

**AGENDA**  
**MIDDLESEX-LONDON BOARD OF HEALTH**

399 Ridout Street North  
Side Entrance, (Recessed Door)  
Board of Health Boardroom

Thursday, 7:00 P.M.  
2014 May 15

**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	Mr. Stephen Orser (Vice Chair)
Ms. Denise Brown	Mr. Ian Peer
Mr. Al Edmondson	Ms. Viola Poletes Montgomery
Ms. Patricia Fulton	Ms. Nancy Poole
Mr. Marcel Meyer (Chair)	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.	Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item #1 - Finance and Facilities Committee Meeting: May 1, 2014
7:15 – 7:25 p.m.	Mr. Mark Studenny, Chair, Governance Committee re Item #2 - verbal report from Governance Committee Meeting: May 15, 2014
7:25 – 8:00 p.m.	Dr. John Craven, SupportNet Studios Inc. and Ms. Alison Locker, Epidemiologist, re Item #3 – The Impact of Prescription and Non-Prescription Drug Use in Middlesex-London

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
<b>Committee Reports</b>						
1	Finance And Facilities Committee: May 1, 2014 Meeting (Report 031-14)	Appendix A <a href="#">May 1<sup>st</sup> Agenda</a>	x	x		To receive information and consider recommendations from the May 1st FFC meeting
2	Governance Committee Meeting: May 15, 2014 (Verbal Report)	<a href="#">March 20<sup>th</sup> Minutes</a> May 15 <sup>th</sup> Agenda	x	x		To receive information and consider recommendations from the May 15 <sup>th</sup> GC meeting
<b>Delegation and Recommendation Reports</b>						
3	The Impact of Prescription and Non-Prescription Drug Use in Middlesex-London (Report 032-14)	Appendix A	x		x	To present a report outlining the impact of prescription and non-prescription drug use in Middlesex-London from the perspective of health services utilization
4	Student Wellbeing and Learning: Foundations For A Healthy School Framework (Report 033-14)	Appendix A			x	To ask the Board of Health to send a letter to commend the Ontario Ministers of Health & Long-Term Care and Education for their collaborative efforts to ensure students' wellbeing in schools
<b>Information Reports</b>						
5	Overdose Prevention in London and Middlesex County: Community Naloxone Program (Report 034-14)	Appendix A			x	To receive information about the London and Middlesex County Naloxone Program
6	Summary Information Report - May 2014 (Report 035-14)	Appendix A Appendix B Appendix C Appendix D Appendix E Appendix F Appendix G			x	To provide a summary of various Health Unit programs in Family Health Services and Environmental Health & Chronic Disease Prevention Services
7	Medical Officer of Health Activity Report – May Report (Report 036-14)	-			x	To provide an update on the activities of the MOH for May

## **Confidential**

The Board of Health will move in camera to discuss a matter concerning employee negotiations.

## **Other Business**

**Next Board of Health Meeting: Thursday, June 19, 2014 7:00 p.m.**

Next Finance and Facilities Committee Meeting: Thursday June 12, 2014 9:00 a.m.

## **Correspondence**

- a) Date: 2014 April 8 (Received 2014 April 17)  
Topic: Follow-up to MLHU letter about the 2013 Middlesex-London Nutritious Food Basket and implications for government policy  
From: The Honourable Deb Matthews, Minister of Health and Long-Term Care  
To: Mr. Marcel Meyer, Chair, Board of Health
  
- b) Date: 2014 April 15 (Received 2014 April 24)  
Topic: Follow-up to MLHU motion advocating for publicly-funded dental treatment for low-income adults, including seniors  
From: The Honourable Deb Matthews, Minister of Health and Long-Term Care  
To: Mr. Marcel Meyer, Chair, Board of Health
  
- c) Date: 2014 April 15 (Received 2014 April 28)  
Topic: Follow-up to MLHU staff letter regarding publicly-funded dental treatment and prevention for low-income adults and seniors.  
From: The Honourable Deb Matthews, Minister of Health and Long-Term Care  
To: Dr. Christopher Mackie, MOH and CEO, and Dr. Maria van Harten, Dental Consultant
  
- d) Date: 2014 May 2 via email  
Topic: alPHa Summary of Ontario Budget 2014  
From: Mr. Gordon Fleming, Manager, Public Health Issues, (alPHa)  
To: All Boards of Health
  
- e) Date: 2014 May 5 via email  
Topic: List of expired Bills that may or may not reappear in future Session of Ontario Parliament  
From: Mr. Gordon Fleming, Manager, Public Health Issues, (alPHa)  
To: All Boards of Health

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

## **Adjournment**



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 031-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 May 15

**FINANCE AND FACILITIES COMMITTEE:  
MAY 1, 2014 MEETING**

The Finance and Facilities Committee (FFC) met at 9:00 a.m. on May 1, 2014 ([Agenda](#)). The draft public minutes are attached as [Appendix A](#). The following items were discussed at the meeting and recommendations made:

Reports	Summary of Discussion	Recommendations for Board of Health's Consideration
2014 Q1 Budget Variance <a href="#">020-14FFC</a>	Mr. Millson explained that this report provides financial projections for the end of the year; however, processes are still evolving to be able to accurately show information by quarter. The FFC received the information and decided that the Board of Health should review the report at the Q2 stage.	It was moved by Mr. Peer, seconded by Mr. Meyer that the FFC Receive Report No. 020-14FFC re 2014 Q1 Budget Variance, along with the explanations provided by Mr. Millson, for information.
2014 BOH Remuneration <a href="#">021-14FFC</a>	Based on County Council decision on March 25th, 2014 to pass a new rate for rate of \$144.16, which represents a 1.5% increase.	It was moved by Mr. Meyer, seconded by Mr. Peer that the Finance & Facilities Committee make recommendation to the Board of Health to increase the Board of Health member compensation rate for a half day meeting to \$144.16 retroactively to January 1st, 2014.
Insurance Review Update <a href="#">022-14FFC</a>	Mr. Millson reported that the review of insurance requirements will continue in 2014 and any approved changes will be implemented for the 2015 operating year.	It was moved by Mr. Peer, seconded by Mr. Bolton that the Finance and Facilities Committee recommend: 1) That the Board of Health no longer contribute or reduce its contributions to City of London's Self Insurance Reserve Fund as the Board has not had any claims; and 2) That the Board of Health direct Health Unit staff to look for Insurance that provides better value than the current Policy.

Reports	Summary of Discussion	Recommendations for Board of Health's Consideration
New Reserve Funds <a href="#">023-14FFC</a>	Dr. Mackie reported that the Health Unit has had discussions with both the City and the County about reserve funds. The FFC had a discussion about reserve funds, and moved in camera for part of the discussion	It was moved by Mr. Peer, seconded by Mr. Bolton that Report 023-14FFC be received for information.  It was moved by Mr. Meyer, seconded by Mr. Bolton that the recommendation to create new reserve funds be tabled until the Finance and Facilities Committee receives the 2013 audited statements and more information is available.
Sick Leave Reserve Fund Balance <a href="#">026-14FFC</a>	This report is related to the discussion about Report No. 023-14FFC	It was moved by Mr. Peer, seconded by Mr. Bolton that Report No. 026-14FFC be tabled until the Finance and Facilities Committee receives the 2013 audited statements and more information is available.
Financial Policies – Group 1 Review <a href="#">024-14FFC</a>	Staff to make minor revisions to the wording in the policies before they are presented to the Board.	It was moved by Mr. Meyer, seconded by Mr. Bolton that the Finance and Facilities Committee recommend that the Board of Health: 1) Endorse the Financial Signing Authority policy as appended to Report No. 024-14FFC re: Finance Policies Review: Report 1 of 3 and recommend that the Board of Health approve this policy with the above revision made; and 2) Receive for information the policies on Moving Expenses, Corporate Credit Cards and Petty Cash as appended to Report No. 024-14FFC re: Finance Policies Review: Report 1 of 3.
2013 Dental Clinic Shortfall <a href="#">025-14FFC</a>	Strategies used in 2013 and new strategies will be used to minimize the shortfall in the Dental Clinic for 2014.	It was moved by Mr. Bolton, seconded by Mr. Meyer that that Report No. 025-14FFC re Dental Clinic 2013 Financial Shortfall be received for information.

### Confidential

At 9:30 a.m., the FFC moved in camera to discuss a matter concerning litigation or potential litigation. The FFC returned to public forum at 9:40 a.m. and reported that a matter was discussed concerning litigation or potential litigation.

### Next Meeting

The June meeting has been rescheduled to Thursday, June 12, 2014 at 9:00 a.m. due to a conflict on June 5<sup>th</sup> with the Association of Local Public Health Agencies (alPHA) joint conference and AGM.



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

**This report addresses the Ontario Public Health Organizational Standards**



**PUBLIC MINUTES**  
**Finance and Facilities Committee**  
**50 King Street, Room 3A**  
**MIDDLESEX-LONDON BOARD OF HEALTH**  
**2014 May 1 9:00 a.m.**

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**COMMITTEE**

**MEMBERS PRESENT:** Mr. David Bolton  
Ms. Trish Fulton (Chair)  
Mr. Marcel Meyer  
Mr. Ian Peer

**REGRETS:** Mr. Stephen Orser

**OTHERS PRESENT:** Dr. Christopher Mackie, Medical Officer of Health & CEO  
Mr. John Millson, Director, Finance and Operations  
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)  
Mr. Wally Adams, Director, Environmental Health & Chronic Disease Prevention  
Ms. Laura DiCesare, Director, Human Resources and Corporate Strategy  
Ms. Heather Lokko, Acting Director, Oral Health, Communicable Disease & Sexual Health Services  
Mr. Chimere Okoronkwo, Manager, Oral Health

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the May Finance and Facilities Committee (FFC) meeting.

**1. DISCLOSURES OF CONFLICT(S) OF INTEREST**

Chair Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

**2. APPROVAL OF AGENDA**

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Agenda for the [May 1, 2014](#) FFC meeting be approved.*

Carried

**3. APPROVAL OF MINUTES**

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Public Minutes from the [March 26, 2014](#) Finance and Facilities Meeting be approved.*

Carried

It was moved by Mr. Bolton, seconded by Mr. Meyer *that the Confidential Minutes from the March 26, 2014 Finance and Facilities Meeting be approved.*

Carried

**4. BUSINESS ARISING FROM THE MINUTES**

None

## 5. NEW BUSINESS

### 5.1. 2014 Q1 Budget Variance (020-14FFC) – Walk on Report

Mr. Millson, Director, Finance and Operations, distributed this report and reviewed it with the Committee. This report provides financial projections for the end of the year; however, processes are still evolving to be able to accurately show information by quarter. For example, wages can be projected quarterly as they are paid consistently each month. However, for some programs (e.g., West Nile) spending does not take place until the second quarter. Mr. Millson also explained that the results of the negotiation process and grant from province are the biggest unknown variables in the 2014 budget. The Senior Leadership Team will be discussing how to present budgets by quarter. The FFC agreed that the Q1 Variance Report does not project variances that are accurate enough for the Board of Health.

The FFC agreed that the Board of Health should review the variance report at the Q2 stage. It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee Receive Report No. 020-14FFC re 2014 Q1 Budget Variance, along with the explanations provided by Mr. Millson, for information.*

Carried

### 5.2. 2014 Board of Health Remuneration ([021-14FFC](#))

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance & Facilities Committee make recommendation to the Board of Health to increase the Board of Health member compensation rate for a half day meeting to \$144.16 retroactively to January 1st, 2014.*

Carried

### 5.3. Insurance Review Update ([022-14FFC](#))

It was moved by Mr. Peer, seconded by Mr. Bolton that the Finance and Facilities Committee recommend:

- 1) *That the Board of Health no longer contribute or reduce its contributions to City of London's reserve fund as the Board has not had any claims, and*
- 2) *That the Board of Health direct Health Unit staff to look for Insurance that provides better value than the current Policy with the City of London.*

Carried

### 5.4. New Reserve Funds ([023-14FFC](#))

Committee members discussed the whether it would be better to draw from reserves or to ask the municipalities for funding to cover any shortfalls – neither of which reflects the usual municipal/provincial cost-share formula.

Dr. Mackie reported that the Health Unit has had discussions with both the City and the County about reserve funds.

At 9:30 a.m., it was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance and Facilities Committee move in camera to discuss a matter concerning litigation or potential litigation.*

Carried

At 9:40 a.m., it was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance and Facilities Committee return to public forum and report that a matter was discussed concerning litigation or potential litigation.*

Carried

It was moved by Mr. Peer, seconded by Mr. Bolton *that Report 023-14FFC be received for information.*

Carried

It was moved by Mr. Meyer, seconded by Mr. Bolton *that the recommendation to create new reserve funds be tabled until the Finance and Facilities Committee receives the 2013 audited statements and more information is available.*

Carried

#### 5.5. Sick Leave Reserve Fund Balance ([026-14FFC](#))

It was moved by Mr. Peer, seconded by Mr. Bolton *that Report No. 026-14FFC be tabled until the Finance and Facilities Committee receives the 2013 audited statements and more information is available.*

Carried

#### 5.6. Financial Policies – Group 1 Review ([024-14FFC](#))

Mr. Millson assisted Committee members with their understanding of this report.

Committee members recommended that staff make minor revisions to language in the policies before they are presented to the Board.

It was moved by Mr. Meyer, seconded by Mr. Bolton *that the Finance and Facilities Committee recommend that the Board of Health:*

- 1) *Endorse the Financial Signing Authority policy as appended to Report No. 024-14FFC re: “Finance Policies Review: Report 1 of 3” and recommend that the Board of Health approve this policy with the above revision made; and*
- 2) *Receive for information the policies on Moving Expenses, Corporate Credit Cards and Petty Cash as appended to Report No. 024-14FFC re: “Finance Policies Review: Report 1 of 3.”*

Carried

#### 5.7. 2013 Dental Clinic Shortfall ([025-14FFC](#))

It was moved by Mr. Bolton, seconded by Mr. Meyer *that that Report No. 025-14FFC re Dental Clinic 2013 Financial Shortfall be received for information.*

Carried

#### 6. **CONFIDENTIAL** (covered earlier in meeting)



**7. OTHER BUSINESS**

- 7.1. Change Date of June Meeting (conflicts with alpha AGM and conference) – Committee members agreed that the June meeting will be rescheduled to Thursday, June 12, 2014 at 9:00 a.m.

**8. ADJOURNMENT**

At 10:50 a.m., it was moved by Mr. Bolton, seconded by Mr. Peer *that the meeting be adjourned.*

Carried

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**TRISH FULTON**  
Chair

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**CHRISTOPHER MACKIE**  
Secretary-Treasurer



TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 May 15

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## THE IMPACT OF PRESCRIPTION AND NON-PRESCRIPTION DRUG USE IN MIDDLESEX-LONDON

### **Recommendation**

*It is recommended that Report No. 032-14 re The Impact of Prescription and Non-Prescription Drug Use in Middlesex-London be received for information.*

### **Key Points**

- Drug use is a serious community issue in Middlesex-London. It has an impact on health services across the continuum of care, from Emergency Medical Services (EMS) and police calls, to emergency department visits and hospitalizations, and admissions to substance misuse programs.
- From 2008 to 2012, opioids cause more overdoses, emergency department visits, hospitalizations, and admissions to substance misuse and addictions programs in Middlesex-London than in Ontario.
- Opioids killed more than twice the number of people per capita in Middlesex-London than in Ontario in 2012
- The Health Unit will use the findings of this report to partner with municipalities and community partners in the development of a community drug strategy.

### **Background**

The November 2013 Board Report [119-13](#) entitled “Middlesex-London I-Track Survey of People Who Inject Drugs” provided an overview of drug use behaviours among a sample of Londoners who inject drugs. This data was collected as part of a Canadian survey conducted by the Public Health Agency of Canada (PHAC). The survey results showed there were a number of areas in which the London participants differed from the national sample. For example, opioids were the predominant drugs injected by the London sample, compared to the stimulant cocaine being the drug most commonly injected by the national sample. These and other findings suggested the need for further investigation of drug use in the Middlesex-London region.

The current report ([Appendix A](#)) examines the issue of drug use in Middlesex-London from the perspective of health services utilization. A variety of information sources were used, including emergency medical services (EMS) calls related to overdoses, drug-related police incidents, emergency department (ED) visits and hospitalizations, and admissions to substance misuse and addictions programs. Supplementary information about opioid prescription rates and prescription-opioid related deaths was also included.

### **Report Highlights**

Prescription and non-prescription drug use in Middlesex-London has an impact on health services across the continuum of care, from Emergency Medical Services (EMS) and police calls, to emergency department (ED) visits and hospitalizations, and admissions to substance misuse programs. For example, in 2013, Middlesex-London EMS responded to 602 calls related to drug overdoses alone, or more than one overdose per day. Between 2008 and 2012, London Police Services responded to an average of 730 incidents per year related to drug possession, and an average of 230 calls per year related to trafficking, distribution and possession of controlled drugs and substances.

For each year between 2008 and 2012, the rates of opioid-related ED visits in Middlesex-London were significantly higher than the Ontario rates by a factor of 1.5. Similarly, the rates of sedatives- and hypnotics-related ED visits (e.g., visits related to benzodiazepine or barbiturate use) were significantly higher in Middlesex-London compared to provincial rates across the study period. There were no significant differences between Middlesex-London and Ontario for other classes of drugs (cannabinoids, cocaine and other stimulants, hallucinogens and solvents).

The patterns of hospitalization rates were similar to those for ED visits. In particular, opioid-related hospitalizations among Middlesex-London residents consistently exceeded the rates for Ontario by a factor of about 1.5. Further, the Middlesex-London rates showed consistent increases over time, from a rate of 34.8 opioid-related hospitalizations per 100,000 population in 2008, to 49.6 per 100,000 in 2012. For the other classes of drugs (cannabinoids, cocaine and other stimulants, sedatives and hypnotics, hallucinogens and solvents), there were no significant differences between hospitalization rates for Middlesex-London residents and Ontario as a whole.

Between 2008 and 2013, there was an average of 2,381 admissions to substance misuse programs per year, representing an average of 1,428 individuals annually. Alcohol, tobacco and cannabis were the most common problem substances in these admissions. However, the rates of prescription opioids as a presenting problem substance among Middlesex-London admissions were significantly higher than those for Ontario for all years between 2008 and 2013. The rates for methamphetamines (a stimulant) as a presenting problem were also significantly higher than the provincial rates, and increased from 35 methamphetamine-related admissions per 1,000 individuals admitted in 2008, to 252 in 2013.

Ontarians who are beneficiaries of a number of social assistance programs have certain medications covered by the Ontario Drug Benefit (ODB) Program. Between 2008 and 2013, the overall opioid prescription rates per 1,000 ODB-eligible population in Middlesex-London generally declined; a similar pattern was observed for the rates for Ontario as a whole. However, the Middlesex-London rates were significantly higher than Ontario rates for all years by a factor of 1.1. The use rate for oxycodone, hydromorphone, methadone, and fentanyl were all significantly higher for Middlesex-London compared to the province. However, the rates of oxycodone and fentanyl prescription use both declined in both Middlesex-London and Ontario over the six year period, while hydromorphone and methadone prescription use rates increased.

Between 2008 and 2012, the annual number of prescription-opioid related deaths among Middlesex-London residents ranged from a low of 13 deaths, to a high of 41 deaths in 2012. That year, prescription opioid-related death rates in Middlesex-London occurred at more than twice the provincial rate (8.8 deaths per 100,000 population vs. 4.1).

## Conclusion

Municipal and community partners have expressed interest in developing a community drug strategy. This report will provide valuable information to inform such a strategy and reduce the harms cause by drug misuse in the community.

This report was prepared by Ms. Alison Locker, Epidemiologist, Oral Health, Communicable Disease and Sexual Health (OHCDSh) Services, and Ms. Heather Lokko, Acting Director, OHCDSh.



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

# The Impact of Prescription and Non-Prescription Drug Use in Middlesex-London



May 2014

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## Acknowledgements

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This report would not have been possible without the invaluable contributions of many individuals and organizations. First, the Ministry of Health and Long Term Care, Public Health Ontario, the Ontario Drug Policy Research Network and Institute for Clinical and Evaluative Sciences, and the Drug and Alcohol Treatment Information System are all acknowledged for providing access to the provincial datasets and analyses that were instrumental for producing this report.

Our community partners are also thanked for providing data, and for taking time to ensure that the information provided was accurate and interpreted appropriately. This includes Jay Loosley and Al Hunt at Middlesex-London Emergency Medical Services (EMS), and Joan Atchison and Chris McCoy at London Police Services. Pam Hill at Addiction Services Thames Valley is also thanked for her support and guidance in the development of this report.

From the Middlesex-London Health Unit, Rhonda Brittan, Social Determinants of Health Public Health Nurse is thanked for her role as a liaison between the Health Unit and a variety of community groups and organizations, including Middlesex-London Emergency Medical Services (EMS), London Police Services, and Addiction Services of Thames Valley. Heather Lokko, Acting Director of Oral Health, Communicable Disease and Sexual Health Services is thanked for her support and guidance in the later stages of this report. Finally, Dr. Christopher Mackie, Medical Officer of Health and Dr. Bryna Warshawsky, former Associate Medical Officer of Health are thanked for their valuable input into and feedback on earlier versions of this report, and for championing its development.



## Executive Summary

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The I-Track report on injection drug use in London, which was released in 2013, showed that people who use injection drugs in London were using a variety of opioids in excess of the Canadian national sample of people who use injection drugs. London was also found to have a much higher prevalence of hepatitis C in people who use injection drugs than the national sample (79.1% versus 68.0%).

This current report provides a more in-depth exploration of the extent and impact of drug use in Middlesex-London in order to guide the development of enhanced strategies to address this important public health issue. It presents information on five categories of drugs which include 1) opioids, 2) cannabinoids, 3) cocaine and other stimulants, 4) sedatives and hypnotics, and 5) hallucinogens and solvents. The current report provides information on a broad range of topics related to drug use including: self-reported illicit drug use from the Canadian Community Health Survey; calls to emergency medical services (EMS) and police incidents related to drug use; emergency department visits and inpatient hospitalizations related to drug use; and problem substances reported on admission to substance misuse and addictions programs. Finally, the report provides a focused analysis on prescription opioid use which contains the following information: opioid prescription rates obtained through the Ontario Drug Benefit Program, and deaths from acute drug toxicity involving prescription opioids obtained from the Office of the Chief Coroner of Ontario. Where available, information for Middlesex-London is compared to the province of Ontario as a whole.

The Canadian Community Health Survey found that 44.3% of participants in Middlesex-London reported drug use in their lifetime, which was higher than the provincial average of 39.8%, with cannabis being the most commonly used drug. In 2013, there were 602 calls to Emergency Medical Services related to drug overdoses, which is an average of 1.6 calls per day. Between 2008 and 2012, London Police Services reported an average of 730 police incidents per year related to drug possession and 230 incidents per year related to drug trafficking, distribution, and possession under the Controlled Drug and Substances Act.

From 2008 to 2012, visits to the emergency department in Middlesex-London were highest for those who reported opioid use compared to all other classes of drugs. Both emergency department visits and hospitalizations for opioid use were significantly higher in Middlesex-London than Ontario as a whole. In 2012, there were 99.8 opioid-related emergency department visits per 100,000 population in Middlesex-London, compared to 77.0 opioid-related emergency visits per 100,000 population in Ontario. In that same year, there were 49.6 opioid-related hospitalizations per 100,000 population in Middlesex-London compared to 32.9 opioid-related hospitalizations per 100,000 population in Ontario as a whole. Rates of hospitalizations for opioids use have increased from 2008 to 2012 in both Middlesex-London and Ontario. Opioids were the drug class responsible for the longest average lengths of stay in hospital.

In 2013, admissions rates to substance misuse and addictions programs were higher in Middlesex-London than Ontario as a whole for people who reported prescription opioids, methamphetamines, and other stimulants as a problem substance on admission. From 2008 to 2012, there was a marked increase in the rate of Middlesex-London residents reporting methamphetamines as a problem substance on admission to these programs. Among individuals admitted to substance misuse and addiction programs, injection drug use in the 12 months before admission was reported approximately twice as often for Middlesex-London than for Ontario as a whole.

Based on rates of individuals who received opioid prescriptions through the Ontario Drug Benefit (ODB) Program, it was determined that prescription rates for all prescription opioids combined and all ages combined had decreased between 2008 and 2012 in both Ontario and Middlesex-London but was significantly higher in Middlesex-London compared to Ontario for all these years. When broken down by age group, opioid prescription rates to ODB beneficiaries were higher in Middlesex-London compared to Ontario for those less than 65 years of age, but similar in the two jurisdictions for those 65 years of age and over. Looking at specific opioid drugs, oxycodone, hydromorphone, methadone and fentanyl prescription rates were higher in Middlesex-London compared to Ontario, whereas codeine, which was the most commonly prescribed opioid, was generally prescribed at a lower rate in Middlesex-London than Ontario as a whole.

Between 2008 and 2012, the number of deaths due to acute drug toxicity involving prescription opioids in Middlesex-London ranged from 13 to 41, corresponding to an average of 22.8 prescription opioid-related deaths per year. The death rate from prescription opioid-related acute drug toxicity was generally higher in Middlesex-London compared to Ontario as whole, and for 2013 the rates were significantly higher in Middlesex-London (8.8 per 100,000 Middlesex-London residents compared to 4.1 per 100,000 Ontario residents).

Combined with the results from the I-Track report, this current report outlines the significant impact of drug use, and opioid use in particular, in Middlesex-London. It is anticipated that this report will form the basis for the development of an inclusive, collaborative community drug strategy to address this significant public health issue.

## I. Introduction

### Background

In 2012, the Middlesex-London Health Unit participated for the first time as a sentinel site in Phase 3 of the I-Track survey of people who use injection drugs. The I-Track survey was conducted by the Public Health Agency of Canada, and one of the main goals was to gain in-depth information about people who inject drugs, and their drug use behaviours. Local I-Track results were analysed and released in 2013<sup>1</sup>. That report showed that there were a number of areas in which London participants differed from the national sample that included all sentinel sites. Opioids were the most common drugs to be injected by London participants, and the prevalence of hepatitis C was higher in the London sample than the national sample (79.1% versus 68.0%). These and other findings suggested the need for further investigation of drug use in the Middlesex-London region.

### Health Burden Associated with Drug Use

Countless studies have documented that drug use, also referred to as substance misuse, is responsible for considerable morbidity and mortality. Many substances, from prescription drugs, to legal/licit drugs (such as tobacco and alcohol) to illegal/illicit drugs (such as heroin, cocaine, crack, methamphetamine, and marijuana) have the potential for misuse. Several of the more common health problems associated with drug use include:

- Acute cardiac and neurological sequelae from poisoning (overdose) up to and including death;
- Increased risk of acquiring sexually transmitted infections (STIs) due to the inhibition-lowering effects of many drugs;
- For people who inject drugs, increased risk of acquiring infectious diseases such as hepatitis B and C, human immunodeficiency virus (HIV), skin infections, and infective endocarditis;
- Chronic mental health problems of addiction and dependence, and the health and social burden associated with these (National Institute on Drug Abuse [NIDA], 2014).

### Global Context

On a worldwide scale, one of the World Health Organization's (WHO) Global Burden of Disease projects has attempted to quantify the extent of the harms associated with illicit drug use and dependence in terms of Disability Adjusted Life Years (DALYs), which account for both morbidity (years lived with disability) and mortality (years of life lost) (Degenhardt, Whiteford & Hall, 2014; Degenhardt et al., 2013). It was identified that significant gaps in good quality data exist for many regions around the world, especially in quantifying drug-related mental health, injuries and violence sequelae. Nonetheless, the results showed that globally, drug use disorders accounted for over 20 million DALYs in 2010 (Degenhardt, Whiteford & Hall, 2014; Degenhardt et al. 2013).

### Canadian Context

Within Canada, substance misuse has had a large impact on the health care system, the economy, and on affected individuals and families. A study by Rehm et al. (2007) estimated that in 2002, approximately 2% of all days spent in the hospital in Canada were due to illegal drug use. This translated into 2,110,102 treatment days across the country, including 31,508 psychiatric treatment days. In addition, the authors estimated that 0.76% of all deaths were attributable to illegal drugs, and that 2.42% of all deaths under 70 years of age were attributable to illegal drug use. This resulted in 62,110 person-years of life lost throughout Canada in 2002.

From the perspective of economic impact, Rehm et al. (2007) estimated that in general, illegal drugs contributed to 20.7% of all substance-related costs, translating to approximately \$262 per capita. This estimate included both direct and indirect costs, such as law enforcement, prevention, research, fires, accidents, workplace losses, administrative costs, and productivity costs. The two major costs were health care and law enforcement, comprising 36% of overall costs. It is important to note, though, that these estimates did not include costs related to misuse of prescription drugs.

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<sup>1</sup> To view the I-Track Report, refer to: <https://www.healthunit.com/uploads/public-health-agency-of-canada-i-track-survey-phase-3.pdf>

## Local Picture

As previously mentioned, the I-Track survey of people who use injection drugs in London identified some important factors whereby the London sample differed from the overall national sample. It was found that compared to the national sample, London participants were more likely to inject opioid drugs such as morphine (75.5% versus 47.0%) and hydromorphone (75.5% versus 47.2%); by comparison, cocaine was the drug most commonly injected in the national sample (58.3% in London versus 64.3% nationally). Participants in London had a higher prevalence of hepatitis C than the national sample (79.1% versus 68.0%), and were also more likely to engage in high risk behaviours such as borrowing (19.6% versus 15.5%) and lending (26.6% versus 15.5%) used needles.

A series of publications by Gomes, Juurlink, et al. (2011) and Gomes, Juurlink et al. (2012) provided information about the geographical distribution of opioid prescriptions and prescription opioid-related deaths in Ontario between 2004 and 2006. Middlesex County, which included the City of London, was found to have a much higher annual opioid prescription rate per 1,000 eligible publicly funded drug program (OPDP) recipients, and a significantly higher annual opioid-related death rate, than the province and many other jurisdictions across the province (Gomes et al., 2012; Gomes et al., 2011). The annual average prescription rate for Ontario from 2004 to 2006 was approximately 5,500 prescriptions per 1,000 OPDP recipients aged 15 to 64 years, while for Middlesex County, it was 7,399 prescriptions per 1,000 (Gomes et al., 2012). As well, for Ontario, the annual age-sex-standardized opioid death rate from 2004 to 2006 was 4.3 deaths per 100,000 population, while for Middlesex County it was 7.2 per 100,000 (Gomes et al., 2012). It is important to note, though, that these findings were based on the number of prescriptions filled, and not the number of individual opioid prescription users. The physical and pharmacological characteristics of each opioid product influence the number of prescriptions filled, for example, some products require a daily prescription while others may be dispensed in larger volumes. To control for this fact, some analyses of this data source, including those found later in this report, focus on prescription opioid users, rather than opioid prescriptions.

## II. Data Sources and Methods

In order to examine the issue of drug use in a community, a number of data sources can be used. This report examines drug use from the perspectives of community and health services utilization. When possible, drug classes based on International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision, Canada (ICD-10-CA) codes were used for comparing information across data sources. Five categories are presented in this report, and include 1) opioids, 2) cannabinoids, 3) cocaine and other stimulants, 4) sedatives and hypnotics, and 5) hallucinogens and solvents. These are described in more detail below, and Appendix A lists the ICD-10-CA diagnosis codes associated with each drug class.

**Opioids** are a type of painkiller that include illicit drugs, such as heroin and opium, but also include prescription drugs that can be misused (Canadian Centre on Substance Abuse [CCSA], 2013b). In this report, opioids include heroin, opium, and the prescription opioids codeine, oxycodone, hydromorphone, morphine, methadone, and fentanyl.

**Cannabinoids** are a type of psychoactive drug that produces relaxation and euphoria (CCSA, 2014). For the purposes of this report, cannabis/marijuana is the only drug included in this category, as it is the most commonly used of all cannabinoids.

**Cocaine and other stimulants** have been grouped into one category because they are all used to increase energy levels or alertness (CCSA, 2013a). Aside from cocaine, the other stimulants in this category include crack, ecstasy, methamphetamines and amphetamines.

**Sedatives and hypnotics** are a category of drugs that act as depressants. These include a variety of prescription drugs such as benzodiazepines and barbiturates (CCSA, 2013c).

**Hallucinogens and solvents** are a wide class of illicit drugs and chemicals that are used for their psychedelic effects. These drugs can include, but are not limited to, household items such as hairspray and other aerosols, glue, and paint (CCSA, 2006).

### Self-Reported Illicit Drug Use

The Canadian Community Health Survey (CCHS) was used to assess self-reported drug use in the general population. The CCHS is an annual cross-sectional telephone survey conducted across the country by Statistics Canada. It provides information on a variety of topics, including health care utilization, determinants of health, and health status via a large sample (130,000 respondents across Canada) that is reliable at the public health unit level. However, given that the information is self-reported and respondents might be reluctant to report illegal activity such as illicit drug use, the CCHS likely underestimates the true prevalence of drug use in the population. Simple weighted frequencies and percentages from 2009 through 2012 were obtained through the Public Health Ontario Snapshots<sup>2</sup> to compare the percentage of people that have used each type of drug included in the survey, for Middlesex-London residents and Ontario as a whole.

### Drug Use Related Emergency Medical Services (EMS) and Police Incidents

Local EMS and police departments provided data in order to assess the burden that drug use in Middlesex-London places on their work. Middlesex-London EMS provided data to assess the proportion of their calls that were attributed to drug use in 2013 and to determine the average number of calls per year pertaining to drug use. London Police Services provided information about incidents related to drug possession, trafficking, distribution, and production under the Controlled Drugs and Substances Act from 2008 to 2012. In addition, the number and types of drug seizures from 2009 to 2012 was obtained from London Police Services 2012 Annual Report. Similar information was not available from Strathroy-Caradoc Police Services or Middlesex Ontario Provincial Police (OPP).

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<sup>2</sup> For more information, visit:

<http://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/default.aspx>

## Drug Use Related Emergency Department Visits

A measure of drug use in the community includes emergency department visits for acute mental health, addiction problems, as well as overdoses, which are coded as poisonings in the ICD-10-CA system. The emergency department visit information included in this report is from the National Ambulatory Care Reporting System (NACRS), which is a dataset administered by the Canadian Institute for Health Information (CIHI). All Ontario hospitals submit emergency department visit information into NACRS. Public health access to this information is through IntelliHEALTH, a Ministry of Health and Long-Term Care (MOHLTC) web-based reporting tool. Data was extracted from 2008 to 2012. Rates of emergency department visits were calculated based on the main diagnosis for each visit in the numerator, while population estimates were used for the denominator. The 95% confidence intervals were calculated using methods from Sullivan, McKenna, Waller, Williamson, and Lee (2010) to compare Middlesex-London and Ontario for each of the five years of data, and reported in parentheses ( $\pm$ value) with their corresponding rates in the text of the report, and shown as error bars above and below the point values in graphs. Appendix A provides a list of the ICD-10-CA codes used in this analysis.

## Drug Use Related Inpatient Hospitalizations

Inpatient hospitalizations for acute mental health, addictions problems, and overdoses are also a measure of drug use in the community. Hospitalization data was obtained from the Discharge Abstract Database (DAD), which is another dataset administered by CIHI. All Ontario hospitals submit hospitalization data to the DAD, and up to 25 diagnosis codes may be recorded for each hospitalization. Similar to ED visits, hospitalization data was accessed through the MOHLTC IntelliHEALTH reporting tool. Inpatient hospitalization rates were calculated based on ICD-10-CA diagnosis codes for the numerator and population estimates for the denominator. Again, 95% confidence intervals were calculated to compare rates for Middlesex-London and Ontario and reported in parentheses ( $\pm$ value) with their corresponding rates in the text of the report, and shown as error bars above and below the point values in graphs. In addition, information about the cumulative length of stay (LOS) for patients with each ICD-10-CA code of interest was extracted to determine the average LOS for each drug class. Because individual records were not available, it was not possible to test for statistically significant differences between Middlesex-London and Ontario for average LOS. Appendix A provides a list of the ICD-10-CA codes used in this analysis.

## Substance Misuse and Addictions Programs

An additional way of examining burden of drug use in the community is by examining information about admissions to substance misuse and addictions programs. The source of data used in this report is the Drug and Alcohol Treatment Information System (DATIS), which provides information about the numbers of admissions and characteristics of individuals admitted to substance misuse and addictions programs in agencies in Middlesex-London and Ontario. There are approximately 80 different sites, representing 25 different organizations within Middlesex-London that submit data to the system. Some examples include Addictions Services Thames Valley, Westover Treatment Centre, St. Joseph's Hospital Withdrawal Management Centre, and Oneida Drug and Alcohol Counselling Centre. Across Ontario, about 160 different organizations submit data to DATIS. A few of these organizations include inpatient units in hospitals, so there may be some overlap between the hospitalization counts discussed earlier and DATIS data. Private institutions not funded by the government do not submit information to DATIS and are therefore not included in this analysis.

The most recent years of data (2008 to 2013) are provided and compared to Ontario as a whole. Significance testing was carried out by calculating the 95% confidence intervals for admission rates in each category of variables, for comparisons between Middlesex-London and Ontario (detailed tables not shown). Again, confidence intervals are reported in parentheses ( $\pm$ value) with their corresponding rates in the text of the report, and shown as error bars above and below the point values in graphs. Upon admission to a treatment centre, clients are asked to report any problem substances that are being used. Up to five problem substances may be recorded for each admission; in many cases, clients list more than one substance. However, some clients do not list any presenting problem substances. This may be due to the fact that they are in the pre-contemplation stage of behaviour change and do not perceive that any substances they may use as being problematic, but are accessing substance misuse and addiction services as a result of interactions with the justice and corrections systems, such as court-ordered attendance, or as a condition of parole. Other clients may report no presenting problem substances if there has been a waiting period to access community substance misuse and addictions programs and their problem substance use has been addressed through other channels. To record presenting problem substances, there are non-specific categories of "unknown", "undifferentiated" and "other psychoactive drugs". As a result, the presenting problem substance results by drug class presented in this report may be underestimated.

## Prescription Opioid Use Rates

To examine opioid prescription patterns in Middlesex-London and Ontario, prescription information from the Ontario Drug Benefit (ODB) Program was requested via the Ontario Drug Policy Research Network (ODPRN) and the Institute for Clinical Evaluative Sciences (ICES). All Ontario seniors 65 years of age and over who have a valid health card are eligible for the ODB Program, as well as other groups of individuals who are under the age of 65 years, such as individuals who receive social assistance through the Ontario Works program or the Ontario Disability Support Program and individuals who are enrolled in a Home Care program. Data on the annual number, rates, and 95% confidence intervals for the annual rates of ODB eligible clients who used prescription opioids by the eligible populations covered under the ODB from 2008 to 2013 were included. The 95% confidence intervals were reported in parentheses ( $\pm$ value) with their corresponding rates in the text of the report, and shown as error bars above and below the point values in graphs.

The information was provided both by all types of opioids aggregated and by individual opioid products. The following opioid products were included in the analysis: codeine, fentanyl, hydromorphone, meperidine, methadone, morphine, oxycodone, and other opioids (includes buprenorphine, propoxyphene, sufentanil, pentazocine, butorphanol). However, antitussives (cough suppressants) that contain opioids were excluded from the analysis. This data was analyzed and included in this report to assess the potential for drug misuse throughout Middlesex-London.

It should be noted that “this report includes data provided by the ODPRN and ICES, both of which are supported by the Ontario Ministry of Health and Long-Term Care (MOHLTC). The opinions, results and conclusions in this report are those of the authors. No endorsement by the ODPRN, ICES, or Ontario MOHLTC is intended or should be inferred”, (ODPRN-ICES, 2014).

## Deaths Due to Acute Drug Toxicity Involving Prescription Opioids

Information about deaths due to acute drug toxicity involving prescription opioids was requested from the Office of the Chief Coroner of Ontario, to supplement the opioid prescription use rate information. Data from 2008 to 2012 were provided, and potentially included a number of prescription opioids, including codeine, fentanyl, hydromorphone, meperidine, methadone, morphine, and oxycodone. Due to low numbers of deaths, it was not possible to break down prescription opioids by specific products. Information about deaths involving other classes of drugs, (such as stimulants, or sedatives and hypnotics) was not available.

Data from 2008 to 2012 are provided for Middlesex-London and Ontario. Rates of deaths due to acute drug toxicity involving prescription opioids were calculated using the annual number of opioid-related deaths in the numerator and population estimates in the denominator. The 95% confidence intervals were calculated to compare rates for Middlesex-London and Ontario, and reported in parentheses ( $\pm$ value) with their corresponding rates in the text of the report, and shown as error bars above and below the point values in graphs.

### III. Self-Reported Illicit Drug Use

#### Highlights

- Middlesex-London has a significantly higher proportion of individuals who have ever used an illicit drug (44.3%), compared to Ontario (39.8%).
- Cannabis was the only substance where Middlesex-London had a significantly higher proportion of individuals reporting use (43.8%), compared to Ontario (39.4%). This result may be partially due to the perceived acceptability of reporting ever having used this drug and a reluctance to report the use of other drugs.
- These indicators include anyone who has ever reported trying one of these drugs in their lifetime, and do not necessarily reflect current or recent drug use rates.

#### Self-Reported Illicit Drug Use

Table 3.1 highlights lifetime, self-reported drug use among Middlesex-London and Ontario residents. In Middlesex-London, almost half of all individuals 12 years of age and over reported ever having tried using an illicit drug (44.3% ± 2.6%). This was significantly higher than the percentage of individuals in Ontario who reported having tried an illicit drug (39.8% ± 0.6%).

Cannabis was the only substance that a significantly higher percentage of Middlesex-London residents reported ever having used (43.8% ± 2.6%), compared to Ontario (39.4% ± 0.7%). It is important to note that this finding may be due to the perceived acceptability of admitting to ever having used this particular drug, as well as the reluctance to report the use of other illicit drugs. In addition, it is also important to recognize that these categories are not an exhaustive list, but rather, are a subset of drugs that are monitored through the Canadian Community Health Survey (CCHS). For example, heroin was the only opioid reported, but opioids include a variety of other prescription drugs, including codeine, morphine, fentanyl, hydromorphone, methadone, and oxycodone. For other drug classes, such as sedatives and hypnotics, the CCHS includes no questions.

It should be noted that the CCHS does not attempt to measure the impact of illicit drug use on our health care system and other services. Other data sources are presented in subsequent chapters will provide a more inclusive list of drugs and analyze which of these are having the greatest impact on current services and resources.



**Table 3.1: Self-reported proportion of the population who have ever used illicit drugs, by drug type, Middlesex-London and Ontario, 2009 to 2012 (combined)**

<b>Drug use indicator, overall</b>	<b>ML % (95% CI)</b>	<b>ON % (95% CI)</b>
Self-reported proportion of the population who have ever used an illicit drug*	44.3 (41.7-46.9)	39.8 (39.2-40.5)
<b>Drug use indicators, by drug class</b>		
<b>Opioids</b>		
Self-reported proportion of the population who have ever used heroin	0.6 (0.2-1.0) ▼	0.5 (0.5-0.6)
<b>Cannabis</b>		
Self-reported proportion of the population who had ever used cannabis*	43.8 (41.2-46.4)	39.4 (38.7-40.0)
<b>Cocaine and other stimulants</b>		
Self-reported proportion of the population who have ever used cocaine or crack	7.6 (6.0-9.1)	6.1 (5.8-6.4)
Self-reported proportion of the population who have ever used MDMA (ecstasy)	4.4 (3.3-5.5)	4.0 (3.8-4.2)
Self-reported proportion of the population who have even used amphetamine (speed)	2.4 (1.6-3.3) ▼	2.3 (2.1-2.5)
<b>Sedative and hypnotics</b>		
No questions asked		
<b>Hallucinogens and solvents</b>		
Self-reported proportion of the population who have ever used hallucinogens, PCP or LSD	6.9 (5.5-8.4)	6.0 (5.7-6.2)
Self-reported proportion of the population who have ever sniffed or huffed glue, gasoline, acetone, or other solvents	§	0.6 (0.6-0.7)
<b>Other</b>		
Self-reported proportion of the population who have ever used steroids	§	0.5 (0.4-0.6)

**Source:** Canadian Community Health Survey (CCHS), Public Health Ontario Snapshots, 2014. Accessed December 18, 2013.

▼ Interpret with caution, as data has high levels of variability

§ Results cannot be released due to high levels of variability

\* Significant difference between Middlesex-London and Ontario

## IV. Drug Use Related Emergency Medical Services (EMS) and Police Incidents

### Highlights

- In 2013, 602 calls were placed to Middlesex-London EMS related to drug overdoses.
- Between 2008 and 2012, London Police Services responded to an average of 730 police incidents per year related to drug possession and 230 incidents per year related to drug trafficking, distribution, and possession.
- From 2009 to 2012, there was an increase in the amount of powder cocaine, methamphetamines, ecstasy, and prescription pills seized by London Police Services, with some variability from year to year.

*“My turning point... was when I ended up in jail.  
The day I got arrested, I remember smiling in the back of the cop car,  
and the police officer actually commented looking in the rear-view mirror,  
‘You look pretty happy for someone that got arrested’, and  
I said that I didn’t get arrested...  
I wasn’t arrested; I got rescued. That’s how I felt.”  
- Richard’s Story ([www.its-possible.ca](http://www.its-possible.ca)).*

### EMS Calls

Figure 4.1 illustrates that in 2013, 1.6% of all EMS calls were related to drug overdoses. There were 602 overdose-related calls to EMS throughout the year, which translates into an average of 1.6 calls per day. These calls related to overdose from all types of drugs, including those related to illicit or licit drugs, prescription or non-prescription medication, and intentional or unintentional overdoses. During the summer months of July, August, and September, the proportion of all EMS calls related to drug overdoses was higher than the annual average of 1.6%, with the proportion of drug overdose calls reaching or surpassing 2.0% of all EMS calls in July and September.

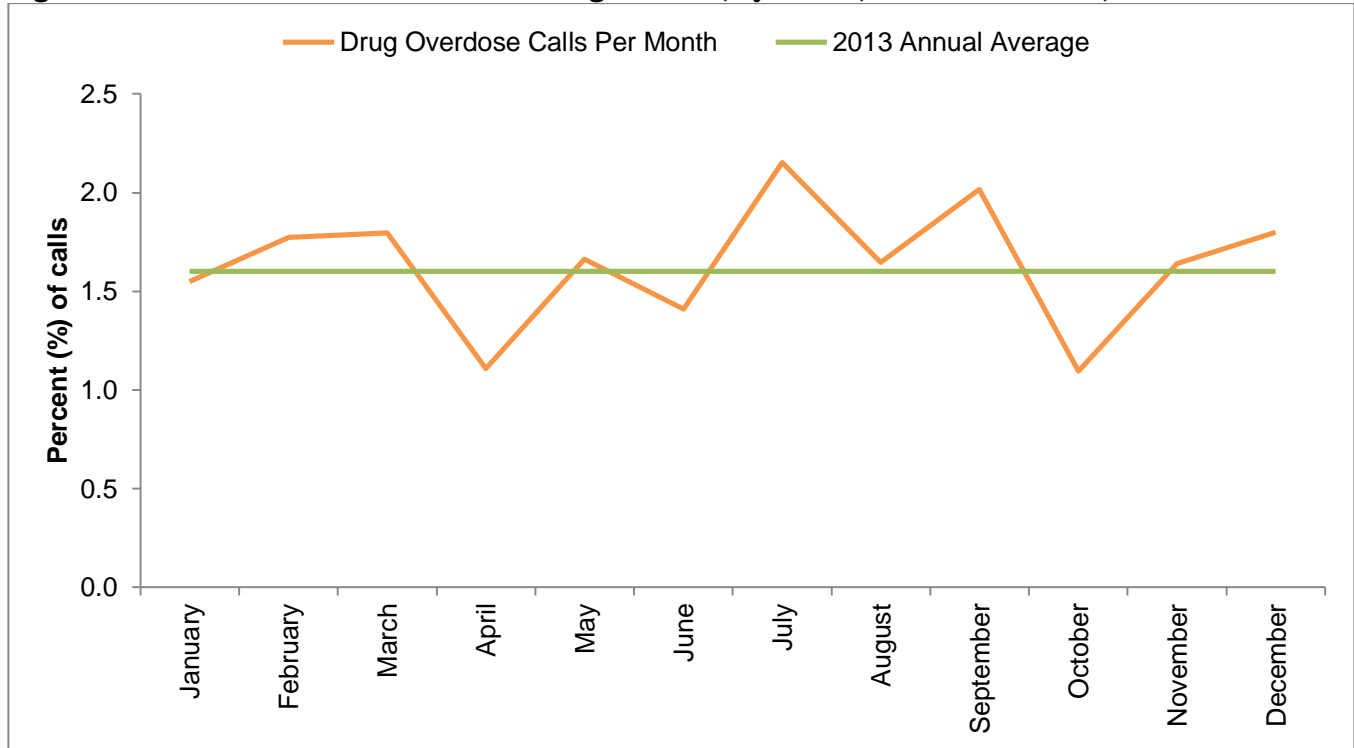
### Drug Offense Incidents

The federal legislation under which police services follow up drug offences is the Controlled Drug and Substances Act (CDSA). In place since 1996, the CDSA outlines drug possession, trafficking, production and distribution offences and their maximum penalties. In March 2012, amendments were made to the Act to include minimum sentences for certain drug classes such as opioids, cannabis, and cocaine.

Figure 4.2 shows that between 2008 and 2012, the majority of CDSA-related incidents investigated by London Police Services were related to possession of controlled drugs and substances, as opposed to trafficking, distribution, or production. On average, from 2008 to 2012, 730 incidents per year were related to drug possession, while 230 incidents per year were related to trafficking, distribution, and possession. In 2013, a total of 985 drug-related incidents were investigated by London Police Services. This included all substances under the CDSA; however, the most frequent illicit drug incidents were related to prescription and non-prescription pills, cannabis, cocaine, methamphetamines, and ecstasy (Joan Atchison, London Police Services, personal communication, April 16, 2014). Using incidents is a way to begin to quantify the impact of drug use on police services throughout the year; however, this does not provide a complete picture. The occurrence of one criminal event can involve more than one individual, yet it would be counted as one incident. As a result, the number of people involved in the incidents may be higher than reflected by the data that reports on incidents.

In addition to incident investigations, London Police Services are also responsible for seizure of drugs and controlled substances. Table 4.1 shows that between 2009 and 2012, there was a general increase in seizures for stimulants like methamphetamines, ecstasy, and cocaine, as well as prescription pills, and a decrease in cannabis and crack seizures, with some year to year variability. The greatest increase was for methamphetamines, which went from three grams seized in 2009 to 1,121 grams seized in 2012. The number of prescription pills seized increased by 27.4%, from 1,180 pills in 2009 to 1,503 pills in 2012.

**Figure 4.1: Percent of EMS calls related to drug overdose, by month, Middlesex-London, 2013**



**Source:** Jay Loosley, Superintendent of Education, Middlesex-London EMS, personal communication, March 7, 2014

**Figure 4.2: Annual number of police incidents for possession, trafficking, distribution, and production of controlled substances, London, 2008 to 2012**



**Source:** Joan Atchison, Planner-Analyst, London Police Services, personal communication, February 10, 2014.

**Table 4.1: Annual amounts of drugs seized by London Police Services, London, 2009 to 2012**

<b>Drugs</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
<b>Cannabis</b>				
Marijuana	1,192,554 grams	95,678 grams	47,285 grams	31,407 grams
Marijuana plants	15,231	14,221	4,202	4,670
Marijuana grows	42	26	16	16
<b>Cocaine and other stimulants</b>				
Crack	528 grams	885 grams	355 grams	457 grams
Powder Cocaine	2,645 grams	2,528 grams	957 grams	3,831 grams
Methamphetamines	3 grams	125 grams	479 grams	1,121 grams
Ecstasy	688 pills	275 pills	846 pills	1,380 pills
<b>Prescription</b>				
Pills	1,180 pills	2,242 pills	1,749 pills	1,503 pills

**Source:** London Police Service, 2012 Annual Business Plan Progress Report 3 Year Concluding Report, ND.

## V. Drug Use Related Emergency Department Visits

### Highlights

- Between 2008 and 2012, opioid-related emergency department visit rates were highest among all drug classes in Middlesex-London. In 2012, there were 99.8 opioid-related emergency department visits per 100,000 population, compared to less than 40.0 visits per 100,000 population related to all other drug classes.
- Opioid-related emergency department visit rates in Middlesex-London were significantly higher than the rates for Ontario between 2008 and 2012. Similarly, the visit rates associated with sedative and hypnotic drugs in Middlesex-London were significantly higher than the Ontario rates between 2008 and 2011.
- Between 2008 and 2012, there were no significant differences between emergency department visit rates in Middlesex-London and Ontario for the other drug classes (cannabinoids, cocaine and other stimulants, and hallucinogens and solvents).

*“I guess at a young age, I knew I was an addict,  
but I didn’t really understand anything about it.  
I just knew that I partied harder or more than anyone else.  
It was go high or go home.”  
- Elaine’s Story ([www.its-possible.ca](http://www.its-possible.ca)).*

The frequency and rates of emergency department visits related to drug use, such as acute intoxication, dependence, or overdose, provides an estimate of the extent of drug use in the community. Data provided in this section are likely conservative because the main diagnosis coded for a given emergency department visit may not always reflect the contribution of drug use to the visit. For example, the main diagnosis for someone who fell and broke their arm because they were under the influence of a specific drug might only reflect the primary medical reason for the visit, a broken arm, and the connection with drug use may not be recorded.

### Opioid-Related Emergency Department Visits

Prescription opioids such as codeine, morphine, and hydromorphone are some of the opioids included in this analysis, as well as the opioid agonist methadone, since it is used in the treatment of opioid addiction and may be misused. Illicit opioids such as heroin and opium are also included.

Between 2008 and 2012, there was an average of 472 opioid-related emergency department visits each year among Middlesex-London residents. Table 5.1 shows that the number of opioid-related emergency department visits far outnumbered those for other drug classes; the annual number of opioid-related emergency department visits ranged between 375 and 521, depending on the year.

Figure 5.1 illustrates that between 2008 and 2012, opioid-related emergency department visit rates were highest among all drug classes in Middlesex-London. As well, compared to Ontario, Middlesex-London had significantly higher rates of opioid-related emergency department visits for all years between 2008 and 2012. The rate of opioid-related emergency department visits in Middlesex-London increased each year between 2008 and 2010, ranging from a low of 83.6 ( $\pm 8.5$ ) visits per 100,000 population in 2008 to a high of 114.2 ( $\pm 9.8$ ) visits per 100,000 population in 2010, after which the rate decreased to 99.8 ( $\pm 9.1$ ) visits per 100,000 population in 2012. In Ontario, the rates ranged from a low of 55.6 ( $\pm 1.3$ ) visits per 100,000 population in 2008 to a high of 77.7 ( $\pm 1.5$ ) visits per 100,000 population in 2011.

### Cannabinoid-Related Emergency Department Visits

Table 5.1 shows that emergency department visits related to cannabinoids were relatively low in Middlesex-London, ranking fourth out of the five drug classes in terms of their relative frequency. The number of cannabinoid-related emergency department visits ranged from 77 to 132 between 2008 and 2012, corresponding to an average of 100 cannabinoid-related emergency department visits each year among Middlesex-London residents.

Figure 5.1 shows that in terms of cannabinoid-related emergency department visit rates, there were no significant differences between Middlesex-London and Ontario between 2008 and 2012. However, there appeared to be a general increasing trend for cannabinoid-related emergency department visit rates both locally and provincially. In Middlesex-London, there were 17.2 ( $\pm 3.8$ ) cannabinoid-related visits per 100,000 population in 2008, which rose to 28.5 ( $\pm 4.9$ ) visits per 100,000 population in 2012, while in Ontario, there were 18.6 ( $\pm 0.7$ ) cannabinoid-related visits per 100,000 population in 2009, which increased to 31.9 ( $\pm 1.0$ ) visits per 100,000 population in 2012.

### **Cocaine and Stimulant-Related Emergency Department Visits**

For emergency department visits related to cocaine and other stimulants, there was an average of 181 visits per year between 2008 and 2012 in Middlesex-London. As shown in Table 5.1, the number of stimulant-related emergency department visits for Middlesex-London residents was highest in 2008, when there were 245 visits. After declining to a low of 142 stimulant-related emergency department visits in 2009, the number increased to 178 visits in 2012.

Figure 5.1 illustrates that between 2008 and 2012 there were no significant differences between Middlesex-London and Ontario for rates of stimulant-related emergency department visits, with the exception of 2011, when the Middlesex-London rate (40.9 ( $\pm 5.8$ ) ED visits per 100,000 population) was significantly higher than the Ontario rate (33.2 ( $\pm 1.0$ ) ED visits per 100,000 population). In Middlesex-London, stimulant-related emergency department visit rates ranged from a low of 31.4 ( $\pm 5.2$ ) visits per 100,000 population to a high of 54.6 ( $\pm 6.8$ ) visits per 100,000 population, with rates fluctuating between 2008 and 2012. Ontario emergency department visit rates for stimulants varied between 30.9 ( $\pm 1.0$ ) visits per 100,000 population and 46.4 ( $\pm 1.2$ ) visits per 100,000 population, with a general increasing trend in the provincial rates since 2009.

### **Sedative and Hypnotic-Related Emergency Department Visits**

On average, there were 198 emergency department visits per year between 2008 and 2012 related to sedative and hypnotic drugs (including benzodiazepines and barbiturates) in Middlesex-London. Table 5.1 shows that from 2009 to 2012, sedative and hypnotic-related emergency department visits were the second most frequently reported drug class in Middlesex-London, with 182 visits in 2012.

Figure 5.1 shows that the sedative and hypnotic-related emergency department visit rates in Middlesex-London were significantly higher compared to Ontario rates for all years except 2012. The Middlesex-London emergency department visit rate ranged from a low of 39.2 ( $\pm 5.7$ ) visits per 100,000 population to a high of 47.8 ( $\pm 6.4$ ) visits per 100,000 population, with a general decrease over time. The Ontario rate of emergency department visits for sedative and hypnotic drugs was stable to slightly increasing over time, ranging from a low of 32.5 ( $\pm 1.0$ ) visits per 100,000 population in 2008 to a high of 35.4 ( $\pm 1.0$ ) visits per 100,000 population in 2012.

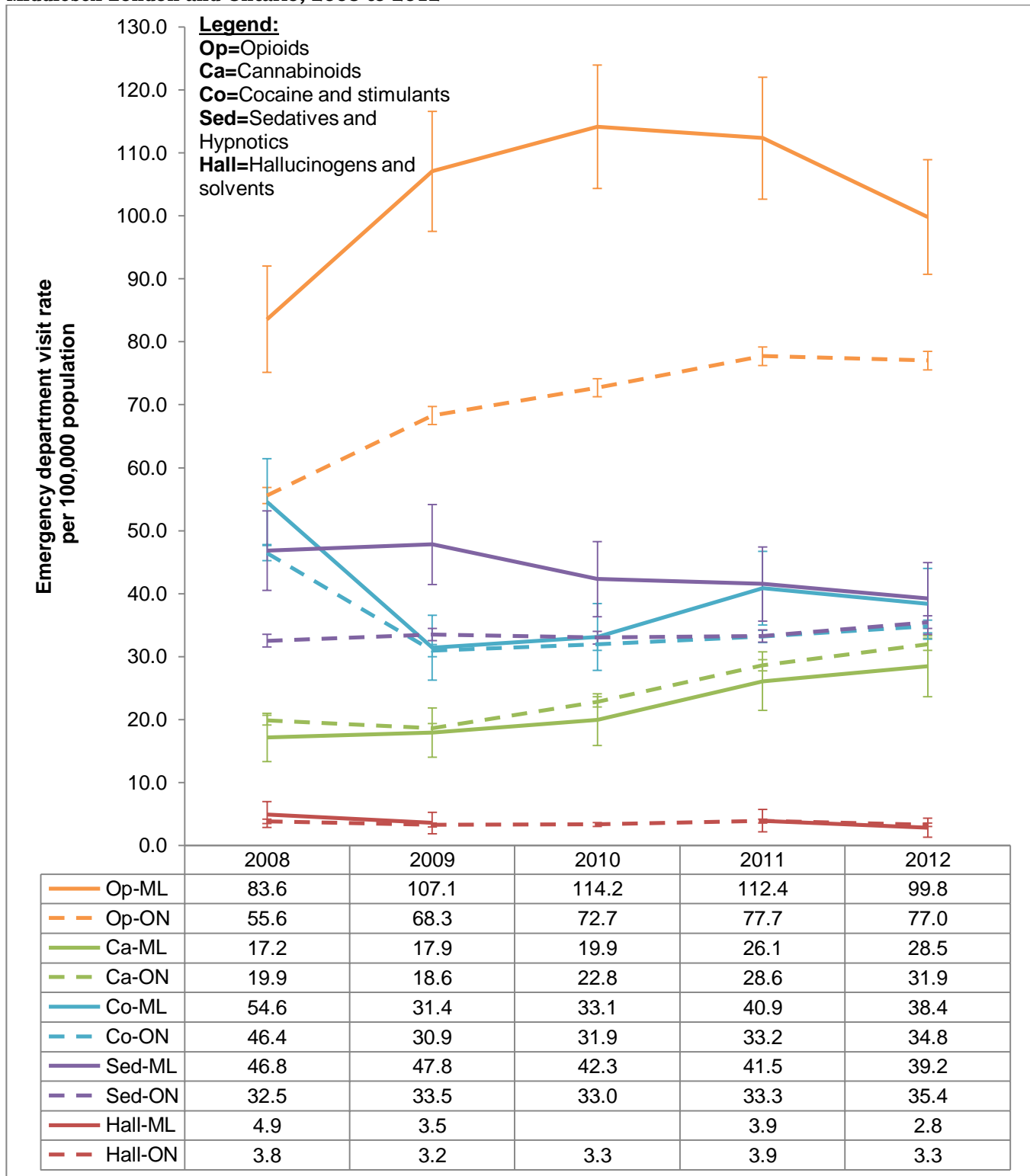
### **Hallucinogen and Solvent-Related Emergency Department Visits**

The final class of drugs examined was hallucinogens and solvents. These were much less commonly associated with emergency department visits in Middlesex-London and across the province. However, for solvents, use may be underreported because there is not an ICD-10-CA code specifically for “huffing”/inhaling recreationally.

From 2008 to 2012, there was an annual average of 15 emergency department visits related to hallucinogens and solvents in Middlesex-London. Table 5.1 shows that in terms of frequency, emergency department visits related to hallucinogens and solvents ranked fifth among all drug classes, with 13 visits in Middlesex-London in 2012.

Figure 5.1 shows that there were no significant differences between the local and provincial rates for emergency department visits related to hallucinogens and solvents. In Middlesex-London, the emergency department visit rate for hallucinogens and solvents ranged from a low of 2.8 ( $\pm 3.3$ ) visits per 100,000 population to a high of 4.9 ( $\pm 3.8$ ) visits per 100,000 population, with a decreasing trend from 2008 to 2012. Middlesex-London data from 2010 could not be shown due to there being five or fewer visits for that year. For Ontario, the rate of emergency department visits was relatively stable, from a low of 3.2 ( $\pm 0.3$ ) visits per 100,000 population in 2009 to a high of 3.9 ( $\pm 0.3$ ) visits per 100,000 population in 2011.

**Figure 5.1: Rates of drug-related emergency department visits per 100,000 population, by drug class, Middlesex-London and Ontario, 2008 to 2012**



**Sources:** Emergency Department Visits – National Ambulatory Care Reporting System (NACRS), Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted March 20, 2014; Population Estimates – Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted December 16, 2013.

**Table 5.1: Number of drug-related emergency department visits and annual ranking by frequency, by drug class, Middlesex-London and Ontario, 2008 to 2012**

Year	2008	2009	2010	2011	2012
<b>Opioids</b>					
ML	375	484	521	517	463
ON	7185	8928	9617	10389	10403
Annual Rank (ML / ON)	1 / 1	1 / 1	1 / 1	1 / 1	1 / 1
<b>Cannabis</b>					
ML	77	81	91	120	132
ON	2570	2431	3015	3822	4312
Annual Rank (ML / ON)	4 / 4	4 / 4	4 / 4	4 / 4	4 / 4
<b>Cocaine and Other Stimulants</b>					
ML	245	142	151	188	178
ON	6007	4043	4222	4434	4697
Annual Rank (ML / ON)	2 / 2	3 / 3	3 / 3	3 / 3	3 / 3
<b>Sedatives and Hypnotics</b>					
ML	210	216	193	191	182
ON	4206	4378	4363	4448	4786
Annual Rank (ML / ON)	3 / 3	2 / 2	2 / 2	2 / 2	2 / 2
<b>Hallucinogens and Solvents</b>					
ML	22	16	-	18	13
ON	496	423	440	516	441
Annual Rank (ML / ON)	5 / 5	5 / 5	- / 5	5 / 5	5 / 5

**Sources:** Emergency Department Visits – National Ambulatory Care Reporting System (NACRS), Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted March 20, 2014.

- Number cannot be reported due to cells counts less than 5



## VI. Drug Use Related Inpatient Hospitalizations

### Highlights

- In Middlesex-London, opioid-related inpatient hospitalizations had a significantly higher impact compared to other classes of drugs. In 2012, there were 49.6 opioid-related hospitalizations per 100,000 population compared to fewer than 20 hospitalizations per 100,000 population related to other drug classes.
- Opioid related hospitalization rates in Middlesex-London were significantly higher compared to Ontario rates. In 2021, the Middlesex-London opioid-related hospitalization rate of 49.6 hospitalizations per 100,000 population was 1.5 times greater than the Ontario rate of 32.9 hospitalizations per 100,000 population.
- There were no significant differences between Middlesex-London and Ontario hospitalization rates for the other drug classes for which there were sufficient numbers of hospitalizations to report (cannabinoids, cocaine and other stimulants, sedatives and hypnotics).
- In Middlesex-London, hospitalizations related to opioids had the longest average length of stay in hospital compared to other drug classes. In 2012, the average length of stay associated with opioid-related hospitalization was 7.5 days, compared to 6.2 days or less for all other drug classes.

*“I did believe that I was really the only one affected [by my addiction] and I was so stuck in my own self-centredness that I thought no one really noticed or really cared.”*  
- *Tabitha’s Story (www.its-possible.ca).*

The frequency of inpatient hospitalizations related to the effects of drug use, such as intoxication, dependence and overdose, provide additional information to assess the impact of drug use in the community. It should be noted that similar to emergency department data, the information provided in this analysis is likely conservative because inpatient hospitalizations may not always be coded to reflect the underlying contribution of drug use. The data included in this section reports not only those who had a most responsible diagnosis related to specific drug use, but also those who had any other diagnostic codes related to drug use.

### Opioid-Related Inpatient Hospitalizations

Inpatient hospitalizations in the opioid drug class included prescription opioids as well as non-prescription opioids, such as heroin. Among Middlesex-London residents, there was an average of 183 opioid-related inpatient hospitalizations each year between 2008 and 2012. Table 6.1 shows that depending on the year, the number of inpatient hospitalizations in Middlesex-London related to opioids ranged from 156 to 230 between 2008 and 2012, and was consistently two to three times greater than the number of hospitalizations for the next most frequently reported drug class in Middlesex-London.

Figure 6.1 shows that inpatient hospitalization rates related to opioid use in Middlesex-London increased from 34.8 ( $\pm 5.5$ ) hospitalizations per 100,000 population in 2008 to 49.6 ( $\pm 6.4$ ) hospitalizations per 100,000 population in 2012. Across the five year time period, local rates were significantly higher than the opioid-related hospitalization rates in Ontario, which increased from 21.7 where in 2012, the inpatient hospitalizations rate was 32.9 ( $\pm 1.0$ ) hospitalizations per 100,000 people.

Table 6.2 provides the average length of stay (LOS) for hospitalizations with diagnosis codes related to drug use. In 2012, the average LOS for a hospitalization related to opioid use was 7.5 days in Middlesex-London. While this was the highest average LOS among all drug classes in Middlesex-London, it was comparable to the average LOS of 8.0 for Ontario.

### Cannabinoid-Related Inpatient Hospitalizations

Between 2008 and 2012, there was an annual average of 56 cannabinoid-related hospitalizations in Middlesex-London. Table 6.1 shows that the number of inpatient hospitalizations in Middlesex-London generally increased, from 41 to 66 between 2008 and 2012.

Similarly, it can be seen in Figure 6.1 that cannabinoid-related hospitalization rates also generally increased, in both Middlesex-London and Ontario. In 2008, the rates of hospitalizations associated with cannabinoids were 9.1 ( $\pm 2.8$ ) and 7.3 ( $\pm 0.5$ ) hospitalizations per 100,000 population in Middlesex-London and Ontario, respectively. By 2012, the cannabinoid-related hospitalization rate in Middlesex-London was 14.2 ( $\pm 3.4$ ) hospitalizations per 100,000 population, while the Ontario rate was 11.2 ( $\pm 0.6$ ) hospitalizations per 100,000 population.

Table 6.2 shows that the average LOS for cannabinoid-related hospitalizations in Middlesex-London was generally lower than the average LOS for Ontario for all year except 2009. In 2012, the average LOS for hospitalizations related to cannabinoids in Middlesex-London was 5.6 days, while the average LOS for Ontario was 6.8 days. Overall, average LOS for cannabinoid-related hospitalization fluctuated between 2008 and 2012, however, some of this variability may have been due to small cell counts.

### **Cocaine and Stimulant-Related Inpatient Hospitalizations**

Table 6.1 shows that depending on the year, there were between 42 and 67 inpatient hospitalizations related to cocaine and other stimulant use in Middlesex-London between 2008 and 2012. This corresponds to an average of 53 hospitalizations each year in the five year time period.

As seen in Figure 6.1, inpatient hospitalization rates associated with cocaine and other stimulant were different in Middlesex-London and Ontario. Stimulant-related hospitalization rates in Middlesex-London increased from 10.9 ( $\pm 3.1$ ) hospitalizations per 100,000 population in 2008 to 14.4 ( $\pm 3.5$ ) hospitalizations per 100,000 population in 2012. During the same time period, Ontario hospitalization rates decreased from 14.6 ( $\pm 0.7$ ) hospitalizations per 100,000 population to 11.9 ( $\pm 0.6$ ) hospitalizations per 100,000. Although different patterns existed between the two jurisdictions, there were no statistical difference between the rates in Middlesex-London and Ontario for any of the five years.

Similarly, different patterns have emerged related to LOS for patients in hospital related to cocaine and stimulant use. Table 6.2 shows that LOS has increased in Middlesex-London from 2008 to 2012, with a peak in 2011 of an average of 7.8 days in hospital. Although the peak also occurs in 2011 for Ontario, the overall trend in Ontario is decreasing lengths of hospital stays.

### **Sedative and Hypnotic-Related Inpatient Hospitalizations**

For inpatient hospitalizations related to sedative and hypnotic drugs, there was an average of 69 hospitalizations per year between 2008 and 2012 in Middlesex-London. Table 6.1 shows that the number of hospitalizations varied from year to year, ranging from a low of 56 hospitalizations in 2011 to a high of 81 hospitalizations in 2009.

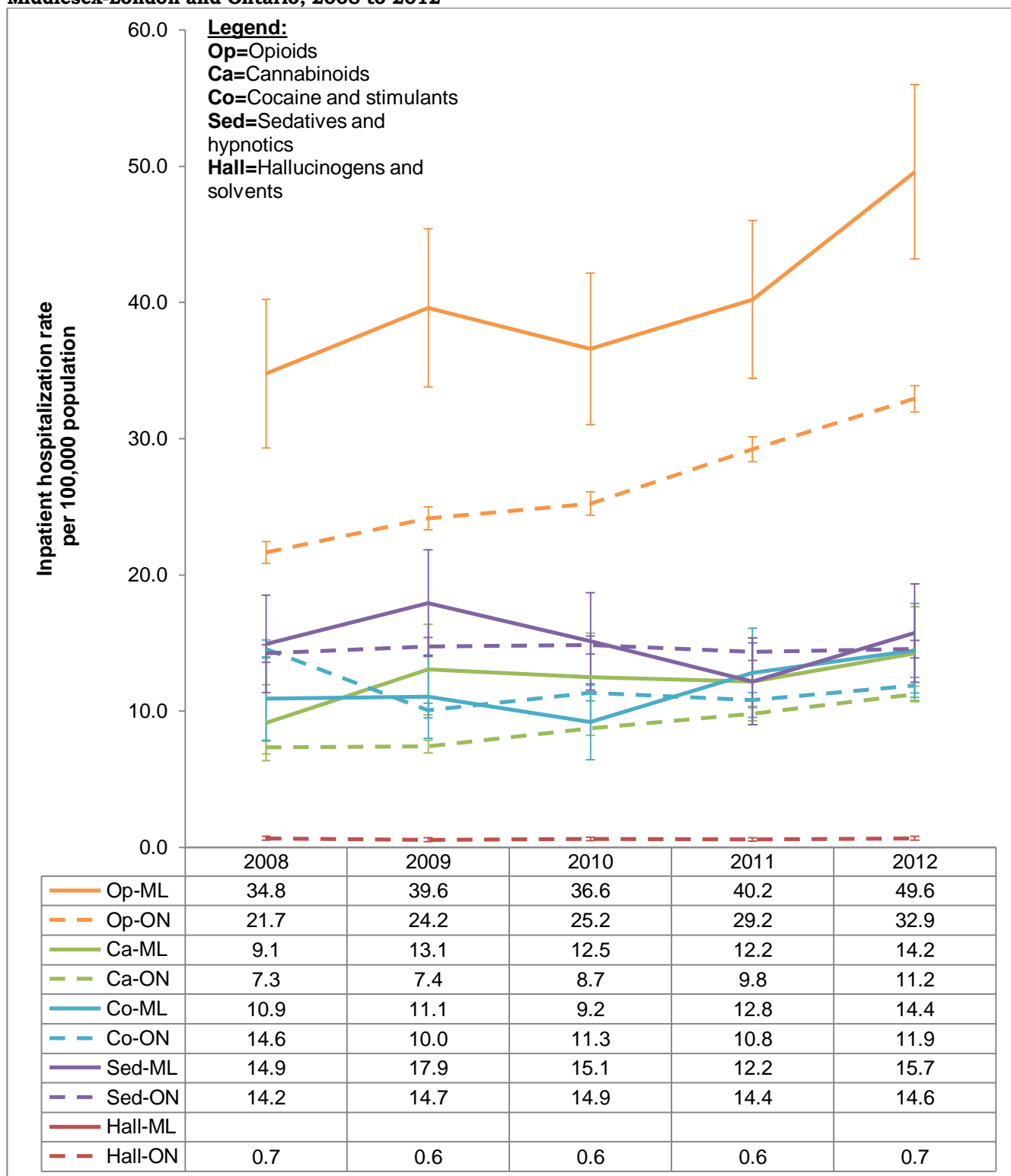
Figure 6.1 shows that between 2008 and 2012, the rates of sedative and hypnotic-related hospitalization in Middlesex-London fluctuated, while in Ontario, inpatient hospitalization rates remained quite stable. Although there were not significant increases or decreases across the five year time period in Middlesex-London, annual fluctuations resulted in a low of 12.2 ( $\pm 3.2$ ) hospitalizations per 100,000 population in 2011, and a high of 17.9 ( $\pm 3.9$ ) hospitalizations per 100,000 population in 2009. In Ontario, the hospitalization rates associated with sedatives and hypnotics was 14.6 ( $\pm 0.6$ ) hospitalizations per 100,000 population in 2012, which was comparable to all other years. Although variation occurred across time, the hospitalization rate for sedative and hypnotic use in Middlesex-London was not significantly different than Ontario.

In terms of average LOS in hospital associated with sedative and hypnotic use, Table 6.2 shows that values remained relatively stable in both Middlesex-London and Ontario between 2008 and 2012, with the exception 2009, when average LOS increased sharply in both Middlesex-London and Ontario. However, average LOS decreased again in 2010. Most recently, in 2012, the average LOS associated with sedative and hypnotic-related hospitalizations was 5.1 days in Middlesex-London which was comparable to the Ontario average LOS of 5.0 days.

### **Hallucinogen and Solvent-Related Inpatient Hospitalizations**

Information about the number, rates of, and average LOS associated with hallucinogen and solvent-related inpatient hospitalizations could not be released for Middlesex-London, due to low cell counts. Figure 6.1 shows that at the provincial level, rates of hallucinogen and solvent-related hospitalization were consistently low, with 0.7 ( $\pm 0.1$ ) hospitalizations per 100,000 population in Ontario in 2012. Figure 6.2 shows that in Ontario in 2012, the average LOS associated with hallucinogen and solvent-related hospitalizations was 10.5 days. Although the provincial average LOS appeared to increase between 2008 and 2012, it should be noted that the annual numbers of inpatient hospitalizations were much lower than for the other drug classes. As a result, the calculation of average LOS may be subject to more random fluctuation, which may potentially account for the observed trend.

**Figure 6.1: Rates of drug-related inpatient hospitalizations per 100,000 population, by drug class, Middlesex-London and Ontario, 2008 to 2012**



**Sources:** Inpatient Hospitalizations – Discharge Abstract Database (DAD), Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted April 22, 2014; Population Estimates – Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted December 16, 2013

**Table 6.1: Number of drug-related inpatient hospitalizations and annual ranking by frequency, by drug class, Middlesex-London and Ontario, 2008 to 2012**

Year	2008	2009	2010	2011	2012
<b>Opioids</b>					
ML	156	179	167	185	230
ON	2800	3158	3336	3906	4449
Annual Rank (ML / ON)	1 / 1	1 / 1	1 / 1	1 / 1	1 / 1
<b>Cannabis</b>					
ML	41	59	57	56	66
ON	948	968	1153	1312	1519
Annual Rank (ML / ON)	4 / 4	3 / 4	3 / 4	3 <sup>†</sup> / 4	4 / 4
<b>Cocaine and Other Stimulants</b>					
ML	49	50	42	59	67
ON	1885	1313	1498	1446	1606
Annual Rank (ML / ON)	3 / 2	4 / 3	4 / 3	2 / 3	3 / 3
<b>Sedatives and Hypnotics</b>					
ML	67	81	69	56	73
ON	1840	1927	1964	1920	1967
Annual Rank (ML / ON)	2 / 3	2 / 2	2 / 2	3 <sup>†</sup> / 2	2 / 2
<b>Hallucinogens and Solvents</b>					
ML	-	-	-	-	-
ON	86	73	81	78	90
Annual Rank (ML / ON)	- / 5	- / 5	- / 5	- / 5	- / 5

**Sources:** Inpatient Hospitalization – Discharge Abstract Database (DAD), Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted April 22, 2014; Population Estimates – Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted December 16, 2013

- Number cannot be reported due to cells counts less than 5

† Same number of hospitalizations in two different drug classes

**Table 6.2: Average length of stay (LOS) (days) in hospital for drug-related hospitalizations, by drug class, Middlesex-London and Ontario, 2008 to 2012**

Year	2008	2009	2010	2011	2012
<b>Opioids</b>					
ML	7.8	8.2	9.0	8.4	7.5
ON	8.3	8.2	8.8	8.0	8.0
Annual Rank (ML / ON)	1 / 1	2 / 1	1 / 1	1 / 2	1 / 2
<b>Cannabis</b>					
ML	4.4	9.3	5.0	5.0	5.6
ON	5.7	6.5	5.7	7.5	6.8
Annual Rank (ML / ON)	4 / 4	1 / 4	4 / 4	4 / 3	3 / 3
<b>Cocaine and Other Stimulants</b>					
ML	4.5	5.6	7.6	7.8	6.2
ON	7.1	6.7	6.4	7.4	6.3
Annual Rank (ML / ON)	3 / 2	4 / 2	2 / 3	2 / 4	2 / 4
<b>Sedatives and Hypnotics</b>					
ML	4.8	6.9	5.6	5.5	5.1
ON	5.0	5.9	5.2	5.4	5.0
Annual Rank (ML / ON)	2 / 5	3 / 5	3 / 5	3 / 5	4 / 5
<b>Hallucinogens and Solvents</b>					
ML	-	-	-	-	-
ON	6.6	6.6	8.5	8.2	10.5
Annual Rank (ML / ON)	- / 3	- / 3	- / 2	- / 1	- / 1

**Sources:** Inpatient Hospitalization – Discharge Abstract Database (DAD), Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted April 22, 2014; Population Estimates – Ministry of Health and Long-Term Care IntelliHEALTH ONTARIO, Extracted December 16, 2013

- Number cannot be reported due to cells counts less than 5

## VII. Admission to Substance Misuse and Addictions Programs

### Highlights

- In 2013, the Middlesex-London rates of admissions to substance misuse and addictions programs reporting prescription opioids, methamphetamines, and other stimulants as a presenting problem substance were significantly higher than the Ontario rates; the rates of admissions related to cannabis, cocaine, benzodiazepines, heroin/opium, codeine, ecstasy, and hallucinogens were significantly lower in Middlesex-London than the comparable Ontario rates.
- For Middlesex-London, cannabis, prescription opioid, and crack were the presenting problem substances with the highest rates of admission between 2008 and 2013.
- Between 2008 and 2013, the rates of admissions to substance misuse and addictions services related to crack and cocaine generally decreased in Middlesex-London. However, there was a marked increase in admissions reporting methamphetamines as a presenting problem over the six year time period.

*“I changed my habits. I tried to control my own addiction, thinking that somehow if I only got high on the weekend, or only did one drug as opposed to another, I could manage that. It took me about two years to get a grip.”*  
 - Tabitha’s Story ([www.its-possible.ca](http://www.its-possible.ca)).

Substance misuse and addiction recovery programs and services are important components of the continuum of care for those who misuse substances. Use of these programs and services provide an indicator of the extent of substance use in a community. It should be noted that this indicator is somewhat dependant on the availability of these programs and services in the local community. It should also be noted that the number of admissions is greater than the number of individuals using these services, since an individual may be admitted more than one time in a calendar year for the same service or different services, or may be admitted for more than one service concurrently.

In Middlesex-London from 2008 to 2013, there was an average of 2,381 admissions to substance misuse and addictions programs, ranging from a high of 2,422 in 2011 to a low of 2,244 in 2008. This represents an average of 1,428 individuals per year admitted from 2008 to 2013, ranging from a high of 1,462 individuals in 2008 to a low of 1,357 individuals in 2010, and corresponding to an average of 1.6 admissions per individual. In Ontario from 2008 to 2013, there was an average of 78,125 admissions to substance misuse and addictions programs, from a high of 79,612 in 2012 to a low of 72,362 in 2013. An average of 46,457 individuals is represented in these admissions between 2008 and 2013, ranging from a high of 46,957 individuals in 2009 to a low of 45,401 individuals in 2013, which corresponds to an average of 1.7 admissions per individual.

Each admission to substance misuse and addictions programs may have up to five substances recorded as the presenting problem substance, that is, the main substance(s) of addiction for which the person is seeking help. Alcohol and tobacco were the most commonly reported presenting problem substances for both Middlesex-London and Ontario. Between 2008 and 2013, alcohol was reported as a presenting problem substance for 58.5% to 60.6% of admissions per year in Middlesex-London; tobacco was reported as a presenting problem substance for 43.8% to 50.6% of admissions between 2008 and 2013 in Middlesex-London. For admissions to substance misuse and addictions programs in the province as a whole, alcohol (67.5% to 70.7% of admissions per year) and tobacco (20.7% to 27.8% of admissions per year) were the most frequently reported presenting problem substances between 2008 and 2013. The analyses that follow exclude alcohol and tobacco because those substances are not the focus of this report.

Figure 7.1 shows the rates of presenting problem substances on admission to substance misuse and addiction services that are significantly different comparing Middlesex-London and Ontario in 2013. For both Middlesex-London and Ontario, the rates of cannabis-related admissions were higher than those for any other substance in 2013, in both Middlesex-London (486.6 cannabis-related admissions per 1,000 individuals admitted) and Ontario (536.0 cannabis-related admissions per 1,000 individuals admitted). However, the Middlesex-London rate of cannabis-related admissions was significantly lower than the provincial rate. Similarly, the 2013 Middlesex-London rates for cocaine-, benzodiazepine-, heroin/opium-, codeine preparation-, ecstasy, and hallucinogen-related admissions were also significantly lower than the comparable Ontario rates.

There were three substances where the rates of presenting problem substance admissions in Middlesex-London were significantly higher than those for Ontario: prescription opioid-related, methamphetamine-related, and stimulant-related admissions. The greatest difference was for methamphetamines, where the 2013 rate in Middlesex-London of 251.9 methamphetamine-related admissions per 1,000 individuals admitted was more than three times greater than the Ontario rate of 73.1 methamphetamine-related admissions per 1,000 individuals admitted. There was also a large difference between the Middlesex-London (430.1 admissions per 1,000 individuals admitted) and provincial (308.6 admissions per 1,000 individuals admitted) rates for prescription opioid-related admissions.

### **Opioids as Presenting Problem Substances**

Information was available about three different types of presenting problem substances in the opioid drug class: prescription opioids, over-the-counter (OTC) codeine preparations, and heroin/opium. Figure 7.2 shows that the rates of admissions related to prescription opioids in Middlesex-London were significantly higher than Ontario for all years between 2008 and 2013. In Middlesex-London, the rates of prescription opioid-related admissions ranged from a low of 382.4 ( $\pm 31.7$ ) prescription opioid-related admissions per 1,000 individuals admitted in 2008 to a high of 580.1 ( $\pm 39.1$ ) admissions per 1,000 individuals admitted in 2011. The rates of prescription opioid-related admissions declined in 2012 and 2013, both in Middlesex-London and Ontario. This may be related to drug policy changes and additional opioid prescribing training of health care providers in recent years.

The rates of admissions reporting OTC codeine preparations as a presenting problem substance remained fairly stable over time for both Middlesex-London and Ontario, with 12.4 ( $\pm 5.7$ ) and 22.3 ( $\pm 1.4$ ) OTC codeine-related admissions per 1,000 individuals admitted in 2013, respectively. Since 2011, the rates of OTC codeine-related admissions have been significantly lower in Middlesex-London compared to Ontario.

For heroin/opium, the rate of substance use and addictions services admissions reporting the use of these substances varied in Middlesex London between 2008 and 2013, and increased over time in Ontario. In 2013, heroin/opium use was reported by 24.1 ( $\pm 8.0$ ) admissions per 1,000 individuals admitted in Middlesex-London, which was significantly lower than the Ontario rate of 65.3 ( $\pm 2.4$ ) admissions per 1,000 individuals admitted.

### **Cannabinoids as Presenting Problem Substances**

Figure 7.3 illustrates that from 2008 to 2013, rates of cannabis-related admissions to substance misuse and addictions programs fluctuated in Middlesex-London, while provincially, the rates were relatively stable. From 2010 onwards, the local rates of admissions reporting cannabis as a presenting problem substance were lower than provincial rates, and the differences were significant in 2010, 2011, and 2013. In the most recent year, the rate of cannabis-related admissions in Middlesex-London was 486.6 ( $\pm 35.9$ ) admissions per 1,000 individuals admitted, compared to the Ontario rate of 536.0 ( $\pm 6.7$ ) admissions per 1,000 individuals admitted.

### **Cocaine and Stimulants as Presenting Problem Substances**

For this drug class, information about five different drugs was available: cocaine, crack, methamphetamines, ecstasy, and amphetamines and other stimulants. Figure 7.4 shows that there were a number of different trends between 2008 and 2013, depending on the drug. In Middlesex-London, the rates of crack, cocaine, and ecstasy as presenting problem substances decreased between 2008 and 2013, while methamphetamines and amphetamines and other stimulants increased during this time period. Most significant was the increase in the rate of methamphetamines as a presenting problem substance, increasing more than seven-fold from 34.9 ( $\pm 9.6$ ) admissions per 1,000 individuals admitted in 2008 to 251.9 ( $\pm 25.8$ ) admissions per 1,000 individuals admitted in 2013. Although increases in the rates of this presenting problem substance were seen provincially as well, it was to a much smaller extent than in Middlesex-London.

In Middlesex-London from 2008 to 2012, crack was the presenting problem substance with the highest rates of admissions, relative to other stimulants, surpassed in 2013 by methamphetamines. The rate of crack-related admissions in Middlesex-London decreased over the six-year time period, ranging from 496.6 ( $\pm 36.1$ ) admissions per 1,000 people admitted in 2008 to 219.5 ( $\pm 24.1$ ) admissions per 1,000 people admitted in 2013. Between 2008 and 2012, the rates in Middlesex-London were significantly lower than the Ontario rates, which declined from 363.9 ( $\pm 5.5$ ) admissions per 1,000 individuals admitted in 2008 to 242.3 ( $\pm 4.5$ ) admissions per 1,000 individuals admitted in 2013.



Between 2008 and 2013, the rates of cocaine-related admissions to substance misuse and addiction programs in Middlesex-London were significantly lower than the Ontario rates in all years except 2011. Rates in Middlesex-London generally decreased from 2008 to 2013, while rates in Ontario have shown some variability. In 2013, the admission rate for cocaine use in Middlesex-London was 212.7 ( $\pm 23.7$ ) per 1,000 individuals admitted compared to 288.5 ( $\pm 4.9$ ) per 1,000 individuals admitted in Ontario.

### **Sedatives and Hypnotics as Presenting Problem Substances**

Benzodiazepines and barbiturates were the only two drugs in the sedatives and hypnotics drug class about which presenting problem substance information was available. Figure 7.5 shows that between 2008 and 2013, the rates of benzodiazepine and barbiturate reported as presenting problem substances were low for both Middlesex-London and Ontario. In Middlesex-London, the benzodiazepine rates decreased from 82.8 ( $\pm 14.7$ ) admissions per 1,000 individuals admitted in 2008 to 25.5 ( $\pm 8.2$ ) admissions per 1,000 individuals admitted in 2013. By comparison, the Ontario rates of benzodiazepines as a presenting problem substance was relatively stable over the six year period, with 60.8 ( $\pm 2.3$ ) admissions per 1,000 individuals admitted reporting benzodiazepine use in 2013. Between 2008 and 2010, the rates of benzodiazepine-related admissions were significantly higher in Middlesex-London than Ontario, but between 2011 and 2013, the local rate was significantly lower than the provincial rate.

Between 2008 and 2013, barbiturates reported as a presenting problem substance was very low in both Middlesex-London and Ontario, with numbers too small to report for Middlesex-London. In Ontario, barbiturate admission rates was relatively stable across the six year time period, ranging from 3.7 ( $\pm 0.6$ ) admissions per 1,000 individuals admitted in 2013 to 4.9 ( $\pm 0.6$ ) admissions per 1,000 individuals admitted in 2010.

### **Hallucinogens and Solvents as Presenting Problem Substances**

For this reporting category, information about two presenting problem substances was available: hallucinogens and glue and other inhalant use. It was very uncommon for any of these substances to be reported as a presenting problem substance in both Middlesex-London and Ontario. Overall, hallucinogens as a presenting problem substance in Middlesex-London had an admission rate that ranged from a low of 4.9 ( $\pm 3.7$ ) admissions per 1,000 individuals admitted in 2009 to a high of 7.5 ( $\pm 4.5$ ) admissions per 1,000 individuals admitted in 2011 (data not shown). In Ontario, hallucinogen-related admission rates generally declined, ranging from 18.6 ( $\pm 1.2$ ) admissions per 1,000 individuals admitted in 2008 to 12.9 ( $\pm 1.0$ ) admissions per 1,000 individuals admitted in 2013 (data not shown).

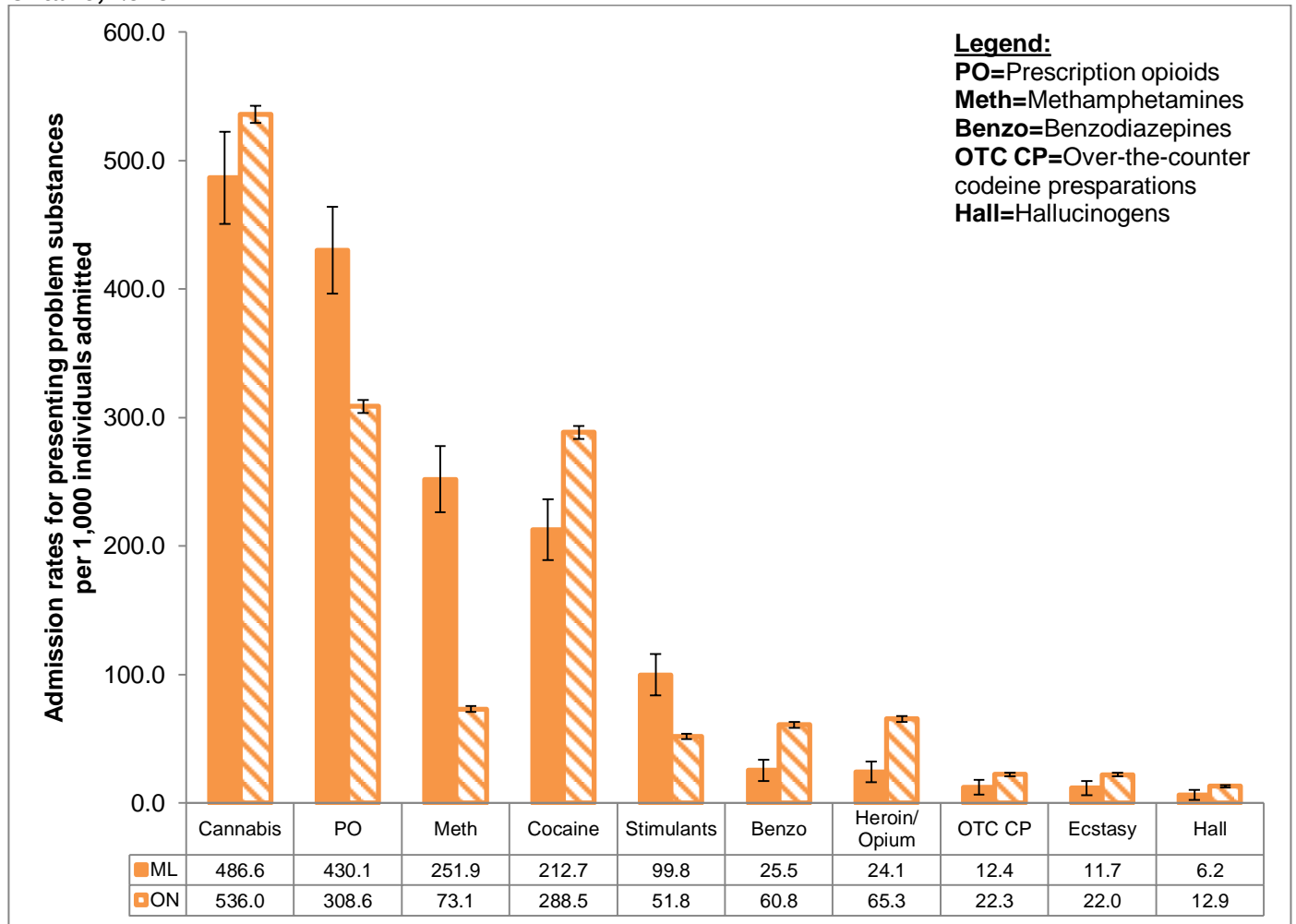
Between 2008 and 2013, the number of admissions to substance misuse and addictions services related to glue and other inhalant use was too low to be reported for Middlesex-London. In Ontario, the rate of admissions reporting glue and other inhalants as presenting problem substances decreased from 12.6 ( $\pm 1.0$ ) admissions per 1,000 individuals admitted in 2009 to 3.6 ( $\pm 0.6$ ) admissions per 1,000 individuals admitted in 2013 (data not shown).

### **Substance Misuse and Addiction Services Admissions and Injection Drug Use**

Besides presenting problem substances, a variety of other information is gathered upon admission to substance misuse and addictions services, including the use of injection drugs in the 12 months prior to admission. Use of injection drugs is an important risk factor for bloodborne infections like hepatitis C (PHAC, 2009) and human immunodeficiency virus (HIV) (PHAC, 2010), and is associated with other health sequelae like infective endocarditis (Brown & Levine, 2002).

Figure 7.6 shows that between 2008 and 2012, Middlesex-London had significantly higher rates of admissions reporting injection drug use in the 12 months prior to admission compared to Ontario; local rates of reported injection drug use were approximately two times greater than the provincial rates. Middlesex-London admission rates for reported injection drug use in the past 12 months ranged from a low of 171.0 ( $\pm 21.2$ ) admissions per 1,000 individuals admitted in 2008 to a high of 212.0 ( $\pm 24.0$ ) per 1,000 individuals admitted in 2012. In contrast, the Ontario rates of admissions reporting injection drug use in the past 12 months were much lower, ranging between 91.6 ( $\pm 2.7$ ) per 1,000 individuals admitted in 2009 and 112.4 ( $\pm 3.1$ ) per 1,000 individuals admitted in 2013.

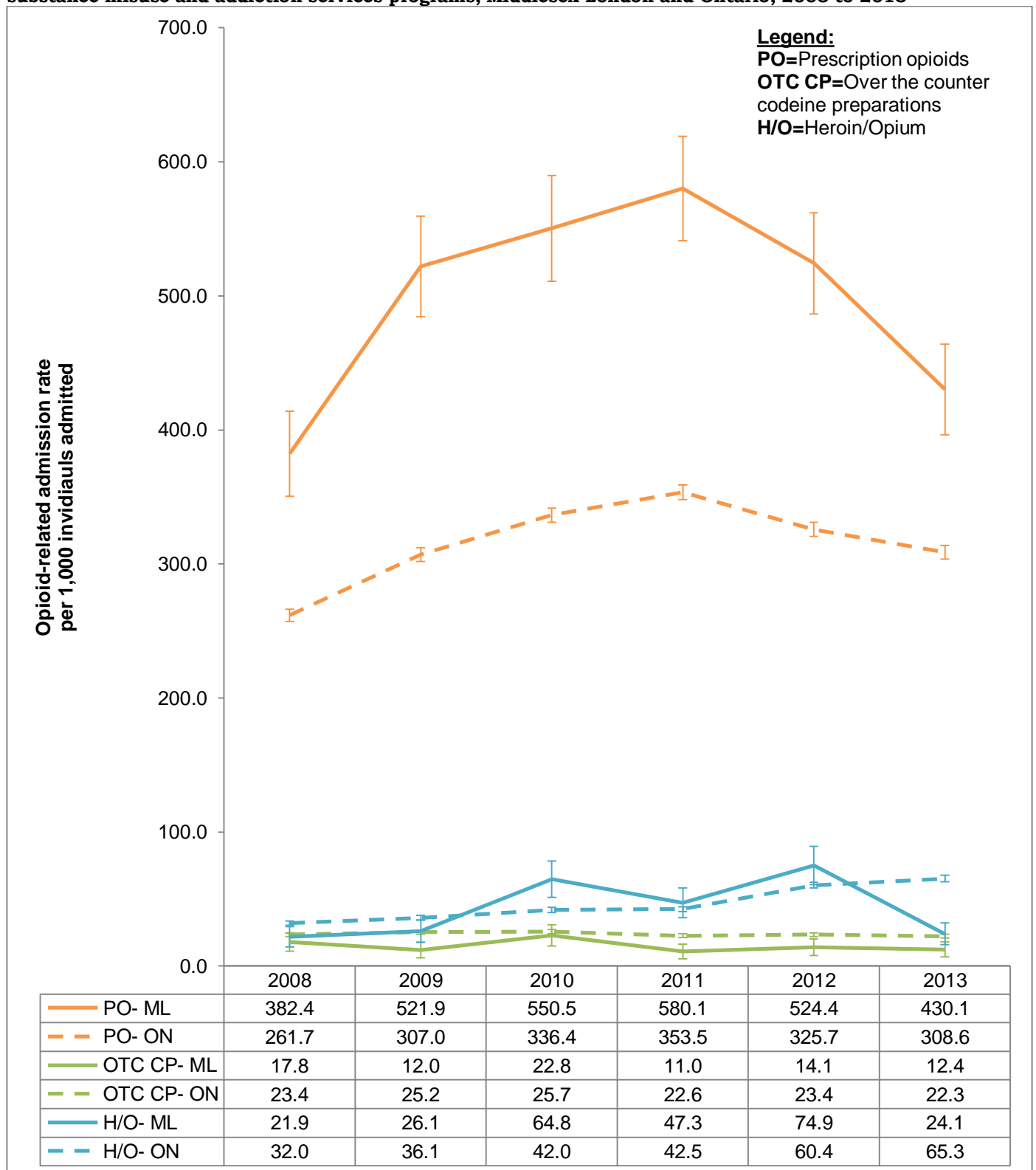
**Figure 7.1: Rates of presenting problem substances admissions per 1,000 individuals admitted to substance misuse and addictions services programs with significant differences\* between Middlesex-London and Ontario, 2013**



**Source:** Drug and Alcohol Treatment Information System, 2014

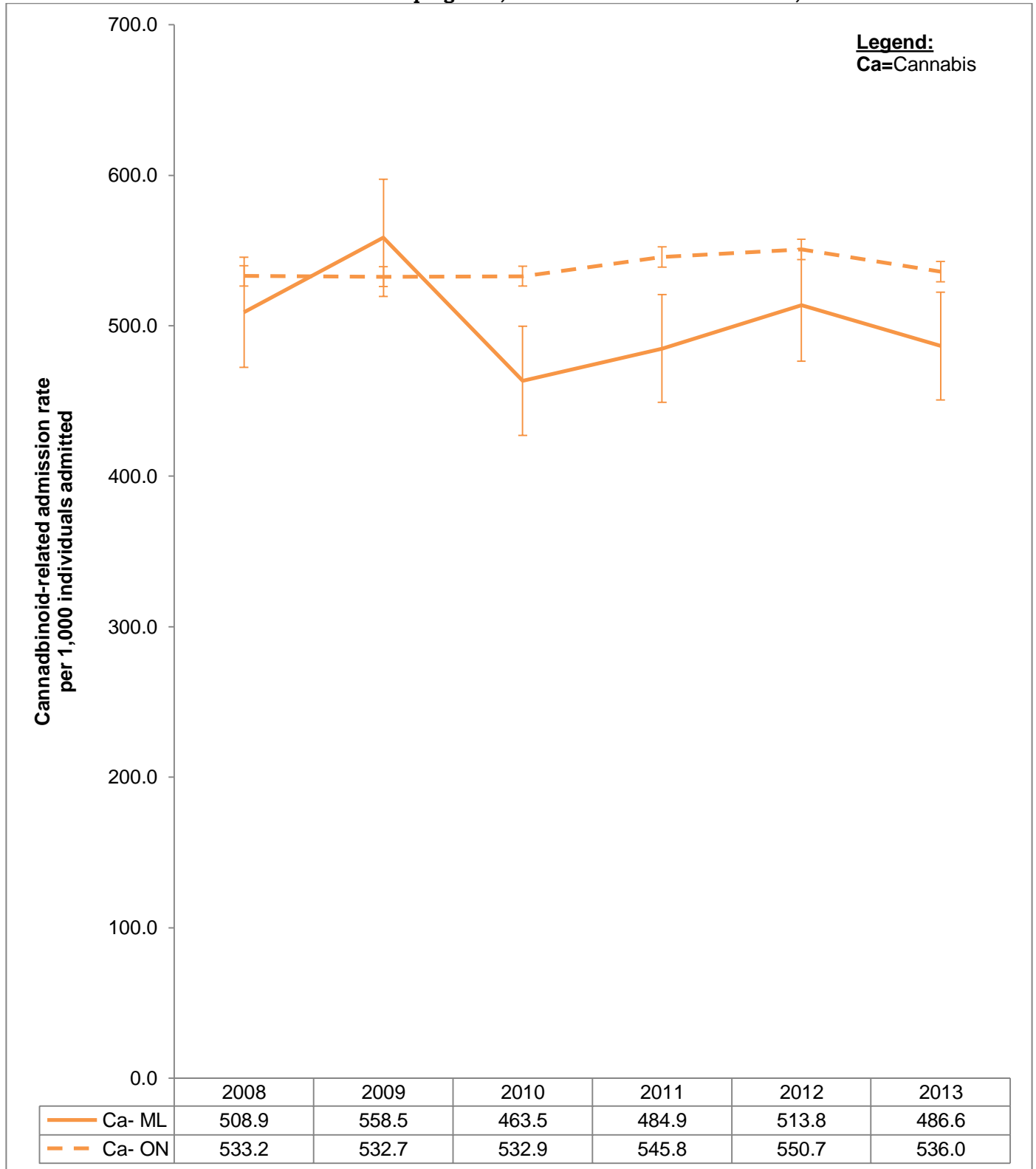
\* Significant differences determined using 95% confidence intervals (CIs)

**Figure 7.2: Rates of opioid presenting problem substance admissions per 1,000 individuals admitted to substance misuse and addiction services programs, Middlesex-London and Ontario, 2008 to 2013**



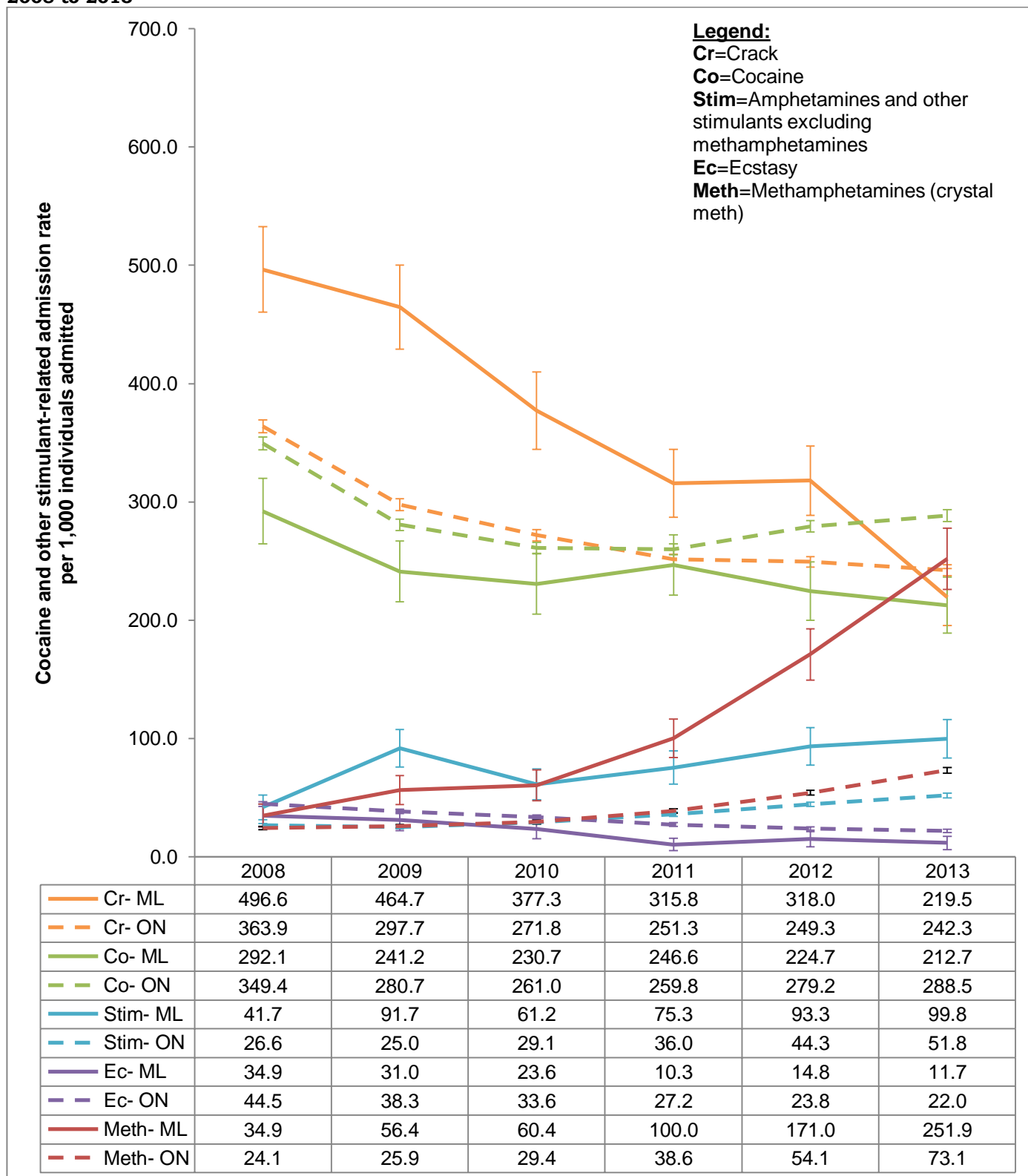
**Source:** Drug and Alcohol Treatment Information System, 2014.

**Figure 7.3: Rates of cannabinoid presenting problem substance admissions per 1,000 individuals admitted to substance misuse and addiction services programs, Middlesex London and Ontario, 2008 to 2013**



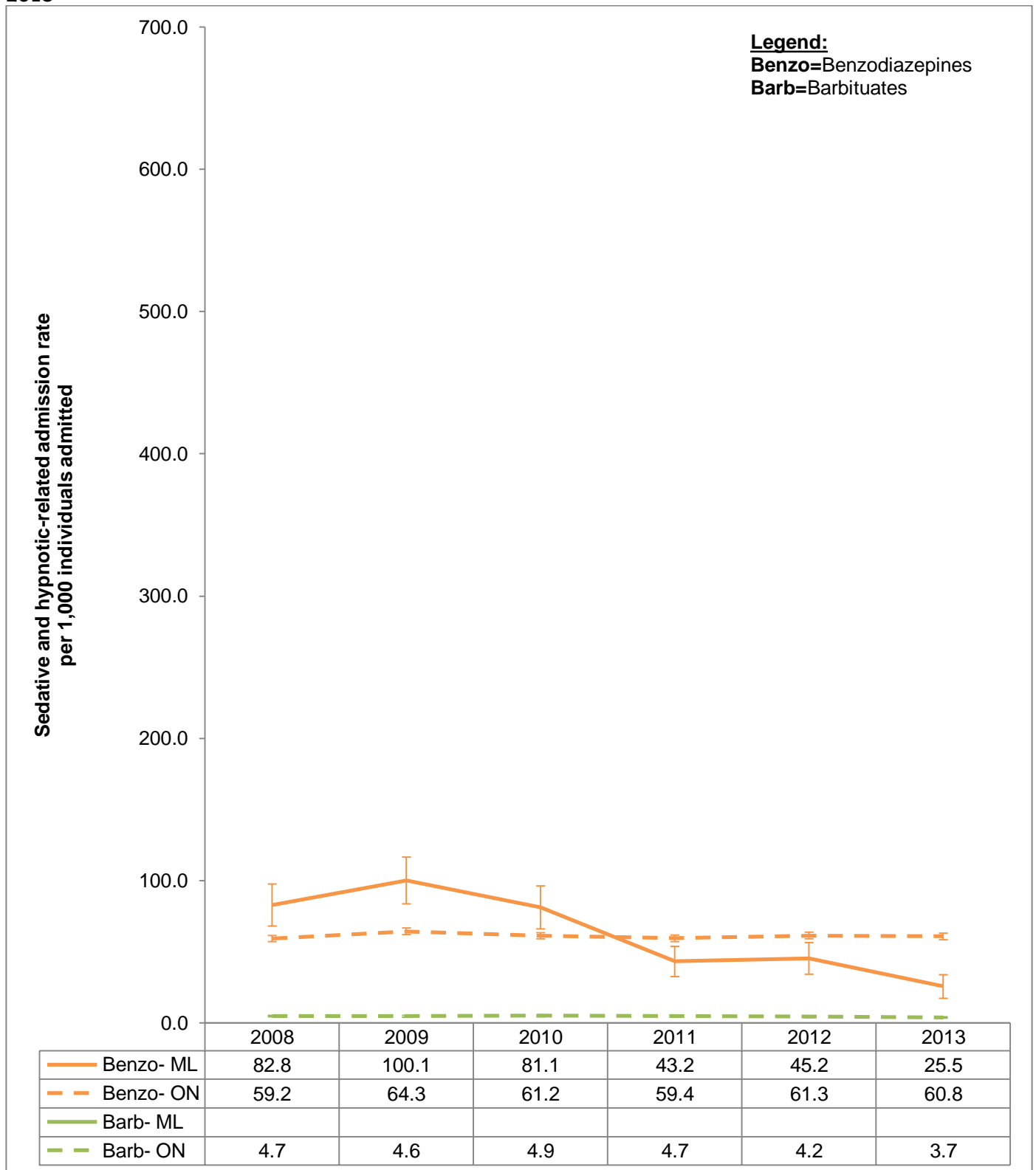
Source: Drug and Alcohol Treatment Information System, 2014.

**Figure 7.4: Rates of cocaine and other stimulant presenting problem substance admissions per 1,000 individuals admitted to substance misuse and addiction services programs, Middlesex-London and Ontario, 2008 to 2013**



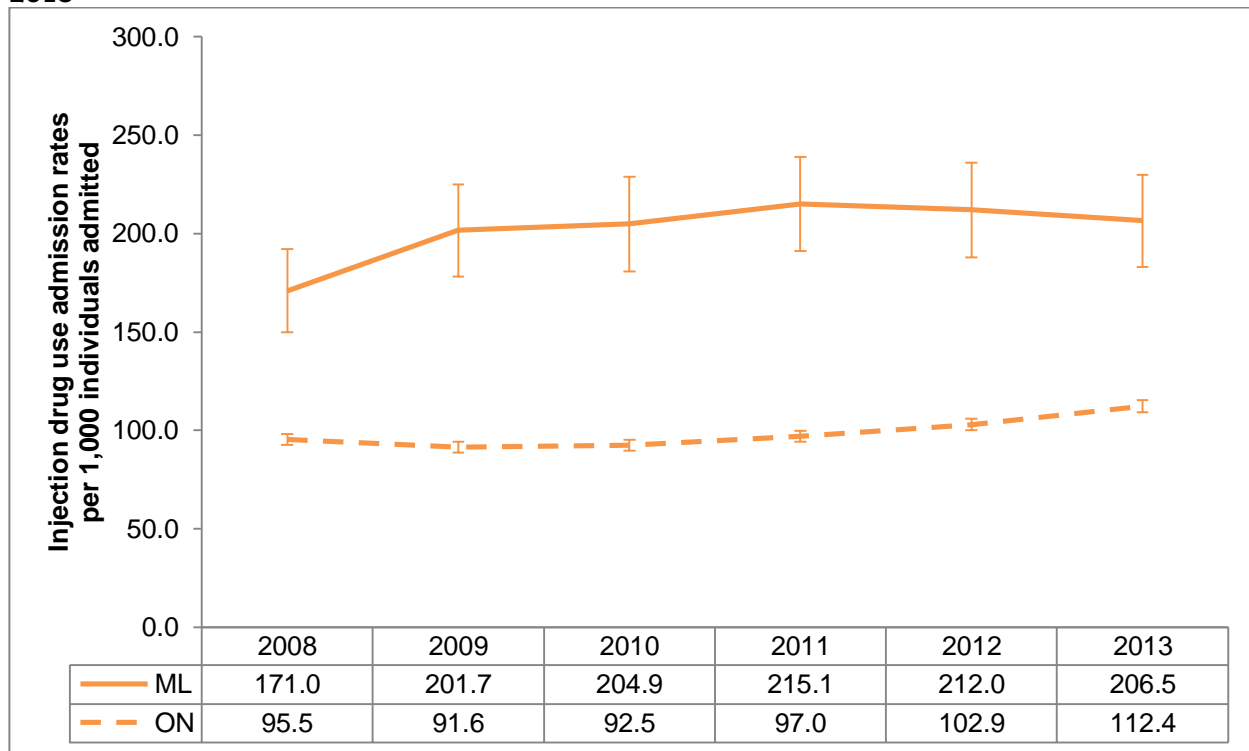
Source: Drug and Alcohol Treatment Information System, 2014.

**Figure 7.5: Rates of sedatives and hypnotics presenting problem substance admissions per 1,000 individuals admitted to substance misuse and addiction services programs, Middlesex-London and Ontario, 2008 to 2013**



Source: Drug and Alcohol Treatment Information System, 2014.

**Figure 7.6: Rates of admissions to substance misuse and addiction services programs reporting injection drug use in the past 12 months per 1,000 individuals admitted, Middlesex-London and Ontario, 2008 to 2013**



**Source:** Drug and Alcohol Treatment Information System, 2014.

## VIII. Prescription Opioids

### Highlights

- Between 2008 and 2013, the use rates for all opioids were slightly higher among Ontario Drug Benefit (ODB) Program beneficiaries in Middlesex-London than beneficiaries in Ontario. However, overall use rates generally declined over the six year time period.
- In Middlesex-London and Ontario, codeine, oxycodone and hydromorphone were the opioid products with the highest use rates among ODB beneficiaries between 2008 and 2013.
- Between 2008 and 2013, codeine and morphine use rates among ODB beneficiaries were generally lower in Middlesex-London compared to Ontario; oxycodone, hydromorphone, methadone and fentanyl use rates were generally higher in Middlesex-London compared to Ontario.
- ODB beneficiary use rates for hydromorphone and methadone generally increased in both Middlesex-London and Ontario between 2008 and 2013, while the general trend for all other opioid products either decreased or remained relatively stable.

*“It felt like, you know, this was maybe going to be how I was going to live the rest of my life. I felt like there was a good chance that I was going to die as an opiate addict.”*  
 - Adrienne’s story ([www.its-possible.ca](http://www.its-possible.ca))

### Overall Prescription Opioid Use Rates

Opioids emerged as an important drug class for rates of emergency department (ED) visits, hospitalizations, and admissions to substance misuse and addictions programs. Information about opioid prescribing rates for people enrolled in the Ontario Drug Benefit (ODB) Program was requested from the Ontario Drug Policy Research Network to further examine opioid prescription patterns. Details about both the number of opioid prescriptions filled by ODB beneficiaries, and the number of individual ODB beneficiaries using those prescriptions were available. It is important to note that the characteristics of each opioid product influence the number of prescriptions filled, for example, some products require a daily prescription while others may be dispensed in volumes sufficient for several months’ supply. Given the potential for some opioids requiring more frequent prescriptions to be over-represented in rates, and for other opioids that are dispensed less frequently to be under-represented, this analysis is based on the numbers of individual ODB beneficiaries using prescription opioids, rather than number of opioid prescriptions filled, in an effort to better reflect prescription opioid use in the ODB-eligible population.

For those aged under 65 years, the opioid use rate was expressed as the number of users of a given opioid product per 1,000 eligible population, which was the number of individuals who have filled at least one prescription covered under ODB that year. For those 65 and over, the opioid use rate was defined as the number of users of a given opioid product per 1,000 ODB users, which was determined by Statistics Canada’s population estimates for those 65 years and older in Middlesex-London and Ontario (ODPRN, ICES, 2014), since everyone 65 years of age and over with a valid health card are eligible for ODB. Between 2008 and 2013, the annual average number of ODB beneficiaries in Middlesex-London who used opioids was 25,169; in Ontario, the annual average was 665,840. It is important to note that this data shows the potential for opioid drug misuse, and does not necessarily reflect actual patterns of misuse.

Figure 8.1 illustrates that between 2008 and 2013, the ODB beneficiary use rate for all prescription opioids combined and all ages combined was significantly higher in Middlesex-London compared to Ontario for all years; however, a trend toward decreasing use rates was noted for both jurisdictions. Prescription opioid use ranged from a high of 265.1 (±3.4) per 1,000 ODB-eligible population in 2008 to a low of 191.7 (±2.4) per 1,000 ODB-eligible population in 2013 in Middlesex-London, while in Ontario, prescription opioid use ranged from 252.6 (±0.6) per 1,000 ODB-eligible population in 2008 to 184.6 (±0.4) users per 1,000 ODB-eligible population in 2013.

The overall analysis comprised of all ages of the ODB-eligible population was further broken down to compare those 65 years of age and over to those under the age of 65 years of age. Figure 8.2 shows that the prescription opioid use rates for ODB beneficiaries less than 65 years old decreased between 2008 and 2013 in both Middlesex-London and in Ontario. However, the Middlesex-London rates for those under 65 years of age, which ranged from 319.4 (±6.4) opioid users per 1,000 ODB-eligible population in 2008 to 166.9 (±3.2) opioid users per 1,000 ODB-eligible population in 2013, were significantly higher than the comparable Ontario rates, which decreased from 283.8 (±1.2) opioid users per 1,000 ODB-eligible population in 2008 to 150.2 (±0.6) opioid users per 1,000 ODB-eligible



population in 2013. Among ODB beneficiaries 65 years and over, there were no significant differences in the rates of opioid users between Middlesex-London and Ontario. For all years between 2008 and 2013, the local rates were very similar to provincial rates, and demonstrated a modest decrease over the six year time period.

### Codeine Use Rates

As shown in Figure 8.3, codeine use rates were the highest among all the specific opioid use rates, both for Middlesex-London and Ontario, but demonstrated a general decline between 2008 and 2013. Across the six year time period, codeine use rates for all ages in Middlesex London were significantly lower than the Ontario rates for all years except 2009. In Middlesex-London, rates decreased from 171.0 ( $\pm 2.7$ ) codeine users per 1,000 ODB-eligible population in 2008 to 103.0 ( $\pm 1.7$ ) users per 1,000 ODB-eligible population in 2013; in Ontario, the rates decreased from 177.8 ( $\pm 0.5$ ) codeine users per 1,000 ODB-eligible population in 2008 to 110.0 ( $\pm 0.3$ ) users per 1,000 ODB-eligible population in 2013.

Table 8.1 shows that among ODB beneficiaries under the age of 65 years, codeine use rates in Middlesex-London were similar to those in Ontario for most years between 2008 and 2013. In 2009, codeine use rates in this age group were significantly higher in Middlesex-London (166.6 ( $\pm 4.3$ ) users per 1,000 ODB-eligible population) compared to Ontario (155.2 ( $\pm 0.8$ ) users per 1,000 ODB-eligible population), but by 2013, the local rate of 72.8 ( $\pm 2.1$ ) users per 1,000 ODB-eligible population was significantly lower than the provincial rate of 77.0 ( $\pm 0.4$ ) users per 1,000 ODB-eligible population under the age of 65 years.

It can be seen in Table 8.2 that among ODB beneficiaries 65 years of age and over, the codeine use rates in Middlesex-London were significantly lower than the comparable Ontario rates, from 2008 to 2013. The Middlesex-London rates decreased from 168.0 ( $\pm 3.3$ ) codeine users per 1,000 ODB-eligible population in 2008 to 131.3 ( $\pm 2.7$ ) users per 1,000 ODB-eligible population in 2013. In Ontario, the rates decreased from 176.8 ( $\pm 0.6$ ) codeine users per 1,000 ODB-eligible population in 2008 to 136.7 ( $\pm 0.5$ ) users per 1,000 ODB-eligible population in 2013.

### Oxycodone Use Rates

Oxycodone, by contrast, had a significantly higher use rate for all years and all ages in Middlesex London compared to Ontario. However, Figure 8.3 shows that both the local and provincial use rates declined dramatically over the past six years. In Middlesex-London, the oxycodone use rates decreased from 94.1 ( $\pm 2.0$ ) users per 1,000 ODB-eligible population in 2008 to 57.2 ( $\pm 1.3$ ) users per 1,000 ODB-eligible population in 2013, while in Ontario, use rates declined from 78.4 ( $\pm 0.4$ ) users per 1,000 ODB-eligible population to 54.0 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population. The reason for the steep decline in use in the past few years may be due to increased awareness among prescribers about the misuse potential of some oxycodone products, and changes to provincial regulations regarding the funding of long-acting oxycodone products under the Ontario Public Drugs Program such that ODB coverage of the drug OxyContin was discontinued and a new form of the drug OxyNEO was introduced in February 2012.

Table 8.1 shows that the significant differences between Middlesex-London and Ontario oxycodone user rates were particularly marked in the under 65 age group. In 2008, there were 143.0 ( $\pm 4.3$ ) users per 1,000 ODB-eligible population in Middlesex-London and 109.3 ( $\pm 0.7$ ) users per 1,000 ODB-eligible population in Ontario. By 2013, the gap between the local and provincial rates of oxycodone use was much smaller, but still significant with 57.7 ( $\pm 1.9$ ) users per 1,000 ODB-eligible population in Middlesex-London and 53.9 ( $\pm 0.4$ ) users per 1,000 ODB-eligible population in Ontario.

Table 8.2 shows that for ODB beneficiaries 65 years of age and over, oxycodone use rates in Middlesex-London were significantly higher than Ontario for all years between 2008 and 2013, except 2012. Similar to the under 65 year old age group, the gap between the local and provincial rates of oxycodone became smaller by 2013, but was still significant, with 57.4 ( $\pm 1.8$ ) users per 1,000 ODB-eligible population in Middlesex-London and 54.5 ( $\pm 0.3$ ) users per 1,000 ODB-eligible population in Ontario.

## Hydromorphone Use Rates

Figure 8.3 shows that for hydromorphone use rates, the rates in Middlesex-London were significantly higher than Ontario rates for all years between 2008 and 2013. Moreover, there appeared to be a trend of increasing use rates in both Middlesex-London and Ontario over time. There were 44.0 ( $\pm 1.1$ ) hydromorphone users per 1,000 ODB-eligible population in Middlesex-London and 34.6 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population in Ontario in 2013. This compares to 28.2 ( $\pm 1.1$ ) hydromorphone users per 1,000 ODB-eligible population in Middlesex-London and 19.6 ( $\pm 0.2$ ) per 1,000 ODB-eligible population in 2008.

Table 8.1 shows that for ODB beneficiaries under 65 years of age, hydromorphone use rates in Middlesex-London increased from 27.5 ( $\pm 1.9$ ) users per 1,000 ODB-eligible population in 2008, to 33.7 ( $\pm 1.4$ ) users per 1,000 ODB-eligible population in 2013. In Ontario, hydromorphone rates also increased from 19.6 ( $\pm 0.3$ ) users per 1,000 ODB-eligible population to 23.8 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population in the same time period.

It can be seen in Table 8.2 that rates of hydromorphone use also increased for ODB beneficiaries 65 years of age and over. In Middlesex-London, hydromorphone rates steadily increased from 28.6 ( $\pm 1.3$ ) users per 1,000 ODB-eligible population in 2008 to 54.1 ( $\pm 1.7$ ) users per 1,000 ODB-eligible population in 2013, while in Ontario, rates increased from 19.6 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population to 43.3 ( $\pm 0.3$ ) users per 1,000 ODB-eligible population.

## Morphine Use Rates

Figure 8.3 illustrates that for morphine, the Middlesex-London and Ontario use rates decreased between 2008 and 2013; however, compared to provincial rates, Middlesex-London had a significantly lower morphine use rate for all ages across all years. Rates in Middlesex-London decreased from 14.7 ( $\pm 0.8$ ) users per 1,000 ODB-eligible population in 2008 to 11.0 ( $\pm 0.6$ ) users per 1,000 ODB-eligible population in 2013, while in Ontario, rates decreased from 17.2 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population to 15.1 ( $\pm 0.1$ ) per 1,000 ODB-eligible population from 2008 to 2013.

Table 8.1 shows that between 2008 and 2013, morphine use rates decreased among ODB beneficiaries under 65 years of age, both locally and provincially. The morphine use rates in this age group decreased from 19.4 ( $\pm 1.5$ ) users per 1,000 ODB-eligible population in 2008 to 12.8 ( $\pm 0.9$ ) users per 1,000 ODB-eligible population in 2013 in Middlesex-London. In Ontario, rates decreased from 19.9 ( $\pm 0.3$ ) users per 1,000 ODB-eligible population to 14.3 ( $\pm 0.2$ ) per 1,000 ODB-eligible population during the six year time period. From 2011 to 2013, the morphine use rates among ODB beneficiaries under the age of 65 years in Middlesex-London were significantly lower than the Ontario rates.

Table 8.2 shows that ODB beneficiaries 65 years of age and over in Middlesex-London had significantly lower morphine use rates compared to Ontario for all years between 2008 and 2013. Middlesex-London rates decreased from 12.5 ( $\pm 0.9$ ) users per 1,000 ODB-eligible population in 2008 to 9.4 ( $\pm 0.7$ ) users per 1,000 ODB-eligible population in 2013. By comparison, the Ontario use rate was relatively stable over the six year time period, from 16.1 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population in 2008 to 15.8 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population in 2013.

## Methadone Use Rates

As shown in Figure 8.3, between 2008 and 2013, the rates of methadone use for all ODB beneficiaries were significantly higher in Middlesex-London compared to the Ontario rates. As well, both the local and provincial use rates generally increased between 2008 and 2013. The Middlesex-London methadone use rate increased from 9.0 ( $\pm 0.6$ ) users per 1,000 ODB-eligible population in 2008 to 14.9 ( $\pm 0.7$ ) users per 1,000 ODB-eligible population in 2013. The Ontario rate also increased, from 5.6 ( $\pm 0.1$ ) users per 1,000 ODB-eligible population in 2008 to 7.7 ( $\pm 0.1$ ) users per 1,000 ODB-eligible population in 2013.

The significant differences between the Middlesex-London and Ontario use rates for all ages were largely driven by ODB beneficiaries under the age of 65 years. Table 8.1 shows that the Middlesex-London methadone use rates in this age group were significantly higher than Ontario rates for all years between 2008 and 2013. Both the Middlesex-London (38.9 ( $\pm 2.0$ ) users per 1,000 ODB-eligible population) and Ontario (22.6 ( $\pm 0.3$ ) users per 1,000 ODB-eligible population) rates peaked in 2011 among this age group, with use rates decreasing in subsequent years. In 2013, there were 30.7 ( $\pm 1.4$ ) methadone users per 1,000 ODB-eligible population in Middlesex-London, while in Ontario, there were 17.0 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population.

In contrast, Table 8.2 shows that the rates of methadone use were quite low among ODB beneficiaries 65 years of age and over, both locally and provincially (<1.0 user per 1,000 ODB-eligible population for both Middlesex-London and Ontario). Remaining relatively stable over the six year time period, there were no significant differences between Middlesex-London and Ontario use rates for this age group.

### **Fentanyl Use Rates**

Figure 8.3 illustrates that while fentanyl use rates generally declined between 2008 and 2013, both locally and provincially, the Middlesex-London use rates were significantly higher than Ontario rates for all years. The Middlesex-London rates decreased from 11.6 ( $\pm 0.7$ ) users per 1,000 ODB-eligible population in 2008 to 8.4 ( $\pm 0.5$ ) users per 1,000 ODB-eligible population in 2013, while for Ontario, fentanyl use rates also decreased, from 10.4 ( $\pm 0.1$ ) users per 1,000 ODB-eligible population to 6.7 ( $\pm 0.1$ ) users per 1,000 ODB-eligible population between 2008 and 2013.

Table 8.1 shows that between 2008 and 2013, fentanyl use rates for ODB beneficiaries under the age of 65 years decreased both locally and provincially, however, Middlesex-London use rates were still significantly higher than the comparable Ontario rates for all years except 2008. The fentanyl use rates in Middlesex-London for this age group ranged from a high of 11.3 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population in 2009 to 7.4 ( $\pm 0.7$ ) users per 1,000 ODB-eligible population in 2013, while the Ontario rate decreased from 9.8 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population in 2008 to 5.9 ( $\pm 0.1$ ) users per 1,000 ODB-eligible population in 2013.

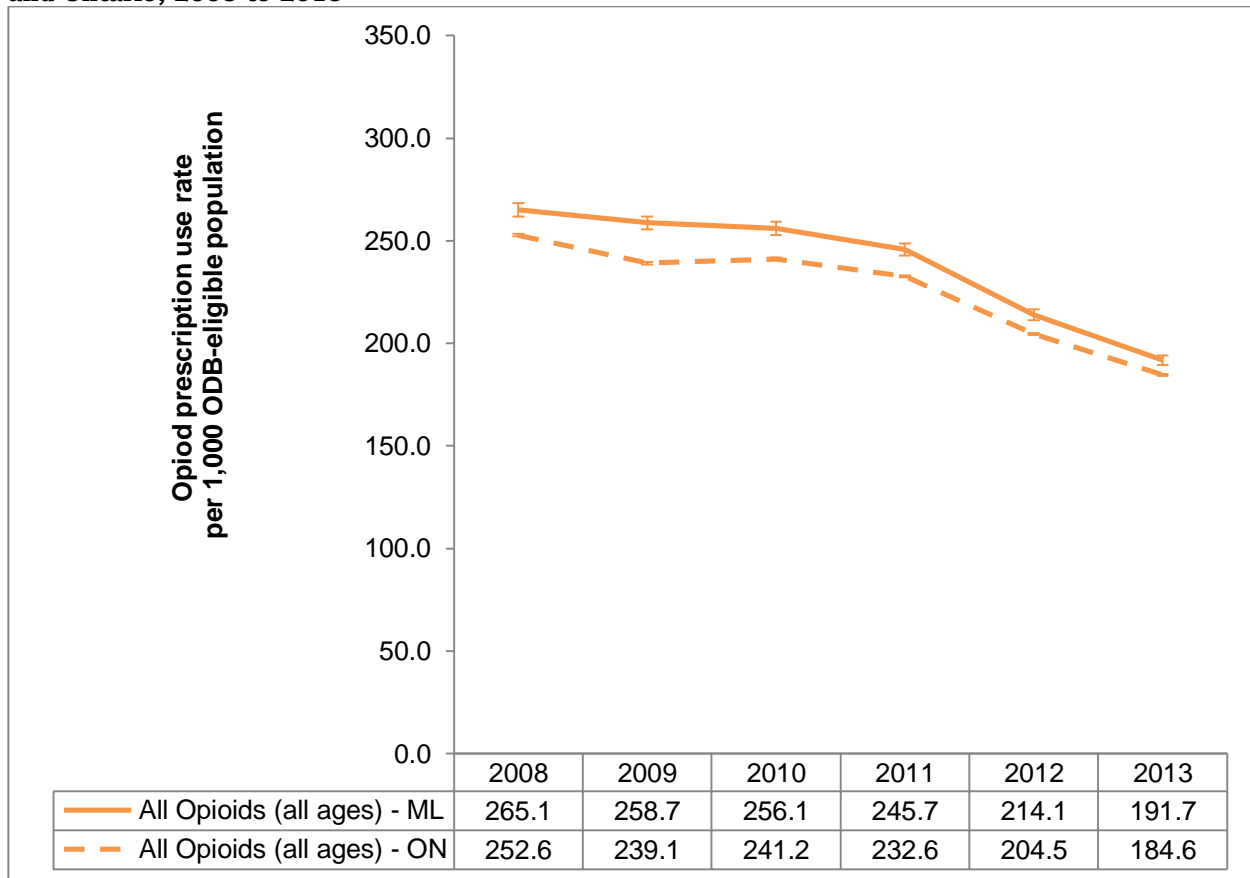
Similarly, Table 8.2 shows that fentanyl use rates for ODB beneficiaries 65 years of age and over decreased in both Middlesex-London and Ontario between 2008 and 2013. Compared to Ontario, use rates were significantly higher in Middlesex-London across the six year time period, ranging from 12.0 ( $\pm 0.9$ ) users per 1,000 ODB-eligible population in 2008 to 9.4 ( $\pm 0.8$ ) users per 1,000 ODB-eligible population in 2013. The provincial rates for fentanyl use in this age group decreased from 10.7 ( $\pm 0.2$ ) users per 1,000 ODB-eligible population to 7.5 ( $\pm 0.1$ ) users per 1,000 ODB-eligible users between 2008 and 2013.

### **Deaths Due to Acute Drug Toxicity Involving Prescription Opioids**

To supplement opioid prescribing information, data about deaths due to acute drug toxicity involving prescription opioids was requested from the Office of the Chief Coroner of Ontario. Between 2008 and 2012, the number of deaths due to acute drug toxicity involving prescription opioids in Middlesex-London ranged from 13 to 41, corresponding to an average of 22.8 prescription opioid-related deaths per year. In Ontario as a whole, there was an annual average of 465.2 prescription opioid-related deaths reported in the five year time period.

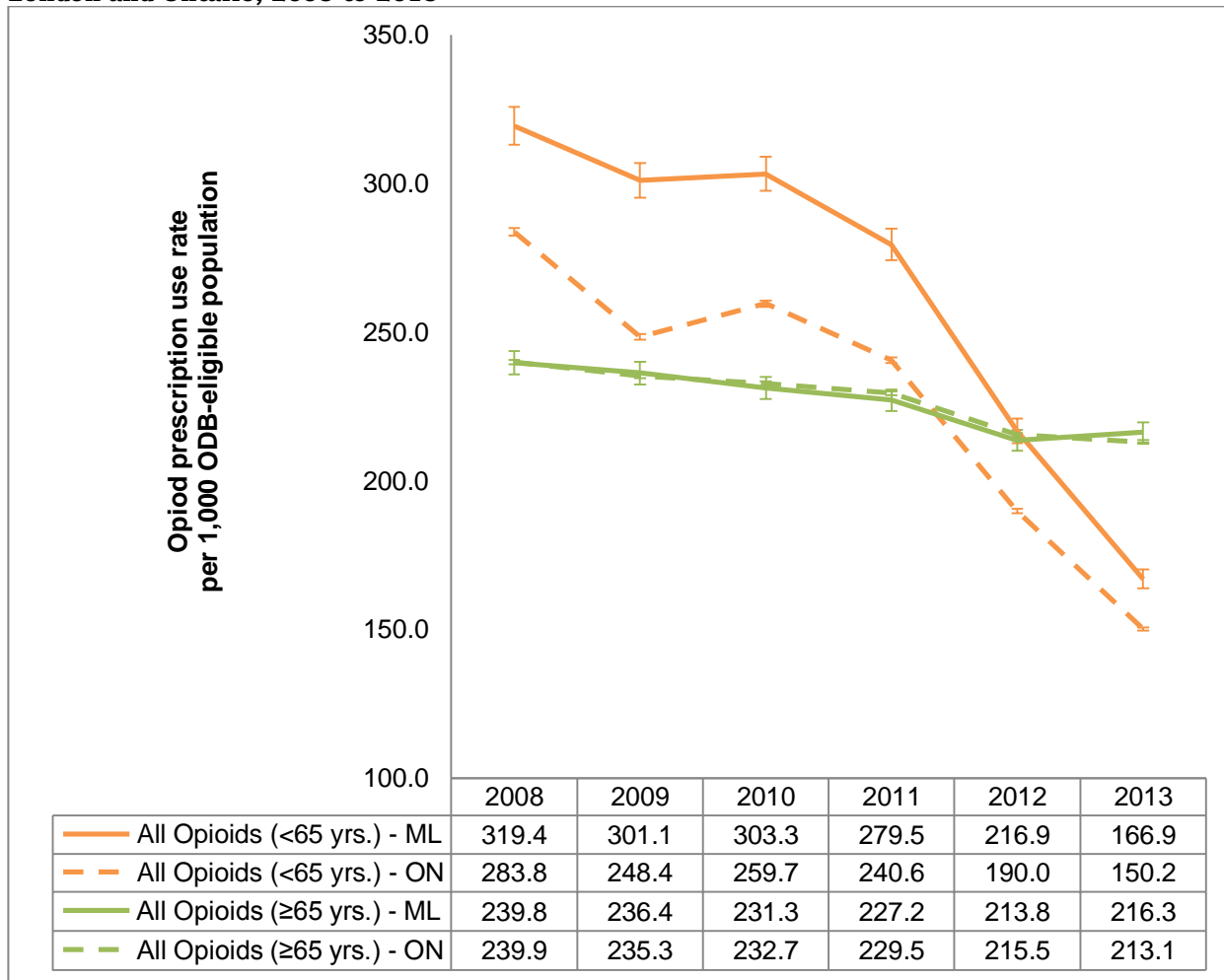
Figure 8.4 shows that between 2008 and 2012, the rates of deaths due to acute drug toxicity involving prescription opioids increased in Ontario, but fluctuated for Middlesex-London. With the exception of 2011, the rate of deaths involving prescription opioids were higher in Middlesex-London than in Ontario; however, 2012 was the only year where the death rates in Middlesex-London (8.8 ( $\pm 2.7$ ) deaths per 100,000 population) were significantly higher than the Ontario rate (4.1 ( $\pm 0.3$ ) deaths per 100,000 population), due to a much higher number of deaths in Middlesex-London than year than in preceding years.

**Figure 8.1: Rates of all opioid product use per 1,000 ODB-eligible population, all ages, Middlesex-London and Ontario, 2008 to 2013**

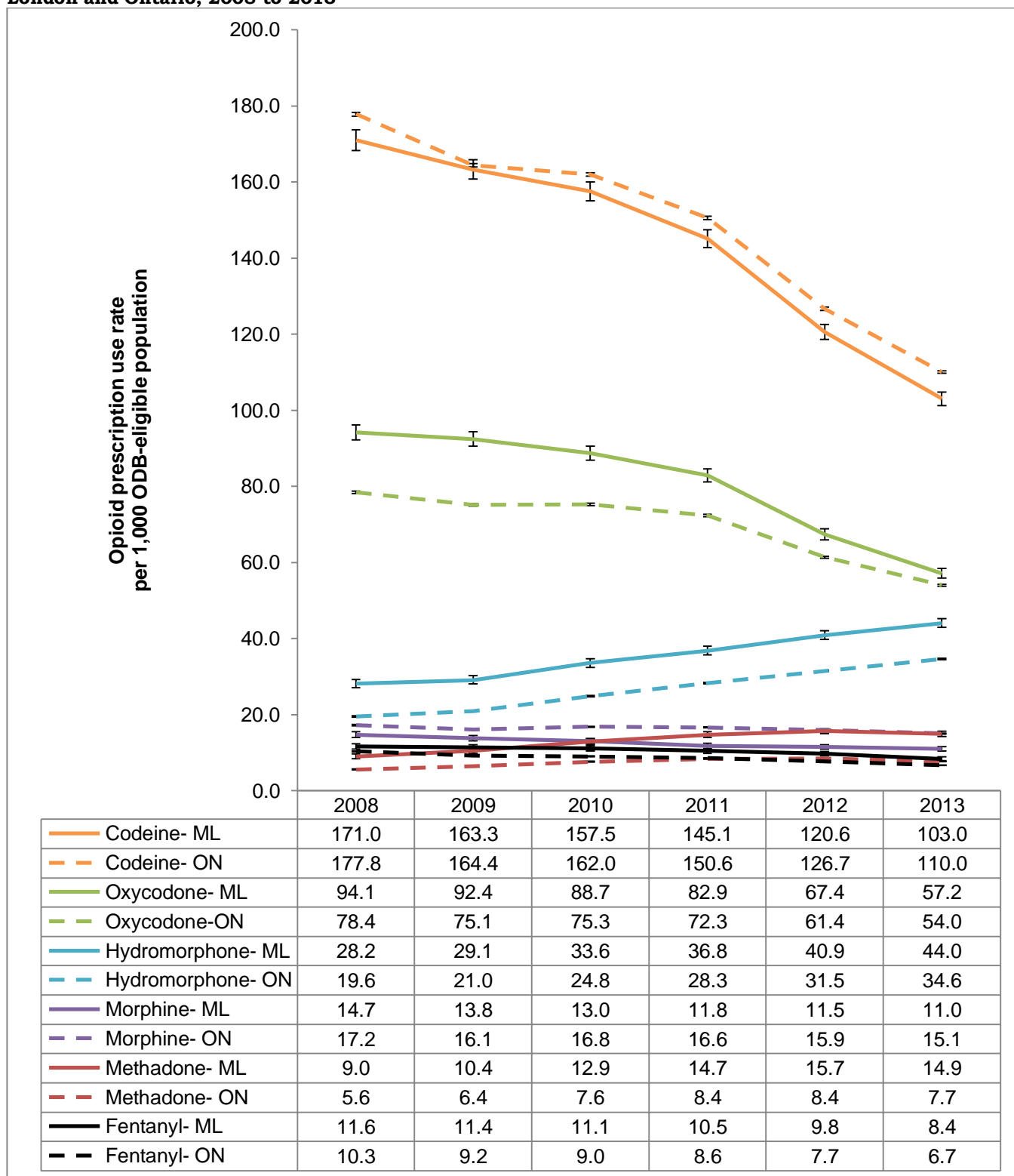


**Source:** Ontario Drug Policy Research Network, 2014

**Figure 8.2: Rates of all opioid product use per 1,000 ODB-eligible population, by age group, Middlesex-London and Ontario, 2008 to 2013**

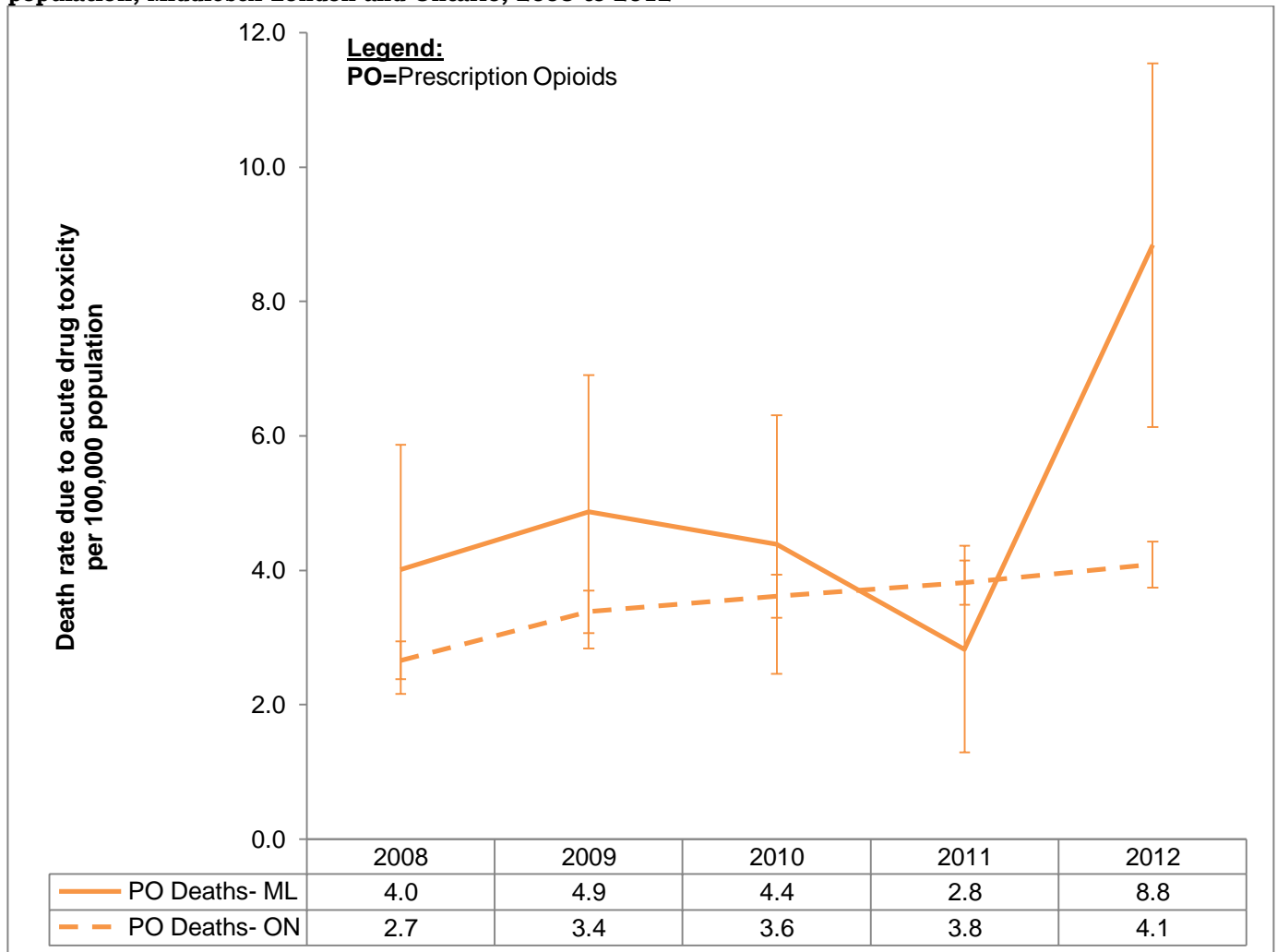


**Figure 8.3: Rates of specific opioid product use per 1,000 ODB-eligible population, all ages, Middlesex-London and Ontario, 2008 to 2013**



Source: Ontario Drug Policy Research Network, 2014.

**Figure 8.4: Rates of deaths due to acute drug toxicity involving prescription opioids per 100,000 population, Middlesex-London and Ontario, 2008 to 2012**



Source: Office of the Chief Coroner of Ontario, 2014

**Table 8.1: Rates of specific opioid product use per 1,000 ODB-eligible population, >65 years of age, Middlesex-London and Ontario, 2008 to 2013**

	2008	2009	2010	2011	2012	2013	Trend
<b>All opioids</b>							
ML	319.4 <sup>^</sup>	301.1 <sup>^</sup>	303.3 <sup>^</sup>	279.5 <sup>^</sup>	216.9 <sup>^</sup>	166.9 <sup>^</sup>	↘
ON	283.8	248.4	259.7	240.6	190.0	150.2	↘
<b>Codeine</b>							
ML	178.5	166.6 <sup>^</sup>	161.2	139.7	101.2	72.8*	↘
ON	181.5	155.2	156.8	138.5	102.2	77.0	↘
<b>Oxycodone</b>							
ML	143.0 <sup>^</sup>	131.9 <sup>^</sup>	128.4 <sup>^</sup>	115.0 <sup>^</sup>	81.9 <sup>^</sup>	57.7 <sup>^</sup>	↘
ON	109.3	96.1	100.1	92.0	70.4	53.9	↘
<b>Hydromorphone</b>							
ML	27.5 <sup>^</sup>	25.7 <sup>^</sup>	29.1 <sup>^</sup>	30.5 <sup>^</sup>	33.5 <sup>^</sup>	33.7 <sup>^</sup>	↗
ON	19.6	18.8	22.2	23.7	24.4	23.8	↗
<b>Morphine</b>							
ML	19.4	18.6	19.0	16.2*	14.9*	12.8*	↘
ON	19.9	17.0	18.5	18.1	16.4	14.3	↘
<b>Methadone</b>							
ML	26.7 <sup>^</sup>	28.6 <sup>^</sup>	35.7 <sup>^</sup>	38.9 <sup>^</sup>	36.6 <sup>^</sup>	30.7 <sup>^</sup>	↗↘
ON	17.3	17.7	21.4	22.6	20.7	17.0	↗↘
<b>Fentanyl</b>							
ML	11.2	11.3 <sup>^</sup>	10.8 <sup>^</sup>	10.5 <sup>^</sup>	9.7 <sup>^</sup>	7.4 <sup>^</sup>	↘
ON	9.8	8.4	8.8	8.4	7.3	5.9	↘

**Source:** Ontario Drug Policy Research Network, 2014

\* Middlesex-London use rate was significantly lower than Ontario rate, using 95% confidence intervals (CIs)

<sup>^</sup> Middlesex-London use rate was significantly higher than Ontario, using 95% CIs

↘ From 2008 to 2013, general trend was a decrease in opioid use rate

↗ From 2008 to 2013, general trend was an increase in opioid use rate

— From 2008 to 2013, no change occurred in opioid use rate

**Table 8.2: Rates of specific opioid product use per 1,000 ODB-eligible population, ≥65 years of age, Middlesex-London and Ontario, 2008 to 2013**

	2008	2009	2010	2011	2012	2013	Trend
<b>All opioids</b>							
ML	239.8	236.4	231.3	227.2	213.8	216.3	↘
ON	239.9	235.3	232.7	229.5	215.5	213.1	↘
<b>Codeine</b>							
ML	168.0*	162.0*	156.1*	149.0*	135.3*	131.3*	↘
ON	176.8	170.1	165.4	158.1	143.3	136.7	↘
<b>Oxycodone</b>							
ML	70.5 <sup>^</sup>	71.0 <sup>^</sup>	67.3 <sup>^</sup>	64.4 <sup>^</sup>	57.5	57.4 <sup>^</sup>	↘
ON	65.0	64.2	62.7	61.8	56.0	54.5	↘
<b>Hydromorphone</b>							
ML	28.6 <sup>^</sup>	31.0 <sup>^</sup>	36.2 <sup>^</sup>	40.8 <sup>^</sup>	46.6 <sup>^</sup>	54.1 <sup>^</sup>	↗
ON	19.6	22.2	26.3	31.0	36.3	43.3	↗
<b>Morphine</b>							
ML	12.5*	11.3*	9.8*	9.3*	9.2*	9.4*	↘
ON	16.1	15.8	16.0	15.9	15.7	15.8	—
<b>Methadone</b>							
ML	0.2	0.3	0.3	0.3	0.3	0.4	—
ON	0.4	0.4	0.4	0.4	0.4	0.4	—
<b>Fentanyl</b>							
ML	12.0 <sup>^</sup>	11.5 <sup>^</sup>	11.4 <sup>^</sup>	10.6 <sup>^</sup>	10.0 <sup>^</sup>	9.4 <sup>^</sup>	↘
ON	10.7	9.7	9.2	8.8	8.0	7.5	↘

**Source:** Ontario Drug Policy Research Network, 2014

\* Middlesex-London use rate was significantly lower than Ontario rate, using 95% confidence intervals (CIs)

<sup>^</sup> Middlesex-London use rate was significantly higher than Ontario, using 95% CIs

↘ From 2008 to 2013, general trend was a decrease in opioid use rate

↗ From 2008 to 2013, general trend was an increase in opioid use rate

— From 2008 to 2013, no change occurred in opioid use rate



## IX. Conclusion

The use of information from a variety of sources, such as a self-reported survey, Middlesex-London Emergency Medical Services, London Police Services, emergency department visits, inpatient hospitalizations, admissions to substance misuse and addiction services, opioid drug prescription rates and opioid-related deaths, provides an understanding of the health service and social impacts related to prescription and non-prescription drug use in Middlesex-London.

Among the five classes of drugs discussed throughout the report, opioid use emerged as an important issue in Middlesex-London. Table 9.1 shows that in 2012 opioids ranked as the leading drug class associated with emergency department visits and inpatient hospitalizations, and had the longest average length of stay in the hospital. Although this trend is similar throughout Ontario, rates in Middlesex-London were consistently significantly higher for opioid use for these hospital-based indicators than the province as a whole. In addition, in 2013, excluding alcohol and tobacco, opioid use ranked second behind cannabis use with respect to the presenting problem substances recorded on admission to substance misuse and addiction services.

Focused analysis of opioid prescription rates from the Ontario Drug Benefit Program showed that while rates of opioid prescriptions to beneficiaries generally declined in Middlesex-London and Ontario, Middlesex-London rates were consistently significantly higher than the provincial rates. As well, the rate of deaths from acute drug toxicity involving prescription opioids was generally higher in Middlesex-London compared to Ontario as whole; the difference was statistically significant in 2013.

Combined with the results from the I-Track report released in 2013, this report outlines the significant impact of drug use, and particularly opioid use, in Middlesex-London. This report provides valuable information to inform the development of an inclusive, collaborative community drug strategy to address this significant public health issue.

**Table 9.1: Summary rankings for emergency department visits, inpatient hospitalizations, average length of stay in hospital, and admissions to substance misuse and addiction services, Middlesex-London, 2012/2013**

	<b>Emergency Department Visits (2012)</b>	<b>Inpatient Hospitalizations (2012)</b>	<b>Average Length of Stay in Hospital (2012)</b>	<b>Substance Misuse &amp; Addictions Services^ (2013)</b>
Opioids	1	1	1	2
Cannabis	4	4	3	1
Cocaine and stimulants	3	3	2	3
Sedatives and hypnotics	2	2	4	4
Hallucinogens and solvents	5	-	-	5

^ Because each category has multiple associated substances, results of the most prevalent substance used are included in the ranking

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## Appendix A: International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision, Canada (ICD-10-CA) Codes for Emergency Department Visits and Inpatient Hospitalizations

**Table A.1–International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision, Canada (ICD-10-CA) codes used to classify drug classes for emergency department visits and inpatient hospitalizations**

<b>Drug Class</b>	<b>ICD-10-CA Codes</b>
Opioid-related health events	F11.0-F11.9; T40.0-T40.4;T40.6
Cannabinoid-related health events	F12.0-F12.9; T40.7
Cocaine and other stimulant-related health events	F14.0-F15.9, T40.5; T41.3
Sedative and hypnotic-related health events	F13.0-F13.9; T42.3-T42.4
Hallucinogen and solvent-related health events	F16.0-F16.9; F18.0-F18.9; T40.8-T40.9

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 May 15

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## **STUDENT WELLBEING AND LEARNING: FOUNDATIONS FOR A HEALTHY SCHOOL FRAMEWORK**

### **Recommendations**

*It is recommended that:*

- 1) Report No. 033-14 re Student Wellbeing and Learning: Foundations for a Healthy School Framework be received for information; and*
- 2) Letters be sent from the Board of Health to the Honourable Deb Matthews, Minister of Health & Long-Term Care, and the Honourable Liz Sandals, Minister of Education, commending the Ministers on their collaborative efforts to ensure students' wellbeing in schools.*

### **Key Points**

- Student wellbeing is an important goal in a new report launched from the Ministry of Education.
- Health Unit staff collaborated with Thames Valley District School Board staff on a provincial webinar and highlighted the collaborative efforts on student wellbeing in our local schools.
- The “Foundations for a Healthy School Framework” is an evidence based document that guides the work of education and health to address student wellbeing. It was distributed at the National Ontario Healthy Schools Conference hosted by the Health Unit in April 2014.

### **Background**

In the fall 2013 the Ministry of Education held regional consultations across the province for the purpose of collecting thoughts and ideas for a renewed vision for the provincial education system. The Health Unit Child and Youth Program Team managers participated in the consultations along with parents, students, teachers, support staff and school and system leaders. In addition, input from individuals and groups outside the education sector, including a number of sessions with the Ministry of Health and Long-Term Care (OMHLTC) businesses and non-profit organizations, was reviewed. *Achieving Excellence*, a new Ministry Report, is the result of their feedback and was launched in April 2014.

The Ministry report builds on the education system's current priorities and encompasses new goals. One important goal of this report focuses on student wellbeing and ensuring that all children and youth will develop enhanced mental and physical health, a positive sense of self and belonging, and the skills to make positive choices. The revised “[Foundations for a Healthy School Framework](#)” ([Appendix A](#)) is an evidence based document that provides guidance to educators and community partners to help address student wellbeing in schools. It outlines how school boards together with public health can develop a healthy school. This document was released at the recent National Ontario Healthy Schools Coalition Conference held in April and hosted by the Health Unit.

## The Importance of Student Wellbeing and the Healthy Schools Framework

Key to a healthy school is an integrated approach to address a range of health related topics which will result in a positive healthy school climate. Schools are increasingly recognized as critical social systems with the potential to enhance the health of their populations. Healthy students are healthy learners and healthy schools are an important part of healthy communities.

The Ministry of Education and OMHLTC care are partnering on many initiatives to forward their goal of student wellbeing. On April 30, 2014 they collaborated to host a provincial webinar session, titled “Collaborating on Student Well-Being: An Information Exchange on Education – Health Partnerships”. The agenda included opportunities to learn about provincial level health and education collaboration, share examples of regional and local-level health and education collaboration and discuss strategies that support successful collaboration. Staff from the Child and Youth Program Team partnered with Thames Valley District School Board to showcase their shared examples of local collaborative health-educational projects. The two local collaborative projects which were presented were our Outdoors: The Ultimate Playground and Healthy Living Champions.

### Conclusion/Next Steps

Education and health for children and youth are intricately intertwined. The recent collaborative focus on student wellbeing between the Ministry of Education and Ministry of Health and Long Term Care is a positive step to address health behaviours among our children and youth in school settings. Health Unit staff member have developed positive and strong relationships with area school boards and will continue to work with them to address student wellbeing by utilizing the Foundations for a Healthy Schools Framework.

This report was prepared by Ms. Christine Preece, Manager, Young Adult Team, and Ms. Suzanne Vandervoort, Manager, Child Health Team.



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

<p><b>This report addresses</b> the following requirement(s) of the Ontario Public Health Standards: Family Health – Child Health Program and Chronic Disease and Injury Prevention.</p>
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Components	High-Quality Instruction and Programs	A Healthy Physical Environment	A Supportive Social Environment	Community Partnerships
<p>Descriptions</p>	<p>Quality instruction provides students with a wide range of opportunities to learn, practise, and demonstrate knowledge and skills related to living a healthy life. Programs offered during the instructional day often lay the foundation for other activities done outside instructional time.</p> <p>Quality programs also include opportunities for teachers and school administrators to participate in professional learning opportunities.</p>	<p>A safe and healthy physical environment improves the conditions for learning. The physical environment includes the school building and grounds, routes to and from the school, and materials and equipment used in school programs.</p>	<p>A supportive social environment has a positive impact on students' learning. Many practices within a school foster such an environment. Students, teachers, and parents can benefit from the support provided, which may be formal (e.g., school policies, rules, clubs, or support groups) or informal (e.g., unstructured peer interaction or free play).</p>	<p>Community partnerships provide access to resources and services available to support staff, students, and families in the development and implementation of healthy schools initiatives. Various organizations can deliver services within the school setting, including public health.</p>
<p>Current Ministry of Education and Ministry of Health Promotion Initiatives</p>	<ul style="list-style-type: none"> <li>✓ Daily Physical Activity</li> <li>✓ Specialist Teachers</li> <li>✓ Swim to Survive Program</li> </ul>	<ul style="list-style-type: none"> <li>✓ Vending machines with healthy foods and beverages</li> <li>✓ Anaphylaxis prevention</li> <li>✓ Eat Smart Cafeteria program (MHP)</li> </ul>	<ul style="list-style-type: none"> <li>✓ Northern Fruit and Vegetable Pilot Program (MHP)</li> <li>✓ Smoke Free Ontario (MHP)</li> </ul>	<ul style="list-style-type: none"> <li>✓ Community use of school facilities</li> <li>✓ Active and Safe Routes to School (MHP)</li> </ul>
<p><b>Health-Related Topics</b></p>				
<p><b>Healthy Eating</b></p>	<ul style="list-style-type: none"> <li>• Establishing a school-wide healthy eating month</li> <li>• Coordinating the healthy eating lessons taught in each grade</li> <li>• Having teachers, school administrators, and student representatives attend a healthy eating conference</li> </ul>	<ul style="list-style-type: none"> <li>• Establishing a healthy menu for the school lunch program</li> <li>• Purchasing a refrigerator for storing healthy food during the school day</li> <li>• Starting a school garden and planting fruits and vegetables in it</li> </ul>	<ul style="list-style-type: none"> <li>• Developing healthy eating guidelines</li> <li>• Including healthy eating tips in each month's school newsletter</li> <li>• Offering a healthy lunch/snack program</li> </ul>	<ul style="list-style-type: none"> <li>• Establishing a subcommittee of the school council to focus on making healthy foods and beverages a priority in the school</li> <li>• Offering a breakfast program in cooperation with the local grocery store</li> <li>• Having a public health nurse or dietician provide a lunch-and-learn session for staff and parents on packing healthy lunches and snacks</li> </ul>
<p><b>Physical Activity</b></p>	<ul style="list-style-type: none"> <li>• Providing staff training on physical activity during a professional development day</li> <li>• Developing class timetables that include daily physical education for all classes in the school</li> <li>• Providing programs that include a wide range of physical activities</li> </ul>	<ul style="list-style-type: none"> <li>• Providing physical activity equipment for all classes to use outdoors during recess and lunch breaks</li> <li>• Converting an unused room in the school into a physical fitness centre</li> <li>• Purchasing bicycle racks and painting lines on the playground pavement for games (such as hopscotch) to promote an active lifestyle</li> </ul>	<ul style="list-style-type: none"> <li>• Organizing intramural programs for the students</li> <li>• Training student leaders to lead other students in physical activities during breaks</li> <li>• Organizing school events that require physical activity (e.g., a fitness day)</li> </ul>	<ul style="list-style-type: none"> <li>• Coordinating a "walking Wednesday" program with support from school staff, students, and community partners (e.g., a seniors' group)</li> <li>• Partnering with a local high school to offer a physical fitness club</li> <li>• Establishing a partnership with a local university to research the impact of the physical activity program on student achievement</li> </ul>
<p><b>Bullying Prevention</b></p>	<ul style="list-style-type: none"> <li>• Adopting a school-wide bullying prevention program</li> <li>• Embedding the program within the school improvement and Student Success planning processes</li> <li>• Purchasing new resources that meet the needs of the school</li> </ul>	<ul style="list-style-type: none"> <li>• Making the playground a bully-free zone</li> <li>• Allocating supervision to high-risk areas of the school</li> <li>• Creating a mural to affirm the school as a bully-free zone</li> </ul>	<ul style="list-style-type: none"> <li>• Establishing a diversity club to provide students with an opportunity to discuss ways to make all students feel welcome in the school</li> <li>• Creating a process whereby all students can feel safe reporting bullying incidents</li> <li>• Hosting an event for staff and board officials to celebrate students' artistic presentations of bullying prevention messages</li> </ul>	<ul style="list-style-type: none"> <li>• Partnering with the local youth centre to provide programs in conflict resolution and development of self-esteem</li> <li>• Providing training on bullying prevention to parents at the school council meeting</li> <li>• Coordinating community volunteers as mentors for students</li> </ul>

Components	High-Quality Instruction and Programs	A Healthy Physical Environment	A Supportive Social Environment	Community Partnerships
<b>Health-Related Topics</b>				
<b>Personal Safety and Injury Prevention</b>	<ul style="list-style-type: none"> <li>Coordinating a school-wide presentation on water safety</li> <li>Planning monthly safety presentations to address specific issues throughout the year (e.g., water safety in May)</li> <li>Having students write and perform skits about safe practices to encourage them to use safe practices</li> <li>Providing coop students with training on workplace safety</li> </ul>	<ul style="list-style-type: none"> <li>Inspecting facilities and equipment for safety.</li> <li>Highlighting safe practices by displaying posters depicting them and installing signs in high-risk areas of the school</li> <li>Establishing the parking area as a no-idling zone</li> </ul>	<ul style="list-style-type: none"> <li>Training peer mediators who are accessible inside and outside the school</li> <li>Communicating safety messages at school assemblies and over the PA system</li> <li>Establishing a consistent set of safety procedures and resources</li> </ul>	<ul style="list-style-type: none"> <li>Providing information on a range of safe practices for the home, school, and community on the school website</li> <li>Establishing a school committee to identify key safety messages and community partners who can provide support in specific safety areas</li> <li>Providing students with the resources to work with parents and other family members to develop and implement a fire safety plan for their home</li> </ul>
<b>Substance Use and Abuse</b>	<ul style="list-style-type: none"> <li>Developing consistent messages for implementing a school-wide substance use and abuse program</li> <li>Presenting age-appropriate information on the effects of drug use at an assembly for a specific grade</li> <li>Providing in-service training for teachers and administrators on signs of drug use and appropriate responses</li> </ul>	<ul style="list-style-type: none"> <li>Establishing an action plan/protocol to monitor school areas for signs of drug use</li> <li>Using resources and learning materials that depict healthy choices.</li> <li>Putting up posters in the school to promote the advantages of substance-free living.</li> </ul>	<ul style="list-style-type: none"> <li>Identifying resources available for students to enable them to seek help for themselves and others</li> <li>Empower students to organize and run a smoking cessation program at the school</li> <li>Implementing discipline strategies that provide support for students with addictive behaviours</li> </ul>	<ul style="list-style-type: none"> <li>Developing and enforcing a school drug policy in collaboration with public health personnel and other community partners</li> <li>Providing an opportunity for students to spend a day at a regional centre for a presentation on substance use and abuse</li> <li>Offering a parents' night in collaboration with the police to address issues concerning substance use</li> </ul>
<b>Healthy Growth and Development</b>	<ul style="list-style-type: none"> <li>Participating in a school board project on the implementation of resources on healthy growth and development</li> <li>Developing a committee to discuss effective teaching methods for encouraging healthy growth and development</li> <li>Inviting public health nurses to help teach lessons on healthy growth and development</li> </ul>	<ul style="list-style-type: none"> <li>Developing guidelines to ensure that materials used and presented in the school are representative of the diverse makeup of the school</li> <li>Providing students with a safe area where they can discuss concerns with a trusted staff member</li> <li>Designing change room facilities, with student input, that take into account dignity and self-esteem</li> </ul>	<ul style="list-style-type: none"> <li>Organizing a parent evening to discuss topics related to healthy growth and development and their connection with the curriculum</li> <li>Reviewing school guidelines related to growth and development to ensure that they are current and that they meet the diverse needs of the students</li> <li>Communicating information on healthy growth and development to students and parents about available programs and support</li> </ul>	<ul style="list-style-type: none"> <li>Working cooperatively with community partners to provide adequate services regarding child welfare</li> <li>Providing information to parents about the services in the community that are available to support personal learning</li> <li>Providing information to parents about the topics covered in the curriculum prior to the teaching of the unit</li> </ul>
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>Identifying areas of the curriculum where mental health can be taught throughout the year</li> <li>Providing staff in-service training on recognizing signs and symptoms and using appropriate intervention strategies when dealing with issues about mental health</li> <li>Providing programming that does not stigmatize mental disorders and that promotes positive healthy behaviours</li> </ul>	<ul style="list-style-type: none"> <li>Establishing an area in the school for students to participate in physical activity and clubs, especially during the winter months</li> <li>Developing a resource section in the library for teachers/parents with a range of books and materials about mental health</li> <li>Establishing a school-based health centre</li> </ul>	<ul style="list-style-type: none"> <li>Providing students with information and training on mental health and with an opportunity to plan and organize a committee to address mental health issues in the school</li> <li>Sending out a student and/or parent survey to establish the areas of mental health that need to be focused on in the school</li> <li>Establishing a protocol to ensure that mental health resources used are consistent with the messages of the school and board</li> </ul>	<ul style="list-style-type: none"> <li>Establishing a school council committee to discuss and coordinate mental health initiatives in the school and community</li> <li>Providing information from community partners in the school newsletter for parents</li> <li>Providing access to researchers to examine mental health issues and support available in the school</li> </ul>
<b>Other</b>	<ul style="list-style-type: none"> <li>Identifying areas of the curriculum that are related to healthy living topics, and introducing health concepts in all areas of the curriculum</li> <li>Providing a summative assessment task for students that focuses on their ability to make healthy choices in health related scenarios</li> </ul>	<ul style="list-style-type: none"> <li>Establishing an information bulletin board in the school to promote monthly health themes, upcoming school events, and community programs</li> </ul>	<ul style="list-style-type: none"> <li>Establishing a student club made up of representatives from each grade to provide input and suggestions on health-related topics in the school</li> <li>Training Student Success teams to address issues related to wellness and health</li> </ul>	<ul style="list-style-type: none"> <li>Establishing a healthy schools committee made up of the principal, teachers, students, parents, and community partners</li> <li>Hosting an annual wellness fair with student presentations on health-related topics and with booths and presentations from community partners</li> </ul>



TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 May 15

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## SUMMARY INFORMATION REPORT FOR MAY 2014

### **Recommendation**

*It is recommended that Report No. 035-14 re Information Summary Report for May 2014 be received for information.*

### **Key Points**

- The Ministry of Children & Youth Services has reappointed MLHU as a Provincial Centre of Education. The Health Unit will continue to provide training to staff across the province for programs like Healthy Babies, Healthy Children.
- MLHU has built a strong partnership with the London Abused Women's Centre, and participated in a recent LAWC event with great success.
- The new Healthy Child Development – Integrated Services for Children Information System will create efficiencies in data entry.
- Ontario Healthy Schools Coalition Conference, co-hosted by the Health Unit and the Ontario Healthy Schools Coalition, included over 415 delegates from across Canada and beyond.
- The Health Unit is currently prioritizing Public Health Nurse services to schools, which will assist in ensuring that schools received services that are matched to their various levels of needs.
- Public Health Ontario funded a Locally Driven Collaborative Project with a focus on Food Literacy. The summary and technical reports have been completed and are ready for dissemination.
- The *Skin Cancer Prevention Act* came into effect on May 1, 2014. The Health Unit is educating tanning bed operators of their obligations under the law.

### **Background**

This report provides a summary of information from a number of Health Unit programs. Appendices provide further details, and additional information is available on request.

### **Family Health Services (FHS)**

1. Ministry of Children & Youth Services (MYCS) – Centre of Education - Since 2011, the Health Unit has been selected by MCYS as the Provincial Centre of Education for the Healthy Babies Healthy Children (HBHC) Program. In 2014, 10 education projects have been identified by MCYS. The education projects will be used province-wide for the training and certification of Public Health Nurses (PHN's) to use Nurse Child Assessment Satellite Training (NCAST) assessment tools, which are required for PHN's to use in their work with families in the HBHC Program. The funding (\$81,000) specifically supports salary costs for PHN time, editing costs for French Translated resources and the purchase and distribution of resources. Further information including a summary of the funding is provided in [Appendix A](#).
2. London Abused Women's Centre (LAWC)- FHS has had a relationship with the London Abused Women's Centre (LAWC) for many years. Over the past two years this relationship has strengthened and grown, due in part to the death of a colleague, Sonia El Birani, who was murdered by her husband

on April 11, 2012. To honour Sonia, Health Unit staff members have participated in a variety of LAWC activities including putting purple lights on 50 King Street and attending the Lighting of the Tree at Victoria Park in November. Staff members have also participated in fundraising events for LAWC such as Purple Day in the fall and the Downtown 5km Run in the spring. Most recently on April 18, twenty-five staff members formed “Team Sonia” and registered to participate in the Downtown 5km Run. ([Appendix B](#)). As well, MLHU staff entered children in the Kiddie Trot and Dr. Christopher Mackie participated in the 1km CEO run ([Appendix B](#)). Team Sonia raised over \$1,500 in donations which was the most money raised by a non-corporate team, and Dr. Mackie won the CEO run. LAWC is planning on naming this 5 KM walk in memory of Sonia in 2015.

3. Healthy Child Development – Integrated Services for Children Information System (HCD-ISCIS) - MCYS supports children and youth to reach their full developmental potential through a number of MLHU delivered programs. These programs include HBHC, Preschool Speech and Language (PSL), Infant Hearing (IHP), and Blind Low-Vision (BLV). The programs provide screening, assessment, and intervention services under the Healthy Child Development (HCD) umbrella. Until now, these four programs have used two separate databases to document the interactions with children and families receiving services. In May 2014 the databases will be linked to form one new HCD-ISCIS information system and will be phased in across the province. It will consolidate the existing applications, HBHC-ISCIS and PSL-ISCIS to improve capacity to enter and analyze data on outcome measurement tools, service types, and risk factors. The new system has the ability to share demographic and family data amongst all four programs in order that data which were previously entered twice for all newborns in Ontario will now only be entered once. [Appendix C](#) addresses a number of frequently asked questions regarding this consolidated electronic child record.
4. Ontario Healthy Schools Coalition Conference - The Ontario Healthy Schools Coalition partnered with Physical and Health Education Canada and the Health Unit to host the 13th annual conference “Coming Together: Supporting the Whole Child”. The conference was held April 9 and 10 at the Hilton Hotel in London. Over 415 people attended including parents, teachers, school administrators, ministry officials, students, public health, police and community agencies. It featured over 40 breakout sessions and six keynote speakers. Presentations ([Appendix D](#)) focused on whole child health topics ranging from influence of social media, caring relationships, healthy eating, positive mental health and physical literacy. Family Health Services staff members were key planners of the conference. In addition, several sessions were led by staff, and opening remarks were delivered by Dr. Mackie. Significant positive feedback has been received by the committee. An evaluation will be completed to advise the Ontario Healthy Schools Coalition Executive regarding future endeavors.
5. Prioritizing Public Health Nurse Services to Schools - Over the past year, the Child and Youth Program team underwent a significant process in order to prioritize PHN services to schools in Middlesex-London. Although schools will continue to have access to services of PHNs, some schools now receive more dedicated and focused PHN time. The assessment was completed for all 160 schools. One component of prioritizing process was the School Engagement Assessment Tool ([Appendix E](#)). To complete this tool PHNs met with Principals to determine the readiness, need and capacity for engaging in a healthy schools approach. In addition community profile data, other services in the school, EDI scores and so on were assessed. Schools were ranked to allow for more focused care and ultimately stronger outcomes for our children and youth. School Board Partners were engaged in the process and highly supportive of the goals and processes to ascertain the most effective use of nurses in school communities.

## **Environmental Health and Chronic Disease Preventions Services (EHCDPS)**

1. Locally Driving Collaborative Project – Food Literacy Summary - Declining food skills in the general population has been identified as an obstacle to healthy eating. Limited opportunities to develop food skills and prepare healthy food puts socially disadvantaged groups at higher dietary risk. Designing food literacy programs to reach at-risk groups and support successful change requires more knowledge about how these groups currently think about food preparation. The LDCP Food Literacy research results provide an analysis of rich qualitative data about the meaning of food skills and food literacy among

high-risk youth, young families, and pregnant women in Ontario. Insights from this research can inform both policy development and public health, school-based, and community programming. The Summary Report ([Appendix F](#)) and [Full Technical Report](#) are available online.

2. [Skin Cancer Prevention Act Increases Protection for Youth](#) - The [Skin Cancer Prevention Act](#), which came into effect on May 1, prohibits the sale and marketing of tanning services and ultraviolet light treatments to anyone under 18 years of age and requires operators to request identification from anyone who appears to be under 25 years of age (see [www.healthunit.com](http://www.healthunit.com) for more information). An example of promotional material from [The Burning Truth](#) initiative of the Centers for Disease Control and Prevention is attached as [Appendix G](#). Operators are required to post health warning and age identification signs advising customers of the health risks associated with tanning bed use, and must register as an operator with the Health Unit. The Health Unit has been educating operators of their obligations under the law and will be launching a social marketing campaign with the message that there is no safe way to tan, whether in the sun or with artificial sources such as tanning lamps, booths or beds.

This report was prepared by Ms. Diane Bewick, Director, Family Health Services and FHS Staff, and Mr. Wally Adams, Director, Environmental Health and Chronic Disease Preventions Services and EHCDPS staff.



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

**Summary: 2014 Centre of Education Projects**

		<b>Funding</b>
<b>Webinar Development</b>		<b>\$33,000</b>
1	Parent-Child Interaction - Feeding Scales Recertification	\$10,000
2	Promoting Maternal Mental Health During Pregnancy	\$10,000
3	Keys to Caregiving	\$13,000
<b>French Translation</b>		<b>\$10,100</b>
4	French Translation: 58 PIPE Parent Handouts working with 'How To Read Your Baby' in	\$2,600
5	French Translation: Teaching Kit Activity Card	\$3,500
6	French Translation: 56 PMMHDP Handouts	\$4,000
<b>Community of Practice Portal – Content Expertise</b>		<b>\$4,000</b>
7	Screening Liaison Nurse Community of Practice – support for development and participation in 3 webinars	\$4,000
<b>NCAST Resources</b>		<b>\$34,000</b>
8	Aboriginal HBHC Resource purchase and shipping of 50 Toolkits	\$14,000
9	Promoting Maternal Mental Health During Pregnancy: Purchase and shipping of updated program materials to Health Units:	\$12,000
10	NCAST Manuals: Purchase and shipping of updated manuals to Health Units	\$8,000
<b>Total Funding</b>		<b>\$81,100</b>

**London Abused Women`s Centre  
22nd Annual Downtown 5km Run, 2.5km Fun Run, Kiddie Trot and 1km CEO Run!  
Friday, April 18, 2014**



MLHU Team Sonia



Dr. Christopher Mackie, CEO & MOH, Middlesex-London Health Unit

Retrieved from:

<https://www.facebook.com/photo.php?fbid=742360879140265&set=a.742358532473833.1073741854.184983851544640&type=3&l=2feecbef2&theater>

## Questions and Answers: Healthy Child Development (HCD)-ISCIS Implementation

### Q1. What is the Healthy Child Development initiative (HCD)?

**A1.** MCYS supports children in Ontario to reach their full developmental potential through a number of programs that are collectively helping to provide children with the best possible start in life. For the purpose of this initiative, these include Healthy Babies Healthy Children (HBHC), Preschool Speech and Language (PSL), Infant Hearing (IHP) and Blind Low-Vision (BLV). Each of these programs supports children and their families with particular risks and challenges, individually or in combination. These programs, under the HCD umbrella, provide screening, assessment and intervention services, family support and referrals to community resources – and all of these activities are entered and tracked in a database called HCD-ISCIS.

**HBHC** supports children and their families by promoting Healthy Child Development to ensure that children achieve their full potential. The program provides prevention, early identification and intervention services to women and their families in the prenatal period and to families with children from birth to their transition to school.

**PSL** identifies children with speech and language disorders as early as possible and provides these children and their families with services to enable them to develop communication and early literacy skills so they are ready to start school.

**IHP** identifies babies born deaf or hard of hearing and provides services to these children and their families to support language and early literacy development so they are ready to start school.

**BLV** provides critical early intervention and parent education services needed by families of children born blind or with low vision to help them achieve healthy development.

Additional information about these programs can be obtained through the [MCYS website](#).

### Q2. What is Healthy Child Development (HCD)-ISCIS?

**A2.** HCD-ISCIS is the consolidation of two existing data applications: HBHC-ISCIS (currently supporting HBHC) and PSL-ISCIS (supporting PSL, IH and BLV). The main driver for the integration of the two information systems was the need to replace PSL-ISCIS with a more modern information system in order to prevent potential loss of critical business information that is used to manage the PSL, IH and BLV programs.

HCD-ISCIS is an enhanced version of HBHC-ISCIS. For HBHC users, there will be no change in the way assessments, family service plans and nursing notes are recorded. However, for users in the PSL, IH and BLV programs, there will be enhancements related to the way outcome measures are recorded, and new service types and risk factors added.

An additional component in the HCD-ISCIS application is the ability to share and search for demographic/family data from within the entire database, including any of the four programs and across all the health units/lead agencies across the province. This enhancement means that the demographic/family information currently entered twice for all newborns in Ontario (through HBHC and IH) may be entered once.

**Q3. How will the demographic/family data be entered into the new HCD-ISCIS application?**

**A3.** Based on the feedback we have obtained, HBHC is, in many cases, the first program to collect the family's demographic information and with the appropriate consent, will be the first program to enter the family's information in the HCD-ISCIS application. However, in other cases, IH may be the most appropriate program to request consent to enter the demographic/family information in the HCD-ISCIS database. We encourage coordination among the public health units and lead agencies at the local level to decide on the best approach to enter the demographic/family information in HCD-ISCIS for your catchment area.

After the demographic/family information is entered in HCD-ISCIS, either by HBHC or IHP, the other programs can search for the family's information and enter their own program-specific information. The first program which provides service to the family will be responsible for obtaining consent to collect and enter the demographic/family information in the HCD-ISCIS provincial database. Existing legislation will continue to apply for the collection and sharing of personal information.

**Q4. What is the demographic/family information that will be visible to users of HCD ISCIS?**

**A4.** The consolidation of the two information systems, HBHC-ISCIS and PSL-ISCIS offers the opportunity to streamline the task of entering the demographic data/family information for any of the programs. In HCD-ISCIS, demographic/family information will be entered once and will be accessible to approved users of the system within the Healthy Child Development initiative across the province. The following information will be visible with consent:

- Address
- Contact information
- Family members names, dates of birth
- Programs enrolled in, or discharged from
- Referral date and/or discharge date

**Q5. Will client/service information be shared?**

**A5.** Service information specific to each program will remain in separate databases and will not be accessed by staff from the other programs or other regions in HCD-ISCIS. Only demographic/family information will be shared with consent.

A user belonging to PSL/IH/BLV site will continue to access PSL/IH/BLV cases in their site. All users belonging to HBHC only sites will continue to access HBHC cases in their site. In the case of agencies responsible for the delivery of all four programs, PSL/IH/BLV and HBHC, users will have program-specific authorizations.

**Q6. What if a family declines consent for having their data entered into HCD-ISCIS? Can I still provide service?**

**A6.** A family can still receive service from any program using the HCD-ISCIS database even if the family does not want their information shared. The HCD-ISCIS application includes a feature that will not permit the record to be shared if the family does not consent to share their demographic/family information.

**Q7. What are the implications of HCD-ISCIS on the process already in place with partners for obtaining consent from families?**

**A7.** Public health units and lead agencies are encouraged to communicate with their program delivery partners (e.g. hospitals and other service providers delivering respective HCD programs) as soon as possible in order to discuss implications related to the consent process for HCD-ISCIS. Best practice research on partnership building, as well as recent experience of health units with their hospital partners in implementing the new HBHC Protocol 2012, highlight the importance of early opportunities for all partners to identify their concerns and collaborate on solutions that consider all partners' needs.

Public health units and lead agencies must consider the needs of their program delivery partners in determining the most effective way to operationalize HCD-ISCIS. For example, information sharing and training may be necessary before any change to process takes place. Another example may be to focus initially on an approach for integrating existing families, followed by establishing new consent processes for new families. Public health units and lead agencies are encouraged to discuss their plans for operationalizing HCD-ISCIS with their ministry program leads.

**Q8. Has the Ministry conducted a Privacy Impact Assessment (PIA) on this new application and what are the findings of the PIA?**

**A8.** The Ministry has conducted a PIA of the HDC program (HBHC, IH, BLV, and PSL). The assessment's findings and proposed mitigation strategies will be distributed to public health units and lead agencies to assist them with their internal privacy assessment work. It is important to note that none of the findings are found to be a barrier for the implementation of HCD-ISCIS.

The PIA for HCD-ISCIS reviewed the Ministry's Privacy practices related to the HDC program. Also included in the assessment was a review of the privacy risks associated with the application and its features. The two key findings are that (a) public health units and lead agencies are deemed the data owners and that (b) HCD-ISCIS is required to adhere to the requirements set out in the Personal Health Information Protection Act (PHIPA) with respect to the collection, use and disclosure of personal health information.

**Q9. What is the protocol for updating the demographic data and who is responsible for updating it?**

**A9.** Only regions and programs that provide services to the family can update the demographic information. When a family comes into service or continues with service, each program will have the responsibility of confirming the consent to share and confirming the same in HCD-ISCIS. There will be an audit log on demographic records that are shared. The log will have a date/time stamp and the name of the public health unit or lead agency that last updated the information.

**Q10. Can HCD-ISCIS produce program-specific monitoring reports?**

**A10.** The HCD-ISCIS will be able to generate program-specific monitoring reports. There will be no changes to the existing reports.

**Q11. Who will provide technical support and training for HCD-ISCIS?**

**A11.** The service desk is still the first point of contact for the application support and eHealth Ontario (eHO) is first point of contact for connectivity and user login issue.



Additional demonstrations on the new functionality of HCD-ISCIS for the PSL/IHP/BLV users will be taking place in October 2013.

Demonstrations on the data sharing functionality of the HCD-ISCIS applications for all users in IHBHC, PSL, IHP, and BLV users will take place in November 2013.

Training on the new HCD-ISCIS application for users in all public health units and lead agencies will take place between March and May 2014. In addition, a new HCD website will be developed for HCD-ISCIS where the new training material and program guidelines will be accessed by all users of the application.

**Q12. Is the Ministry of Health and Long-Term Care (MOHLTC) aware of the implementation of HCD-ISCIS?**

**A12.** The Ministry of Children and Youth Services provides regular updates about HCD-ISCIS to the Public Health Leadership Council which is led by the Chief Medical Officer of Health with the MOHLTC and attended by Medical Officers of Health and others from the Public Health sector (e.g. COMOH, OPHA, alpha).

**Q13. Who has been involved in the development of HCD-ISCIS?**

**A13.** The development of the HCD-ISCIS application is a joint initiative of the Child and Youth Development Branch (CYDB) of MCYS and the Children, Youth and Social Services I&IT Cluster in collaboration with eHealth Ontario (eHO). The project has been developed with input from the Legal Services Branch and the Freedom of Information Unit of the Ministry of Community and Social Services (MCSS).

In addition, the development of the application requirements has been done in consultation with HBHC-ISCIS and PSL-ISCIS users from health units and lead agencies. Several PSL-ISCIS users have participated in the initial data migration training and will be conducting the first data migration testing on September 27, 2013.

There will be additional opportunities for input and feedback on the proposed functionality for HCD-ISCIS from HBHC, PSL, IH and BLV users in October and November 2013.

**Q14. When does my health unit/agency need to be ready for these changes?**

**A14.** Migration of data from PSL-ISCIS to HCD-ISCIS will take place in stages beginning in early 2014, with final deployment of the application by June 2014. This means that the ability to share demographic/family data across all the programs and across all regions/agencies will be fully functional next summer. From then on, sharing of information could be enabled/activated when a new record is added (e.g., through a new birth being added or a new service being provided) or when an existing record is accessed (e.g., when a new birth is added for an existing family, continuation of services to an existing family, discharging or transferring a family). Practically though, the sharing of demographic/family data will be a controlled process that will happen incrementally, and only with appropriate consents obtained.

Public health units and lead agencies are encouraged to discuss their plans for operationalizing HCD-ISCIS with their ministry program leads.

**Q15. What is my role as a service provider in connecting with the other programs in this initiative?**

**A15.** Additional information about programs under HCD-ISCIS is available on the MCYS website <http://www.children.gov.on.ca/htdocs/English/topics/earlychildhood/index.aspx>.

Public health units and lead agencies delivering any of the programs represented under HCD-ISCIS are encouraged to collaborate with services providers in their local catchment area to support an integrated approach to services for children and families that meets local needs. Service providers will benefit from increased knowledge about referral sources and community-based resources in their communities to facilitate referral and recommendation to other services and to enable effective service planning and coordination for families.

**Q16. What are the timelines for implementation of HCD-ISCIS?**

**A16.** The planned timelines are as follows:

1. Data migration testing for PSL, IH and BLV lead agencies begins on September 27, 2013.
2. Demonstration on the new functionality specific to the PSL, IHP and BLV users on October 9, 2013.
3. Demonstration on the data sharing functionality for all users (HBHC, PSL, IH and BLV) in November, 2013.
4. Trial deployments will start in December, 2013.
5. Final data migration is planned in waves between March and June 2014.
6. Final deployment of the application will take place by June 2014.

**Q17. Where can I get more information?**

**A17.** If you require additional information about HCD-ISCIS, please call Mercedes Mompel, Senior Policy Analyst, Ministry of Children and Youth Services (416) 327-7836 or [mercedes.mompel@ontario.ca](mailto:mercedes.mompel@ontario.ca).

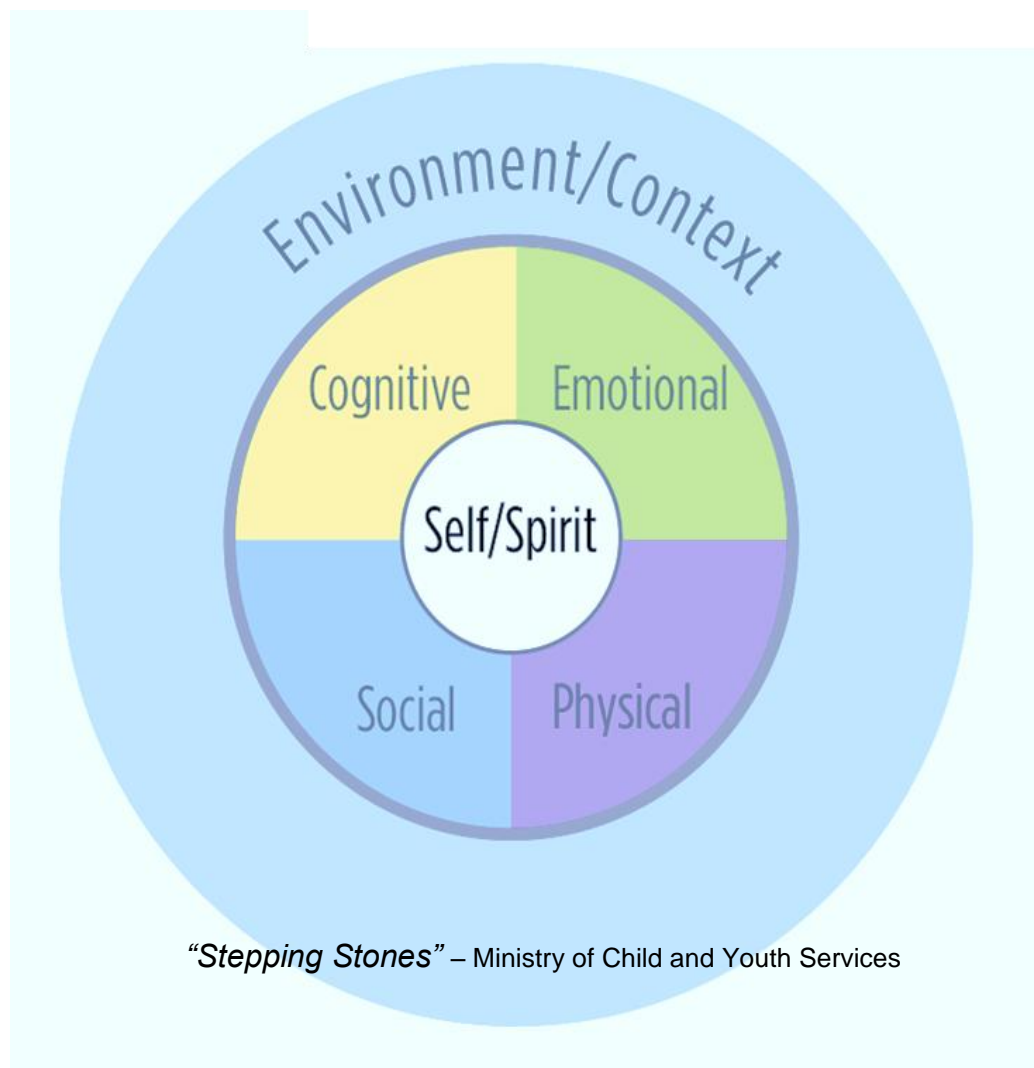
# Ontario Healthy Schools Coalition National Healthy Schools Conference

*Coming Together: Supporting the Whole Child*

Wednesday, April 9<sup>th</sup> and Thursday, April 10<sup>th</sup> 2014

Hilton Hotel and Conference Centre

London, Ontario



“Stepping Stones” – Ministry of Child and Youth Services



◊ Coalition ontarienne des écoles en santé ◊  
◊ Ontario Healthy Schools Coalition ◊

<http://ontariohealthyschools.com>



HEALTHY  
SCHOOLS  
MATTER  
GET INVOLVED

## *Conference at a Glance*

Time	Wednesday, April 9 <sup>th</sup> 2014
7:30 am	Registration Opens
8:30-9:00 am	Continental Breakfast and Opening Greetings
9:00-10:00 am	<b>Keynote</b> – Rona Maynard
10:30-11:30 am	Breakout Session 1
11:30-12:30 pm	LUNCH
12:30-1:30 pm	Breakout Session 2
1:45-2:45 pm	Breakout Session 3
3:00-4:00 pm	Breakout Session 4
4:00-4:30 pm	Draw for Prizes for Day 1 Evaluations Must be present to WIN
5:30-6:45 pm	DINNER
6:45-7:00 pm	<i>Jo Read Dance</i> Presentation
7:00-8:30 pm	<b>Keynote</b> – Dr. Clair Crooks

***Breakfast, Lunch and Snacks will be provided on both days***

Time	Thursday, April 10 <sup>th</sup> 2014
7:30 am	Registration for Day Two
8:00 am	Continental Breakfast and Opening Remarks
8:30-9:30 am	<b>Keynote</b> – Dr. Jamie Mandigo
9:30-10:30 am	Breakout Session 5
10:45-11:15 am	<b>Physical Literacy in Action – Dr. Amanda Stanec</b>
11:15-12:15pm	<b>Keynote</b> – Michel Chikwanine
12:15-1:00 pm	LUNCH
1:00-2:00 pm	Breakout Session 6
2:15-3:15 pm	Breakout Session 7
3:30-4:30 pm	<b>Keynote</b> – Dr. Stan Kutcher
4:30-5:00 pm	Draw for Prizes- Evaluations Must be present to WIN
7:00-9:00 pm	<b>Keynote</b> – Dr. Dean Kriellaars

## Keynote Speakers

**Wednesday, April 9<sup>th</sup> 9:00-10:00 am**

**Ms. Rona Maynard**

Rona served as Editor of *Chatelaine* through a decade of growth and innovation in which she attracted a new generation of readers to Canada's number one magazine for women. She became renowned for the honesty of her editorials. Rona's presentation will focus on how her achievements are rooted in her personal journey out of shyness and chronic depression. She will emphasize how she had to learn to live each day and how she eventually learned to make a difference in the other people's lives. Rona will emphasize to how caring relationships do make a difference and are a key component of healthy schools.

**Wednesday, April 9<sup>th</sup> 7:00-8:30pm**

**Dr. Claire Crooks**

Dr. Crooks is the Associate Director of the CAMH Centre for Prevention Science and an Adjunct Professor (Faculty of Education) at Western University. She is one of the lead developers and researchers of the *Fourth R*, a relationship-based program aimed at preventing violence and related risk behaviours among adolescents. The *Fourth R* has been implemented in over 2000 schools in Canada and the United States and is identified as a best practice program by the Public Health Agency of Canada. She is particularly interested in the development and evaluation of strategies that meet the unique needs of Aboriginal youth, and is the lead author of *Engaging Aboriginal Youth: A toolkit for service providers* (2010, Trafford). She is co-author of more than 50 articles, chapters, and books on topics including school-based programming with Aboriginal youth, children's exposure to domestic violence, child custody and access, adolescent dating violence and risk behavior, and trauma. Dr. Crooks received her B.A. from Princeton University in New Jersey, and her M.A. and Ph.D. from Queen's University.

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**Thursday, April 10<sup>th</sup> 8:30-9:30 am**

**Dr. Jamie Mandigo**

Dr. James Mandigo is an Associate Professor at Brock University. He will provide an interactive session aimed at helping participants understand why we need physically literate children and youth in our schools. He will describe how physical literacy addresses several domains of the whole child and is linked to a child's emotional and mental well-being and thus benefits a healthy school community. Jamie will provide practical ideas about how communities can come together to develop physically literate schools, workplaces and communities.

**Thursday, April 10<sup>th</sup> 11:15am- 12:15 pm**

**Michel Chikwanine – Me to We**

Born in the Democratic Republic of Congo, Michel has already overcome many struggles. His passion in the possibility of change makes him a remarkable individual and humanitarian. Now a university student, Michel shares his personal story leaving audiences with a new perspective on life, a sense of hope through social responsibility and a desire for change.

**Thursday, April 10<sup>th</sup> 3:30-4:30 pm**

**Dr. Stan Kutcher**

Dr. Kutcher is an internationally-renowned expert in the area of adolescent mental health and a national and international leader in mental health research, advocacy, training, policy, and health services innovation. Dr. Kutcher uses his considerable expertise to advance the work of the Sun Life Financial Chair in Adolescent Mental Health, building awareness and knowledge about mental health in young people. This is achieved through the development of programs that address adolescent mental health promotion, education and research, locally, nationally and internationally. Dr. Kutcher will address the issue of mental health literacy as a foundational component for school mental health. He will describe the development of a school based approach (grades nine and ten) to mental health literacy and report on how this has been applied, evaluated and researched with examples from different Canadian provinces.

**Thursday, April 10<sup>th</sup> 7:00-9:00pm**

**Dr. Dean Kriellaars**

Dr. Kriellaars will provide evidence and practical support to help coaches, parents, community members and educators help children and youth to become physically literate.

He will speak to the practicality of implementing physical literacy regardless of who you are and what age group of children you work with. Dr. Kriellaars believes that physically literate children are healthy children who will succeed in life.

Dr. Kriellaars was awarded the Healthy Living Award for his outstanding activities in building community wellness in the province of Manitoba. He is part of the leadership team of the Canadian Sport for Life movement, works with PHE Canada, the Sport Medicine and Science Council of Manitoba, as well as the RCMP on community wellness initiatives.

## HOW TO REGISTER

### Conference Registration

<http://ontariohealthyschools.com>

To register please complete the [on-line](#) form including payment options and indicating breakout session choices. We encourage you to register early in order to ensure availability in the breakout sessions of your choice.

<http://www.karelo.com/register.php?BID=532&BT=10&Ev=11814>

If you are not already a member of the Ontario Healthy Schools Coalition (OHSC) and wish to [join](#), please see:

<http://www.karelo.com/register.php?Ev=13293>

If you wish to [join](#) the OHSC and receive the lower registration fee you **must** do so before registering for the Conference.

**Conference Substitution and Cancellation Policy:** Substitutions may be made anytime up to the start of the event, subject to a \$10 administration fee, without incurring a cancellation fee. Cancellations received by OHSC before March 10<sup>th</sup> 2014 will be assessed a \$50 cancellation fee per person. Cancellations received after March 10<sup>th</sup> 2014 are transferable, but non-refundable. No refunds will be given for no-shows.

**Registration fees do not include hotel.** Conference delegates requiring overnight accommodations are responsible to make arrangements directly with the Hilton Hotel.

**Hotel registration:** A block of rooms is being held at the Hilton Hotel, London ON under OHSC Conference for the nights of Tuesday April 8<sup>th</sup> and Wednesday April 9<sup>th</sup>; reservations **MUST** be made by March 10<sup>th</sup> 2014.

[http://www.hilton.com/en/hi/groups/personalized/Y/YXULOHF-OHS-20140408/index.jhtml?WT.mc\\_id=POG](http://www.hilton.com/en/hi/groups/personalized/Y/YXULOHF-OHS-20140408/index.jhtml?WT.mc_id=POG)

**OR call 1-800-HILTONS** and provide the code "OHS" Rates begin at \$119 (plus tax). These rates are guaranteed until March 10<sup>th</sup>, (pending availability) Please make reservations as soon as possible.

### Conference Registration Fees – OHSC Members

Conference Registration for OHSC Members	
	Regular Registration Until March 31 <sup>st</sup> 2014
Full Two Day Conference Registration	\$315
One Day Conference Registration	
Wednesday, April 9 <sup>th</sup>	\$195
Thursday, April 10 <sup>th</sup>	\$195

### Conference Registration Fees - OHSC Non-Members

Conference Registration for OHSC Non- Members	
	Regular Registration Until March 31 <sup>st</sup> 2014
Full Two Day Conference Registration	
<b>Additional Non-Member fee</b>	\$30 Individual \$100 Organization
One Day Conference Registration	
Wednesday, April 9 <sup>th</sup>	\$195
Thursday, April 10 <sup>th</sup>	\$195
<b>Additional Non-Member fee</b>	\$30 Individual \$100 Organization

Included in conference fees are breakfast, lunch and snacks.  
Please note dinner is included on Wednesday, April 9<sup>th</sup> but not on April 10<sup>th</sup>.

### *Conference Registration Fees - Students*

<b>Students</b> are welcome to attend as participants. Elementary students are encouraged to attend on <b>Thursday, April 10<sup>th</sup></b> and must be accompanied by school staff	
Conference Registration Per Day	
Wednesday, April 9 <sup>th</sup>	\$40
Thursday, April 10 <sup>th</sup>	\$40

### *Travel Discounts*

Robert Q Airbus offers assistance to conference participants with their travel plans by extending a 15% off the Robert Q regular fare on any of Robert Q scheduled routes to/from our London depot and the Toronto Pearson or Detroit Metro airports.  
There is an additional fee for service to a residence or hotel here in London, please inquire at the time of booking. Please refer to Robert Q Airbus website [www.robertq.com](http://www.robertq.com).

Please refer to code **#2073** or enter the number in "promotion code" online to receive the discounted fare.

## Breakout Session Descriptions

### Session One - Wednesday, April 9<sup>th</sup> 10:30 - 11:30

Code	PRESENTER	DESCRIPTION
1-A	<b>Dr. Michelle Gilpin and David Inglis</b> Thames Valley District School Board	<b>How Does Mental Health Fit in the Health and Physical Education Curriculum?</b> This presentation will provide a review of a collaborative process and outcome that occurred in order to support elementary and secondary teachers who are asked to address mental health issues in context of their HPE curriculum. It will describe specific strategies that are used to support instruction and make explicit links between mental health and the HPE curriculum. The goals of this workshop are to facilitate greater awareness of how curriculum expectations can be translated into meaningful and accessible lessons in relation to mental health.
1-B	<b>Emina Secerbegovic and LJ Bartle</b> Parks and Recreation Ontario	<b>Building Leadership Through HIGH FIVE</b> This presentation will introduce participants to HIGH FIVE® principles of healthy child development and design guidelines and demonstrate how HIGH FIVE trainings can be integrated into the curriculum to equip students with a certified set of skills to successfully work with children in sport and recreation environments.
1-C	<b>Marg Schwartz</b> Alberta Project Promoting Active Living and Healthy Eating (APPLE)	<b>Best Practice Strategies to Implement CSH – APPLE Schools</b> This interactive session will provide some processes, tools, strategies and resources to facilitate change in a school community. The session will engage learners to think about ways they can enhance and reflect on the work they are doing to affect positive changes to the health of students, parents, partners and staff and most importantly to change the culture of a school to be one that promotes and supports healthy behaviours.
1-D	<b>Chris Friesen</b> Principal, Thames Valley District School Board	<b>Measuring Success Differently</b> At Woodstock Collegiate Institute (secondary school) we are committed to the philosophy that each student should leave our school better than when they came. Better how? By whose standards? We believe that we need to empower students to identify for themselves which area they need to improve in and then help them achieve that so they can be positive, contributing members of society when they graduate. This presentation will cover the strategies we are using to achieve this vision.
1-E	<b>Jessica Reid</b> Fostering, Empowering, Advocating Together (FEAT) for Children of Incarcerated Parents	<b>Breaking the Cycle: Supporting the Forgotten Children Affected by Parental Incarceration</b> This workshop will provide attendees with strategies to support and optimize the outcomes of these at-risk children in the classroom, schools and community settings. The focus of this interactive workshop is to review the impact of parental incarceration, identify the unique needs of these at-risk children, and provide strategies to optimize their outcomes, support the whole child, and strengthen our classrooms, schools, and communities.
1-F	<b>Margaret Good</b> Ontario Physical and Health Education Association (OPHEA) and Middlesex-London Health Unit	<b>Youth Engagement: Promote Tobacco Free School</b> Join us for this interactive session where you will learn directly from youth leaders and their adult allies who are participating in OPHEA's Smoke-Free Ontario Pilot Program. Find out how they've been using the Healthy School approach to lead, plan and implement youth-led activities that integrate youth tobacco prevention with other health-related topics.



## Breakout Session Descriptions

Session Two - Wednesday, April 9 <sup>th</sup> 12:30 - 1:30		
Code	PRESENTER	DESCRIPTION
2-A	<b>Eileen Silver</b> Ministry Of Education, Safe and Healthy Schools	<b>Working together for Healthy Kids: Strengthening Partnerships Between Regional Public Health Units and District School Boards</b> There are many examples of how school boards and public health units work together to help advance the health and well-being of kids. By working together to develop a consistent service delivery model, education and public health partners can support the well-being of children and youth. Exemplary models of collaboration between public health units and school boards in Ontario will be discussed.
2-B	<b>Sue Grantis and Wendy Davies</b> Niagara Region Public Health and Youth Net Niagara Coordinators	<b>Youth Net Niagara: Creating a Culture of Positive Mental Health in School Settings</b> Youth Net Niagara is a 'for youth, by youth,' mental health promotion and early intervention program implemented in high schools in the Niagara Region. Public health school nurses lead a dynamic group of volunteer facilitators from Brock University. Trained in ASIST and group facilitation, these facilitators are supported by public health nurses and school staff to engage youth in discussion, provide follow-up and make referrals to community agencies. Youth Net is an evidenced- based, award winning suicide prevention program developed by CHEO.
2-C	<b>Sarah Grzincic</b> Harmony Movement	<b>The Role of Equity in Health: Well-Being for the Whole Child</b> Participants will explore the diversity of their communities, examine the relationships between equity and health, and discuss effective strategies for promoting the health and well-being of all students. Some of the topics this workshop will address include food security, bullying, body image, depression, substance use, high-risk sexual behaviour, and youth violence.
2-D	<b>Julie Rochefort</b> Association of Size Diversity and Health (ASDAH) and Noojmowin Teg Health Centre	<b>First, Do No Harm. Raising the Red Flag on Schools Healthy Eating and Obesity Prevention Initiatives</b> Participants will develop an increased awareness of the unintentional harm associated with school obesity awareness campaigns. The presentation will critically review both Canadian and International school-based studies while providing strategies to assess weight bias within organizations and schools.
2-E	<b>Kathy Furlong, Ryan Ewaskiw and Jeff Schiller</b> Thames Valley District School Board	<b>Fitness Integrated Intentional Teaching</b> The presentation will outline a brief review of both neuroscience and physiology research studies that demonstrate that 30 minutes of cardio activity results in a one hour learning bump and improved mental health. Learn how 30 minutes of cardio activity is being implemented in an elementary setting through QDPA, in a secondary setting and sharing the results of the collaborative inquires.
2-F	<b>Jaxson Khan</b> UNConference	<b>Connect, Learn, and Network – Double Session (12:30-2:45pm)</b> The unconference format creates an open space for peer-to-peer learning, collaboration and creativity where everyone has something to share and everyone has something to learn. Come prepared to share your expertise in this peer-to-peer directed conference within a conference.

## Breakout Session Descriptions

### Session Three - Wednesday, April 9<sup>th</sup> 1:45 - 2:45

Code	PRESENTER	DESCRIPTION
3-A	<p><b>Angela Townend and Dianne Kennaley</b> London Family Health Team &amp; Catholic Family Services of Durham</p>	<p><b>Mental Health 101: Creative Strategies to Foster Student Wellness</b> 10 to 20% of Canadian youth are affected by a mental illness. A significant number of these children are diagnosed with anxiety, depression and/or ADHD. This workshop will demonstrate how the unique relationship between a student and his/her teacher is invaluable to promoting emotional wellness in the classroom.</p>
3-B	<p><b>Natalie Martin and Dana Zummach</b> Champlain Cardiovascular Disease Prevention Network (CCPN) and the Heart and Stroke Foundation</p>	<p><b>Working Together to Create Healthy School Environments</b> To share knowledge &amp; experiences from implementing the Champlain School Facilitation Pilot Program 2013-14 a program to create physically active, healthy eating environments in schools using a comprehensive school health framework (CSH). Presentation includes lessons learned regarding strategies to engage entire school communities (i.e. administrators, teachers, parents, students, community) in mobilizing change.</p>
3-C	<p><b>Caroline Teske</b> Walk Away, Ignore, Talk it out, Seek Help (WITS)</p>	<p><b>Creating Responsive Communities for the Preventions of Bullying and Peer Victimization</b> This workshop will focus on the definition, prevalence and impact of bullying and victimization, as well as an overview of the WITS Program.</p>
3-D	<p><b>Rebecca Patkau</b> Thames Valley District School Board</p>	<p><b>Books for Breakfast: Reaching Students Brains Through Their Stomachs</b> Sharing the ups and downs of working with a unique group of Grade 9 students in developing an English program in a way to meet the basic needs of the students while still covering the expectations of the English curriculum. Throughout the year, students became an engaged, inclusive community of learners who not only read novels and poetry, but also wrote a variety of real-life purposes, presented in front of classmates and the larger school community.</p>
3-E	<p><b>Ann Tyrrell</b> City Of Hamilton, Public Health Services, Salfleet Secondary School's Health Action Team</p>	<p><b>Health Action Teams (HATs): Involving Students and Sharing Stories of the HAT's Impact</b> Participants will increase their knowledge of HAT recruitment strategies for students and parents. HATs addresses factors linking education and health. Keeping youth in school requires not only academic support, but a feeling of connection at school.</p>
3-F	<p><b>Jaxson Khan</b> UNConference</p>	<p><b>Connect, Learn, and Network</b> The unconference format creates an open space for peer-to-peer learning, collaboration and creativity where everyone has something to share and everyone has something to learn. Come prepared to share your expertise in this peer-to-peer directed conference within a conference.</p>

## Breakout Session Descriptions

### Session Four - Wednesday, April 9<sup>th</sup> 3:00 - 4:00

Code	PRESENTER	DESCRIPTION
4-A	<p><b>Myra Stephen, Caroline Hicks, Paul Grogan and Jennifer Munro-Galloway</b></p> <p>Ontario Ministry of Education, Curriculum Division</p>	<p><b>Mental Health and the Ontario Curriculum</b></p> <p>Participants will examine the revised Healthy Schools framework, the new preface in revised curricula, the Supporting Minds educator resource, new videos highlighting mental health and well-being across the curriculum and resources from the Joint Consortium for School Health.</p>
4-B	<p><b>Carol Yandreski and Christene de Vlaming-Kot</b></p> <p>Community Health Nurses Initiatives Group of Ontario</p>	<p><b>Supporting the Health of the Whole Child: The Role of the Public Health Nurse in 21<sup>st</sup> Century Schools</b></p> <p>This interactive presentation will summarize key findings and recommendations of a discussion paper entitled "Healthy Schools, Healthy Children: Maximizing the contributions of public health nursing in school settings". Participants will provide feedback and offer their recommendations for further action on this report.</p>
4-C	<p><b>Muriel Abbott and Phillipa Myers</b></p> <p>London &amp; Middlesex Local Immigration Partnership</p>	<p><b>Welcoming All Voices-Building Inclusive Parent Groups in Schools</b></p> <p>This workshop, developed by parents and community members from a range of disciplines and organizations, uses a strength-based, proactive approach to draw on parents' skills, stimulate insightful discussion and provide planning opportunities to take home. A toolkit with practical strategies and skills that can be applied by parent leaders in their unique school community, "Welcoming All Voices" promotes collaboration between parents, schools and community for student success.</p>
4-D	<p><b>Patricia Howell-Blackmore</b></p> <p>Lions Quest Canada – The Canadian Centre for Positive Youth Development</p>	<p><b>Making Developmental Assets Live and Breathe For Our Kids!</b></p> <p>This workshop will make real life sense out of a checklist of 40 Developmental Assets. We will review the 40 critical factors that all children and youth need to succeed and show you the compelling research that links the assets to risky behaviours. Come and hear stories, strategies and pick up some tools to get you started on increasing assets for all kids.</p>
4-E	<p><b>Andrea Collins</b></p> <p>York Region Public Health</p>	<p><b>Active Tools for Schools (ATS)</b></p> <p>This presentation will provide an overview of Active Tools for Schools (ATS). ATS is designed to help elementary schools make the active choice, the easy choice by providing easy access to user-friendly resources and information that promote increased levels of physical activity. It is based on the Comprehensive School health model and is available to schools at no cost. ATS breaks down the broad concept of physical activity into 9 elements and includes four main components: a checklist, a prioritization tool, reference charts with web-links and a safety- first poster.</p>
4-F	<p><b>Sarah Jackson and Christine Preece</b></p> <p>Physical and Health Education Canada</p>	<p><b>Healthy Schools in Canada</b></p> <p>Achieving Healthy School communities can seem like a challenge. Learn more about PHE Canada's tools, free resources available to support you in your journey to becoming a health promoting school. Learn what steps to take to gain positive movement forward in your school. Share with others your stories of success and problem solve solutions to challenges you face.</p>

## Breakout Session Descriptions

### Session Five - Thursday, April 10<sup>th</sup> 9:30 - 10:30

Code	PRESENTER	DESCRIPTION
5-A	<b>Cindy Andrew</b> The Psychology Foundation of Canada	<b>Helping Children and Youth Learn to Manage Stress: Tools for Lifelong Mental Health and Resiliency</b>  This participatory workshop will focus on a series of practical resources and strategies that counsellors, teachers, other school-based professionals, parents and others can use to i) help children and youth learn to manage stress and ii) to foster positive mental health within their school communities.
5-B	<b>Sean Twyford</b> Ontario Ministry of Children and Youth Services	<b>Stepping Stones: A Resource on Youth Development</b>  Stepping Stones is an evidence-based resource designed for anyone who lives and works with young people. It describes how young people ages 12 to 25 grow and develop – cognitively, emotionally, socially and physically – and offers tips for youth on the supports and opportunities they need to transition successfully into adulthood. This interactive presentation will discuss; what the resource is; how it was created (recruiting youth consultants, engaging youth and community service providers); how it can be used to support youth well-being; and what young people want you to know.
5-C	<b>Christine Callaghan and Yosselin Deras</b> Middlesex-London Health Unit	<b>Be Brighter with Breakfast - A program that moves Comprehensive School Health from Words to Action</b>  Be Brighter with Breakfast is a comprehensive school health approach that links healthy eating and student well-being with student success. The goal of the initiative is to improve breakfast eating patterns among secondary school youth through education, supportive environments, community partnerships and youth engagement strategies. Specifically, this session will provide an overview of the program and how the respective activities are weaved through the 4 components of comprehensive school health and how a school community can work together to promote positive change.
5-D	<b>Pierre Gautier</b> OPP Officer Provincial Gangs Issues Coordinator	<b>Gangs and Graffiti</b>  This presentation will provide information about street gangs and graffiti including information about myths associated with street gangs, risk factors that contribute to youth joining gangs, signs that students might be mimicking the gang lifestyle. Prevention and intervention strategies to support parents, educators, public health and community in their efforts to protect youth from the dangerous world of street gangs will be discussed and presented.
5-E	<b>Trevor Sookraj, Michael Pallotto and Michael Norris</b> Ontario Student Trustees' Association (OSTA-AECO)	<b>Well-Being? What Does That Mean to Students</b>  This presentation will focus on the leadership of students related to the challenges of healthy eating and mental health in schools. This student lead presentation will facilitate further dialogue and engagement with student attendees by asking for their input on potential strategies. The OSTA-AECO presenters will also provide attendees with a five-step plan on how to involve students in the decision-making process, displaying both an adult and student perspective on how to ensure students are involved in the process of developing solutions to support healthy eating and mental health.
5-F	<b>Dave Inglis and Ted Temertzoglou</b> Thames Valley District School Board and Thompson Publishing	<b>Cross Curricular Literacy</b>  This active cross-curricular session incorporates numeracy, literacy, physical literacy and DPA using Thompson Educational New Functional Fitness Chart Series, Active Start (K-3), Perfect Practice (4-6), Game On! (7-9) and Yoga 1. Participants will come away from this session with ideas on how to easily integrate movement skills across the curriculum, build fun fitness circuits and get students moving both inside and outside the gym. Teachers will also have an opportunity to brainstorm and develop more cross curricular ideas and lessons that build upon those developed by other school boards across Ontario.
5-G	<b>Sandasha Ferguson</b> London Police Service, School Safety Officer	<b>Internet safety, Cyber Bullying and the Law</b>  Information provided to further help keep yourself and your children safe while using the internet. The following Social Media/Internet sites and information that will be touched on are as follows: Facebook, Snapchat, Tumblr, Qooh Me, Kik, Instagram, Geotagging, Omegle, Ask.FM, Internet Predators, MSN, Twitter, Games/Applications, Webcams, Sexting, Phishing Scams, Cyberbullying and the Law with relation to these topics. Constable Ferguson's presentation is geared towards highschool aged and older.

## Breakout Session Descriptions

Session Six - Thursday, April 10 <sup>th</sup> 1:00 - 2:00		
Code	PRESENTER	DESCRIPTION
6-A	<b>Sharon Delurey and Teija Cumming</b> York Region Community and Health Services	<b>Partnerships: The Key to Successful School Travel Planning</b> Participants will learn how a unique partnership between Public Health and School Boards can be very effective in promoting and implementing Healthy Schools/School Travel Planning. Participants will feel encouraged and empowered to promote the best practice School Travel Planning Model in conjunction with the Healthy School framework to achieve an effective comprehensive approach to active school travel.
6-B	<b>Aaron Pickup</b> Educator, Nancy Campbell Collegiate Institute	<b>The Student Serenity Project</b> This workshop will outline four integrated activities that will enable students to share positive thoughts and feelings with each other in the hopes that these reach someone in need. The four activities include: The Student Serenity Show, The Peace Phone, Classroom Visits and Awareness Wrist Bands. This project is founded on the core belief; each child deserves the chance to experience the power of positive thoughts and feelings through the words we use.
6-C	<b>Annie Kidder and Kelly Gallagher-Mackay</b> People for Education	<b>Beyond EQAO– Broadening Measures of Success in Our Schools</b> In this workshop, participants will help to identify and define health-related “school success” goals, and explore methods to measure progress toward those goals. The evidence is clear that students need more than foundational skills in literacy and numeracy for long-term success. Schools support the development of good physical and mental health ; strong social-emotional skills; creativity and innovation; democratic engagement; and a positive school climate.
6-D	<b>Michelle Boyce</b> Alphabet Community Centre	<b>Student Success and Engagement for Marginalized Populations</b> Working from actual case studies of marginalized students who failed their initial years of high school and who through community partnership, creating safe environments and problem solving, students have gone on to successful University/College Education achieving honour roll. The presentation will include the important role community partners can play in student success. This workshop provides real tools with proven success stories.
6-E	<b>Kim Hordal-Hlewka</b> Ever Active Schools- Alberta	<b>Healthy Active Schools Symposium- Students Leading the Way</b> The Healthy Active School Symposia are one day events designed to provide Alberta school communities with the knowledge, skills and resources to address school health issues including physical activity, healthy eating and positive social environments through empowering student leadership. During this presentation participants will see how the HASS event is planned and executed as well as the impact that this event has had on Alberta schools.
6-F	<b>Amanda Stanec</b> Move, Live, Learn	<b>Understanding Physical Literacy and Supporting its Development in a Fun and Meaningful Way</b> Physical literacy is a rather novel term. Hence, not everyone understands how to develop physical literacy in the individuals with whom they work with (i.e., their students, children, and athletes). This session will explain physical literacy in a practical way, and will leave attendees inspired to develop it in youth in upbeat and fun environments. Information related to the cognitive and affective components of physical literacy will be highlighted to ensure true definition of physical literacy is understood.
6-G	<b>John Weatherup</b> The Canadian Union of Public Employees (CUPE)	<b>Healthy Learning: HL2, The Determinants of Brain Health</b> This presentation will describe a demonstrations project in Toronto schools that link mental wellness, healthy eating, and physical activity to intergenerational activities with seniors by utilizing a healthy schools approach. This innovative program began in Thistledown Secondary School and they partnered with George Brown College. Since then this program has expanded to other schools with an emphasis on healthy living and student employment. Participants will be sure to leave this workshop inspired and motivated to make a difference in their school community.

## Breakout Session Descriptions

### Session Seven - Thursday, April 10<sup>th</sup> 2:15 – 3:15

Code	PRESENTER	DESCRIPTION
7-A	<p><b>Jacqui Strachan and Margaret Good</b> People for Education and OPHEA</p>	<p><b>Working Together for Healthy Schools and Communities</b></p> <p>Everyone has a role to play in supporting the physical, mental and emotional well-being of our students. By bringing school staff, students, parents, and government and community organizations together, healthy school communities can become a reality. In this session, we'll share practical tips, tools and strategies for engaging the broader community in a student health initiative. Participants will have an opportunity to share successes and discuss any challenges they have experienced in engaging diverse stakeholders in implementing healthy school initiatives.</p>
7-B	<p><b>Michelle Cowin, Lisa Kelliher and Youth from London</b> Middlesex London Health Unit</p>	<p><b>Engaging Youth Through Social Media</b></p> <p>"Youth Create Healthy Communities" is a youth advocacy group that takes action on their own health issues. They have gathered together to attempt to change the bylaw for youth transportation in the City of London and will share their experience. They also wanted to increase knowledge about the influence the media has on youth health behaviors so they brought together youth to develop short videos that are youth friendly and attractive.</p>
7-C	<p><b>Marisa Mariella and Halina Salciccioli</b> Hamilton-Wentworth Catholic School Board- Bishop Ryan and Cardinal Newman Catholic Secondary Schools</p>	<p><b>iMATTER: Taking Care Of Teen Mental Health</b></p> <p><i>Taking Care of Teen Mental Health</i> is an award-winning evidence-based initiative implemented in many caring secondary schools across Ontario. Based on best practices, <i>iMATTER</i> uses peer power to dispel myths, break stigma, and build empathy.</p>
7-D	<p><b>Zsuzsi Trim and Jacqui Candlish</b> Hamilton Public Health Service</p>	<p><b>The Hamilton Helmet Initiative (HHI) - A Comprehensive Approach to Reducing Brain Injury</b></p> <p>The session will highlight the approach used to establish the HHI to: support access to high quality, subsidized helmets for summer and winter sports, coordinate access to free helmets to student and families, including support helmet related programs, and materials for use within the community such as: Sport Helmet Campaign packages and posters; helmet fitting signage; video, cards and posters; safety checklist; and sample articles.</p>
7-E	<p><b>Suzanne Zwarych</b> CAMH Centre for Prevention Science</p>	<p><b>Supporting Parents and Schools Through Technology: Using Webinars and an Online Community of Practice</b></p> <p>This session will highlight a project funded by the Ontario "parents reaching out" grant to provide a forum for parents to access information on current issues such as cyberbullying, mental health, and media violence. Live webinars were offered to overview the topics and a community of practice was created where parents posted messages, reviewed resources, and dialogued with other parents. All participants will be provided with the website link to access the recorded webinars and have the opportunity to review the process.</p>
7-F	<p><b>Lynn Campanella</b> Entrepreneur</p>	<p><b>The Importance of Physical Play</b></p> <p>Not every child will be an athlete but every child should be shown proper techniques to be physically literate and the best way to practice these techniques is through play. Play is a natural process for accelerated learning, yet some people still perceive Play to be a frivolous time-waster. In this workshop we discover the definition, the value and the benefits of Play. Not only will we discover more about the science of Play but we will play various games that will easily increase the confidence and competency level of the students we work with.</p>
7-G	<p><b>Dr. Dean Kriellaars</b> Associate Professor, School of Medical Rehabilitation, Department of Physical Therapy, University of Manitoba.</p>	<p><b>The Importance of Physical Literacy for All Children</b></p> <p>Dr. Kriellaars will provide basic information about the concept of physical literacy and the tools available that can be used by teachers, parents, coaches and recreation coordinators to assist in the development of physically literate children and youth.</p>

## Conference Registration Planning Template

Please use this template to assist in planning and submitting the registration and workshop selections. This is not to be used as a mail in registration form.

All conference registrations must be made on-line at - <http://www.karelo.com/register.php?BID=532&BT=10&Ev=11814>

Please be prepared to supply the following information

Name				Title
Organization				
Address				
City				Province
Email				Phone
Food Allergies	Please Circle	YES	NO	
Please Explain Dietary Requirements				
Accessibility	Please Circle	YES	NO	
Please Describe				

### Breakout Sessions

Please prepare the breakout selections for each of the sessions by selecting from the list below. Please refer to the full conference brochure for descriptions of each breakout workshop.

Wednesday, April 9 <sup>th</sup>			
Session 1 10:30-11:30	Session 2 12:30- 1:30	Session 3 1:45 – 2:45	Session 4 3:00-4:00
<input type="checkbox"/> 1-A	<input type="checkbox"/> 2-A	<input type="checkbox"/> 3-A	<input type="checkbox"/> 4-A
<input type="checkbox"/> 1-B	<input type="checkbox"/> 2-B	<input type="checkbox"/> 3-B	<input type="checkbox"/> 4-B
<input type="checkbox"/> 1-C	<input type="checkbox"/> 2-C	<input type="checkbox"/> 3-C	<input type="checkbox"/> 4-C
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<input type="checkbox"/> 1-E	<input type="checkbox"/> 2-E	<input type="checkbox"/> 3-E	<input type="checkbox"/> 4-E
<input type="checkbox"/> 1-F	<input type="checkbox"/> 2-F	<input type="checkbox"/> 3&4-F	<input type="checkbox"/> 3&4-F

Thursday, April 10 <sup>th</sup>		
Session 5 9:30-10:30	Session 6 1:00 – 2:00	Session 7 2:15-3:15
<input type="checkbox"/> 5-A	<input type="checkbox"/> 6-A	<input type="checkbox"/> 7-A
<input type="checkbox"/> 5-B	<input type="checkbox"/> 6-B	<input type="checkbox"/> 7-B
<input type="checkbox"/> 5-C	<input type="checkbox"/> 6-C	<input type="checkbox"/> 7-C
<input type="checkbox"/> 5-D	<input type="checkbox"/> 6-D	<input type="checkbox"/> 7-D
<input type="checkbox"/> 5-E	<input type="checkbox"/> 6-E	<input type="checkbox"/> 7-E
<input type="checkbox"/> 5-F	<input type="checkbox"/> 6-F	<input type="checkbox"/> 7-F
<input type="checkbox"/> 5-G	<input type="checkbox"/> 6-G	<input type="checkbox"/> 7-G

*The 2014 OHSC National Conference Planning Committee Members:*

Linda Steel, Conference Co-Chair, Trustee, *London District Catholic School Board*

Arlene Morell, Conference Co-Chair, President, *Thames Valley Council of Home and School Associations*

Christine Preece, OHSC Co-Chair, Manager, Child and Youth Team, *Middlesex-London Health Unit*

Sarah Jackson, Program Manager, Healthy Promoting Schools,  
*Physical & Health Education Canada*

Dr. Jacqui Specht, Director, Canadian Research Centre on Inclusive Education, Faculty of Education, *Western University*

Dr. Suzanne Zwarych, *Project Scientist, Centre for Addiction and Mental Health, Western University*

Joyce Bennett, Trustee and Past Chair, *Thames Valley District School Board*

Rita Girioux-Patience, Trustee, *Conseil scolaire Catholique Providence*

Maryse Heroux, Directrice adjointe, Ecole elementaire Marie Curie, *Conseil scolaire Viamonde*

Monique Castonguay, Directrice de projets speciaux, *Conseil scolaire Catholique Providence*

Sandasha Ferguson, Community Police Services Officer, *London Police Service*

Darrell Jutzi, Manager, Quality Assurance and Professional Practice,  
*Elgin-St. Thomas Public Health Unit*

Sue McMahon, Curriculum Resource Teacher, Health and Physical Education,  
*London District Catholic School Board*

David Inglis, Learning Coordinator, Health & Physical Education and Student Success, *Thames Valley District School Board*

Jaxson Khan, Student Representative, *Western University*

Katherine Steel-Reurink, Student Representative, *London District Catholic School Board and Western University*

Page Forron, Student Trustee, *Thames Valley District School Board*

Blake Van Berlo, Student Trustee, *London District Catholic School Board*

Suzanne Vandervoort, Manager, Child and Youth Team, *Middlesex-London Health Unit*

Lisa Kelliher, Health Promoter, *Middlesex-London Health Unit*

Angela Armstrong, Project Manager, *Middlesex-London Health Unit*



*The 2014 OHSC National Conference Planning Committee Partners:*



◊ Coalition ontarienne des écoles en santé ◊  
◊ Ontario Healthy Schools Coalition ◊



**Western Education**



**London District Catholic School Council**



## School Engagement Assessment Tool (SEAT)

School Name: \_\_\_\_\_

Principal/Vice Principal: \_\_\_\_\_

Date: \_\_\_\_\_

PHN: \_\_\_\_\_

Why am I collecting this information?

- This **annual** school assessment is intended to assist public health practitioners and school administrators in determining readiness for engaging in a healthy schools approach. This assessment process will assist us with prioritizing our work and help determine level of services to schools for this year. Your school board is aware of this process.

It will allow us to determine:

- The level of service to provide based on resources available
- How to help you best and where to focus resources within the school

### Notice of Collection:

The Information obtained during this interview is collected under the authority of the Health Protection and Promotion Act and applicable privacy legislation. This information will be used for delivery of public health programs and services and may be used for evaluation or statistical/research purposes. Any questions about the collection of this information should be directed to the MLHU Privacy Officer, Middlesex-London Health Unit, 50 King Street, London, ON N6A 5L7, (519) 663-5317 x 2251 Fax: (519) 663-9413 or e-mail: [privacy@mlhu.on.ca](mailto:privacy@mlhu.on.ca)

1. How long have you been a Principal/Vice-Principal at this school? \_\_\_\_\_ (No Score)
2. Have you had any experience working with the healthy schools approach? A 'healthy school' promotes the physical, mental, social and spiritual health of the whole school community and constantly strengthens its capacity as a healthy setting for living, learning and working. (Capacity)
  - No experience =0
  - Some experience = 1
  - A lot of experience =2
  - Unsure = 0
3. How well do you think the healthy schools approach fits your education mandate and benefits your school community? (Readiness)
  - Not at all = 0
  - Somewhat = 1
  - Very well = 2
4. How would you describe the 'health' of your school community?  
(Think about 'health' in terms of holistic referring to physical, social, spiritual, mental and emotional health) (Need)
  - Poor health = 2
  - Moderate health = 1
  - Good Health = 0

5. What are the top three areas of health you see as a concern at your school? (No Score- Need)

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6. The healthy schools model can be used to address the concerns you identified above. This would involve a comprehensive approach using the following: parent engagement, student engagement, health curriculum, community partnerships and environmental supports.

a) Which of these strategies are you currently using to address the above concerns? Please a check mark in each box. (feel free to include examples if it is helpful for you) (Capacity)

Health Topic	Parent Engagement	Student Engagement	Quality Health Curriculum	Community Partnerships	Environment Supports (Physical and Social)

Each check mark = 1 point.

Add all check marks to get a score out of 15.

Choose the score for 6a from the below rating scale.

0-4 = 0

5-9 = 1

10-15 = 2

b) Are there any gaps in addressing the above concerns? (Need)

Health Topic	Parent Engagement	Student Engagement	Quality Health Curriculum (lesson plans, resources needed?)	Community Partnerships	Environment Supports (Physical and Social)

Each check mark = 1 point.

Add all check marks to get a score out of 15.

Choose the score for 6b from the below rating scale.

0-4 = 0

5-9 = 1

10-15 = 2

7. Considering how many priorities principals have, how likely would you be to rank healthy school initiatives as a current high priority? (Readiness)

- Not at all likely =0
- Somewhat likely = 1
- Very likely = 2

8. Are there any barriers to implementing a healthy school approach at this time? (I.e. Do you have a champion? Staff buy in) (No Score – Capacity and Readiness)

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9. After our discussion about the healthy school approach are you willing to work with a Public Health Nurse to address your schools health concerns? (Readiness\*)

- Yes =1
- No = 0

10. Next Steps: After we summarize our assessment data for all schools I will follow up with you about your level of service. Do you have any other comments?

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*A study of*

# FOOD LITERACY

...among youth, young pregnant women and young parents who are at risk for poor health



## WHAT WE WANTED TO KNOW

1. What does food preparation mean to these groups?  
How do they feel about it?
2. What types of foods can they prepare?  
What do they commonly prepare?
3. How are they learning food skills?  
What do they want to learn?
4. What challenges do they face with preparing food?  
What strategies do they use?
5. What types of supports would help?

A Locally Driven Collaborative Project with health professionals from eight Public Health Units in Ontario

In-depth interviews with 85 young people, 16 to 25 years of age, in a mix of rural, urban and Northern places including:

- Chatham-Kent
- City of Hamilton
- City of Kawartha Lakes
- London
- Northumberland County
- Sudbury & District
- Waterloo
- Windsor-Essex County

## WHY THIS MATTERS

In our current food environment where processed convenience foods are readily available, expensive and often unhealthy, becoming food literate is a life skill that enhances resilience. Through youth and new parents, we have an opportunity to begin to influence a new generation of healthy eating.

# WHAT IS FOOD LITERACY

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- It is a set of skills and attributes that help people sustain the daily preparation of healthy, tasty, affordable meals for themselves and their families.
- It builds resilience, because it includes food skills (techniques, knowledge and planning ability), the confidence to improvise and problem-solve, and the ability to access and share information.
- It requires external support with healthy food access and living conditions, broad learning opportunities and positive socio-cultural environments.

“So if you learn how to make stuff from basically nothing, like just make it from different stuff that you have around the house, then you have something to eat.”

-Steve, age 18



“Before, I was living with a lot of other people and I cooked and baked for them. But it’s harder to cook for yourself than for fourteen people. I do like cooking, just not for myself.”

-Sadie, age 18



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## WHAT DID WE LEARN?

- The range of food skills among these young people is broad and evolves over time. They are motivated to prepare food because of factors that include:
  - Cost, taste, personal health, child health, independence, pleasure, and creativity
- Preferred ways of learning:
  - Direct experiential learning
  - School-based opportunities
  - Community cooking programs
- The most common reason for preparing their own food was “knowing what’s in it”
- Recipes and online learning were not a substitution for hands-on opportunities
- Many young people never used recipes and valued the ability to improvise
- Preparing food for others or with their children was a source of pride and satisfaction
- Confidence in the kitchen was higher among those who learned earlier in life

# WHAT DID THEY TELL US?

Food preparation is an important life skill for everyone. However, what they knew how to make and what they actually prepared on a daily basis depended on personal and environmental factors:

## Food Preparation Skills & Experience

- Ability to use food preparation utensils, appliances
- Ability to use recipes and follow instructions
- Ability to improvise with ingredients

## Organizational Skills & Experience

- Planning
- Budgeting
- Buying and storing food

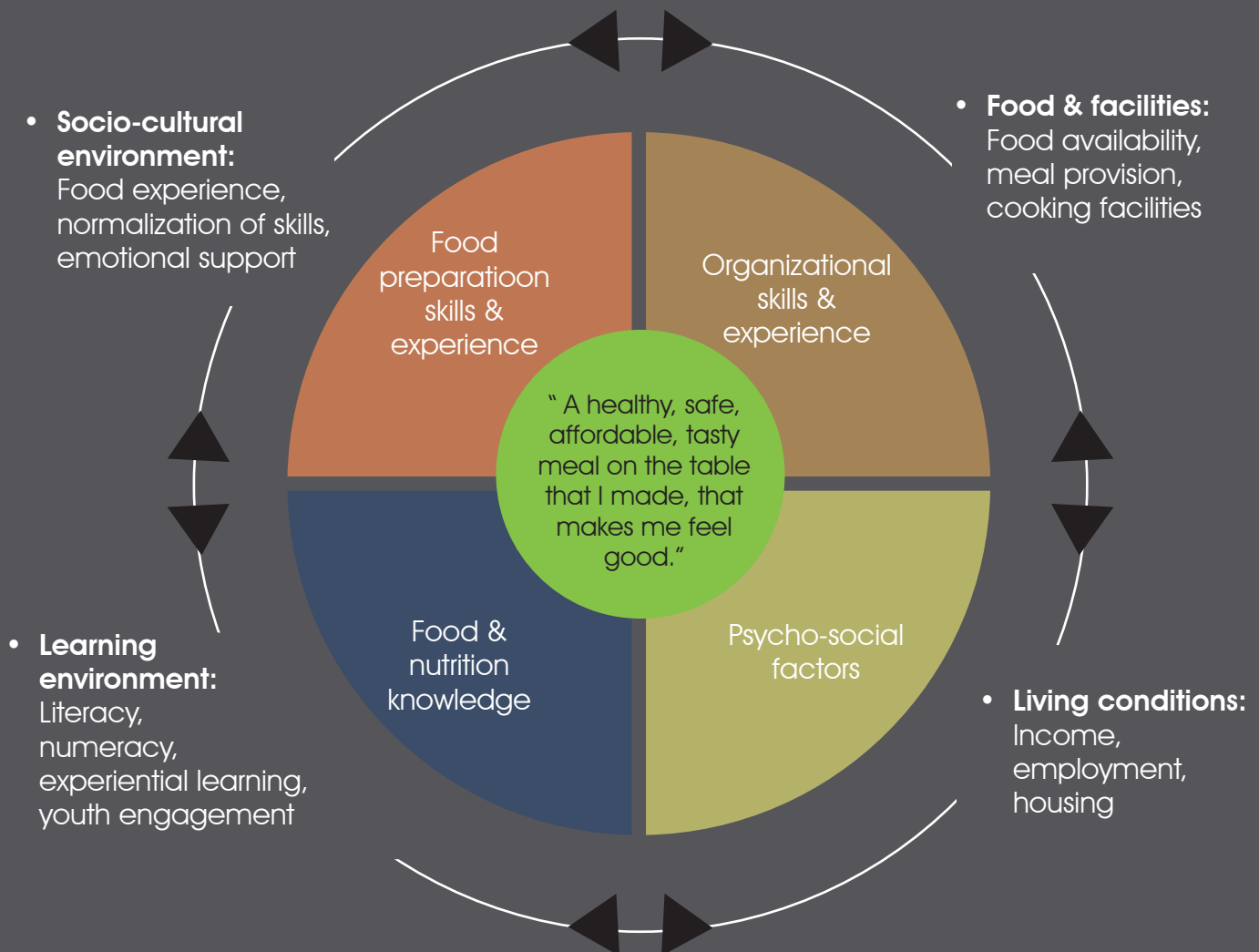
## Food & Nutrition & Knowledge

- Knowledge about food, nutrition, food safety
- Interpreting food labels, where to find information
- Where food comes from

## Psycho-Social Factors

- Satisfaction, creativity, social connectedness (eating together, transferring skills), feeling healthy
- Resilience, self-efficacy, confidence, control, household food security

# WHAT DETERMINES FOOD LITERACY?



## PROMISING PRACTICES:

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- Community Food Advisors or Peer Nutrition Programs
- Food Hubs or Centres

### Opportunities to incorporate food literacy into existing programs:

- Canada Prenatal Nutrition Program
- Healthy Babies, Healthy Children
- Student involvement in food preparation in cafeterias and student nutrition programs
- Ontario school curriculum
- Before and after school programs
- Good Food Box programs
- Community gardens
- Community kitchens

"I took a foods class at school for two years and then when I was pregnant, Building Healthy Babies used to do cooking classes so I learned stuff there. That was good because I realized I had to cook for myself so I might as well learn. It's just like you learned how to walk and you walk for the rest of your life. So if you are taught in simple ways that's easy to remember, patterns of how you do things like how you cut onions and tomatoes – like I showed my sister how to do it and now she has no problem to do it."  
– Anya, age 21, 3 children

"When I move out is when I'm starting to cook on my own. My dad always kind of like showed me, but no -- I've never tried anything. So now I found this little apartment and I figure I have only \$150 for food each month, and like I'm scared, man. Like I was just starting to do my budgeting thing, and I'm going to go out shopping for food, and I need some pots and pans too."  
- Jay, age 17

## WHAT CAN WE DO?

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- Public health units have an important role in building community capacity for food literacy programs and partnerships.
- Incorporate food literacy into the school system:
  - Curriculum and classroom
  - Before and after programs
  - Community use of schools
- Increase the number of community programs with a cooking component, in both rural and urban areas.
- Train teachers and food skills facilitators to combine food literacy programs with resiliency building.
- Encourage parents/teachers to involve children in age-appropriate food preparation from a young age.
- Advocate for affordable housing with functional kitchens, and increased access to healthy food.
- Create programs that build job skills e.g., incubator kitchens, culinary training, food service, catering, safe food handler courses.
- Advocate for adequate program funding and appropriate kitchen facilities in community settings.

The team gratefully acknowledges funding received from Public Health Ontario through the Locally Driven Collaborative Projects program. The views expressed in this publication are the views of the project team and do not necessarily reflect those of Public Health Ontario. The technical report for this study "Making something out of nothing": Food literacy among youth, young pregnant women and young parents who are at risk for poor health", 2013 is available at [www.osnp-ph.on.ca/resources/index.php](http://www.osnp-ph.on.ca/resources/index.php)





THE BURNING TRUTH

# TANNED SKIN IS NOT HEALTHY SKIN

**DON'T GET *BURNED* BY TANNING MYTHS**

## #TanMyth

Some people believe the tanning bed gives them a "healthy glow".

## #BurningTruth

Whether tanning or burning, you are exposing yourself to harmful UV rays that damage your skin. In fact, every time you tan, you increase your risk of melanoma. The truly healthy glow is the one you were born with.

@cdc\_cancer \* [www.cdc.gov/cancer/skin/burningtruth/](http://www.cdc.gov/cancer/skin/burningtruth/) \* #burningtruth



National Center for Chronic Disease Prevention and Health Promotion  
Division of Cancer Prevention and Control





TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 May 15

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## **MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – MAY**

### ***Recommendation***

***It is recommended that Report No. 036-14 re Medical Officer of Health Activity Report – May be received for information.***

The following report highlights activities of the Medical Officer of Health (MOH) from the April Medical Officer of Health Activity Report to May 2, 2014.

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

- April 10 Attended the Coming Together: Supporting the Whole Child Forum, co-hosted by MLHU and the Ontario Healthy Schools Coalition
- April 11 Introductory meeting with Dr. Denise Goens, Clinical Research Lab, Western University
- April 14 Co-presented the CE Beynon Award with Charlene Beynon to Melanie
- April 15 Attended the South West Primary Care Congress with family physicians, nurse practitioners and others from across SW Ontario
- April 15 Introductory meeting with Ms. Susan Truppe, MP, London North Centre
- April 16 Met with Dr. Maureen Carew regarding the Panorama system
- April 17 Met with Brian Meehan and Roxanne Riddell to plan United Way fundraising within the municipal sector
- April 18 Raised funds for the London Abused Women's Centre in The 22nd Annual McFarlane Rowlands Downtown 5K Run & CEO 1K, placing first in the CEO Challenge in Victoria Park.
- April 22 Met with Dr. Hsiu-Li Wang to discuss FoodNet implementation
- April 23 Attended the South West LHIN Health System Leadership Council Meeting at the Stratford General Hospital.
- April 24 The MOH attended Middlesex Municipal Day. The theme was *Working Together in Middlesex County*. The community of Strathroy-Caradoc hosted this year's event which was held in the Mt. Brydges Community Centre.
- April 28 Participated in the first CUPE negotiations meeting. Proposals were exchanged.

- April 29 Met with Ms. Sandra Coleman, CEO of CCAC, to discuss taking the role of co-chair on the LHIN's Health Systems Leadership Council
- April 30 Met with Dr. Amardeep Thind and Ms. Diane Bewick to discuss MLHU taking a paid role in developing a course for the new MPH course at Western University
- May 1 Attended the Board of Health Finance & Facilities Committee meeting
- May 1 Met with Mr. Brian Lester, Executive Director, Regional HIV/AIDS Connection, to tour RHAC's facilities and discuss Counterpoint resources.



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