days, long after the effects have worn off. Thus even in cases of motor vehicle collisions, the detection of cannabis in body fluids does not necessarily mean that someone was impaired at the time of collision (Hall, 2014; Room et al., 2010).

Brain Development: In addition to the risk of motor vehicle collisions, there is growing evidence that regular cannabis use in adolescence can cause harm to the developing brain. Regular cannabis use beginning in adolescence and continuing through young adulthood appears to produce cognitive impairment, with unclear evidence on whether this impairment is fully reversible (Hall, 2014). Early, regular cannabis use has been associated with low levels of educational attainment, diminished life satisfaction, higher likelihood of developing cannabis use disorder, and increased risk of developing mental health problems (CAMH, 2014). Additionally, some research shows that regular adolescent cannabis users are more likely to use other illicit drugs, although the association is not fully understood (Hall, 2014). Given that a large portion of cannabis users are youth, youth cannabis use is a significant public health concern.

Mental Health: Research has found that individuals who use cannabis, especially frequent and high potency users, are at increased risk for psychosis and psychotic symptoms. Regular cannabis use in adolescence has been associated with increased risk of being diagnosed with schizophrenia (CAMH, 2014, CCSA, 2014).

Dependence: Although much lower than the dependence rates for other drugs (e.g., nicotine, alcohol and cocaine), about 9% of cannabis users develop dependence (CAMH, 2014). Cannabis has remained the third most common identified drug of dependence (behind alcohol and tobacco) in both Canada and the United States over the past 20 years (Hall, 2014). Long term frequent users have higher risk of dependence than those who use occasionally (CAMH, 2014). For Ontario youth, the 2015 OSDUHS survey found that among past year users about 7% of students grade 9-12 report symptoms of dependence.

Pregnancy: THC can pass through the placenta, as does carbon monoxide when cannabis is smoked (CDPHE, 2015). Maternal cannabis use during pregnancy has been shown to modestly reduce birth weight (Hall, 2014). There is also some evidence that cannabis use during pregnancy can affect development and learning skills throughout childhood, including children's cognitive functioning, behaviour, substance misuse and mental health (Porath-Waller, 2015).

Respiratory Problems: Regular cannabis smoking has been associated with respiratory symptoms of chronic bronchitis and reduced lung function (Hall, 2014). Cannabis smoke contains many of the same carcinogens as tobacco smoke. Furthermore, cannabis smokers tend to inhale unfiltered smoke, inhale more deeply and hold smoke in their lungs (Room et al., 2010). While there is some evidence that smoking cannabis can be a risk factor for cancers of the lung and upper respiratory tract, this association remains unclear as many cannabis smokers have also smoked tobacco (Hall, 2014). With regards to second hand cannabis smoke, few studies have been conducted. However, because of the similarities in composition between tobacco and marijuana smoke, marijuana second hand smoke is likely to be a similar public health concern (Springer & Glanz, 2015).

Product quality: The quality of cannabis sold on the illegal market is questionable, however hard to qualify due to lack of testing. There have been accounts of contamination with molds, bacteria and pesticides as well as other contaminants, including other drugs. Unknown contamination is a potential risk for health problems and disease outbreaks. Licenced producers of medical marijuana in Canada are required to grow under strict conditions and batches must be tested for contaminants.

6.2 Indirect Harms

The public health impact of cannabis cannot be fully understood without consideration of the impact of the policies and legal sanctions that have been put in place to manage it. Relative to the health dangers of the drug itself, there has been a growing concern about the disproportionate social harms stemming from its prohibition. A conviction for a marijuana related offence results in a criminal record that can reduce opportunities for education, employment, and travel. From a public health lens, the illegality of cannabis has hindered the ability of health and education professionals to effectively prevent and address problematic use (CAMH, 2014).

The consequences of cannabis criminalization were well described over a decade ago by the Senate Special Committee on Illegal Drugs: "In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed to discrimination by the police and the criminal justice system; society sees the power and wealth of organized crime enhanced as criminals benefit from prohibition; and governments see their ability to prevent at-risk use diminished" (Senate Special Committee on Illegal Drugs, 2002 , p. 42).

The cost to enforce the current cannabis law is significant. In 2002 the estimated annual cost in Canada of enforcing cannabis possession laws, including police, courts and corrections, was 1.2 billion dollars (CAMH, 2014).

The need for a public health approach to the management of cannabis is paramount. A balance between the health risks, social harms and legal ramifications is necessary.

7.0 A Public Health Approach...What Is It?

In May of 2014 the Canadian Public Health Association released a discussion paper entitled "A New Approach to Managing Illegal Psychoactive Substances in Canada", recommending a public health approach as the best alternative to prohibition and criminalization for the management of psychoactive substances.

A public heath approach addresses the public health concerns of cannabis use while aiming to eliminate or reduce the health and social harms resulting from its criminal prohibition.

A public health approach is "based on the principles of social justice, attention to human rights and equity, evidence informed policy and practice, and addressing the underlying determinants of health" (CPHA, 2014, p. 7).

The "Paradox of Prohibition" (Figure 1) provides a visual model demonstrating where a public health approach sits on a continuum of regulatory approaches. It proposes that supply and demand is best controlled and social and health problems are lowest when the extremes of complete prohibition and free market legalization and commercialization are avoided.

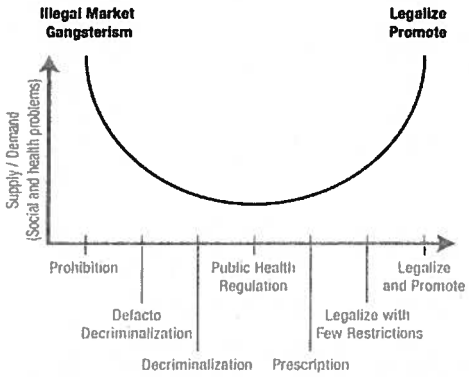

Figure 1: Paradox of Prohibition. Health Officers Council of British Columbia (2011). Reprinted with permission.

Public health approaches to tobacco and alcohol provide supporting evidence of effective strategies that could be applied toward a public health approach to cannabis.

Tobacco is a legal, but extremely harmful substance with no medical benefits, significant health harms, and is the focus of substantial public health efforts and government regulatory control aimed to dissuade consumption and reduce public harms. "Canada has been a world leader with regards to federal legislation about sponsorship restrictions, graphic packaging warnings and banning flavours" (Health Officers Council of BC, 2011, p.47). Provincially, the *Smoke-Free Ontario Act* puts in place many measures related to the sale, promotion and use of tobacco including prohibitions against the sale and supply of tobacco products to persons under the age 19, measures to control advertising such as banning displays, and indoor and outdoor smoking restrictions. Additionally, public health plays a role in tobacco use prevention, screening, brief intervention and cessation support for individuals that use tobacco products. The *Tobacco Tax Act* also provides substantial provincial control around the taxation and regulation of tobacco products from the production of raw leaf tobacco through to the sale of manufactured tobacco products.

Alcohol is legal and widely consumed but with clear evidence of health and social harms. Efforts to mitigate these harms include a combination of provincial and municipal regulatory approaches. These approaches include taxation, government based controls over production and distribution, minimum pricing, age restrictions for purchase, and restrictions retail outlet density and hours of sale. These are policies that have been shown to reduce alcohol related problems when implemented alongside targeted measures such as youth education, drinking and driving countermeasures, promotion of Canada's Low Risk Alcohol Drinking Guidelines, and screening and referral to treatment (Babor et al., 2010; CAMH et al., 2015).

Haden and Emerson (2014) have applied these public health based strategies to describe a public health model of cannabis regulation that incorporates evidence-based strategies from both tobacco and alcohol policy.

8.0 Trends Away From Prohibition

Evidence from other countries' experiences with cannabis policy approaches is incomplete. Furthermore, the policy and regulatory landscape within each jurisdiction is constantly evolving. When looking at the literature and reviewing related commentary, whether or not a certain cannabis policy is presented as a success or failure depends on the perspective of the writer. Outlined below are some of the key characteristics, differences and outcomes from countries that have moved away from a prohibition based approach.

8.1 The Netherlands

In the Netherlands a formal policy of non-enforcement has been in place since 1976 for the possession and sale of small amounts of cannabis. The intent of this policy was to separate cannabis from other hard drug use. Dutch policy and regulations continue to shift in response to emerging evidence related to cannabis, internal and external politics and lessons learned over time (MacCoun, 2011).

- Dutch 'coffeeshops' operate under strict licensing conditions, including age restrictions, limits on per person amounts, a ban on sales of alcohol and other drugs, and regulations related to shop appearance, signage and marketing.

- While purchase and use of cannabis is permitted, production is illegal. Thus, cannabis sold in coffeeshops comes from an illegal and unregulated production system (CCSA, 2014; Roles, 2014).
- There has been success in separating cannabis from the market for other illegal drugs (Room et al., 2010).
- During early commercialization, prior to advertising and age restrictions, there was evidence of more cannabis use by youth and an earlier age of first use. This trend reversed when increased regulations for coffeeshops were implemented in the mid-90's (Room et al., 2010).
- Evidence suggests that prevalence of cannabis use is lower in the Netherlands than in several neighboring countries as well as Canada and the US (MacCoun, 2011).

8.2 Portugal

Portugal decriminalized the possession of all drugs for personal use in 2001 at the same time as a national drug strategy was implemented aimed at providing a more comprehensive and evidence-based approach to drug use. This made possession and acquisition of personal amounts of drugs an administrative offence rather than a criminal offence.

- Offenders are referred to a Commission for the Dissuasion of Drug Addiction (CDT) who provide a range of sanctions ranging from a fines and community service to treatment (Hughes & Stevens, 2010).
- Early evidence suggests small increases in reported illicit substance use by adults, however reductions have been seen in problematic use, adolescent use, substance related harms, and criminal justice system burden (Hughes & Stevens, 2010).

8.3 Uruguay

In 2013 Uruguay became the first country to legalize the personal use and sale of cannabis. The law allows three ways to legally acquire marijuana: self-production of a limited number of plants by registered users, joining a cannabis club, or purchasing at a pharmacy. Households are permitted to grow up to six plants each. As written, the law states that to purchase from a pharmacy, people must be residents of Uruguay age 18 or over, and must be registered with a national database. Marijuana cannot be used in public places (CCSA, 2014). Change of Uruguay government since the law was initially passed has affected the extent and rate of implementation. Information on early outcomes is not readily available.

8.4 United States

While cannabis remains illegal for sale at the US federal level, there are significant differences in cannabis control policy across states. Fifteen states have decriminalized the possession of small amounts for personal use, with Oregon being the first state to do so. In 2012, Colorado and Washington State became the first two states to legalize recreational use of cannabis. Colorado began retail sales in January of 2014, while Washington State did so in July of 2014 (CCSA, Nov 2015). Since then, Alaska, Oregon and the District of Columbia have passed legislation allowing possession and personal use of cannabis for non-therapeutic purposes.

Colorado and Washington State are being looked to as a key source of information regarding legalization of cannabis and the resultant health, social, economic and public safety impacts. The early legalization experiences in these states will be highly informative to the development of Canadian policy. The Canadian Centre on Substance Abuse (CCSA) led a delegation in 2015 to both Colorado and Washington State with the aim to collect evidence to inform Canadian policy. Much of the data needed to evaluate the impact of legalization is not yet available. The CCSA will continue to monitor data from Colorado and Washington as it becomes available (CCSA, Nov 2015).

There are significant differences between how Colorado and Washington is implementing legalized cannabis, particularly related to the scope of government regulation. While Washington has a higher level of regulation, Colorado began with a more free-market approach.

8.4.1 Colorado

- Colorado took 1 year from voted legalization to implementation.
- Licensing body is Colorado Department of Revenue.
- Age restriction is 21 and over.
- Personal production of up to 6 plants permitted that must be in an enclosed locked space.
- Early legalization has been market driven, with new products and commercial branding.

- The extent of the edibles market was unanticipated and has become a large part of the market resulting in the need to address high potencies, child enticing packaging, and overconsumption.
- The Colorado Department of Public Health and the Environment (CDPHE) is responsible for monitoring changes in drug use patterns and health effects of marijuana. The CDPHE is also involved in the development of policies and regulations to protect public health and safety.
- Data on first year patterns of use and health outcomes is extremely limited. However, early data has shown increasing trends of poison centre calls, hospitalizations and emergency room visits possibly related to marijuana, and increase in hospitalization rates for children with possible marijuana exposure.
- The Rocky Mountain High Intensity Drug Trafficking Area (RMHIDTA) is concurrently tracking impact of marijuana legalization. While reported findings have been fairly widely quoted, this data should be interpreted with caution. RMHIDTA is a US Federally funded agency whose stance is to uphold US federal drug policy.

8.4.2 Washington State

- Washington took 18 months from voted legalization to implementation.
- Licensing body is Washington State Liquor and Cannabis Board.
- Age restriction is 21 and over.
- Personal production not permitted.
- In comparison to Colorado, Washington has stricter licensing laws: e.g. growers cannot sell and sellers cannot grow, limits on farm sizes, limited large corporate operations.
- Taxes are higher than in Colorado.
- The Washington State Institute for Public Policy (WSIPP) is responsible for evaluating legalization outcomes under the categories of public health, public safety, youth and adult rates of use and maladaptive use, economic impacts, criminal justice impacts and state and local administrative costs and revenues. While an evaluation plan is in place, initial outcome results are not expected until September 2017 (Darnell, 2015).

8.5 What are Canadians saying?

Canadian public opinion over the past several years has continued to shift away from a prohibitionist approach to cannabis. While there have been many polls, a recent poll conducted by Forum Research specifically surveyed Canadians about a model of cannabis legalization with regulation. According to this poll, 59 percent of Canadians support a change to law that would legalize tax and regulate recreational marijuana usage under some conditions. With regards to manufacturing and distribution if legalized, the largest proportion of respondents (40%) agreed with a model of corporations being licensed to grow marijuana, and sales controlled through government agencies where it could be restricted, regulated and taxed. However, 15% of respondents preferred an individual model where private consumers may grow their own product (Forum Research, 2015).

9.0 Policy Recommendation: A Public Health Approach

Legislative approaches to cannabis fall along a continuum, ranging from criminal prohibition at one end to unrestricted access and free market production at the other. Decriminalization and legalization (see definitions Appendix I) are approaches that have been used in other jurisdictions. The details within each legislative approach can vary widely. Limitations to the decriminalization approach have been previously described: Middlesex London Health Unit Report No. 047-15, July 2015.

The Center for Addiction and Mental Health's *Cannabis Policy Framework* (CAMH, 2014) provides a strong policy framework for cannabis, recommending legalization with strict regulation. The Canadian Centre on Substance Abuse's 2014 policy brief *Marijuana for Non-Therapeutic Purposes* as well as the

recommendations provided in the 2015 report *Cannabis Regulation: Lessons Learned in Colorado and Washington State* should also be considered key documents in the discussion of cannabis policy reform. Middlesex London Health Unit recommends an approach to cannabis policy that is consistent with many elements proposed by CAMH and CCSA. The positions of these organizations and others can be found in Appendix II.

Further, the Colorado Department of Public Health and Environment has developed a public health framework as a model to guide evidence based public health functions and activities including assessment, policy development and assurance (Ghosh et al., 2016).

The Ontario Public Health Standards mandates boards of health to reduce the frequency, severity and impact of substance misuse; with regards to cannabis, criminal prohibition is a barrier to effectively meet these objectives.

In the context of the coming legalization, strict regulation for the non-medical use of cannabis is recommended to best prevent and reduce health and social harms associated with cannabis use. A public health approach to cannabis would combine public education and awareness with regulations for production, distribution, product promotion and sale. This approach acknowledges that cannabis is not a benign substance and that policy built upon evidence is the recommended best approach to minimize the risks and harms associated with use.

9.1 Recommended considerations for public health focused regulations:

- Minimum age for access and use
- Regulations that address public consumption to the same extent as public smoking
- Regulations related to product formats, quality and THC potency
- Limits on marketing and advertising
- Labelling and packaging that clearly indicates dose and potential health harms
- Limit availability through measures including retail outlet density, business licencing, hours of sales
- Pricing and taxation at level that will curb demand while eliminating or minimizing black market access
- Public education about cannabis and potential health harms
- Targeted youth-focused prevention strategies aimed at preventing early use
- Drug –driving countermeasures that prevent and address cannabis impaired driving
- Access to treatment for problematic substance use that incorporates a harm reduction approach

9.2 Additional considerations:

- Sufficient time must be taken to develop regulations and build capacity to implement these regulations, ensure systems are in place to monitor patterns of use and health outcomes, and develop evidence based prevention and harm reduction messaging.
- Flexibility is paramount. Regulations must be responsive to new evidence as it becomes available.
- An incremental approach is warranted. It will take time to ensure that legalization is done well. Prior to full legalization, consideration should be given to the immediate decriminalization of possession of small amounts of cannabis as an interim step to mitigate the unintended health and social consequences of criminalization.
- Canada is a large and diverse country. Geographical, provincial, social, cultural, and other contextual factors must be taken into consideration in the development of Canadian policy.
- Sectors including but not limited to public health, enforcement, substance use, the medical marijuana industry as well as provincial and municipal levels of government should be consulted.
- Management of existing criminal records for cannabis possession should be a priority.
- Attention to unintended negative consequences is important. A health equity lens must be considered for any regulations that are put in place. For example, consequences of regulations that prohibit public consumption of cannabis will be disproportionately born by homeless or unstably housed populations.

- Investment in research and establishing an evidence base with ongoing data collection related to prevalence of use and health effects is paramount.

- Revenue gained through marijuana taxation should go towards education, prevention and treatment programs and relevant research.

In closing, despite prohibition, Canada has one of the highest rates of cannabis use in the world thus requiring a new approach to the issue. A public health approach is needed to minimize the health and social harms of cannabis. Moving forward in a proactive manner in the context of legalization of cannabis possession and use, strict regulations is the most promising approach to minimize harm.

References

Babor, T., Caetano. R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., ... Rossow, I. (2010). *Alcohol no ordinary commodity: Research and public policy.* New York, NY: Oxford University Press.

Boak, A., Hamilton, H.A., Adlaf, E.M. & Mann, R.E. (2015). Drug use among Ontario students, 1977-2015: Detailed OSDUHS findings (CAMH Research Document Series No. 41) Toronto ON: Centre for Addiction and Mental Health. Retrieved from http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Documents/2015%20OSDUHS%20Documents/2015OSDUHS_Detailed_DrugUseReport.pdf

Beirness, D. & Porath-Waller, A. (2015). Clearing the Smoke on Cannabis: Cannabis Use and Driving-An Update. Ottawa: ON: Canadian Centre on Substance Abuse. Retrieved from http://www.ccsa.ca/Resource%20Library/CCSA-Cannabis-Use-and-Driving-Report-2015-en.pdf

Canadian Centre on Substance Abuse (CCSA). (2014). *Marijuana for Non-Therapeutic Purposes: Policy Brief.* Retrieved from http://www.ccsa.ca/Resource%20Library/CCSA-Non-Therapeutic-Marijuana-Policy-Brief-2014-en.pdf

CCSA (2015, April). *Cannabis (Canadian Drug Summary).* Retrieved from http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Drug-Summary-Cannabis-2015-en.pdf

CCSA (2015, November) *Cannabis Regulation: Lessons Learned In Colorado and Washington State.* Retrieved from http://www.ccsa.ca/Resource%20Library/CCSA-Cannabis-Regulation-Lessons-Learned-Report-2015-en.pdf

Canadian Drug Policy Coalition (2015). *Cannabis Policy.* Retrieved from http://drugpolicy.ca/wp-content/uploads/2015/09/CDPC-Cannabis-Brief-Final-Web.pdf

Canadian Public Health Association (CPHA). (2014). *A New Approach to Managing Illegal Psychoactive Substances in Canada.* Retrieved from http://www.cpha.ca/uploads/policy/ips_2014-05-15_e.pdf

Centre for Addiction and Mental Health (CAMH) (2014). *Cannabis Policy Framework.* Retrieved from http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

CAMH et al., (2015). *Why Ontario needs a provincial alcohol strategy.* [News Release] Retrieved from http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/Why_Ontario_needs_an_alcohol_strategy.pdf

Colorado Department of Public Health and Environment (CDPHE). (2015) *Monitoring Health Concerns Related to Marijuana in Colorado: 2014.* Retrieved from http://www2.cde.state.co.us/artemis/hemonos/he1282m332015internet/he1282m332015internet01.pdf

Darnell, A.J. (2015). *I-502 Evaluation Plan and Preliminary Report on Implementation.* Olympia: Washington State Institute of Public Policy. Retrieved from http://www.wsipp.wa.gov/Reports/570

Forum Research (2015, December) *One fifth use marijuana now.* [News Release] Retrieved from http://poll.forumresearch.com/post/2438/most-want-it-grown-sold-through-government-agencies/

Ghosh, T., Van Dyke, M., Maffey, A., Whitley, E., Gillim-Ross, L., Wolk. L. (2016) The public health framework of legalized marijuana in Colorado. *American Journal of Public Health* 106(1) 21-27. Retrieved from http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2015.302875

Haden, M. & Emerson, B. (2014) A vision for cannabis regulation: A public health approach based on lessons learned from the regulation of alcohol and tobacco. *Open Medicine,* 8(2) Retrieved from http://www.openmedicine.ca/article/view/630/552

Hall, W. (2014). What has research over the past two decades revealed about the adverse health effects of recreational cannabis use? *Addiction,* 110, 19-35

Health Canada. (2014). *Canadian Alcohol and Drug Use Monitoring Survey (CADUMS): Summary results for 2012.* Ottawa, Ontario: Health Canada. Retrieved from http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2012/summary-sommaire-eng.php#s2

Health Canada. (2015). *Authorized Licensed Producers under the Marihuana for Medical Purposes Regulations.* Retrieved from http://www.hc-sc.gc.ca/dhp-mps/marihuana/info/list-eng.php

Health Canada. (2015, April 29). *Medical Use of Marijuana.* Retrieved from http://www.hc-sc.gc.ca/dhp-mps/marihuana/index-eng.php

Health Officers Council of British Columbia. (2011). *Public Health Perspectives for Regulating Psychoactive Substances.* Retrieved from http://drugpolicy.ca/wp-content/uploads/2011/12/Regulated-models-Final-Nov-2011.pdf

Hughes, C.K. & Stevens, A. (2010). What can we learn from the Portuguese decriminalization of illicit drugs? *British Journal of Criminology,* 50, 999-1022.

Hughes, C.K. & Stevens, A. (2012). A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of illicit drugs. *Drug and Alcohol Review,* 31, 101-113.

Kalant, H. & Porath-Waller, A. (2014). *Clearing the smoke on cannabis – Medicinal use of cannabis and cannabinoids.* Ottawa: ON: Canadian Centre on Substance Abuse. Retrieved from http://www.ccsa.ca/Resource%20Library/CCSA-Medical-Use-of-Cannabis-2012-en.pdf

MacCoun, R.J. (2011). What can we learn from the Dutch cannabis coffeeshop system? *Addiction,* 106, 1899–1910

Monte, A., Zane, R. & Heard, K (2015). The implications of marijuana legalization in Colorado. *Journal of the American Medical Association,* 313(3), 241-242.

Ontario Public Health Working Group (2004). *Marijuana: A public health perspective. A position paper submitted to the Ontario Public Health Association.*

Porath-Waller, A. (2015). *Clearing the smoke on cannabis – Maternal cannabis use during pregnancy.* Ottawa: ON: Canadian Centre on Substance Abuse. Retrieved from http://www.ccsa.ca/Eng/topics/Marijuana/Marijuana-Research/Pages/default.aspx

Roles, S. (2014). *Cannabis policy in the Netherlands: moving forwards not backwards.* Transform Drug Policy Foundation. Retrieved from http://www.tdpf.org.uk/blog/cannabis-policy-netherlands-moving-forwards-not-backwards

Room, R., Fischer, B., Hall, W., Lenton, S., Reuter, P. (2010). *Cannabis Policy: Moving Beyond Stalemate.* Oxford: Oxford University Press

Springer, M.L. & Glanz, S.A. (2015). *Marijuana Use and Heart Disease: Potential Effects of Public Exposure to Smoke.* San Francisco: University of California. Retrieved from https://tobacco.ucsf.edu/sites/tobacco.ucsf.edu/files/u795/MSHS%20fact%20sheet(2)CA%204-13-15.pdf

The Senate Special Committee in Illegal Drugs (May 2002). *Discussion Paper on Cannabis.* Retrieved from http://www.parl.gc.ca/Content/SEN/Committee/371/ille/library/discussion-e.pdf

Appendix I - Glossary of Terms

Cannabis: Cannabis, more commonly called marijuana, is the dried flowers, fruiting tops and leaves of the cannabis plant, most frequently, Cannabis sativa (CCSA, 2015).

Criminalization: The production, distribution and possession of cannabis are subject to criminal justice sanctions ranging from fines to incarceration. Conviction results in a criminal record. (CCSA, Nov 2015)

Decriminalization: Non-criminal penalties, for example, civil sanctions such as tickets or fines, replace criminal penalties for personal possession. Individuals charged will not, in most cases, receive a criminal record. Most decriminalization models retain criminal sanctions for larger-scale production and distribution. (CCSA, Nov 2015). Decriminalization still leaves cannabis in an unregulated market of producers and sellers (Canadian Drug Policy Coalition, 2015).

Legalization: Criminal sanctions are removed. The substance is generally still subject to regulation that imposes guidelines and restrictions on use, production and distribution, similar to the regulation of alcohol and tobacco. (CCSA, Nov 2015)

Psychoactive Substance: A name given to a classification of substances that affect mental processes such as mood, sensations of pain and pleasure, motivation, cognition and other mental functions (CPHA, 2014).

Public Health Approach: "A public health approach ensures that a continuum of interventions, policies, and programs are implemented that are attentive to the potential benefits and harms of substances as well as the unintended effects of the policies and laws implemented to manage them...ensuring that the harms associated with interventions are not disproportionate to the harms of the substances themselves" (CPHA, 2014, p, 7).

Regulation: Regulation refers broadly to the legislative or regulatory controls in place with regard to the production, distribution and possession of cannabis. The term is, however, increasingly being used in reference to the guidelines and restrictions on use, production and distribution of cannabis under legalization approaches. (CCSA, Nov 2015)

Appendix II – Positions of Others

CAMH: CAMH recommends legalization with strict regulation, offering 10 basic principles to guide regulation of legal cannabis use.

CCSA: "CCSA promotes a national, evidence-informed, multi-sectoral dialogue to develop policy options that will reduce the negative criminal justice, social, and health impacts of marijuana use in Canada. Changes to marijuana policy should be made based on the principles of applying available evidence, reducing harms, promoting public health and equitable application of the law. Based on the evidence available, decriminalization provides an opportunity to reduce enforcement-related health and social harms without significantly increasing rates of marijuana use. This option also provides the opportunity to further investigate and learn from alternative models such as the legalization approaches being implemented internationally" (CCSA, Oct 2014).

CPHA: CPHA endorses a public health approach to the management of illegal psychoactive substances. They have no formal stance specific to cannabis, however endorse Low Risk Cannabis Use Guidelines and support "comprehensive approaches to addressing the use of psychoactive substance based on an accurate assessment and evaluation of the benefits and risks, with an appropriate balance and integration of the four pillars of prevention, harm reduction, treatment, and enforcement, and also needs to include adequate investments in health promotion, education, health protection, discrimination reduction, rehabilitation, research, and monitoring trends; and a public health approach to problematic substance use be central to the development and implementation of a proposed national framework for action on substance use and abuse in Canada."

Canadian Association of Chiefs of Police (CACP) Resolution #03-2013: Does not support the decriminalization or legalization of cannabis in Canada. Rather propose an amendment to the *Controlled Drug and Substances Act* and the *Contraventions Act* in order to provide officers with the discretionary option of issuing a ticket for simple possession (30 grams or less of cannabis marihuana or 1g or less of cannabis resin (CACP, 2013).

Strengthening Ontario's Smoking and Vaping Laws

Proposed changes to regulations made under the *Smoke-Free Ontario Act* and *Electronic Cigarettes Act, 2015*

Public Consultation Paper
March 10, 2016

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Purpose

This consultation paper aims to solicit feedback from businesses, retailers, employers, health care facilities, public health experts, medical marijuana users, physicians, medical organizations, and the general public on the impacts of the Ministry of Health and Long-Term Care's proposal to strengthen Ontario's smoking and e-cigarette (vaping) laws.

This paper outlines the ministry's proposal to make changes to Ontario's smoking and vaping laws that would restrict where people can smoke medical marijuana and vape an e-cigarette, where e-cigarettes can be sold, and how e-cigarettes can be displayed and promoted.

Feedback

Your feedback and comments will inform the development of proposed amendments to Ontario Regulation 48/06[1] made under the *Smoke-Free Ontario Act* (SFOA)[2] and Ontario Regulation 337/15[3] made under the *Electronic Cigarettes Act, 2015* (ECA)[4].

Comments on this public consultation paper are welcome until **April 24, 2016** and can be provided in three different ways:

- Complete the Response Form provided on the Regulatory Registry in connection with this paper at http://www.ontariocanada.com/registry.

- Email comments directly to SFOA-ECA-Consultations@ontario.ca quoting this paper "Strengthening Ontario's Smoking and Vaping Laws"

- Mail comments to:

  Population and Public Health Division
  Ministry of Health and Long-Term Care
  777 Bay Street, Suite 1903, 19th Floor
  Toronto, ON M7A 1S5

Please note that all comments received from organizations, including individuals indicating an affiliation with an organization, will be considered public information and may be used and disclosed by the ministry to help in developing its final proposal.

[1] Ontario Regulation 48/06 made under the *Smoke-Free Ontario Act* can be found here - https://www.ontario.ca/laws/regulation/060048
[2] The *Smoke-Free Ontario Act* can be found here - https://www.ontario.ca/laws/statute/94t10
[3] Ontario Regulation 337/15 made under the *Electronic Cigarettes Act, 2015* can be found here: https://www.ontario.ca/laws/regulation/150337
[4] The *Electronic Cigarettes Act, 2015* can be found here - https://www.ontario.ca/laws/statute/15e07

Comments from individuals who do not indicate an affiliation will also be considered public and will be used and disclosed by the ministry to help in developing its final proposal. However, any personal information, such as names or contact details, would be removed prior to disclosure of the comments.

Summary

The Ministry of Health and Long-Term Care (the "ministry") is committed to improving the health and wellness of Ontarians. In May 2015, the *Making Healthier Choices Act, 2015*[5] received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, and increasing the maximum fines for youth-related sales offences. The *Making Healthier Choices Act, 2015* also created new legislation - the *Electronic Cigarettes Act, 2015* – to regulate the sale, use, display, and promotion of e-cigarettes.

On January 1, 2016, provisions in the *Electronic Cigarettes Act, 2015* came into force, which prohibit the sale or supply of e-cigarettes to persons who are less than 19 years old.

The ministry is considering further legislative and regulatory amendments that would strengthen smoking and e-cigarettes laws. This proposal is outlined below:

1. Expand "no smoking rules" to apply to medical marijuana;
2. Prohibit the use of e-cigarettes - including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of "e-cigarette" to include "e-substance";
5. Expand the list of places where e-cigarettes are prohibited for sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

If approved, this proposal would have a variety of impacts on the public, businesses and employers in Ontario. The ministry is interested in hearing from stakeholders about these impacts, and welcomes continued input.

[5] The *Making Healthier Choices Act, 2015* can be found here - http://www.ontla.on.ca/bills/bills-files/41_Parliament/Session1/b045ra.pdf

Background

Electronic cigarettes

E-cigarettes are an emerging trend in Ontario. Concerns have been raised about the potential negative health effect of e-cigarettes. The World Health Organization recommends taking precautionary action on e-cigarettes, and jurisdictions around the world have put into place restrictions to protect people from potential health impacts. In Ontario, the government has also taken precautionary measures to protect people, especially youth, from exposure to e-cigarettes and potential harms through restrictions on e-cigarette sales to minors, restrictions on where e-cigarettes can be used, restrictions on where e-cigarettes can be sold, and restrictions on how they can be displayed and promoted in stores.

Medical marijuana

Possession of marijuana is a criminal offence under the federal *Controlled Drugs and Substances Act*. However, the federal government provides access to a legal source of marijuana for medical purposes under its *Marihuana for Medical Purposes Regulations* (MMPR) made under the *Controlled Drugs and Substances Act*. Health Canada has not approved marijuana as a therapeutic product.

In order to obtain marijuana for medical purposes, a person must have a medical document from a physician and obtain medical marijuana from a licensed producer. As of September 2015, there are just over 30,000 clients in Canada who were registered with licensed producers of marijuana under federal regulation.

Evidence about the use, forms, and effectiveness of medical marijuana is still evolving. Although methods of consuming marijuana are also rapidly evolving, smoking is the most common form of consumption[6]. People can also consume medical marijuana using a vaporizer, which is considered an "e-cigarette" under the *Electronic Cigarettes Act, 2015.*

While there are some laws that impact where a medical marijuana user may smoke, vape, or ingest marijuana for medical purposes, such as the *Liquor Licence Act* and driving laws, they do not address the specific forms of smoking or vaping in public places.

Proposal

The following summary outlines and explains the proposed rules to strengthen smoking and e-cigarette laws in Ontario. The ministry is soliciting feedback on how these rules

[6] Canadian Centre on Substance Abuse. "Clearing the Smoke on Cannabis: Respiratory Effects of Cannabis Smoking." J. Diplock and D. Plecas. 2015

would affect you and how they can be improved to protect the health of Ontarians. Note that the final regulation may be different from what is in this proposal.

1. Expand no smoking rules to apply to medical marijuana

Issue

Ontario's *Smoke-Free Ontario Act* (SFOA) currently only applies to tobacco. It includes prohibitions on the smoking of tobacco in all enclosed public spaces and enclosed workplaces (including movie theatres and restaurants) and a number of outdoor public spaces (including playgrounds, restaurant/bar patios). It does not address the smoking of marijuana or other substances.

There are few laws, such as liquor license and driving laws, which address where a medical marijuana user may smoke, vape, or ingest marijuana for medical purposes.

Proposed approach

The ministry is proposing to amend the SFOA and Ontario Regulation 48/06 made under the SFOA to establish that the "no smoking" rules apply to medical marijuana. This would provide reasonable and precautionary safeguards to employees, customers and bystanders from exposure to medical marijuana smoke.

This would mean that smoking medical marijuana would be illegal in the following locations in which the smoking of tobacco is prohibited:

- Enclosed public places (e.g. shopping malls, theatres, schools)
- Enclosed workplaces (e.g. retail stores, office buildings, factories)
- Schools and school grounds
- Common areas in condominiums, apartment buildings and university/college campuses
- Child care centres within the meaning of *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present
- Reserved seating areas of outdoor sports or entertainment venues
- Motor vehicles while another person who is less than 16 years old is present
- Restaurant and bar patios
- Sheltered areas with a roof and more than two walls
- Children's playgrounds
- Publicly owned sporting areas
- Nine meters from any entrance or exit of a public hospital, private hospital, psychiatric facility, long-term care home, and independent health facility

- Outdoor grounds of public hospitals, private hospitals and psychiatric facilities
- Outdoor grounds of certain government of Ontario office buildings

However, under the proposal, a specific exemption would permit smoking medical marijuana in:

- Scientific research and testing facilities;

Other exemptions in the SFOA for smoking tobacco would not apply to medical marijuana, i.e. designated guest rooms in hotels, motels and inns, controlled smoking areas in residential care facilities (e.g. long-term care homes), and traditional use of tobacco by Aboriginal persons.

The proposal, if approved and implemented, would continue to be enforced by inspectors appointed under the SFOA. These inspectors are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, employees, businesses, retailers, employers, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
  Do you have specific suggestions to improve this proposal?

2. Prohibit the use of e-cigarettes - including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes –in all enclosed public places, enclosed workplaces, and other specified outdoor areas

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* and its regulation contain provisions that would prohibit the use of e-cigarettes (i.e. vaping) in enclosed workplaces, enclosed public places and a number of other prescribed places (e.g. restaurant and bar patios, playgrounds).

E-cigarettes are a relatively new and quickly evolving technology; the evidence concerning their potential health effects and implications for tobacco control efforts is in its early stages. The restrictions under the *Electronic Cigarettes Act, 2015* ensure that Ontarians are protected from the potential harms that vapour exposure could have on their health.

Vaporizers, which are considered e-cigarettes under the *Electronic Cigarettes Act, 2015*, can be used to consume medical marijuana. The current regulation, Ontario

Regulation 337/15, made under the ECA (which is not yet in force) includes an exemption for medical marijuana users, which would permit them to use an e-cigarette for medical marijuana in places where vaping is otherwise prohibited.

Proposed Approach

The ministry is proposing that vaping be prohibited in enclosed workplaces, enclosed public places, and other prescribed places. This would protect employees, customers and bystanders from any potential harms associated with exposure to e-cigarettes – no matter the substance being vaped. This proposal would require a change to the regulation.

This would mean that using an e-cigarette (vaping), including the use of a vaporizer to consume medical marijuana, would be prohibited in the following places:

- Enclosed public places (e.g. shopping malls, theatres, schools)
- Enclosed workplaces (e.g. retail stores, office buildings, factories)
- Schools and school grounds
- Common areas in condominiums, apartment buildings and university/college campuses
- Child care centres within the meaning of *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present
- Reserved seating areas of outdoor sports or entertainment venues
- Motor vehicles while another person who is less than 16 years old is present
- Restaurant and bar patios
- Sheltered areas with a roof and more than two walls
- Children's playgrounds
- Publicly owned sporting areas
- Nine meters from any entrance or exit of a public hospital, private hospital, psychiatric facility, long-term care home, and independent health facility
- Outdoor grounds of public hospitals, private hospitals and psychiatric facilities
- Outdoor grounds of certain government of Ontario office buildings

However, under this proposal, specific exemptions for e-cigarettes would permit e-cigarette use/vaping, including the use of a vaporizer to consume medical marijuana, in the following places:

- Scientific research and testing facilities;
- Designated outdoor areas on hospital grounds and on the grounds of specific government of Ontario office properties (to be phased out by January 1, 2018).

The exemption permitting the use of e-cigarettes in theatrical stage productions under specified conditions, would not apply to vaping medical marijuana.

Note that under the ministry's proposal, there would not be an exemption to permit testing/sampling of e-cigarette devices or products in stores that sell e-cigarettes. Under this proposal, e-cigarette use inside stores would be prohibited, as stores are considered enclosed workplaces and enclosed public places. However, stores could continue to be able to display, promote and provide informational material about e-cigarettes under conditions that protect children and youth from exposure. (More details are provided under issue 6, with regard to Display and Promotion.)

The proposal, if approved and implemented, would be enforced by inspectors appointed under the ECA. These inspectors are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, employees, businesses, retailers, employers, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes

Issue

As of January 1, 2016, Ontario's *Electronic Cigarettes Act, 2015* prohibits the sale or supply e-cigarettes to a person who is less than 19 years old. It also prohibits the sale or supply of e-cigarettes to a person who appears to be less than 25 years old without asking the person for identification and being satisfied that the person is at least 19 years old.

Vaporizers, which are considered e-cigarettes under the *Electronic Cigarettes Act, 2015*, can be used to consume medical marijuana. The current regulation (which is not yet in force) made under the *Electronic Cigarettes Act, 2015* includes an exemption for medical marijuana users and would permit a minor to buy or obtain an e-cigarette for medical marijuana purposes.

Proposed approach

The ministry is proposing to change the regulation to specify that a parent, guardian or caregiver would be permitted to *supply* (but not sell) an e-cigarette to a minor to consume medical marijuana, if the minor is authorized to possess medical marijuana under federal law.

As noted above, the ECA is enforced by inspectors appointed under the Act, who are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, medical marijuana licensed producers, parents, guardians, caregivers, health care providers, physicians, hospitals, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

4. Expand the definition of "e-cigarette" to include "e-substance"

Issue

As of January 1, 2016, Ontario's *Electronic Cigarettes Act, 2015* prohibits the sale or supply e-cigarettes to a person who is under 19 years old and to a person who appears to be less than 25 years old without proof of identification. The ECA also contains provisions, which are not yet in force, which would restrict the display and promotion of e-cigarettes in places where they are sold.

Under the ECA,

"electronic cigarette" means any of the following:

1. A vaporizer or inhalant-type device, whether called an electronic cigarette or any other name, that contains a power source and heating element designed to heat a substance and produce a vapour intended to be inhaled by the user of the device directly through the mouth, whether or not the vapour contains nicotine.
2. A component of a device described in paragraph 1
3. Any other prescribed device or product.

The current definition of e-cigarette is a device designed to heat a substance. There is some confusion around whether the substance being heated in an e-cigarette (e.g. e-liquid) is a component of the device, and whether or not the substance is covered by the Act's restrictions on selling, displaying and promoting e-cigarettes.

Proposed approach

The ministry is proposing to clarify by regulation that the definition of "electronic cigarette" in the ECA includes "e-substance"; i.e. any substance manufactured or sold for use in an e-cigarette device (e.g. e-liquid).

This would mean that businesses selling e-cigarettes would not be able to sell or supply an e-substance to a minor. In addition, businesses would not be able to display and promote e-substances, except under certain circumstances (see Issue 6 "Prescribe conditions under which a business selling e-cigarettes could display or promote products").

As noted above, the *Electronic Cigarettes Act, 2015* is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on businesses that sell e-cigarettes or any substance meant to be used in an e-cigarette, as well as on e-cigarette users and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

5. Expand the list of places where e-cigarettes are prohibited from sale

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* contains provisions that would prohibit the sale of electronic cigarettes in public hospitals, private hospitals, psychiatric facilities, long-term care homes, pharmacies, and grocery stores containing pharmacies. Ontario's *Smoke-Free Ontario Act* also prohibits the sale of tobacco in these places.

However, the *Smoke-Free Ontario Act* also prohibits the sale of tobacco in additional places set out in regulation, such as post-secondary institution campuses, independent health facilities, schools and school grounds (including private schools), child care centres, places where home child care is provided, and certain Government of Ontario office buildings.

Proposed approach

To ensure comparable rules for where tobacco and e-cigarettes may be sold, the ministry is proposing to prescribe the following additional places as places where e-cigarettes cannot be sold:

- Independent health facilities
- Schools and school grounds, including private schools
- Campuses of post-secondary institutions including universities and colleges,
- Child care centres within the meaning of the *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present.
- Certain office buildings owned by the Government of Ontario and prescribed in the regulation under the *Smoke-Free Ontario Act*.

As noted above, the ECA is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on e-cigarette users, e-cigarette retailers, schools, colleges, universities, businesses, health care providers, physicians, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* contains provisions that would:

- prohibit the display of e-cigarettes in a way that would permit a consumer to view or handle an e-cigarette before purchasing it in a store; and
- prohibit the promotion of e-cigarettes at places where e-cigarettes or tobacco products are sold or offered for sale.

These restrictions would protect the well-being of children and youth by limiting their exposure to e-cigarette products.

Proposed approach

The ministry is proposing to permit certain signs/documents to be made available to inform the public that they have e-cigarettes for sale, and educate customers about the types of e-cigarettes available for sale and how to use them.

Signs/documents would need to meet the following conditions:

- A maximum of three (3) signs referring to e-cigarettes and/or e-cigarette product accessories. These signs must:
  - not exceed 968 square centimeters;
  - have a white background with black text;
  - not provide any information about a brand of e-cigarette (including its components and e-substances).
- Documents listing brands, specifications, instructions, or other details about products available for sale, could only be made available for viewing:
  - inside the store;
  - to adults over 19 years of age

The ministry is also proposing to permit the display and promotion of e-cigarette products (but not the testing or sampling of e-cigarettes) in places where they are sold, provided that the following conditions are met:

- Owner must inform its local public health unit in writing that it wishes to operate under the exemption;
- Products and promotional material must not be visible from the outside of the store;
- Individuals under the age of 19 would not be permitted to enter the shop;
- Customers could only access the store from outdoors or from areas in an enclosed shopping mall;
- Store could not be a thoroughfare (e.g. kiosk in a mall corridor).

As noted above, the ECA is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on e-cigarette users, e-cigarette retailers, distributors, manufacturers, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

Peterborough County-City
HEALTH UNIT
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April 28, 2016

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
ehoskins.mpp@liberal.ola.org

Dear Minister Hoskins,

Re: Environmental Health Program Funding

At its meeting held on April 13, 2016, the Board of Health for the Peterborough County-City Health Unit considered correspondence from the North Bay Parry Sound District Health Unit regarding the above noted matter.

The Board echoes the recommendations outlined in their resolution (attached), and appreciates your attention to this important public health issue.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and
Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes-Brock
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Medical Officers of Health
Ontario Boards of Health

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North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
in your community . . . here for your health
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70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
myhealthunit.ca TOLL FREE 1 800 563 2808

February 22, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, *the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and*

Whereas, *the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and*

Whereas, *the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and*

Whereas, *recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and*

Whereas, *in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and*

Whereas, *the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and*

Whereas, *in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and*

Whereas, *in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and*

Whereas, *recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any support for staff training,*

Now Therefore Be It Resolved, *that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:*

1) *Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;*

2) *Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;*

3) *Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and*

4) *Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.*

Furthermore Be It Resolved, *that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.*

Sincerely,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)

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May 3, 2016

The Honourable Dr. Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins,

The Board of Health for the District of Algoma recently received a staff report regarding the Herpes Zoster Vaccine. We note the February 25th letter from The Board of Health for Peterborough County-City Health Unit to you requesting the addition of the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults. We also note the statement in the Ontario 2016 Budget that "The government is making the shingles vaccine free for eligible Ontario seniors between the ages of 65 and 70 — saving them about $170 and reducing emergency room visits and hospitalizations."

We commend your government on adding the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults and look forward to the speedy implementation of this new cost-effective initiative which will benefit thousands of Ontario senior citizens.

Sincerely,

Lee Mason

Mr. Lee Mason,
Chair, Algoma Public Health

cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Hon. David Orazietti, M.P.P.
Ontario Boards of Health
Linda Stewart, Association of Local Public Health Agencies

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Peterborough County-City
HEALTH UNIT
...because health matters!

April 27, 2016

The Hon. Jane Philpott
70 Colombine Driveway,
Tunney's Pasture
Postal Location: 0906C
Ottawa, ON K1A 0K9
Hon.Jane.Philpott@Canada.ca

Dear Minister Philpott:

On behalf of the Board of Health for the Peterborough County-City Health Unit, I am writing to express our concern about formula industry violations of the *International Code of Marketing of Breastmilk Substitute* (the Code), and to request that your government advocate for legislation of the Code in Canada.

The aim of the Code is to protect optimal health outcomes for infants through breastfeeding, and support appropriate use of breastmilk substitutes (i.e., baby formula). The Code focuses attention on how the infant formula industry influences consumers to support the use of breastmilk substitutes, thereby undermining maternal and child health. Violations of the Code in Canada are rampant, and easily spotted: targeting women purchasing maternity wear; advertisements in pregnancy and parenting magazines; invitations to mothers to sign up for "baby clubs" from which they receive free samples or coupons for formula. Even more concerning are Code violations through the health care system, including provision of free formula to health care facilities.

Our public health agency is committed to protecting and supporting breastfeeding as outlined in the Ontario Public Health Standards, and has achieved the World Health Organization's *Baby Friendly* designation, a best practice in infant feeding. Despite this commitment, local surveillance data indicates that while more than 90% of local mothers initiate breastfeeding, more than half of all local babies have received at least one formula supplement by the time they are two weeks old. These statistics speak to the normalization of formula feeding, and the effectiveness of the industry in undermining a mother's intention to breastfeed.

Despite Canada's adoption of the Code, there is currently no legislation in place to ensure that industry complies with the Code provisions. Such legislation would be an asset, given the important role of breastfeeding in maternal and child health, and the inability of industry to voluntarily adhere to this ethical framework.

Jackson Square, 185 King Street, Peterborough, ON K9J 2R8 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

In closing, I ask that Canada's commitment to maternal and child health, and the Code be honoured by legislation of the Code in Canada.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

cc: The Right Hon. Justin Trudeau, Prime Minister of Canada
Dr. Gregory W. Taylor, Chief Public Health Officer, Public Health Agency of Canada
Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

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Matthew L. Gaskell
Commissioner of Corporate Services

April 29, 2016

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

COPY

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated April 7, 2016 re: Invasive Personal Services Settings (PSS) (Our File No. P00)

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on April 27, 2016, Council adopted the following recommendations of the Committee:

A) That the correspondence of Haliburton, Kawartha, Pine Ridge District's (HKPRD's) Board Chair urging the Ontario government to enact legislation for infection prevention and control requirements for invasive Personal Services Settings (PSS) under the *Health Protection and Promotion Act* and *Provincial Offences Act* be endorsed; and

B) That the Premier of Ontario, Minister of Health and Long-Term Care, Durham's MPP's, Leaders of the Opposition and NDP, Chief Medical Officer of Health and all Ontario boards of health be so advised.

Attached is a copy of the Memorandum from Dr. Robert Kyle, Commissioner and Medical Officer of Health dated April 7, 2016 regarding Invasive Personal Services Settings (PSS).

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

"Service Excellence for our Communities"

If this information is required in an accessible format, please contact the Accessibility Co-ordinator at 1-800-372-1102 ext. 2009.

c: The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP, (Pickering/ Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
The Honourable Rona Ambrose, Leader of the Conservative Party of Canada
The Honourable Tom Mulcair, Leader of the New Democratic Party
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

DURHAM REGION

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unicipality
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Accredited
blic Health Agency

MEMORANDUM

To: Health & Social Services Committee

From: Dr. Robert Kyle

Date: April 7, 2016

Re: Invasive Personal Services Settings (PSS)

On January 21, 2016, Haliburton, Kawartha, Pine Ridge District's (HKPRD's) Board Chair sent the attached correspondence to all Ontario boards of health for support (Appendix A).

In essence, the correspondence urges the Ontario government to enact legislation for infection prevention and control requirements for invasive PSS under the *Health Protection and Promotion Act* and *Provincial Offences Act*.

On March 9, 2016, Regional Council passed By-law #17-16 that authorizes *Know Before You Go,* the Region's PSS inspection disclosure program, which regulates invasive PSS. However, unlike single-tier and regional governments which serve as boards of health and have by-law making authority, most independent boards of health do not have the ability to pass such by-laws, hence, provincial legislation needs to be enacted.

Accordingly, I recommend that the Health & Social Services Committee recommends to the Regional Council that:

a) The correspondence of HKPRD's Board Chair respecting invasive PSS is endorsed; and

b) The Premier of Ontario, Minister of Health and Long-Term Care, Durham's MPPs, Leaders of the Opposition and NDP, Chief Medical Officer of Health and all Ontario boards of health are so advised.

Respectfully submitted,

Dr. Robert Kyle

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT
HEALTH UNIT

1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

21 January 2016

The Hon. Kathleen Wynne
Premier of Ontario
Legislative Building - Queen's Park
Toronto ON M7A 1A1

Re: Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings under the *Health Protection and Promotion Act*

Dear Premier Wynne

Ontario has no legislation regulating infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS). The PSS Protocol under Ontario Public Health Standards (OPHS) govern the activities of Public Health Units regarding PSS infection control such as causing one inspection per year for invasive services which is the same frequency for non-invasive PSS such as a hair salon.

Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities. Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease.

Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place. The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit views the importance of public health regulations to minimize the risk of blood-borne disease transmission from invasive personal service settings.

The Haliburton, Kawartha, Pine Ridge District Board of Health therefore urges the Government of Ontario to enact legislation for infection prevention and control requirements for invasive PSS under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act*.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT HEALTH UNIT

Mark Lovshin
Board of Health Chair

.../2

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Encl. 2

Cc:

The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Ms. Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Mr. Lou Rinaldi, MPP, Northumberland-Quinte West
Mr. Patrick Brown, MPP, Simcoe North – Leader of the Progressive Conservative Party of Ontario
Ms. Andrea Horwath, MPP, Hamilton Centre – Leader of the New Democratic Party of Ontario
Dr. David Williams, Chief Medical Officer of Health
Board of Health Chairs
Association of Local Public Health Agencies

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT BOARD OF HEALTH RESOLUTION

TITLE: Enactment of Legislation to enforce infection prevention and control practices within invasive Personal Service Settings (PSS) under the *Health Protection and Promotion Act.*

SPONSOR: Haliburton, Kawartha, Pine Ridge District Health Unit

WHEREAS Ontario has no legislation governing infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS); and

WHEREAS The Personal Service Setting Protocol under the *Ontario Public Health Standards* (OPHS) governs the activities of public health units regarding PSS infection control; and

WHEREAS The OPHS mandate one inspection per year for invasive personal service settings, which is the same frequency for non-invasive PSS such as a hair salon; and

WHEREAS Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities; and

WHEREAS Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease; and

WHEREAS Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place.

NOW THEREFORE BE IT RESOLVED that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests the Government of Ontario to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act.*

AND FURTHER that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests that the Association of Local Public Health Agencies advocate to the Premier of Ontario and the Minister of Health and Long-Term Care, to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act.*

Haliburton, Kawartha, Pine Ridge Health Unit

21 January 2016

Backgrounder – Resolution for Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings under the Health Protection and Promotion Act

Public Health Inspectors report an increase in the number of tattoo shops opening for business since the spring. Two shops in Bobcaygeon, one in Fenelon Falls and one in Minden have opened within a few months of each other.

Public health inspectors in accordance with best practice inspect these shops without provincial legislation outlining legal requirements for infection control needs and operator responsibility.

Infection control practices are major components of assessing a tattoo shops to reduce transmission risks of blood-borne disease. Invasive personal services setting such as tattoo shops require extra attention and time for Public Health Inspectors to mitigate risk to the public by ensuring operators have adequate infection control practices in place.

Ontario has no legislation governing infection control practices within invasive Personal Service Settings. The Ontario Public Health Standards mandate one inspection per year in invasive Personal Service Settings, which is similar to that for a hair salon.

Recommendations

1. That the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit urges the Government of Ontario to move forward with the development and implementation of Legislation for infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act*; and

2. That the Board of Health of the Haliburton, Kawartha, Pine Ridge District Health Unit advises the Premier of Ontario of this recommendation, and copies the Minister of Health and Long-Term Care, Leaders of the Opposition Parties, and the MPPs of Northumberland County, City of Kawartha Lakes and Haliburton County; and

3. That the Board of Health of the Haliburton, Kawartha, Pine Ridge District Health Unit recommends to the delegates of the 2016 Association of Local Public Health Agencies that its resolution regarding the enactment of legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion* Act with a suitable enforcement program such as short-form wording under the Provincial *Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act* be endorsed.

alPHa
Association of Local
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April 28, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

Thank you for your letter dated April 20, 2016. I am pleased to note that we are in agreement about the positive contributions local public health units can make in working with Local Health Integration Networks (LHINs) to facilitate and support better health and wellness outcomes for all Ontarians.

From a public health perspective, we appreciate the direction to expand the focus of LHIN planning to include population health. However, as we noted in our letter to you dated February 29, 2016, LHINs are one of the many partners with whom public health works to keep people healthy. In the absence of more detailed information, we remain concerned about the form that "integration" and "formal linkages" may take.

We wish to reiterate that alPHa's member Medical Officers of Health, Boards of Health and Affiliate organizations are concerned that some of the *Patients First* proposals regarding local public health may have unintended consequences. These consequences include an erosion of the public health system's capacity to improve the health of Ontarians through our intersectoral work on the determinants of health. We also reiterate alPHa's position, based on experience in jurisdictions elsewhere that the aims of public health are best served by Boards of Health that are truly independent, with funding and accountability flowing directly from the Ministry. alPHa's concerns are more fully expressed in our attached letter and your office has received numerous letters and resolutions from individual Boards of Health expressing similar concerns.

We are committed to finding win-wins so that Ontarians can continue to benefit from a strong and effective public health system while knowing that a quality health care system is there for them when they need it.

Sincerely,

Jaeger

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister of Health and Long-Term Care
Nancy Naylor, Associate Deputy Minister of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Board of Health Chairs
Medical Officers of Health
Ontario MPPs

Attachment

alPHa
Association of Local
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February 29, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations, the Association of Local Public Health Agencies (alPHa) is pleased to provide comment on the Ministry of Health and Long-Term Care discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. We received and reviewed the paper with much interest and anticipation. There is much to consider from a local public health perspective. We offer our preliminary comments herein and will be very pleased to engage further as the government's work progresses to strengthen patient-centred health care in Ontario.

We note the fact that how a "problem" is defined will greatly inform the solutions that are considered.

Patients First conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care. One solution to this problem is to better integrate population health within the health system, specifically through establishing closer linkages between LHINs and public health units. We are aware of recent work exploring the use of the population health approach in health system planning (CIHI 2014) and appreciate the merits of this work in contributing to health system sustainability. Further, we believe that local public health has valuable expertise to offer in this area. Indeed this approach is one of the five actions for health promotion as set out in the 1986 Ottawa Charter for Health Promotion.

A wider problem is improving and supporting the health and health equity of Ontarians which is effectively the mandate of the Ontario public health system. A solution to this problem would be to support and strengthen the public health system which works on all five Ottawa Charter actions for health promotion. The public health system understands that although access to a quality health care system is a determinant of individual and population health, it is a relatively minor determinant as compared with social and economic circumstances that create opportunities for health, mediated by factors such as education, food security, physical activity opportunities, social networks, effective coping strategies, etc. The public health system is that part of the overall health system that is specifically mandated to work with both health and non-health sector partners to act on these determinants and create opportunities for health for all.

We are concerned that some of the *Patients First* proposals regarding public health may have the unintended consequence of eroding the capacity of the public health system to improve the health of Ontarians through our intersectoral work on the determinants of health.

At the same time, we firmly hold that public health can assist in reorienting the health care system and see this as a valuable contribution of public health to the problems of health care system sustainability as set out in *Patients First*. We also hold that health care system sustainability is achieved by ensuring a strong public health system that can stem the tide of need; focusing on healthy people first.

In the recommendations that follow, we list and briefly describe what we present are the conditions necessary to achieve both. That is, to ensure that public health is able to contribute to the reorientation of the health care system so that population and public health priorities inform health care planning, funding and delivery, while at the same time protecting public health's ability to work upstream to promote and protect the health of all Ontarians.

Recommendations

1. **Funding and Accountability** – Provincial Public Health Funding and Accountability Agreements (PHFAA) must continue to be directly negotiated between local boards of health and the MOHLTC.
   a. A direct relationship mitigates against the threat of resource reallocation (financial and functional) to the acute care system as has been evidenced in the experience of other regions with integrated health systems.
   b. The direct relationship ensures that common Ministry principles and standards are upheld and implemented for all boards, further ensuring that all Ontarians benefit equitably from the public health system.
   c. The direct relationship with the Ministry is needed to maintain the independent voice of public health at LHIN tables; otherwise public health would be advising on health resource allocation and also be a resource recipient.

2. **Independent Voice of Boards of Health –** Boards of health must be maintained as defined in the Health Protection and Promotion Act, directly accountable to the Minister of Health.
   a. Boards of health must continue as entities with an independent voice with roles and responsibilities as set out in statute, standards and accountability agreements.
   b. Municipal representation on boards of health ensures invaluable connections with decision makers and staff in non-health sectors where there is scope of authority over key determinants of health (e.g. bylaws, built environment, social services, child care, planning, long term care, drinking water, recreational facilities, first responders, etc.).
   c. For certain boards of health (e.g. single tier and regional boards), local government is the de facto board of health, creating governance issues if required to report to an appointed LHIN board.
   d. Ways to strengthen boards of health should be explored; this should form part of the work of the Expert Panel following the report of the Institute on Governance (IOG).

3. **Integration of Local Population and Public Health Planning with Other Health Services –** The Ontario Public Health Standards and Ontario Organizational Standards, as required, should be modified to require boards of health to align their work and ensure that population and public health priorities inform LHIN health planning, funding and delivery. Reciprocal amendments should be made to the LHIN legislation (or other mandate documents as appropriate) to require LHIN boards to ensure that population and public health priorities inform LHIN health planning, funding and delivery. alPHa looks forward to participating in the following activities.
    a. Identification of the enabling policies and structures to ensure an effective relationship between the medical officer of health and LHIN leadership.
    b. The identification of the resources and funding required for public health to effectively engage in this work.

4. **Process for Determining Respective Roles –** The respective roles of local public health and LHINs (and other system players involved with population and public health including the Population and Public Health Division, MOHLTC, the Capacity Planning and LHIN Support, Health Analytics Branch, MOHLTC and Public Health Ontario) must be determined through a transparent, inclusive and deliberative process that is informed by evidence. We maintain that this is a key role of the proposed Expert Panel.
    a. It must be recognized that the work for public health as described in *Patients First* is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.
    b. There is an important distinction between providing population health information and translating this information into planning, funding and delivery decisions for acute care and other downstream services. It should not be assumed that the latter is a public health competency.

5. **Geographic Boundaries –** LHIN boundaries should be re-configured to align with municipal, local public health, education and social service boundaries to support their relationships with local public health and population health and health care system planning.

Local public health appreciates that a population health approach to health system planning is an emerging paradigm that may contribute to the sustainability of the health care system. Local public health also agrees with the *Patients First* discussion document that the public health system has expertise that may support such a reorientation of the health care system. Simply put, however, we must ensure that this "fix" to the health care system does not "break" the public health system.

We are committed to engaging in a thoughtful change management process with you that minimizes system disruption, mitigates risks associated with system instability and fosters balance between the systems intended to treat illness and the systems intended to prevent disease and promote health. To this end, we look forward to ongoing dialogue with government on the issues addressed in this letter. We trust that this will take place in many ways, including our participation in the proposed Expert Panel. We remain available for further consultation and are eager to pursue next steps.

In closing, I would reiterate that we are committed to finding win-wins so that Ontarians can continue to benefit from a strong and effective public health system while knowing that a quality health care system is there for them when they need it.

Sincerely,

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister of Health and Long-Term Care
Nancy Naylor, Associate Deputy Minister of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Board of Health Chairs
Medical Officers of Health

May 13, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins,

At its April 21, 2016 meeting, the Middlesex-London Board of Health reviewed correspondence from Dr. Valerie Jaeger, President, Association of Local Public Health Agencies (alPHa) regarding alPHa's preliminary comments on your Ministry's discussion paper *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*.

The Middlesex-London Board of Health passed the following motion to endorse this letter:

> It was moved by Mr. Peer, seconded by Ms. Fulton, *that the Board of Health endorse the letter from the Association of Local Public Health Agencies re Patients First discussion paper*.
>
> Carried

The Middlesex-London Board of Health supports the recommendations outlined in the attached letter to your Ministry.

Yours sincerely,

Jesse Helmer
Chair, Middlesex-London Board of Health

cc: Dr. Valerie Jaeger, President, Association of Local Public Health Agencies
Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies
All Ontario Boards of Health

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
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E-mail: info@alphaweb.org

February 29, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations, the Association of Local Public Health Agencies (alPHa) is pleased to provide comment on the Ministry of Health and Long-Term Care discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. We received and reviewed the paper with much interest and anticipation. There is much to consider from a local public health perspective. We offer our preliminary comments herein and will be very pleased to engage further as the government's work progresses to strengthen patient-centred health care in Ontario.

We note the fact that how a "problem" is defined will greatly inform the solutions that are considered.

Patients First conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care. One solution to this problem is to better integrate population health within the health system, specifically through establishing closer linkages between LHINs and public health units. We are aware of recent work exploring the use of the population health approach in health system planning (CIHI 2014) and appreciate the merits of this work in contributing to health system sustainability. Further, we believe that local public health has valuable expertise to offer in this area. Indeed this approach is one of the five actions for health promotion as set out in the 1986 Ottawa Charter for Health Promotion.

A wider problem is improving and supporting the health and health equity of Ontarians which is effectively the mandate of the Ontario public health system. A solution to this problem would be to support and strengthen the public health system which works on all five Ottawa Charter actions for health promotion. The public health system understands that although access to a quality health care system is a determinant of individual and population health, it is a relatively minor determinant as compared with social and economic circumstances that create opportunities for health, mediated by factors such as education, food security, physical activity opportunities, social networks, effective coping strategies, etc. The public health system is that part of the overall health system that is specifically mandated to work with both health and non-health sector partners to act on these determinants and create opportunities for health for all.

We are concerned that some of the *Patients First* proposals regarding public health may have the unintended consequence of eroding the capacity of the public health system to improve the health of Ontarians through our intersectoral work on the determinants of health.

At the same time, we firmly hold that public health can assist in reorienting the health care system and see this as a valuable contribution of public health to the problems of health care system sustainability as set out in *Patients First*. We also hold that health care system sustainability is achieved by ensuring a strong public health system that can stem the tide of need; focusing on healthy people first.

In the recommendations that follow, we list and briefly describe what we present are the conditions necessary to achieve both. That is, to ensure that public health is able to contribute to the reorientation of the health care system so that population and public health priorities inform health care planning, funding and delivery, while at the same time protecting public health's ability to work upstream to promote and protect the health of all Ontarians.

Recommendations

1. **Funding and Accountability** – Provincial Public Health Funding and Accountability Agreements (PHFAA) must continue to be directly negotiated between local boards of health and the MOHLTC.
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    a. It must be recognized that the work for public health as described in *Patients First* is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.
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In closing, I would reiterate that we are committed to finding win-wins so that Ontarians can continue to benefit from a strong and effective public health system while knowing that a quality health care system is there for them when they need it.

Sincerely,

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister of Health and Long-Term Care
Nancy Naylor, Associate Deputy Minister of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Board of Health Chairs
Medical Officers of Health

May 13, 2016

Ms. Peggy Sattler
Main Legislative Building, Room 359
Queen's Park, Toronto, ON
M7A 1A5

Dear Ms. Peggy Sattler,

At its April 21, 2016 meeting, the Middlesex-London Board of Health reviewed correspondence from Dr. David McKeown, Medical Officer of Health, Toronto Public Health regarding the *Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act*. The Middlesex-London Board of Health passed the following motion to endorse this letter:

> It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that the Board of Health endorse the letter from Toronto Public Health re Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act.*
>
> Carried

The Middlesex-London Board of Health supports advocating for workplace recognition of the physical and emotional toll that domestic or sexual violence can have on people and the impact this may have on their employment.

Yours sincerely,

Jesse Helmer
Chair, Middlesex-London Board of Health

cc: Dr. David McKeown, Medical Officer of Health, Toronto Public Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Deb Matthews, MPP London-North Centre
Jeff Yurek, MPP Elgin-Middlesex-London
Monte McNaughton, MPP Lambton-Kent-Middlesex
Theresa Armstrong, MPP London-Fanshawe
All Ontario Boards of Health

TORONTO

Dr. David McKeown
Medical Officer of Health

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dmckeown@toronto.ca
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March 8th, 2016

The Honourable Peggy Sattler
Main Legislative Building, Room 359
Queen's Park, Toronto, ON
M7A 1A5

Re: *Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act*

Dear Ms. Peggy Sattler,

I am writing to express my support for the proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act, which would require all employers to provide employees experiencing violence with workplace accommodations and paid and extended leave. It also would require all employers to receive information and instruction about domestic and sexual violence in the workplace.

In Canada, half of all women have experienced at least one incident of physical or sexual violence in their lifetime, and every six days, a woman is killed by her partner or ex-partner. Domestic and sexual violence have immediate and long lasting health, social and economic consequences for victims, their families, communities and society as a whole.

People experiencing domestic and sexual violence are in a position of significant physical, mental, emotional and financial hardship. Although some employers may have policies related to assisting employees experiencing violence, the proposed amendments will ensure universal access to important measures. This bill, if enacted, would promote safety in the workplace for the victim and their coworkers; reduce the burden of providing evidence when leave is necessary; prevent victims from losing their jobs when financial security is vital; help offset the costs associated with coping with or leaving an abusive partner; and afford them the time, energy and resources to focus on healing and rebuilding their lives. The attached document provides a more detailed public health rationale for key elements of this bill.

As the damaging effects of domestic and sexual violence are also seen in the workplace, a comprehensive public health approach to addressing these issues must include measures

in the workplace. I strongly support your proposed bill as an important measure that would help mitigate the negative impact of violence on the health and well-being of thousands of victims.

Sincerely,

Dr. David McKeown
Medical Officer of Health

Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act, 2016 – A Public Health Perspective

Domestic and Sexual Violence: Serious public health concerns

Domestic and sexual violence are significant public health concerns. Half of all women in Canada have experienced at least one incident of physical or sexual violence since the age of 16.[1] In Canada, women are more likely to experience violence by an intimate partner than by any other perpetrator.[2] Every six days, a woman in Canada is killed by her partner or ex-partner.[2] Men also experience domestic and sexual violence; however women are much more likely to be victims of severe forms of abuse, multiple victimizations, injuries and death.[2]

Domestic and sexual violence have immediate and long lasting health, social and economic consequences for victims, their families, communities and society as a whole. Women who have experienced violence have higher rates of stress-induced physiological changes, mental disorders, including depression, anxiety, sleep and eating disorders, homelessness, loss or separation from family and friends, loss of employment, debt and destitution.[2]

Children exposed to domestic and/or sexual violence also suffer a range of physical and mental health consequences. These consequences may put children on a negative developmental trajectory, including educational and economic under-performance, unsafe sexual practices and becoming future victims or perpetrators of abuse.[2, 3]

The impact of domestic violence in the workplace

The damaging effects of domestic violence also take place in the workplace. A recent Canadian survey found that one in three employees has experienced some form of domestic violence. Over 80% of those employees said that domestic violence had a negative effect on their work performance and over a third reported that co-workers were affected as well.[4]

Domestic violence in the workplace has substantial negative impacts not only on the victim, but also their co-workers, clients and the organization as a whole. These include:

- Reduced employee productivity;
- Potential harm to employees, co-workers and/or customers when violent abusers enter the workplace;

- Increased absenteeism;
- Decreased employee morale;
- Strained relations among co-workers;
- Replacement, recruitment and training costs when victims are injured or dismissed for poor performance;
- Higher company health expenses; and
- Liability costs if someone at the workplace is harmed.[5, 6]

Canadian employers lose an estimated $77.9 million annually due to the direct and indirect impacts of domestic violence.[2]

A comprehensive public health approach to addressing domestic and sexual violence must include measures in the workplace, such as those outlined in the proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act, 2016, that would amend the Employment Standards Act and the Occupational Health and Safety Act.

Public Health Rationale for Proposed Amendments

The following is the health rationale in support of the proposed amendments to the Employment Standards Act and the Occupational Health and Safety Act, specifically with regards to the provision of alternate work location and hours; paid and extended leave; prescribed sufficient evidence; and information and instruction about domestic and sexual violence in the workplace.

Provision of Alternate Work Hours and Location

Perpetrators of domestic abuse can interfere with a worker's employment. Providing alternate work hours and an alternate work location are important safety precautions and help an employee maintain work performance.

Perpetrators can interfere with an employee's work in a number of ways, including:

- Preventing them from getting to work through psychological or physically controlling behaviours or threats;
- Repeatedly phoning or emailing the victim;
- Coming to the workplace and asking questions of co-workers about the victim;
- Being dishonest with co-workers about the victim's whereabouts;
- Threatening co-workers;
- Verbally abusing the victim’s or organization’s property;
- Physically harming the victim and/or co-workers; and

- Stalking and/or watching the victim, which is one of the primary risk factors for attempted and actual murder of female partners in intimate relationships.[5, 6]

Studies estimate that 36 to 75% of domestic violence victims are bothered by their abusive partners while at work. In a study of employed women who recently filed domestic violence orders, 35% were stalked on the job.[6]

Providing an employee with alternate work hours is an important safety precaution with several benefits. It might prevent the perpetrator from interfering with the victim getting to work. It also allows the victim to alternate their hours and avoid routine, which may make it more difficult for the perpetrator to know the victim's work schedule. Flexible hours also allow the victim time to remove themselves from the abusive situation and or seek health or other supportive services to deal with issues arising from the violence which may be affecting their ability to attend work, or work safely and productively.

An alternate work location that is unknown to the perpetrator is also an important safety measure as it helps to prevent the victim from being abused at work and creates a secure environment where the employee, co-workers and clients can be safe and maintain work performance. Maintaining job performance helps the victim retain their job, which is an important factor in being able to leave an abusive partner.

Entitlement to Paid and Extended Leave

The health consequences of domestic and sexual violence can have a significant impact on work performance, which may put them at risk of losing their job. Victims of violence report increased levels of depression, stress, anxiety, embarrassment or shame due to stigma and fear of job loss. These lead to an inability to concentrate, more absenteeism and tardiness at work, overall lower work productivity and poor job performance. Victims of domestic violence report being fired or having to quit as a direct result of domestic abuse.[7]

The challenges involved when dealing with abuse may require taking time off work well beyond the time available through other leave entitlements currently available to employees, such as sick days and vacation. Dealing with an abusive incident or choosing to leave an abusive partner requires several actions and access to a range of services and supports, and takes substantial time, effort and financial resources. This includes accessing health services, relocating temporarily or permanently; seeking support services from a victim services organization and/or other professional counselling; finding affordable child care services and retaining a lawyer to address one or more legal issues, including family, child protection, criminal and/or immigration. Some groups, such as persons with low income, racialized women, women with disabilities, Indigenous women, and the LGBTQ community, may experience greater difficulty taking these steps due to a lack of or barriers to existing services, such as insufficient emergency, transitional and permanent housing; the cost of legal representation; lack of programs and mental health services; and the cost and time associated with transit.[8, 2]

An extended leave is an important measure that enables victims to maintain employment at a time when economic independence and financial security are vital and allows them to focus on the actions required for them and their family to heal from the abuse and rebuild their lives. Receiving pay for a portion of this leave helps offset the costs associated with dealing with domestic and/or sexual violence, which is especially critical for individuals living on low incomes.

Prescribed Sufficient Evidence

Acquiring the necessary evidence to prove that one needs accommodation or leave from work because of violence can exacerbate the employee's level of stress. Some types of evidence are easier to acquire than others (e.g., note from health provider vs. police record). Providing flexibility in the type of evidence that is acceptable lessens the burden of proof and enables employees to exercise a level of control over their personal information, which may minimize barriers to seeking access to accommodation or a leave.[9]

Adding Information and Instruction about Domestic Violence in the Workplace to the Occupational Health and Safety Act

Domestic and sexual violence are sensitive and complex issues. In order for management and staff to protect themselves, co-workers and their organization, they must be trained to recognize the signs of violence; the importance of being sensitive; and to fully understand their roles and responsibilities, as outlined in workplace domestic and sexual violence policies and procedures. For example, there is still a lot of stigma around domestic violence. Victims of domestic violence might choose not to disclose to their employer because they fear losing their job, are ashamed and believe that the employer will be apathetic. Employers who are educated about domestic and sexual violence are more likely to create a supportive work environment, implement protective measures and ensure available resources are utilized.[6, 10, 5]

Despite the importance of education on domestic and sexual violence, studies show that few employers currently provide training to managers, supervisors and employees on what to do if they themselves experience domestic violence or if they suspect a colleague of being a victim of domestic violence.[4] A survey of Canadian employers found that while the majority had a domestic violence policy in place, less than one third trained their managers and employees on this subject.[4] When employers were asked why they had created domestic violence policy and associated procedures, 70% said it was to comply with legislation.[4] Similarly, mandating information and instruction in the workplace will help ensure employers and their employees are prepared to respond to employees experiencing domestic and sexual violence and administer their policies and procedures in an effective, sensitive, and consistent manner.

Conclusion

This bill acknowledges that people experiencing domestic and sexual violence are in a position of significant physical, mental, emotional and financial hardship. Although some employers may have policies to support employees experiencing violence, the proposed amendments will ensure universal access to important safety measures. It will promote safety in the workplace for victims and their co-workers; reduce the burden of providing evidence when leave is necessary; help prevent victims from losing their jobs when financial security is vital; help offset the costs associated with coping with or leaving an abusive partner, which is critical for vulnerable populations; and afford them the time, energy and resources to focus on rebuilding their lives. Mandating information and instruction on domestic and sexual violence in the workplace will also ensure employers and their employees will be prepared to effectively assist employees in crisis.

References

1. Canadian Women's Foundation. (2015). Fact Sheet: Moving women out of violence. Retrieved at: http://www.canadianwomen.org/sites/canadianwomen.org/files//FactSheet-StopViolence-ACTIVE%20-%20May2015.pdf
2. Toronto Public Health. (2015) Action *on Intimate Partner Violence against Women*. Available online at: http://www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-85930.pdf
3. World Health Organization. (2010). Preventing Intimate partner and sexual violence against women: Taking action and generating evidence. Retrieved at: http://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf
4. The Conference Board of Canada. (2015). *Domestic Violence and the Role of the Employer.*
5. Public Services Health & Safety Association. (2010). *Addressing Domestic Violence in the Workplace: A Handbook*. Available at: http://www.pshsa.ca/wp-content/uploads/2013/02/DomVioWkplace.pdf
6. WorkSafe BC. (2012). Addressing Domestic Violence in the Workplace: A Handbook for Employers. Retrieved at: http://www2.worksafebc.com/pdfs/Violence/AddressingDomesticViolenceOutsideBC.pdf
7. PreVAiL. (2014). Research Brief: The impacts of Intimate Partner Violence on Workers and Workplaces. Retrieved at: http://prevail.fims.uwo.ca/docs/PreVAiL%20Work%20and%20IPV%20Research%20Brief%20March%202014.pdf
8. Mendoza, H., Dale, A., and Coombs, M. (2013). Policies Matter: Addressing violence against women through reflection, knowledge and action. Available at: http://womanabuse.ca/policiesmatter/Blueprint_FinalReport-Sept13_2013.pdf
9. Australian Government. National Employment Standards Act. Retrieved at: http://www.alrc.gov.au/publications/17-national-employment-standards/family-violence-related-leave
10. Occupational Health and Safety Council of Ontario. (2010). Domestic Violence Doesn't Stop When Your Worker Arrives at Work: What employers need to know to help. Retrieved at: http://www.osach.ca/products/resrcdoc/OHSCO_EmployerBooklet.pdf

simcoe muskoka
DISTRICT HEALTH UNIT

April 20, 2016

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

Dear Prime Minister:

Re: A Public Health Approach to the Legalization of Cannabis in Canada

The Simcoe Muskoka District Health Unit (SMDHU) is mandated by the Ministry of Health and Long-Term Care (MOHLTC) under the Ontario Public Health Standards (2008) to address the prevention of the "adverse health outcomes associated with substance use". Prevention efforts include the delayed use of substances, such as cannabis, as well as incorporating harm reduction strategies in the delivery of health unit services. We are pleased that you are aware of the need for a well-regulated system for cannabis access which promotes public health and safety, reduces the harms associated with the use of marijuana, and helps to restrict access to youth.

In May of 2014, The Canadian Public Health Association (CPHA) identified the need for a public health approach in the management of psychoactive substances that is "based on the principles of social justice, attention to human rights and equity, evidenced informed policy and practice, and addressing the underlying determinants of health". [5] The SMDHU Board of Health has similarly passed a resolution today strongly urging you to adopt a public health approach regarding the legalizing of cannabis, with strict regulation of its use, production, distribution, product promotion, and sale.

Despite prohibition, cannabis is the most commonly used illegal drug in Canada, with youth and young adults having the highest rates of use. Research shows that cannabis use is associated with adverse health consequences, most notably for those who begin use at an early age and use it frequently. The evidence suggests that cannabis use — particularly chronic use — can have negative impacts on mental and physical health, brain function (memory, attention and thinking), driving performance and dependence. In addition, women who use cannabis during pregnancy can negatively affect the development and behaviour of their future children. [1, 2, 3, 4]

While cannabis use has the potential for many health harms, it is also important to consider the disproportionate social harms stemming from its prohibition. In addition to being ineffective and costly, prohibition has led to a series of harmful consequences including the criminalization and marginalization of users while hindering the ability of health and education professionals to effectively prevent and address problematic use. [1, 5] We are aware that you are familiar with the

Centre for Addiction and Mental Health (CAMH) Cannabis Policy Framework (October 2015) and strongly recommend that a public health approach to legalizing cannabis should include some or all of the following evidence informed guidelines for a regulatory framework as proposed by CAMH:

- **Establish a government monopoly on sales.** Control board entities with a social responsibility mandate provide an effective means of controlling consumption and reducing harm.
- **Set a minimum age for cannabis purchase and consumption.** Sales or supply of cannabis products to underage individuals should be penalized.
- **Limit availability.** Place caps on retail density and limits on hours of sale.
- **Curb demand through pricing.** Pricing policy should curb demand for cannabis while minimizing the opportunity for continuation of lucrative black markets. It should also encourage use of lower-harm products over higher-harm products.
- **Curtail higher-risk products and formulations.** This would include higher-potency formulations and products designed to appeal to youth.
- **Prohibit marketing, advertising, and sponsorship.** Products should be sold in plain packaging with warnings about risks of use.
- **Clearly display product information**. In particular, products should be tested and labelled for Tetrahydrocannabinol (THC) and Cannabidiol (CBD) content.
- **Develop a comprehensive framework to address and prevent cannabis-impaired driving.** Such a framework should include prevention, education, and enforcement.
- **Enhance access to treatment and expand treatment options.** Include a spectrum of options from brief interventions for at-risk users to more intensive interventions.
- **Invest in education and prevention.** Both general (e.g. to promote lower-risk cannabis use guidelines) and targeted (e.g. to raise awareness of the risks to specific groups, such as adolescents or people with a personal or family history of mental illness) initiatives are needed. (1)

When implementing these critical policy changes we strongly encourage your government to take sufficient time to develop and build capacity to implement these regulations and to ensure systems are in place to monitor patterns of use and health outcomes. In addition, we recommend that you develop evidence based prevention and harm reduction messaging for broad dissemination across the country. (1)

Thank you for considering a comprehensive public health approach to cannabis policy in Canada. Please do not hesitate to contact me should you wish to discuss further.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward, Board of Health Chair
Simcoe Muskoka District Health Unit

c. Bill Blair, MP (Scarborough Southwest)
Dr. Kellie Leitch, MP (Simcoe-Grey)
The Honourable Tony Clement, MP (Parry Sound–Muskoka)
Patrick Brown, MPP (Simcoe North)
Ann Hoggarth, MPP (Barrie)
Norm Miller, MPP (Parry Sound-Muskoka)
Julia Munro, MPP (York-Simcoe)
Jim Wilson, MPP (Simcoe-Grey)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Boards of Health in Ontario

References:

1. Crépault J-F. Cannabis Policy Framework. [Report online]. Toronto: Centre for Addiction and Mental Health; 2014 [Last accessed 2016/03/03]. Available from: http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

2. Canadian Centre on Substance Abuse. Substance Abuse in Canada: The Effects of Cannabis Use during Adolescence. [Report online]. Ottawa: Canadian Centre on Substance Abuse, 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Effects-of-Cannabis-Use-during-Adolescence-Report-2015-en.pdf

3. Porath-Waller AJ, Beirness, DJ, Diplock J, Kalant H. Clearing the Smoke on Cannabis: Highlights [Report online]. Canadian Centre on Substance Abuse (CCSA), 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Clearing-Smoke-on-Cannabis-Highlights-2015-en.pdf

4. Beirness D, Porath-Waller A. Clearing the Smoke on Cannabis: Cannabis Use and Driving-An Update. [Report online]. Ottawa: Canadian Centre on Substance Abuse; 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Cannabis-Use-and-Driving-Report-2015-en.pdf

5. Canadian Public Health Association. A New Approach to Managing Illegal Psychoactive Substances in Canada. [Discussion paper online]. Ottawa: Canadian Public Health Association, 2014 [Last accessed 2016/03/03]. Available from: http://www.cpha.ca/uploads/policy/ips_2014-05-15_e.pdf

ELGIN ST. THOMAS
PUBLIC HEALTH

March 23, 2016

The Right Honourable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Prime Minister Trudeau:

Re: Public Health Approach to Cannabis Legalization and Regulation

The Board of Health for Elgin St.Thomas Public Health brings forth the following resolution for government to carefully consider as it explores policy options around the legalization of cannabis.

WHEREAS Canada's recently elected federal government has indicated a clear intention to move forward on activities to legalize and increase public access to marijuana, and

WHEREAS within the current legal context, cannabis is widely used in the Elgin St.Thomas catchment area: 46.8 % of adults (aged 19 years and older) reported ever using marijuana, cannabis, or hashish, and 26.6 % of adults reported use of marijuana, cannabis, or hashish in the previous 12 months.

WHEREAS residents in our community are not only using marijuana at regular intervals but are doing so in conjunction with the operation of motor vehicles which can lead to an increased risk of crashes, and

WHEREAS the Canadian Centre for Substance Abuse (CCSA) has identified that consuming cannabis regularly during adolescence interferes with the function and development of and individual's brain system and that delaying the age of use onset is recommended to reduce the harms associated with youth, and

WHEREAS the Centre for Addiction and Mental Health (CAMH), Canada's leading hospital for mental illness, has concluded that legalization, combined with strong health-focused regulation, could provide and opportunity to reduce the harms associated with cannabis use, and

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WHEREAS there is an existing framework of lower-risk cannabis guidelines (LRCUG) endorsed by a number of organizations including CAMH and the Canadian Public Health Association (CPHA), that can serve as a meaningful base for public education to reduce high-risk cannabis use and harms and

NOW THEREFORE BE IT RESOLVED that Elgin St.Thomas Public Health Board of Health supports a public health approach to any cannabis legalization framework introduced into Ontario, including a strong health-centred and age-restricted regulations to reduce the health and societal harms associated with cannabis use, and

FURTHER THAT this resolution be shared with the Honorable 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.

Members of Elgin St.Thomas Public Health Board of Health respectfully request that the Right Honourable Prime Minister use a public health approach to the regulation and legalization of cannabis in Canada.

Sincerely,

Cynthia St. John
Executive Director

Dr. Joyce Lock
Medical Officer of Health

cc: The Honourable Jane Philpott, Minister of Health, Government of Canada
The Honourable Eric Hoskins, Minister of Health and Long-Term Care, Government of Ontario
The Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
The Honourable Madeleine Meilleur, Attorney General of Ontario
Karen Vecchio MPP Elgin- Middlesex- London
Jeff Yurek MP Elgin- Middlesex- London
The Honourable Kathleen Wynne, Premier of Ontario
Dr. Gregory Taylor, Chief Public Health Officer, Public Health Agency of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Linda Stewart, Executive Director, Association of Local Public Health Agencies (alPHA)
Dr. Catherine Zahn, President and Chief Executive Officer, Centre for Addiction and Mental Health Ontario Boards of Health
Linda Sibley, Executive Director, Addiction Services of Thames Valley
Heather Debruyn, Executive Director, Canadian Mental Health Association

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

No. 37 -2016

MOTION/RESOLUTION

Moved by ..... Dennis Brown .....

Seconded by ..... L. MacDonald .....

THAT the Board of Health for the Northwestern Health Unit endorse the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Position Statement on Responses to Food Insecurity and resolution shared with Ontario Boards of Health, the Association of Local Public Health Agencies (alPHa) and the Ontario Society of Nutrition Professionals in Public Health (OSNPPH).

	Yea	Nay	Abstained	Disclosure of Interest
C. Baron				
D. Brown				
Y. Kirlew				
L. MacDonald				
J. Roy				
J. Ruete				
P. Ryan				
T. Sachowski				
S. Smith				
B. Thompson				

Date: April 26, 2016

Chair..... Julie Ray .....

Apirl, 2016

Evelyn Vaccari
Chair, Ontario Society of Nutrition Professionals in Public Health
c/o Toronto Public Health
Sent via e-mail: evaccar@toronto.ca

Lyndsay Davidson
Chair, Ontario Society of Nutrition Professionals in Public Health
Food Security Workgoup
c/o Chatham-Kent Public Health
Sent via e-mail: lyndsayd@chatham-kent.ca

Dear Ms. Vaccari and Ms. Davidson:

The Northwestern Health Unit (NWHU) Board of Health is writing to inform you that during the Apirl, 2016 Board of Health meeting the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Position Statement on Responses to Food Insecurity was officially endorsed.

Food insecurity is a serious issue in our NWHU area with approximately 1,600 people in our municipalities who are food insecure. Cost of eating continues to rise in the NWHU area, at a faster rate than income or social assistance; in 2015 the cost of feeding a family of four was $1,060.50, an increase of 15.7% since 2010. Cost of eating is particularly high in First Nations communities in the NWHU area; a 2015 study found that costs were about 70% higher on-reserve compared to municipalities (NWHU, 2015).

We acknowledge that income responses, such as improved social assistance, affordable social housing and the investigation of a Basic Income Guarantee are needed to address the root cause of food insecurity, which is poverty.

The detrimental health effects of being unable to access healthy food are an important issue that need to be urgently addressed. Thank you for working with the Boards of Health to raise awareness about this important issue. Poverty and food insecurity affect us all and we are all part of the solution.

Sincerely,

DURHAM REGION

April 29, 2016

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

COPY

The Regional Municipality of Durham

Corporate Services Department - Legislative Services

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Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated April 7, 2016 re: Bill 139, *Smoke-Free Schools Act, 2015* (Our File No. P00)

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on April 27, 2016, Council adopted the following recommendations of the Committee:

A) That the correspondence of North Bay and Parry Sound District's Medical Officer of Health urging passage of Private Member's Bill 139 and recommending that plain cigarette packaging and higher tobacco taxes be considered by all levels of government be endorsed; and

B) That the Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Todd Smith, MPP, Durham's MPP's, Association of Local Public Health Agencies (alPHa) and all Ontario boards of health be so advised.

Attached is a copy of the Memorandum from Dr. Robert Kyle, Commissioner and Medical Officer of Health dated April 7, 2016 regarding Bill 139, *Smoke-Free Schools Act, 2015*.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

"Service Excellence for our Communities"

If this information is required in an accessible format, please contact the Accessibility Co-ordinator at 1-800-372-1102 ext. 2009.

DURHAM REGION

The Regional Municipality of Durham

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An Accredited Public Health Agency

MEMORANDUM

To: Health & Social Services Committee

From: Dr. Robert Kyle

Date: April 7, 2016

Re: Bill 139, *Smoke-Free Schools Act, 2015*

On February 22, 2016, North Bay Parry Sound District's (NBPSD's) Medical Officer of Health sent the attached correspondence to all Ontario boards of health for support (Appendix A).

In essence, the correspondence urges passage of Private Member's Bill 139; it also recommends that plain cigarette packaging and higher tobacco taxes be considered by all levels of government.

Bill 139 amends the *Smoke-Free Ontario Act* and *Tobacco Tax Act* as outlined in the Bill's Explanatory Note (Appendix B).

Supporting this correspondence is consistent with Regional Council's public health mandate, as Durham's board of health, as regards comprehensive tobacco control (*Ontario Public Health Standards, 2008)*

Accordingly, I recommend that the Health & Social Services Committee recommends to the Regional Council that:

a) The correspondence of North Bay and Parry Sound District's Medical Officer of health respecting Bill 139 is endorsed; and

b) The Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Todd Smith, MPP, Durham's MPPs, alPHa and all Ontario boards of health are so advised.

Respectfully submitted,

Dr. Robert Kyle

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

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70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
myhealthunit.ca TOLL FREE 1 800 563 2808

February 22, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Subject: Bill 139: Smoke-Free Schools Act – BOH Resolution #BOH/2016/01/11

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/11:

***Whereas**, tobacco use is the leading cause of preventable death and disability in Canada (Ministry of Health and Long-Term Care, 2010), and*

***Whereas**, the number of daily and occasional cigarette smokers in the North Bay Parry Sound District Health Unit is 7% higher than the provincial average (25.8% vs. 18.7%; NBPSDHU, 2014), and*

***Whereas**, Bill 139: Smoke-Free Schools Act introduced by MPP Todd Smith is slated for third reading in the Ontario Legislature this year, and*

***Whereas**, Bill 139: Smoke-Free Schools Act includes a prohibition on the sale of any tobacco products in schools, increased fines for offenders caught selling illegal tobacco, and increased suspension periods of driver's licenses for people convicted of using a vehicle for unauthorized delivery/transportation of illegal tobacco, sharing the proceeds of disposition of forfeited property with police forces if they were involved in the investigation, a requirement that the Government establish a public education program about the health risks associated with the use of tobacco, and*

***Whereas**, the illegal sale of contraband cigarettes undermines public health's efforts to reduce smoking rates and protect children and youth from the dangers of smoking, and*

***Whereas**, higher tobacco taxes have been identified as the most effective strategy to reduce smoking prevalence and Ontario has one of the lowest tobacco tax rates in Canada (Smoke-Free Ontario Scientific Advisory Committee, 2010; Ontario Tobacco Research Unit, 2015), and*

***Whereas**, plain and standardized packaging is an effective counter measure to the tobacco industry's use of packaging as an important part of tobacco promotion, and*

***Whereas**, Bill 139: Smoke-Free Schools Act has been endorsed by the Canadian Cancer Society, the Heart & Stroke Foundation, and the Ontario Campaign Against Tobacco (OCAT),*

***Now Therefore Be It Resolved**, that the Board of Health for the North Bay Parry Sound District Health Unit support Bill 139: Smoke-Free Schools Act and that legislation for plain and standardized cigarette packaging and higher tobacco taxes be considered by all levels of government, and*

***Furthermore Be It Resolved,** that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, the Association of Local Public Health Agencies (alpha), MPP Todd Smith (Prince Edward-Hastings), MPP Victor Fedeli (Nipissing), MPP Norm Miller (Parry Sound-Muskoka), Premier Kathleen Wynne, and Ontario Boards of Health.*

Sincerely,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

C: Todd Smith, MPP, Prince Edward-Hastings
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Hon. Kathleen Wynne, Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

Appendix B

Bill 139, Smoke-Free Schools Act, 2015

Smith, Todd

Current Status: Ordered referred to the Standing Committee on General Government

View the Bill

Bill 139 2015

An Act to amend the Smoke-Free Ontario Act and the Tobacco Tax Act

Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Smoke-Free Ontario Act

1. (1) The Smoke-Free Ontario Act is amended by adding the following section:

Public Education Program

Public education program

3.0.1 (1) The Government shall establish a public education program about the health risks associated with the use of tobacco and the program shall be for the purpose of reducing the use of tobacco and exposure to tobacco.

Same

(2) The public education program may involve any of the following:

1. Consulting and collaborating with one or more non-profit organizations in the development and the delivery of the program.
2. Including information about the health risks associated with the use of tobacco in the curriculum in schools as defined in the Education Act.
3. One or more non-government organizations conducting research about the public's knowledge of the health risks associated with the use of tobacco, including the different health risks associated with the use of various forms of tobacco and the different health risks associated with the use of legal and illegal tobacco products.
4. Addressing misinformation among the members of the public with respect to the health risks associated with the use of tobacco, including misinformation regarding the health risks associated with the use of various forms of tobacco and the different health risks associated with the use of legal and illegal tobacco products.

(2) Subsection 4 (2) of the Act is amended by adding the following paragraphs:

5. A school as defined in theEducation Act.
6. A building or the grounds surrounding the building of a private school, where the private school is the only occupant of the premises, or the grounds annexed to a private school, where the private school is not the only occupant of the premises.

(3) If, on the day this section comes into force, section 5 of Schedule 2 to the Making Healthier Choice Act, 2015 is not in force, the Table to section 15 of the Smoke-Free Ontario Act is amended by repealing,

3 (6), 4 (1), 6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	0	2,000	5,000
	1	5,000	10,000
	2	10,000	25,000
	3 or more	50,000	75,000

and substituting,

3 (6), 4 (1)	0	5,000	5,000
	1	10,000	10,000
	2	25,000	25,000
	3 or more	50,000	75,000
6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	0	2,000	5,000
	1	5,000	10,000
	2	10,000	25,000
	3 or more	50,000	75,000

(4) On the later of the day this section comes into force and the day section 5 of Schedule 2 to the Making Healthier Choices Act, 2015 comes into force, the Table to section 15 of the Smoke-Free Ontario Act, as re-enacted by section 5 of Schedule 2 to the Making Healthier Choices Act, 2015, is amended by repealing,

3 (6), 4 (1), 6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	0	2,000	5,000
3 (6), 4 (1), 6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	1	5,000	10,000
3 (6), 4 (1), 6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	2	10,000	25,000
3 (6), 4 (1), 6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	3 or more	50,000	75,000

and substituting,

3 (6), 4 (1)	0	5,000	5,000
3 (6), 4 (1)	1	10,000	10,000
3 (6), 4 (1)	2	25,000	25,000
3 (6), 4 (1)	3 or more	50,000	75,000
6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	0	2,000	5,000
6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	1	5,000	10,000
6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	2	10,000	25,000
6, 10, 14 (16), 16 (4), 17 (6), 18 (1), 18 (4), 18 (5)	3 or more	50,000	75,000

Tobacco Tax Act

2. (1) Subsection 1 (1) of the Tobacco Tax Act is amended by adding the following definition:

"police force" means police force as defined in subsection 2 (1) of the Police Services Act; ("corps de police")

(2) Subsection 6 (2.1) of the Act is amended by striking out "a fine of not less than $1,000 and not more than $10,000" at the end and substituting "a fine of not less than $2,500 and not more than $25,000".

(3) Subsection 6 (16) of the Act is amended by striking out "a fine of not less than $200 and not more than $1,000" and substituting "a fine of not less than $1,000 and not more than $5,000".

(4) Clause 7 (4) (a) of the Act is repealed and the following substituted:

(a) to a fine of not less than $2,500 and not more than $25,000; and

(5) Clause 7.0.1 (2) (a) of the Act is repealed and the following substituted:

(a) to a fine of not less than $2,500 and not more than $25,000; and

(6) The Act is amended by adding the following section:

Sharing of proceeds

23.3 (1) If a police force has participated in the investigation of an offence that leads to the forfeiture to the Crown of property under this Act, the Minister may, in accordance with the regulations, share the proceeds of disposition of that forfeited property with the police force.

Regulations

(2) The Lieutenant Governor in Council may make regulations respecting the sharing of the proceeds of disposition of any property that is forfeited to the Crown under this Act.

(7) Section 24 of the Act is amended by adding the following subsection:

Debt due to police or Crown

(10.11.1) The costs incurred by a police force or the Crown in removing, storing or disposing of a vehicle under this section are a debt due to the police force or Crown, as the case may be, and may be recovered by the police force or Crown in any court of competent jurisdiction.

(8) Subsection 29 (3) of the Act is amended by striking out "If a person authorized by the Minister" at the beginning of the portion before clause (a) and substituting "If a police officer or a person authorized by the Minister".

(9) Paragraph 1 of subsection 29 (14) of the Act is amended by striking out "a fine of $100" and substituting "a fine of $500".

(10) Paragraph 2 of subsection 29 (14) of the Act is amended by striking out "a fine of $250" and substituting "a fine of $1,250".

(11) Paragraph 3 of subsection 29 (14) of the Act is amended by striking out "a fine of $500" and substituting "a fine of $2,500".

(12) Clause 29 (15) (a) of the Act is amended by striking out "a fine of not less than $500 and not more than $10,000" at the beginning and substituting "a fine of not less than $2,500 and not more than $25,000".

(13) Subparagraph 1 i of subsection 35 (2) of the Act is amended by striking out "a fine of not less than $500 and not more than $10,000" at the beginning and substituting "a fine of not less than $2,500 and not more than $25,000".

(14) Subparagraph 2 i of subsection 35 (2) of the Act is repealed and the following substituted:

i. a fine of $250 for each 200 cigarettes, and

(15) Subsection 35.1 (2) of the Act is amended by striking out "transportation of tobacco products or tear tape and is convicted of an offence for doing so under subsection 9.1 (4), 9.2 (4), 31 (2), 34.1 (4) or 35 (2.0.1)" in the portion before clause (a) and substituting "transportation of fine cut tobacco or tear tape and is convicted of an offence for doing so under subsection 9.2 (4) or 31 (2)"

(16) Section 35.1 of the Act is amended by adding the following subsection:

Court may order suspension of driver's licence, ss. 9.1 (4), 31 (2) or 35 (2.0.1)

(2.1) If a person uses a motor vehicle for the unauthorized delivery or transportation of tobacco products and is convicted of an offence for doing so under subsection 9.1 (4) 31 (2) or 35 (2.0.1), the court shall, on sentencing the person, in addition to any other penalty that may be imposed, order the Registrar of Motor Vehicles to suspend the person's driver's licence for a period of,

(a) on a first conviction, not more than one year; and

(b) on a subsequent conviction, not less than one year.

Commencement and Short Title

Commencement

3. This Act comes into force on the day it receives Royal Assent.

Short title

4. The short title of this Act is the Smoke-Free Schools Act, 2015.

EXPLANATORY NOTE

The Bill amends the Smoke-Free Ontario Act and the Tobacco Tax Act.

Smoke-Free Ontario Act

The Smoke-Free Ontario Act is amended to require the Government to establish a public education program about the health risks associated with the use of tobacco. (new section 3.0.1 of the Act)

Currently, the Act prohibits the sale of tobacco in designated places. Amendments are made to add schools, as defined in the Education Act, and private schools as designated places. (subsection 4 (2) of the Act)

Amendments are made to increase the fines that apply if a person is convicted of presenting illegal age identification or is convicted of selling tobacco in a designated place. (section 15 of the Act)

Tobacco Tax Act

The Tobacco Tax Act is amended to permit the Minister to share the proceeds of forfeited property with police forces who participate in the investigation of an offence that leads to the forfeiture. (new section 23.3 of the Act)

The Act is amended to provide that the costs incurred by a police force or the Crown to remove, store or dispose of a vehicle under section 24 of the Act are a debt due to the police force or the Crown and may be recovered in court. (new subsection 24 (10.11.1) of the Act)

Currently, subsection 29 (3) of the Act gives persons authorized by the Minister certain enforcement powers relating to unmarked tobacco products. An amendment is made to also give those powers to police officers.

Amendments are made to increase the penalties that apply to offences relating to interjurisdictional importers, the manufacturing of tobacco products, the possession of unmarked cigarettes and the purchase or receipt of marked or unmarked cigarettes for resale. (subsections 6 (2.1) and (16), 7 (4), 7.0.1 (2), 29 (14) and (15), and 35 (2) of the Act)

Currently, a person's driver's licence may be suspended if he or she uses a motor vehicle in the commission of certain offences. Amendments are made to increase the suspension periods in respect of convictions under subsections 9.1 (4), 31 (2) and 35 (2.0.1) of the Act. (new subsection 35.1 (2.1) of the Act)

Porcupine
Health Unit • Bureau de santé

May 2, 2016

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The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON
M7A 2C4

Dear Minister Hoskins,

On April 22, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

WHEREAS, the relationship between poor oral health and poor physical and mental health is clear; and

WHEREAS, the relationship between poor oral health and risks associated with childhood development are known; and

WHEREAS, individuals in the community of lower socio-economic status suffer a more significant burden of poor health; and

WHEREAS, providing fluoride via community water offers the positive benefits equally for everyone in the community; and

WHEREAS, global health experts and evidence support community water fluoridation to prevent tooth decay;

THEREFORE BE IT RESOLVED THAT, the Porcupine Health Unit recommends that the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada-recommended level of 0.7 mg/L) to prevent dental caries; and

FURTHER THAT, the Province provide the funding and technical support to municipalities to implement community water fluoridation.

Thank you for your attention to this important public health issue.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls