AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

Thursday, 7:00 p.m.
2014 March 20

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Mr. David Bolton
Ms. Denise Brown
Mr. Al Edmondson
Ms. Patricia Fulton
Mr. Marcel Meyer (Chair)
Mr. Stephen Orser (Vice Chair)
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:05 – 7:15 p.m.	Chair, Governance Committee re Item #1 Governance Committee (GC) Report March 20, 2014 (Verbal Report)
7:15 – 7:25 p.m.	Ms. Rhonda Brittan, Public Health Nurse, Oral Health, Communicable Disease & Sexual Health Services re Item #3 Needle/Syringe Disposal and Recovery (Report 022-14)

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Governance Committee (GC) Report – March 20, 2014 Verbal Report	–	x	x		To receive information and consider recommendations from the March 20th GC meeting
Delegation and Recommendation Reports						
2	Skin Cancer Prevention Act Regulations and Required Resources Report 020-14	Appendix A Appendix B		x		To commend the Ontario Government for the Skin Cancer Prevention Act and to advocate for adequate funding from the MOHLTC for local public health to support enforcement and promotion activities
3	Needle/Syringe Disposal and Recovery Report 022-14	Appendix A	x		x	To receive information about how the Health Unit, City of London, London CAReS and the Regional HIV/AIDS Connection are working together toward comprehensive approaches to ensure proper needle/syringe disposal
Information Reports						
4	Overview of Withdrawal Management Report 023-14	–			x	To provide an overview of withdrawal management services available provincially and locally
5	Local Representation at National Homelessness Conference Report 021-14	–			x	To receive information about local representation at national homelessness conference
6	Medical Officer of Health Activity Report – February Report 024-14	–			x	To provide an update on the activities of the MOH for March

CONFIDENTIAL (if necessary)

OTHER BUSINESS - Verbal Report - Human Resources re Associate Medical Officer of Health Position
- Next Board of Health Meeting: Thursday, April 24, 2014

CORRESPONDENCE

a) Date: 2014 February 24 (Received 2014 February 28)
Topic: Support of the passage of Bill 131, Youth Smoking Prevention Act, 2013
From: Ms. Julie Roy, Chair, Board of Health, Northwestern Health Unit
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

b) Date: 2014 February 28 (Received 2014 February 28)
Topic: Support of Bill 162, Making Healthier Choices Act, 2014 – Menu Labelling Legislation
From: Mr. Barry Ward, Chair, Board of Health, Simcoe Muskoka District Health Unit
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

c) Date: 2014 February (Received 2014 March 7)
Topic: Praise from Participants in Smart Start for Babies – Teen
From: Ms. J. McIlwain
To: Middlesex-London Board of Health

d) Date: 2014 March 5 (Received 2014 March 10)
Topic: Request to Expand Publicly Funded Human Papillomavirus Vaccination Program
From: Ms. Amanda Rayburn, Chair, Wellington-Dufferin-Guelph Board of Health
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

e) Date: 2014 March 10 (Received same)
Topic: VQA Wines at Farmers' Markets
From: Mr. Gordon Fleming, Manager, Public Health Issues alPHa
To: All Boards of Health, Senior Staff and MOH's

Copies of all correspondence are available for perusal from the Secretary-Treasurer.

ADJOURNMENT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 020-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 March 20

SKIN CANCER PREVENTION ACT REGULATIONS AND REQUIRED RESOURCES

Recommendation

It is recommended that:

1. ***The Board of Health endorse Report No. 020-14 re: "Skin Cancer Prevention Act Regulations and Required Resources"; and,***
2. ***The Board of Health send a letter, attached as Appendix B, to the Right Honourable Premier Kathleen Wynne and to the Honourable Deb Matthews, Minister of Health and Long Term Care to commend the Ontario Government for the Skin Cancer Prevention Act, and to advocate for adequate funding for local public health from the Ministry of Health and Long-Term Care to support enforcement and promotion activities.***

Key Points

- The *Skin Cancer Prevention Act (Tanning Beds)* prohibits the selling, offering for sale or marketing of tanning services or ultraviolet light treatments (for tanning) to persons under the age of 18 years.
- Public health units will be designated under the *Act* to enforce the legislation.
- Public health units currently receive no funding from the Ministry of Health and Long-Term Care to support the promotion and enforcement of the *Skin Cancer Prevention Act* and regulations in order to protect children and youth from melanoma skin cancer and other health risks from the use of artificial tanning equipment.

Skin Cancer Prevention Act

On October 10, 2013, the *Skin Cancer Prevention Act (Tanning Beds)* received royal assent. This major all-party legislative achievement prohibits providing ultraviolet light treatments to persons under the age of 18. Under this legislation, it is illegal to advertise or market artificial tanning or ultraviolet light treatments to persons under the age of 18. Businesses or individuals who sell such services or treatments to adults would be required to notify their local Medical Officer of Health that they intend to do so, and to post signs in their businesses about the health effects of the services or treatments.

Skin cancer accounts for approximately one-third of cancers diagnosed in Ontario, and it is estimated to have resulted in an economic burden of more than $344 million in 2011. With most people receiving much of their lifetime exposure of ultraviolet radiation (UVR) during childhood and adolescence, it is imperative that they avoid the additional burden of artificial UVR from tanning equipment at this age. UVR from tanning equipment is an established human carcinogen.

Recommendations on the Draft Regulations

On January 3, 2014, a plain language summary of the draft regulation under the *Skin Cancer Prevention Act (Tanning Beds)* was posted to the Regulatory Registry for a 45-day period for public and stakeholder comment. According to the summary, the proposed regulation intends to address definitions, identification,

advertising, marketing, signage and protective eyewear. Given the legislative requirement that public health units will be designated under the *Act* to enforce this legislation and in the absence of actual regulatory language, Health Unit staff prepared and submitted comments, attached as Appendix A.

Adequate Funding for Public Health Units Is Required

The similar enforcement model for the tobacco regulations (Ontario Regulations 48/06) under the *Smoke-Free Ontario Act* provide an ideal model for the *Skin Cancer Prevention Act*. There is strong evidence that active surveillance from public health units is necessary to ensure compliance. Additionally, lessons learned from public health units' collective experience with tobacco legislation and regulations clearly illustrate that mandatory compliance visits, including youth access inspections, will increase compliance with such legislation. To fulfill this new mandate, local public health units will require additional funding from the Ministry of Health and Long-Term Care, as outlined in Appendix B. In consultation with public health units, a funding model should be developed to support the following required activities:

- ***Compliance monitoring***: youth access checks and mandatory inspections of facilities where tanning services or ultraviolet light treatments are offered
- ***Staff and owner/operator training***: training of public health unit staff who will be responsible for compliance and enforcement activities, and the provision of training to operators/owners of tanning facilities
- ***Registry development***: development of an electronic registry or database, including technical support and a set of required data fields so that statistics and reports can be generated locally, regionally and provincially to ensure accountability and to measure outcomes
- ***Public education and promotion:*** it is well documented in the literature that voluntary compliance with legislation increases when enactment is supported with the implementation of a creative and coordinated social marketing campaign that not only promotes the legislation but also promotes awareness of the dangers of tanning and exposure to ultraviolet radiation regardless of age.

Conclusion/Next Steps

Overexposure to ultraviolet radiation (UVR) from artificial sources (tanning beds) is a significant public health concern. The Ontario government has taken legislative action and has provided funding to public health units to protect youth from the promotion of and access to tobacco products. It is equally important that public health units are adequately funded to support the promotion and enactment of the *Skin Cancer Prevention Act* and regulations in order to protect children and youth from melanoma skin cancer and other health risks from the use of artificial tanning equipment.

This report was prepared by Ms. Lil Marinko, Public Health Nurse and Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundations: Principles-1, 2, 4; Foundational Standard: 3, 8, 9, 10, 11, 12, 13; Chronic Disease Prevention – Ultraviolet Radiation Exposure: 1, 6, 7, 11

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Comments Re: Draft Regulations for Bill 30 *Skin Cancer Prevention Act* (Tanning Beds) 2013 Middlesex-London Health Unit

Linda Stobo, Manager Chronic Disease Prevention and Tobacco Control
Lilliana Marinko, RN

We would like to provide comments below based on the summary that accompanied the release of Bill 30 and in the absence of actual regulatory language.

Re: Definitions

We recommend that all terms that provide authority and/or that may be used for compliance and enforcement are defined in the regulations to provide clarity.

"**Minister** - we would like consideration of the addition of "any person designated by the Minister to act on the Minister's behalf" to provide greater flexibility in providing authority under the Act.

"**Owner"** is the terminology used in the legislation and **"owner/operator**" is used in the draft regulation summary. Within the regulation, both "owner" and "operator" should be clearly defined/clarified since the owner of a commercial tanning operation may not be the person who manages or controls a commercial tanning operation. It is our recommendation that owners and operators (or persons most in charge) should be held accountable under the *Act.* The definition of "operator" within the *Health Protection and Promotion Act* and corresponding Regulations may prove useful.

"**Tanning services**" should be clearly defined in the regulations with reference to using/offering any device that can be equipped with one or more ultraviolet lamps and induces skin tanning or other cosmetic effects.

"**Prescribed class**" needs to be defined in the regulations since it is included under sub-section 2(5). This inclusion without parameters may provide a potential legislative loophole and/or may create confusion for both the owner/operators and the Public Health Units who are responsible for enforcement.

"**Spray tanning**" should be clearly defined in the regulations. It is understood that "spray tanning" is excluded from the *Act* and Regulations; however, an unintended consequence may be the increased use of spray tanning as an alternative to tanning. Clear parameters around what is considered "spray tanning" would help to define the issue.

Re: Apparent Age

Comment: Before selling tanning services to any person who appears to be less than 25 years old, an operator must request identification and be satisfied that the person is at least 18 years old. The *Act* does not legislate currently what forms of identification are acceptable. Acceptable identification must be government issued, that includes photograph, name and date of birth. This requirement for acceptable identification should be clearly defined within the regulations.

Re: Proposed Valid Identification

Comment: *The only acceptable identification should be government issued identification that includes date of birth and photograph. Acceptable identification is:*

- Ontario driver's licence
- Canadian passport
- Canadian citizenship card
- Canadian Armed Forces identification card
- Liquor Control Board of Ontario photo card

When identification is presented other than Ontario- issued, the same consideration of government issued identification that includes name, date of birth, and photograph should be observed.

Consideration should be given to the inclusion of language within the regulations to cover **Improper Identification.** The inclusion of language similar to "n*o person shall present as evidence of his/her age identification that is not lawfully issued to him/her" would incorporate some consumer responsibility into the regulation and legislation.*

Re: Owner's Responsibility

Comment: The legislation outlines that the owner shall be liable for youth access unless they exercised **due diligence** to prevent contravention. It is imperative to provide strict and specific responsibilities of owners/operators that would meet the requirement of "**due diligence"** as without clear guidelines it becomes problematic for enforcement of the *Act*. Our health unit has had experience in tobacco control and may be able to provide some guidance in this matter and can offer a framework to develop the parameters – please refer to Appendix A. For example, it should become the responsibility and legal obligation of those who sell or offer tanning services to provide consumers with information about the risks associated with tanning, to ask for identification, to provide education for staff regarding the law and appropriate identification, and to have the appropriate policies in place regarding documentation, etc. High expectations for due diligence should be included in any training material provided by the Ministry for operators.

Re: The proposed exception of the Owner's responsibility

Comment: Under sub-section 2 (5), the legislation reads, Subsections (1) and (2) do not apply to a person who belongs to a **prescribed class**, as long as the person is complying with all applicable requirements provided for in the regulation; this provides an opportunity to bypass the legislation. Who is the **prescribed class and what is the intention of the exception**? **Could you provide some comments or explanation as to why the exception was included in the legislation?** Our position is that tanning services should not be provided to anyone under the age of 18 years regardless; there should be no exemptions.

It is the position of our Health Unit that medical exemptions for artificial tanning should not be included. The use of commercial tanning beds for treatment of underlying medical problems is not endorsed by the Canadian Dermatology Association. The scientific evidence is clear that commercial tanning facilities are not the appropriate substitute for treatment as they provide a larger range of ultraviolet light (UV) wavelengths than UV equipment specifically designed for treatment. The first line of treatment for any medical problem that is treated with UV is medication; UVR therapy indications are limited.

Tanning operators should not be permitted to accept a prescription for UVR treatments or services. Anecdotal evidence suggests use of prescriptions for Vitamin D treatments at tanning salons in the Province of British Columbia and in the city of Ottawa. The language should be explicit in the regulations so that it is clear for both operators and those enforcing the legislation; no prescriptions allowed.

Re: No Self-Tanning

Comment: Under the legislation, no tanning services can be provided by a device that does not require the presence of an attendant so it is important that the regulations outline what that statement actually means. Does "the presence of an attendant" mean someone in the building, at the front desk, or in close proximity? We propose that the regulations clearly define that this means that an attendant needs to be able to restrict access to the device and provide control over the maximum length of time of exposure.

Coin-operated machines would not be permitted for use under the legislation. There should be a consideration for some regulations in place to allow an inspector to stop use of such device, for example, an order for seizure of such device or the suspension of operation as it is illegal. It may be problematic for inspectors to physically remove the coin-operated devices but there should be an action(s) that allows inspectors to prohibit public access to the device.

Tanning devices may also be found in some condominiums or health clubs as an added service to their members. It is our understanding that the condominiums use self-serve tanning

devices and health clubs may or may not have an attendant. For those devices within common areas of condominiums, condominium corporations may not view these devices as public service, but part of the "private dwelling". This example requires consideration and within the regulation, a clear definition of private dwelling is necessary to ensure that public health units have appropriate authority to inspect and prohibit public/client use to these devices. The Public Pool Regulations and Public Spa Regulations address pools and spas in private health clubs and privately-owned condominium units. These Regulations may provide elements for consideration.

Re: Proposed Regulations for Advertising and Marketing of Tanning Services and Treatments for Tanning

Comment: Tanning operators should be prohibited from claiming any health benefits of tanning services or ultraviolet treatments for tanning since it promotes the idea that tanning behaviour is healthy. The regulations should clearly restrict advertising and marketing to youth, such as in or near elementary and high schools, university and college campuses. No advertisements should be placed in media, electronic or otherwise, that includes images targeted to youth; images used in advertisements should not portray/use youth under 25 years of age in advertisements, campaigns or strategies to market tanning services. There should be a discontinuation of any materials such as tanning bed stickers or accelerants that attract youth to tanning services, especially at point of sale, through giveaways, or promotional items. No advertisements in youth magazines, youth websites, or other venues that are frequently used or accessed by youth should be permitted. Under no circumstances should health benefit claims for the use of UVR be allowed in any type of advertisement, promotion or marketing strategy. In particular some tanning bed operators are using social media to advertise their special deals, targeted to youth and young adults. These social media ads target specific age groups/demographics. These types of advertising tactics need to be spelled out in the regulation as prohibited.

Similar to the Province of New Brunswick (http://laws.gnb.ca/en/ShowPdf/cs/2013-c.21.pdf), we would support no direct or indirect advertising promoting artificial tanning that makes false or misleading claims about health effects from tanning including advertising that includes the following statements:

- That artificial tanning is beneficial to a person's health
- That artificial tanning is a means of obtaining vitamin D
- That artificial tanning is a means of obtaining a base tan

The summary of the draft of the proposed regulation indicates the term "tanning services" will be defined in a manner that excludes spray tanning. However, many tanning operators offer both UVR beds and spray tanning, therefore youth will be able to continue to access these

services in tanning operations; therefore it is imperative to keep access, marketing and advertising away from youth.

An unintended consequence of excluding spray tanning from the legislation and regulations may be the increased use of spray tanning. The Health Unit encourages the Ministry of Health and Long-Term Care to advocate to Health Canada for the development and public release of safety information related to the use of commercial spray tanning booths. Recommendations about protective measures need to be issued by Health Canada to the public and protective measures regarding spray tan should be incorporated into the materials developed and distributed for training and education on owner/operator requirements under the Skin Cancer Prevention Act and Regulations. For example, dihydroxyacetone (DHA), the colour additive that darkens the skin and that is contained in some sunless tanning products, is approved by Health Canada for external application only. Health Canada needs to provide clarity to the public and spray tanning service providers about the use of spray tanning booths. The US Food and Drug Administration (FDA) has taken a position that all-over spray has not been approved; the FDA advises that consumers should request measures to protect their eyes and mucous membranes, and measures should be in place to prevent inhalation. Leadership on this issue in Canada is required.

Addition of **Display and Promotion**

No person shall promote tanning services in/or at any place where tanning services or ultraviolet light treatments for tanning are sold, offered for sale, or provided, where youth are ordinarily invited/permitted access either expressly or by implication, or whether a fee is charged for entry.

Addition of **Display and Promotion at Places of Entertainment/Recreation**

No person shall employ or authorize anyone to promote tanning services or the sale of tanning services at any place of entertainment or recreation that the person owns, operates or occupies. This would prohibit the promotion of tanning services at places where youth and young adults frequent like restaurants, cafes, recreational facilities, bars, bowling alleys, golf courses, etc.

Re: Proposed Regulations for Signs

All signs required to be posted under the Act and regulations shall be posted in a conspicuous manner and shall not be obstructed from view. Improper signage and obstruction are to be denoted as contrary to the regulations and are eligible for fine.

A person who sells, offers to sell, or provides tanning services or ultraviolet light treatments for tanning shall post the sign at any location where services are sold or offered in a place where

the sign is clearly visible to the person who sells or supplies the service and to the person to whom the tanning service is sold or offered.

The content to be posted should clearly describe the government identification that is necessary to access services, the age restriction and health warnings. The Government ID signage should state clearly that anyone aged 25 years and under will be asked for identification to access tanning services.

Simple, clear, and concise language should be used on the signs.

Recommend that signage is government issued and distributed to keep size, shape, colour, and messaging consistent. The Ontario Ministry of Health and Long-Term Care can develop and distribute signage through that Ministry and/or local public health units.

We strongly recommend no use of distance in the regulations for posting signage, such as "one meter from …" as it provides challenges for enforcement and potential court or prosecution challenges. Key areas in a tanning facility should have signage, including point of sale and entrance to the facility. Posting signs throughout the facility may dilute our message, or create more interest in tanning by inadvertently "advertising" the fact that access is not allowed for youth. The "display, promotion and handling" section of Regulation 48/06 under the *Smoke-Free Ontario Act* provides excellent guidance on the limitations and restrictions that should be enacted to prohibit the inadvertent advertising of tanning services to youth. The number of signs should be restricted and restrictions placed on the type of signage allowed (e.g. black font on white background, no larger than 14 Arial font).

Re: Proposed Regulation Regarding Protective Eyewear

Comment: The operator should provide each client/customer with ultraviolet radiation safety eyewear that complies with the Radiation Emitting Devices Regulations (Tanning Equipment) and covers the eyes securely. This regulation addresses the specific wavelength range of the eyewear to ensure safety. Additional inclusion of instructions for use, for example how to wear them, as well as the inclusion of operator responsibility to ensure eyewear are free of cracks, pitting or discolouration to minimize any damage to the eyes is imperative.

There is also a risk of transmission of infectious diseases (e.g. Pink Eye) from sharing protective eyewear equipment. It is therefore recommended that customers of tanning salons be encouraged to purchase their own personal protective eyewear equipment from the operators for their own personal and exclusive use. If protective eyewear equipment is provided by the tanning salon, it should either be single-use and disposed of after use on a single client, or else such equipment must be disinfected in accordance with Infection Control guidelines.

With the inclusion of eyewear in the legislation and proposed regulations, it does allow health protection to be part of the regulations for all individuals that access tanning services.

Re: The Proposed Notice of Operation

Comment: Along with the notice of operation to the Medical Officer of Health in the area where tanning services or treatments are offered, there should be consequences if notice is not provided prior to the selling of such services, or in the case of existing facilities, after 60 days of the coming into force of this section. Failure of notification should be cause for an immediate fine. This section of the *Act* should have short form wording attached to facilitate the levying of fines for lack of notification.

A mandatory provincial or municipal registry is recommended as it would be useful and practical to identify the tanning operators in the city and county.

Re: Inspectors

Comment: Recommend that *at the time an inspector removes records or other things, that the proprietor be prohibited from doing anything to remove or destroy any other records or things until the process is complete.*

Re: Additional Considerations for the Proposed Regulations

1. The Regulations for the *Skin Cancer Prevention Act* should follow a similar model to that which exists for the tobacco regulations (Ontario Regulations 48/06) under the *Smoke-Free Ontario Act*

Evidence suggests that through self-regulation the tanning industry has not been compliant with voluntary regulations. There is strong evidence that more active surveillance from public health units is necessary to ensure compliance. In a study released October 2008, the evidence showed that artificial tanning facilities in Toronto were not following Health Canada's voluntary safety guidelines. The key findings were:

- 96% of all personnel operating the tanning facilities did not communicate with the researchers about Health Canada's tanning safety guidelines
- 60% of tanning facilities did not ask the age or ask for identification from the researchers who were under the age of 19 years
- 60% of tanning facilities visited did not identify, neither verbally or through a skin assessment survey that the researcher had type I skin that burns and never tans.
- 99% of tanning facilities did not recommend against tanning for the researchers with type 1 skin type.
- Only 12 % of facilities visited were reported to have the Health Canada voluntary guidelines posted in an area that could be seen by the researchers

(Canadian Cancer Society, Ontario Division (October 2008) Media Backgrounder: Results from 2007 study of Toronto's artificial tanning facilities).

Additionally, lessons learned from public health units' collective experience with tobacco legislation and regulations clearly illustrate that unless there are mandatory compliance visits by each jurisdiction voluntary compliance with the regulations will not be achieved (Sinclair C, Makin JK. Implications of Lessons Learned From Tobacco Control for Tanning Bed Reform. Prev Chronic Dis 2013;10:120186. DOI: http://dx.doi.org/10.5888/pcd10.120186)

2. Enforcement Protocols and Directives

The Ontario Tobacco Research Unit (OTRU) has just released results from a study they conducted with three public health units testing a risk-based enforcement model for public health unit inspections of tobacco retailers. The model demonstrated that even low risk tobacco retailers required at least one youth access check per year, and for higher risk tobacco retailers, two to perhaps even 4 or five inspections are required. By increasing the frequency of inspections for high risk tobacco retailers, compliance increased. Legislation without active compliance and enforcement activities will not yield the results intended with the enactment of the *Skin Cancer Prevention Act*. Mandated inspections are required to ensure consistent application and enforcement of the *Act* across Ontario. The Middlesex-London Health Unit welcomes the opportunity to participate in consultations to assist in the development of a Protocol for inclusion under the Ontario Public Health Standards and the development of enforcement directives (i.e. mandated inspections, interpretation of advertising restrictions, etc…) to ensure consistent application and compliance with the *Skin Cancer Prevention Act* and its Regulations.

3. Funding for Public Health to Adequately Promote and Enforce the Legislation

Funding enhancements for public health units to support the promotion and enforcement of the new legislation are required. This is a significant addition to the requirements under the Ontario Public Health Standards and as a result, a funding model should be developed, in consultation with public health units to support the following required activities:

- Compliance monitoring: additional funding for public health units for inspections of facilities to meet the new requirements under the Ontario Public Health Standards
- Training of PHU staff who will be responsible for compliance and enforcement activities, including the training of operators/owners of tanning facilities
- Registry development, including technical support and a set of required data fields so that statistics and reports can be generated locally, regionally and provincially to ensure accountability and to measure outcomes
- Public education and promotion of the new legislation through a creative and coordinated social marketing campaign that not only promotes the legislation but that promotes the dangers of tanning and exposure to ultraviolet radiation, regardless of age.

4. Consistent Province Wide Development of Educational Materials

There should be consistent, province-wide educational materials (including signage) developed and provided to the Public Health Units for owners/operators that outline obligations under the law. A **Tanning Operator Manual that has the following inclusions is required:**

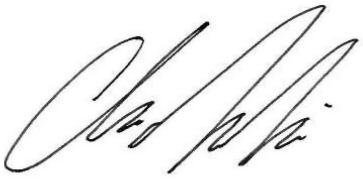
- Section for the law
- ID (similar to the sheets used in Tobacco and Alcohol
- Signage
- Health effects
- Skin type
- Owner/operator obligations
- Documentation

The Middlesex-London Health Unit welcomes any and all opportunities to work with our partners at the Ministry of Health and Long-Term Care to support a successful implementation of the *Skin Cancer Prevention Act* and Regulations.

Please don't hesitate to contact us:

Lilliana Marinko, BScN, R.N.
Public Health Nurse
Email: lil.marinko@mlhu.on.ca
Tel: (519) 663-5317 ext. 2679

Linda Stobo, B.Sc., MPH (Candidate)
Chronic Disease Prevention and Tobacco Control Manager
Email: linda.stobo@mlhu.on.ca
Tel: (519) 663-5317 ext. 2388



_____

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

March 20, 2014

Right Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Room 281
Queen's Park
Toronto, ON M7A 1A1

RE: Public Health Unit Funding for Enactment of the Skin Cancer Prevention Act

Dear Right Honourable Premier Wynne;

The Middlesex-London Board of Health wishes to commend you for the successful passage of the *Skin Cancer Prevention Act (Tanning Beds)*, 2013. This comprehensive legislation will prevent skin cancer by protecting youth from the harmful effects of exposure to ultraviolet radiation through the use of tanning beds.

At its March 20, 2014 meeting, the Middlesex-London Board of Health considered Report No. 020-14 re: "Skin Cancer Prevention Act Regulations and Required Resources" and passed the following:

It was moved by _____, seconded by _____:

1) *That the Board of Health endorse Report No. 020-14 re: "Skin Cancer Prevention Act Regulations and Required Resources"; and,*

2) *That the Board of Health send a letter, attached as Appendix B, to the Right Honourable Premier Kathleen Wynne and to the Honourable Deb Matthews, Minister of Health and Long Term Care to commend the Ontario Government for the Skin Cancer Prevention Act, and to advocate for adequate public health unit funding from the Ministry of Health and Long-Term Care to support public health unit enforcement and promotion activities.*

A copy of Report No. 020-14 is attached for your reference.

Evidence suggests that, through self-regulation, the tanning industry has not been compliant with voluntary regulations. There is strong evidence that active surveillance and mandatory compliance inspections conducted by public health units are necessary to ensure compliance with the *Act* and the regulations. To fulfill this additional mandate, adequate funding from the Ministry of Health and Long-Term Care is required.

The Middlesex-London Board of Health welcomes any and all opportunities to work with our partners at the Ministry of Health and Long-Term Care to support the successful implementation and enforcement of this important piece of public health legislation.

Sincerely,

Marcel Meyer
Chair, Middlesex-London Board of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 022-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 March 20

NEEDLE/SYRINGE DISPOSAL AND RECOVERY

Recommendation

It is recommended that Report No. 022-14 re Needle/Syringe Disposal and Recovery be received for information.

Key Points

- For people who use injection drugs, use of a sterile needle/syringe and related equipment for each injection reduces the risk of acquiring HIV and hepatitis B and C.
- In 2013, Counterpoint Needle Syringe Program (NSP) distributed 2,369,658 needles/syringes while 1,210,683 were returned. Many of the outstanding syringes will have been disposed in a safe manner, though not through the NSP. Nevertheless, improper disposal is an inherent risk of needle/syringe use. This challenge is not unique to the local area.
- The Health Unit, City of London, London CAReS, and the Regional HIV/AIDS Connection are working together toward comprehensive approaches to support proper needle/syringe disposal.

Background

Provision of sterile needles/syringes and related equipment for use with each injection is an important public health intervention to mitigate risk among the population who use injection drugs. Proper disposal of used equipment reduces the risk of blood-borne infections, including HIV and hepatitis B and C associated with equipment sharing, and also reduces accidental needle stick injuries among the general public.

Barriers to proper disposal of used needles/syringes are cited in the literature. These include lack of knowledge of correct practices or locations; inability to properly store and dispose of used equipment related to living situations (e.g. homelessness); limited Needle Syringe Program (NSP) hours of operation and alternative disposal sites; and concerns about arrest for possession. Best practices for disposal and handling of used injection equipment are summarized in Appendix A. These recommendations are part of a 2013 best practice document for Canadian harm reduction programs, and are consistent with practices in London.

In follow-up to the September 2013 Board Report No. 092-13 entitled Harm Reduction Strategies, the current report describes needle/syringe disposal and recovery processes and strategies, as well as proposed strategies for enhancement. These strategies are a joint effort of the Middlesex-London Health Unit (MLHU), the City of London, London CAReS, and the Regional HIV/AIDS Connection.

Needle Disposal and Recovery within the City of London

Counterpoint Needle Exchange Program: The Counterpoint Needle Exchange program is operated by the Regional HIV/AIDS Connection (RHAC) and funded through the Health Unit. It consists of a primary site at RHAC, satellite sites at MLHU and My Sister's Place, and mobile outreach. The mobile outreach component is funded by the AIDS Bureau of the Ministry of Health and Long-Term Care. Clients who use the NSP are educated regarding appropriate storage and disposal; offered sharps containers; and are encouraged to return used equipment to the NSP sites or to the mobile outreach worker, or to dispose of them in stationary needle collection bins that are located around the city. In the 12 month period from January 1, 2013 to December 31, 2013, 2,369,658 syringes were distributed, while 1,210,683 were collected among the NSP sites and mobile outreach. Used equipment is not handled by staff, thus return numbers are estimates.

In the 2012 I-Track survey of people who use injection drugs in London, the majority of respondents (n=197) indicated that they most often disposed of used syringes in a drop box (57.9%) or returned them to the NSP (45.2%); 10.7% reported putting used syringes in a secured container and placing this in the garbage. A small proportion reported disposing directly in the garbage (5.1%) or on streets (1.0%). (Note: percent totals add to over 100.0% as more than one response was possible). Despite the strong association between the use of NSPs and safer disposal practices cited in the literature, improper disposal of injection drug equipment can be an inherent risk and ongoing challenge of needle/syringe distribution.

Stationary needle collection bins and role of London CAReS: Since 2008, 13 stationary needle collection bins have been installed at strategic locations by the City of London as part of London CAReS for collection of discarded injection equipment. In 2011 and 2012, approximately 114,000 and 186,000 syringes were recovered from the bins, respectively. In 2013, approximately 268,310 syringes were recovered. The growing use of the bins has been attributed to the placement of additional bins and enhanced collection efforts including neighborhood awareness and education provided to the community who use drugs. Current bin locations are listed on MLHU's "Safe Disposal of Sharps" webpage. Locations of the bins are based on known 'hot spots' for discarded syringes and/or public concern. Maintenance of the bins is the responsibility of London CAReS.

London CAReS outreach teams have regular shifts throughout the week for retrieval of syringes in identified 'hot spots' and identification of any new 'hot spots'. CAReS also responds to calls from the community regarding syringes found in public places, with the primary target area being the core of the city. By April 2014, this service will operate 24 hours per day. Additionally, CAReS works in partnership with community volunteers who conduct clean-up efforts along the Thames River and other areas in the city.

Community organizations, businesses and pharmacies: Many community businesses and organizations have been proactive in recognizing the need for safe disposal of sharps and have had sharps containers installed at their locations. Many have independent contracts for disposal, thus these collected syringes are not counted. Some pharmacies distribute sharps containers and accept them back when filled; these returns are also not counted. The City of London Parks and Recreation and Roads and Transportation departments also play a role in needle/syringe collection and recovery. This includes installing the bins, participating in community clean up events and training Parks and Recreation staff on safe collection practices for discarded drug use equipment. City Recreation Centres now contain wall-mounted sharps containers.

Information for the public: Information about safe handling and disposal of sharps is on MLHU's website under " Safe Disposal of Sharps" and on the RHAC website under "Safe Needle Disposal". The City of London links to information on the MLHU website. In the past, public information had recommended disposing properly packaged used needles and syringes in municipal waste. This practice is no longer recommended.

Moving Forward

The Health Unit, City of London, London CAReS, and the Regional HIV/AIDS Connection are working together toward comprehensive approaches that increase access to safe disposal options, increase NSP return rates, minimize improper disposal of injection equipment and ensure that stray needles and needle debris in the community are dealt with promptly and safely. Strategies will include, but are not limited to, improvements in tracking, enhanced information on safe disposal to people who use injection drugs and the general public, and additional stationary bins.

This report was prepared by Ms. Rhonda Brittan, Public Health Nurse, Oral Health, Communicable Disease and Sexual Health Services.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections (including HIV).

Appendix A (Report 022-14)

Best Practices for disposal and handling of used injection equipment

Below are recommended best practice policies for needle syringe programs (NSPs) and other harm reduction programs to facilitate disposal of used injection equipment and non-injection equipment:

- Regular review and assessment of compliance with local, provincial/territorial and federal regulations regarding collection, storage, transportation, security and disposal of biomedical waste
- Educate clients and staff members on how to properly handle, secure and dispose of used injection and non-injection equipment
- Encourage clients to return and/or properly dispose of used injection and non-injection equipment
- Provide clients with tamper resistant sharps containers in a variety of sizes
- Provide multiple, convenient locations for safe disposal of used equipment in rural and urban settings.
- Do not penalize or refuse to provide new equipment to clients who fail to return used drug equipment. Evidence shows that strict exchange policies, such as “one-for-one” are neither necessary nor desirable to achieve high return rates
- Visually estimate the amount of returned equipment; staff should not touch used equipment and neither staff nor clients should manually count used equipment
- Encourage staff and clients to be vaccinated against hepatitis B
- Provide access to safety devices for staff and procedures for first aid and post-exposure prophylaxis (PEP)

Strategies to encourage proper disposal

Several strategies have been suggested within the research literature to increase proper disposal:

- providing multiple locations for return and disposal of equipment
- increased hours of operation of NSPs and other harm reduction programs
- conducting visits to retrieve biohazard bins and syringes from homes and drug use spaces
- installing public disposal boxes
- encouraging pharmacy disposal
- conducting community clean ups
- providing spaces for people who use drugs

Reference:
Working Group on Best Practice for Harm Reduction Programs in Canada. (2013). *Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1*. Retrieved from: http://www.catie.ca/sites/default/files/bestpractice-harmreduction.pdf

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 023-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 March 20

OVERVIEW OF WITHDRAWAL MANAGEMENT

Recommendation

It is recommended that Report No. 023-14 re Overview of Withdrawal Management be received for information.

Key Points

- Withdrawal Management Services are designated as provincial services under specific Ministry of Health and Long-Term Care (MOHLTC) service categories and are administered by Local Health Integration Networks (LHINs).
- In Ontario, there are 39 organizations that offer community and/or residential withdrawal management services; twenty-seven have residential programs, of which four are Level 3 centres that offer medically-assisted withdrawal.
- Locally, withdrawal management services are provided by The Salvation Army Centre of Hope Withdrawal Management Centre (Level 2 Residential service) and Addiction Services of Thames Valley (Community Tele-Withdrawal service).

Background

Withdrawal management assists people in overcoming substance dependence by helping them to obtain at least a temporary state of abstinence. People are supported through the withdrawal process, provided an opportunity to seek help with any concurrent conditions, and referrals for ongoing treatment are facilitated. In follow-up to a request from the Board of Health in September 2013, this report will provide the history of withdrawal management as a provincial service, and an overview of current withdrawal management services in Ontario and Middlesex-London.

History of Withdrawal Management

In the early 1970s, Detoxification Centres were developed under the Ontario Ministry of Health with the goals of providing a community setting for alcohol detoxification and linking with referral and recovery. By 1975, 13 centres had been established in Ontario. Over the following decade, the need became apparent for facilities for women, youth and more diverse populations, as well as the problem of poly-substance abuse.

During the mid-1990s, language changed from "detox" to "withdrawal management," and there was growing recognition of the need for alternative models. Residential services were developed for less densely populated areas, for those who had barriers to attending residential services and for those with less intensive observation needs.

Withdrawal Management in Ontario

Withdrawal Management Services in Ontario are designated as Provincial Services under the following Ministry of Health and Long-Term Care (MOHLTC) service categories: Residential Withdrawal Management (Levels 1, 2, and 3) and Community Withdrawal Management (Levels 1, 2, and 3). "Medical detox," more appropriately referred to as medically-assisted withdrawal, whereby medication is prescribed

and given by the centre to reduce withdrawal symptoms, corresponds to Level 3. Newer categories of services such as Day Withdrawal Management Service (DWMS) and Telephone Supported Withdrawal Management Service (TSWMS) are emerging to provide care when barriers to other categories of withdrawal management exist. The Ontario Withdrawal Management Standards, 2008 set out minimum standards of practice to guide the operation of withdrawal management services.

Residential withdrawal management agencies are sponsored by hospitals under service agreements which are established between the Local Health Integration Network (LHIN), MOHLTC, the sponsoring hospital, and the withdrawal management service. According to data from the Drug and Alcohol Helpline (DAH), there are currently 39 organizations that offer community and/or residential withdrawal management services in Ontario; twenty-seven have residential programs, of which four are Level 3 centres. These Level 3 centres are located in Toronto, Ottawa, and Sioux Lookout.

Withdrawal Management in Middlesex-London

The Salvation Army Centre of Hope Withdrawal Management Centre (COH-WMC) opened its doors in 2005. Prior to this, withdrawal management services were provided through St. Joseph's Hospital at an off-site location. COH-WMC is a Level 2, 18-bed residential withdrawal management centre under the sponsorship of Alexandra Hospital in Ingersoll. COH-WMC provides care for both men and women over the age of 16 who are intoxicated/high, in withdrawal or in crisis due to alcohol or drugs. The centre is open 24 hours a day, seven days per week. Referrals can be made by the client or through a care provider, either by phone or in-person. Of the 18 beds, eight are observation beds for those in active withdrawal. Clients are monitored closely and are referred to medical care when necessary. As a Level 2 Centre, a physician is not on site, however if medication is prescribed by an off-site physician, staff are able to administer it. The other 10 beds are for clients who have completed withdrawal and are expressing a desire to go on to treatment and recovery. Provincial assessments and referrals are administered in the Program.

Stabilization while waiting for intake into treatment centres and attaining long term abstinence is challenging, and re-admissions account for approximately 70% of the 1200-1400 admissions each year. In situations where the Centre's observation beds are at capacity, clients are triaged, provided referrals, assessed for safety and encouraged to call back frequently.

Addiction Services of Thames Valley (ADSTV) TeleWithdrawal and Crisis Support Program is a newer initiative to help fill unmet addiction and mental health service needs in the Thames Valley catchment area of the South West LHIN. It serves the populations of London-Middlesex, Elgin and Oxford Counties. The program provides a client-centred, harm reduction approach to community withdrawal management and crisis support including acute and post withdrawal assessment, consultation, planning, relapse prevention, comprehensive community referrals and education. Services are provided by a team of four registered nurses with support from other health care providers to deliver care using telemedicine technology. Program development started in May of 2012, with the first client entering the program in December 2012. Since that time, there have been approximately 35 clients have entered the program.

Conclusion

Withdrawal Management is part of a continuum of services addressing addictions in our community. It is important for those working in harm reduction and other areas of public health to be aware of and able to refer clients to withdrawal management services. Withdrawal management can serve as a bridge to accessing other health and social services, including longer term addictions treatment.

This report was prepared by Ms. Rhonda Brittan, Social Determinants of Health Public Health Nurse in Oral Health, Communicable Disease and Sexual Health Services.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 021-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 March 20

LOCAL REPRESENTATION AT NATIONAL HOMELESSNESS CONFERENCE

Recommendation

It is recommended that Report No. 021-14 re Local Representation at National Homelessness Conference be received for information.

Key Points

- All Our Sisters 2014 is a national conference held in London which allows for knowledge exchange and solution building on issues relating to homelessness and housing insecurity among women at risk.
- MLHU is integrally involved in planning the All Our Sisters 2014 national conference, and functions as the Treasurer for the All Our Sisters committee.
- The Middlesex-London Health Unit will sponsor four local women to attend the May 2014 conference, at a total cost of $2,000 to ensure that there is local representation of women with the lived experience of homelessness.

Background

The "All Our Sisters 2014" conference is the second national forum on housing and safe communities for women and will be held in London from May 12 to 14, 2014. The conference hosts delegates from across Canada who are committed to creating a national network of partners to address national, regional, and local issues relating to women and homelessness. These issues include the social, economic, health, and practical issues affecting homeless women and women at risk of homelessness. The forum provides an opportunity for service providers, community members, policy makers, government officials, academics, change agents, and women with lived experience of homelessness to come together to promote safe and sustainable housing and safe communities for women. The conference promotes collaboration between diverse agencies, organizations, and individuals at local and regional levels, and supports the development of strategies for a sustainable national network.

Homelessness intersects with many issues relevant to public health, such as injury prevention, exposure to health hazards, mental health, addictions, sexual health, and healthy child development. Public Health Nurses on the Best Beginnings team provide services to homeless women and families in shelters in London and Middlesex County, and also provide home visits for women who are at risk of homelessness. The Reproductive Health team is currently assessing the extent of the issue of homelessness among pregnant women in our community. Harm reduction services are provided by the Sexual Health team to women who may be homeless or at risk of homelessness. In order to provide effective service to women experiencing homelessness or living in unsafe housing, we need to better understand the unique needs and challenges they face.

The Voice of Homeless Women

The participation in the conference of women with lived experience of homelessness allows their voices to be heard and provides service providers access to this unique perspective. Women who are homeless, or at risk of homelessness, bring diverse knowledge and experiences to the conference, filling a gap which would otherwise be missing. At the first All Our Sisters conference in 2011, 118 attendees and presenters were women from across Canada with lived experience of homelessness. Six of these women were supported to attend through MLHU ($3,000). MLHU also contributed $2,000 towards speaker costs.

The 2014 conference will also feature women from coast to coast, telling their stories about the barriers they face in attaining safe and sustainable housing, as well as the root causes of homelessness. The conference steering committee solicits sponsorships for honorariums to enable homeless women from across Canada to participate in the forum. The cost for one local woman to attend the conference is $500. In addition to in-kind contribution in the form of staff time organizing the event, MLHU will support the attendance of 4 local women to participate in this 3 day event ($2,000). Several staff and managers are involved in planning for the 2014 conference. MLHU is also acting as the treasurer for the event including the receiving and disbursement of funds. Other agencies committing funds include the University of Western Ontario, Sisters of St. Joseph, London Business Professional Women`s Group, Catholic Women`s League, WOTCH and Unifor Canada.

MLHU Policy Development

Currently MLHU does not have a policy or guidelines to assist us in determining contributions (in-kind and financial) to community sponsored health related events. The Senior Leadership Team is in the process of establishing a series of criteria which will ensure equity and due process as opportunities of this nature arise.

This report was prepared by Ms. Kathy Dowsett, Manager, Best Beginnings Team and Ms. Heather Lokko, Manager, Reproductive Health Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Foundational Standard

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 024-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 March 20

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – MARCH

Recommendation

It is recommended that Report No. 024-14 re Medical Officer of Health Activity Report – March be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the February Medical Officer of Health Activity Report to March 5, 2014.

The MOH and John Millson, Director, Finance and Operations made a presentation to Middlesex County Council Budget Committee on February 14.

On February 19, the MOH and Board of Health Chair, Marcel Meyer attended a Pillar workshop entitled The Power of Partnership – Executive Director & Board Relations. This event was led by Janet Frood of Horizon Leadership, and helped to provide tools and processes to support productive relationships between CEOs and Board members.

The MOH attended the 2014 alPHa Winter Symposium – Public Health Challenges and the Science of Persuasion in Toronto February 20th & 21st. The focus of this year's conference was communication, focusing on enhancing skills essential to maximizing the effectiveness of messages to targeted audiences.

On February 24th the MOH met with Board Member Al Edmondson and several Health Unit staff to discuss an initiative to explore obesity in school-aged children.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

February 14	Introductory meeting with Dr. Michael Strong, Dean, Schulich School of Medicine & Dentistry. This meeting was also attended by Dr. Amardeep Thind, Acting Director for the Masters of Public Health program
February 18	Interview with London Free Press reporter Jonathan Sher to discuss Public Health Nurse interaction with high school students
February 24	Introductory meeting with staff from the London Area Network of Substance Users (LANSU) Interview with London Free Press reporter Jonathan Sher to discuss Vaccinations
February 25	Introductory meeting with Martha Powell, President & Chief Executive Officer London Community Foundation

February 26 Attended a meeting of the Homeless Prevention System Implementation Team

February 27 Attended a Family Health Services Managers meeting
Attended a committee meeting of the Foundational Standard Community of Practice
Attended meeting at City Hall regarding City of London Final Budget Approval

February 28 Introductory meeting with Dr. Beth Henning, former Medical Officer of Health in Oxford County

March 3 Presented to a class of students enrolled in the Masters of Public Health at The Schulich School of Medicine Western University. The MOH's portion of the class presentation was in regards to budgets
Introductory meeting with Brian Lester, Executive Director Regional HIV/AIDS Connection

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

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health