AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2014 June 19

Mission - Middlesex-London Board Of Health

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

Members Of The Board Of Health

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

Secretary-Treasurer

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:05 – 7:15 p.m.	Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item #1 - Finance and Facilities Committee Meeting: June 12, 2014
7:15 – 7:30 p.m.	Ms. Mary Lou Albanese and London Community Foundation re Item #3 - London Official Plan
7:30 – 7:45 p.m.	Ms. Shaya Dhinsa and Regional HIV Aids Connection re Item #2 - Ontario Harm Reduction Distribution Program: Distributing Safer Smoking Supplies

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance And Facilities Committee: June 12, 2014 Meeting (Report 038-14)	Appendix A June 12 Agenda	x	x		To receive information and consider recommendations from the June 12th FFC meeting
Delegation and Recommendation Reports						
2	Ontario Harm Reduction Distribution Program: Distributing Safer Smoking Supplies (Report 039-14)	Appendix A	x	x		To seek Board of Health approval to provide safer smoking supplies to users to decrease the transmission of HIV, Hepatitis C and other communicable diseases.
3	MLHU Input To "The London Plan" (Report 040-14)		x	x		To consider the role of the Health Unit with respect to the proposed London Official Plan
4	London Road Safety Strategy (Report 041-14)	Appendix A		x		To ask the Board of Health to endorse the Board Chair to sign the London Road Safety Charter with other road safety partners
Information Reports						
5	Summary Information Report June 2014 (Report 042-14)	Appendix A Appendix B			x	To provide a summary of various Health Unit programs in Family Health Services and Environmental Health & Chronic Disease Prevention Services
6	Medical Officer of Health Activity Report – June Report (Report 043-14)				x	To provide an update on the activities of the MOH for June

CONFIDENTIAL

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

OTHER BUSINESS

Next Board of Health Meeting: Consider cancelling July or August
Next Finance and Facilities Committee Meeting?

CORRESPONDENCE

a) Date: 2014 April 29 (Received 2014 May 7)
Topic: Follow up to letter from MLHU re Bill 62, Making Healthier Choices Act
From: The Honourable Deb Matthews, Minister of Health and Long-Term Care
To: Mr. Marcel Meyer, Chair, Board of Health

b) Date: 2014 May 21 (Received 2014 May 26)
Topic: Maintaining Preventative Dental Services in the Ontario Public Health Standards
From: Copy of correspondence from Mr. Barry Ward, Chair, Simcoe Muskoka District Health Unit
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

c) Date: 2014 May 21 (Received 2014 May 26)
Topic: Violations of the International Code of Marketing of Breast Milk Substitutes by Manufacturers in Canada
From: Copy of correspondence from Mr. Barry Ward, Chair, Simcoe Muskoka District Health Unit
To: The Right Honourable Stephen Harper, Prime Minister of Canada

d) Date: 2014 May 22 (Received 2014 May 22)
Topic: Fact Sheet and Web Page for Provincial Candidates during 2014 Ontario Election Campaign
From: Copy of correspondence from Dr. Charles Gardner, Medical Officer of Health, Simcoe Muskoka District Health Unit
To: Chairs, Boards of Health

e) Date: 2014 June 9 (via email)
Topic: Questionnaire Response: 2014 Middlesex-London Health Unit Election Survey
From: Ms. Deb Matthews, Provincial Liberal Candidate, London North Centre
To: Mr. Dan Flaherty, Manager, Communications

f) Date: 2014 June 11 (via email)
Topic: Disposition of Resolutions from 2014 alPHa Annual General Meeting
From: Ms. Susan Lee, Manager, Administrative & Association Services, Association of Local Public Health Agencies (alPHa)
To: All Board of Health Members

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

ADJOURNMENT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 038-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 June 19

FINANCE AND FACILITIES COMMITTEE: JUNE 12, 2014 MEETING

The Finance and Facilities Committee (FFC) met at 9:00 a.m. on June 12, 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
2013 Draft Financial Statements 027-14FFC	Mr. David Ross, Audit Manager, and Mr. Ian Jeffries, Partner, KPMG LLP, presented the Audit Findings Report for the year ending December 31, 2013.	It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance & Facilities Committee review and make recommendation to the Board of Health to approve the audited Financial Statements for the Middlesex-London Health Unit, December 31, 2013 as appended to Report No. 027-14FFC.* Carried
Benefit Provision - Administrative Services Only (ASO) 026-14FFC	Mr. Anthony Raheb and Ms. Patti Landry, Consultants, Aon Hewitt, presented a review of Benefit Funding for the Health Unit.	It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance & Facilities Committee receive Report No. 026-14FFC for information with respect to the benefit funding arrangements for Middlesex-London Health Unit (MLHU).*Carried
Office Space Needs Assessment 028-14FFC	The FFC reviewed the work plan an architectural firm is using to develop technological and process changes required in an alternative work environment.	It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance & Facilities Committee receive Report No. 028-14FFC re Office Space Needs Assessment for information*. Carried
Financial Policies – Group #2	DEFERRED	

Confidential

The FFC considered matters in camera concerning personal matters about an identifiable individual, a proposed or pending acquisition of land by the Middlesex-London Board of Health and labour relations or employee negotiations.

Next Meeting

The next meeting of the Finance and Facilities Committee will Thursday, July 3, 2014 at 9:00 a.m.

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

PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2014 June 12 9:00 a.m.

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. Lisa Ellington, Payroll & Benefits Analyst
Mr. Ian Jeffries, Partner, KPMG LLP
Ms. Patty Landry, Aon Hewitt
Mr. Anthony Raheb, Health and Benefits Consultant, Aon Hewitt
Mr. David Ross, Audit Manager, KPMG LLP

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

DISCLOSURES OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Mr. Bolton, seconded by Mr. Meyer *that the Agenda for the **June 12, 2014** FFC meeting be approved.*

Carried

NEW BUSINESS

2013 Draft Financial Statements (Report 027-14FFC)

Mr. John Millson, Director, Finance & Operations assisted Committee members with their understanding of this report.

After a discussion about the depreciation value of Health Unit capital assets such as furniture, computers and vehicle(s), Mr. Millson introduced the representatives from KPMG LLP.

Mr. David Ross, Audit Manager, and Mr. Ian Jeffries, Partner, KPMG LLP, presented the Audit Findings Report (Appendix B to **Report 027-14FFC**) for the year ending December 31, 2013.

In response to a question regarding the Committee's role in bank reconciliations and statutory remittances, Mr. Jeffries recommended that Committee members should periodically ask the Director, Finance and Operations, to confirm that such processes are completed in a timely manner.

At 9:50 a.m., it was moved by Mr. Peer, seconded by Mr. Bolton *that the Finance and Facilities Committee move in camera to discuss matters concerning personal matters about an identifiable individual.*

Carried

At 10:10 a.m., it was moved by Mr. Peer, seconded by Mr. Bolton *that the Finance and Facilities Committee return to public forum and report that matters concerning personal matters about an identifiable individual were discussed.*

Carried

Mr. David Ross and Mr. Ian Jeffries, KPMG LLP, left the meeting at 10:10 a.m.

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance & Facilities Committee review and make recommendation to the Board of Health to approve the audited Financial Statements for the Middlesex-London Health Unit, December 31, 2013 as appended to Report No. 027-14FFC.*

Carried

Benefits Funding review - Benefit Provision - Administrative Services Only (ASO) (Report 026-14FFC)

The FFC agreed that Report 026-14FFC re Benefits Funding review - Benefit Provision - Administrative Services Only (ASO) could be discussed in a public forum. It was agreed that Report 026-14FFC and its appendix will be posted online with the June 12, 2014 agenda.

Mr. Anthony Raheb and Ms. Patti Landry, Consultants, Aon Hewitt, assisted Committee members with their understanding of this report. Mr. Millson also introduced Ms. Lisa Ellington, Payroll and Benefits Analyst with the Health Unit.

Mr. Bolton left the meeting at 10:30 a.m.

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance & Facilities Committee receive Report No. 026-14FFC for information with respect to the benefit funding arrangements for Middlesex-London Health Unit (MLHU).*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Public Minutes from the May 1, 2014 Finance and Facilities Meeting be approved.*

Carried

NEW BUSINESS

Office Space Needs Assessment (Report 028-14FFC)

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance & Facilities Committee receive Report No. 028-14FFC re Office Space Needs Assessment for information.*

Carried

At 11:00 a.m., it was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee move in camera to discuss matters concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health and labour relations or employee negotiations.*

Carried

At 11:30 a.m., it was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance and Facilities Committee return to public forum and report that matters concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health and labour relations or employee negotiations were discussed.*

Carried

It was agreed that Report 029-14FFC re Financial Policies – Group #2 be deferred until a future meeting.

OTHER BUSINESS

The next meeting will be July 3, 2014, at 9:00 a.m. The Committee agreed to cancel the meeting scheduled for August 7, 2014.

ADJOURNMENT

At 11:32 a.m., it was moved by Mr. Meyer, seconded by Mr. Peer *that the meeting be adjourned.*

Carried

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TRISH FULTON
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 039-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 June 19

ONTARIO HARM REDUCTION DISTRIBUTION PROGRAM: DISTRIBUTING SAFER SMOKING SUPPLIES

Recommendation

It is recommended that the Board of Health approve the distribution of safer smoking supplies through the existing harm reduction sites.

Key Points

- Nearly half of injection drug users in London report also using crack in the preceding six months.
- Cocaine smoking is increasing across Ontario and is a public health concern.
- Limited availability of safer smoking supplies have resulted in sharing of supplies. This may lead to increased infections and use of makeshift equipment that can cause injury.
- Distributing safer smoking supplies is expected to decrease the transmission of HIV, Hepatitis C and other communicable diseases among people who smoke crack cocaine.

Crack Cocaine Use in Middlesex-London

Crack cocaine smoking is increasing across Ontario and is a public health concern. The 2012 Report on the Public Health Agency of Canada I-Track Survey of injection drug users revealed that 48.5% of Middlesex-London respondents reported crack/freebase as a non-injection substance they had used in the six months prior to being interviewed. The 2014 report, Prescription and Non-Prescription Drug Use and Their Impacts in Middlesex-London, noted the following information:

- 7.6% of the general population in Middlesex-London reported having ever tried cocaine or crack
- Generally, no significant differences were seen between Middlesex-London and Ontario rates for *stimulant-related emergency department visits*
- While different patterns of *stimulant-related hospital admissions* were noted, there were no statistical differences between the rates for Middlesex-London and Ontario.
- *Crack- and cocaine-related admissions to substance misuse and addictions programs* decreased in Middlesex-London and were lower than Ontario rates. In 2013 for Middlesex-London, crack was reported as a presenting problem substance for 220 per 1,000 admissions, and the rate for cocaine was similar at 213 per 1,000 admissions.

While the report points out that crack/cocaine use in Middlesex-London is generally lower than in the province, it is still an issue that we need to acknowledge and address.

Evidence of Effectiveness of Safer Smoking Supplies Distribution

A literature review completed by the Ontario Harm Reduction Distribution Program in April 2014 (Appendix A) highlighted a number of findings related to the effectiveness of safer smoking programs, such as the following:

- There was a decrease in sharing previously-used supplies and an increase in using safer supplies
- The frequency of re-using a stem decreased from 288 times down to 40 times (11 months after implementation)

- Use of metal pipes (as opposed to glass stems) decreased by 29%, the use of inhalers (as opposed to mouthpieces) by 27%, the use of pop cans (as opposed to glass stems and mouthpieces) by 27%, and the use of car antennae (as opposed to wooden push sticks) from 7% - 1%. All declines were highly statistically significant.
- The proportion of study participants sharing pipes 'every time' decreased from 37% to 13%
- Offering safer smoking supplies created opportunities to teach people who use crack about safer smoking and crack use practices, and to engage those who use crack in services such as income assistance, addiction treatment and health care

Harm Reduction Efforts

Safer crack use kits have been distributed in numerous cities in all regions of Canada, including but not limited to Toronto, Edmonton, Winnipeg, Ottawa, Vancouver, Yellowknife, Halifax, Montreal, and Guelph. Some of these programs have been successfully integrated into public health programs, and some municipal governments have publicly outlined why such programs are important. In June 2007, a Vancouver Island Health Authority pilot program was temporarily placed on hold due to community and city council concerns. However, in 2008 the program was reinstated and expanded across Vancouver Island. The Ministry of Health in B.C. has distributed crack pipe mouthpieces through outreach workers in needle exchange and other community health services since 2008. In 2011, the Vancouver Coastal Health Authority launched a free crack-pipe pilot program that distributed 60,000 pipes per year in the Downtown Eastside, driving prices down (previous pipe prices of up to $10 had been creating situations of violence). Ottawa Public Health has had a safer crack use kit distribution program since 2005. The program was originally developed in April 2005 by Ottawa Public Health and continued until July 2007 when the Ottawa City Council in its capacity as the Ottawa Board of Health withdrew its support of the program. In December 2007, following a proposal by community agencies, the program was reinstated by Ontario's provincial government. Several published studies of Ottawa Public Health's safer crack kit distribution program show evidence of a gradual change in behaviours to reduce the risk of HIV and HCV transmission, and evidence of transitioning from a higher risk method of drug use (i.e. injecting) to one with lower risks (i.e. smoking).

Ontario's Needle Syringe Programs (NSPs) have successfully expanded the reach and availability of harm reduction supplies to people who inject drugs to help mitigate the risks associated with drug use. However, considerable disparity remains between efforts aimed at reducing harms among people who inject drugs, and people who smoke crack cocaine.

The Ontario Harm Reduction Distribution Program (OHRDP) conducts annual surveys with Ontario's 36 core NSPs to ensure they are meeting community needs and current trends. The 2013 survey contained a section on safer smoking, and results showed that 88% of NSPs saw a need to distribute safer smoking supplies, 49% indicated they would consider distributing safer smoking supplies and 36% said were already in the process of distribution. Seven of the NSP's indicated they would not distribute safer smoking supplies due to financial and political barriers. As a result of the survey, OHRDP with support from the AIDS and Hepatitis C Programs at the Ministry of Health and Long Term Care, are providing provincially-funded safer smoking supplies to the 36 core Needles Syringe Programs in Ontario.

Health Units currently offering Safer Inhalation kits through their NSPs include: Elgin St. Thomas, Haldimand Norfolk, Sudbury, Halton, Hamilton, Toronto, Haliburton Kawartha, Durham Region, Wellington Dufferin Guelph, and Thunder Bay. Health Units in Waterloo Region, Oxford County, and Eastern Ontario will be offering Safer Inhalation Kits as of July 2014.

Benefits to Supplying Safer Smoking Supplies

Supplying safer smoking supplies provides benefits at both individual and population levels. At the individual level, there is generally a decrease in risky health behaviours (such as sharing supplies) and an increase in positive health behaviours. There is some evidence that the availability of safer smoking supplies may reduce the frequency of injecting drugs. Offering safer smoking supplies can 1) create the opportunity

to connect those who use crack to existing services such as income assistance, addiction treatment, and health care; 2) decrease the sharing of drug smoking paraphernalia; and 3) provide opportunities to teach people who use crack about safer smoking and crack use practices. At the population level, in communities where safer smoking programs exist there is decreased transmission of communicable diseases associated with crack use, which translates into less risk of disease transmission within the larger community. Given the high incidence rates of HIV and Hepatitis C among those who engage in crack use, preventing disease transmission through the distribution of safer smoking supplies may reduce costs to the healthcare system.

Safer Inhalation Kits in Middlesex-London

Counterpoint Harm Reduction Services will support the roll-out of the Safer Inhalation Program in Middlesex-London through education, community engagement and rapport building with service users through their fixed sites and outreach program. Service Users will be provided training on new methods of safer smoking practices. Visual education through posters and pamphlets, as well as dialogue with individuals to discuss practices and recommendations will occur during visits to the exchange and on outreach. The key messages for service users will focus on the risks of crack smoking, when to replace and dispose of equipment, and the safe disposal of equipment. Community education will be part of the services offered with Safer Inhalation Kits. This will involve working in partnership with this Health Unit engaging in dialogue with London Police Services as well as community service providers to address questions and concerns and to provide evidenced based information on the impacts of providing safe inhalation equipment.

Conclusion

While rates of crack- and cocaine-related emergency department visits, hospital admissions and admission to substance misuse and addictions programs are lower in Middlesex-London than Ontario rates, they cannot be ignored. By providing safer smoking supplies, we will reduce the disparity in harm reduction efforts between those who inject drugs and those who smoke crack cocaine. We will be better positioned to reduce the harms associated with smoking crack cocaine, and expect to see benefits at both the individual and population level.

This report was prepared by Ms. Shaya Dhinsa, Manager, Sexual Health, Ms. Heather Lokko, Acting Director, OHCDSH, and Ms. Sonja Burke, Director, Counterpoint Harm Reduction Services.

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

Literature Review

Effectiveness of Safer Smoking Programs: Why it is important to distribute safer smoking supplies to those who smoke crack cocaine

Background: Crack cocaine use in Canada

Numerous studies conducted in Canada over the past 15 years indicate that crack cocaine use is on the rise. A study of people who use drugs in five Canadian cities (Vancouver, Edmonton, Montreal, Toronto, and Quebec City) found that 55% of participants had smoked crack in the past 30 days (Fisher et al. 2006). A Canadian surveillance report of 794 people who inject drugs found that 52% of the sample had also smoked crack cocaine in the last six months (Public Health Agency of Canada, 2006). In another longitudinal study among a cohort situated in Vancouver BC, the proportion of participants who reported daily crack use over a nine year period, increased from 12% in the first 3.5 years, to 27% in the next 3 years, to 40% in the final three years of the study (DeBeck et al. 2009).

> ***"Crack use …is becoming increasingly prevalent among Canadian street drug users"*** *- Fischer et al, 2006*

> ***"Among stimulant users, smoking crack is becoming the preferred method of drug administration over snorting and injecting due to its low cost, ease of ingestion and efficiency..."*** *-Leonard et al., 2011*

Many studies demonstrate fairly consistent characteristics of people who use crack cocaine. In a sample studied by Ivsins et al. (2011) people who use crack were characterized by unstable income (100%), reliance on government income assistance (81%), dealing drugs for support (58%), and being unstably housed (71%). The vast majority had legal problems (87%) and about half (52%) rated their health as 'fair' or 'poor'. Fischer et al. (2006) demonstrated similar findings, namely that crack cocaine users were less likely to be housed permanently, had no paid work in the previous month, and were more likely to engage in illegal activities such as sex work or drug dealing when compared to those who were non crack-users. Fischer et al. (2006) referred to people who use crack as the "marginalized of the marginalized" given the fact that compared to those who misuse other substances; those who engage in crack use have higher risks of social exclusion. Despite these unfortunate findings, Persaud et al. (2013) bring another perspective to crack cocaine use. In their qualitative research study of people with long term crack cocaine use, the research team found that for some, smoking crack was a form of 'controlling chaos' and provided a safer route of drug administration than injection drug use which was seen as having a higher risk of acquiring infectious diseases.

Despite the increase of crack cocaine use in Canada and the marginalization of people who use crack cocaine, harm reduction programs are targeted to those who inject drugs. This creates a missed opportunity to reduce harms associated with crack cocaine use (*see objective 1 below*) and connect people who smoke crack cocaine to health and social services.

Objectives

This literature review will provide Needle Syringe Programs (NSPs) in Ontario with information regarding:

1) **The harms associated with unsafe crack cocaine smoking practices**
2) **Best practice recommendations about supplies for safer crack smoking**
3) **The effectiveness of safer smoking programs**
4) **The findings from a survey conducted by Ontario Harm Reduction Distribution Program (OHRDP) of interest for safer smoking programs or programs currently underway in Ontario; and**
5) **Program implementation and considerations**

This literature review will help NSPs understand 1) why OHRDP will be offering safer smoking supplies to programs and 2) the importance of providing these supplies to service users.

Literature Review

Methods

A literature review was used to inform this report. The databases used were Medline, PsychInfo, Embase, Global Health**,** Ovid Healthstar**,** Health & Psychosocial Instruments, & the Cochrane Collaboration. Keywords searched were: safe inhalation, inhalation equipment, inhalation supplies, effectiveness, and crack kits. Material was also identified using a snowball search method using Google Scholar and articles suggested by key informants to account for the novelty of the topic and the likelihood that the research question has not yet been comprehensively indexed. Grey literature was incorporated due to relevancy regarding program design considerations. No limit was placed on country, year or language. This resulted in 14 studies reviewed, 3 of which were revealed via snowball sampling methods. References from commentaries were not included in the scientific review of results. All studies except three were conducted in Canadian settings.

OHRDP's 2013 Environmental Scan was used to inform objective 4 (survey of interest for safer smoking programs or programs currently underway in Ontario).

Results

Objective 1: The harms associated with unsafe crack cocaine smoking practices

Overview of findings

- Non-injection drug use has emerged as a risk factor for communicable diseases (Macias et al., 2008).
- Smoking crack is an independent risk factor for HIV sero-conversion among those who use drugs intravenously (DeBeck et al., 2009).
- Hepatitis C virus has been found on crack pipes, and if shared, could be a route of hepatitis C transmission (Tortu et al., 2004).
- Sharing equipment used for crack smoking has been shown to be independently associated with hepatitis C infection (Macias et al., 2008).
- A high proportion of people who smoke crack report having used another person's equipment (Ivsins et al., 2011).
- Limited accessibility to safer smoking supplies leads to shared drug smoking paraphernalia (Ti et al., 2011; Persaud et al. 2013).

Harms and Risks of Smoking Crack Cocaine:

There is evidence that HIV, HBV, HCV, pneumonia, and tuberculosis can be passed to others when crack smoking supplies are shared (Boyd et al., 2008; Fischer et al., 2007; Malchy et al., 2011). There are two health risk behaviours among people who smoke crack that may lead to the transmission of infection and/or injury:

1) Sharing smoking supplies despite cuts, burns, oral sores or blisters; and
2) Using sharp and damaged supplies that can wound the user (Ivsins et al. 2011).

Both behaviours create the opportunity for infected blood or saliva to be passed from one person to another. Furthermore, sharing supplies is an extremely common practice among those who engage in crack smoking. It has been reported that at minimum, 50-90% of the crack smoking population has used another person's supplies (Ivsins et al., 2011).

Most studies confirm that crack cocaine smoking is a risk factor (through association) for sero-conversion of HIV and HCV. The associations found are mostly noted as 'possible' due to participants' recall bias regarding past intravenous drug use and misuse of multiple substances. There are two major studies that contribute to our understanding that transmission of disease is highly plausible. In 2004, Tortu et al. found the presence of hepatitis

Literature Review

C virus on crack smoking supplies, and Macias et al., (2008) confirmed in their study that infected blood or saliva on crack smoking supplies could cause HCV to be transmitted if supplies are shared since there can be enough HCV RNA in blood coming from open sores, as well as in saliva, to be passed to another (this was established after extrapolating the work of Hermida et al., 2002). These findings may explain why some non-injection drug users, with no identified source of exposure, were infected with HCV (Kingston-Riechers, 2001). Other smoking supply components (*see objective 2*) in addition to the 'crack pipe' have been linked to the transmission of HCV. Sharing the inhalation tube (the mouthpiece) has also been found to be significantly associated with HCV infection.

> ***"Blood (from oral ulcerations) or saliva contamination of inhalation equipment could transmit quantities [of HCV] sufficient to surpass the critical threshold…necessary for productive infection"*** *-Macias, et al., 2008*

> ***"Those who engage in crack use often use damaged inhalation equipment, and share this with others despite having open wounds"*** *-Ivsins et al., 2011*

Regarding HIV, DeBeck et al., (2009) conducted a longitudinal study of over 1000 injection drug users (IDUs) who were HIV-negative at enrollment. In this particular study, it was found that smoking crack was an independent risk factor for HIV sero-conversion. Furthermore, with increased time engaging in crack smoking, increased risk of HIV seroconversion was seen with hazard ratio of 1.28 during the first study period, 2.27 in the second and 4.01 in the third (DeBeck et al., 2009). Overall, incidence of HIV infection among the participants was 2.7 (95% CI 2.2-3.1) per 100 person years, which meant that 13.1% of the participants became HIV positive during the 9.3 year study period. It was acknowledged that participants likely had more HIV positive people within their social networks, elevating the risk of HIV infection among these participants.

HIV/HCV and STI and other risk considerations:

Crack cocaine smoking has been associated with an increased risk of sexually transmitted infections (STIs). Shannon et al. (2008) created gender risk profiles comparing injection drug users (IDUs) who used crack with those who were classified as "never injectors". Higher rates of HIV and HCV were found among the "dual users"; however, researchers demonstrated that women IDUs who engage in crack use, engage in sexual networks with higher risks. The risks of transmitting HIV and HCV through unsafe sexual practices have long been established, as has been the fact that exchanging sexual acts (including oral sex), for substances (including crack), is a practice often employed when the individual has no other means to pay. Shannon et al. (2008) demonstrated that the strongest association with dual use was trading sex for drugs or money, and that women "dual users" are significantly more likely to exchange sex for drugs and money while intoxicated - putting them at an overall greater risk to contract an STI. In the same study, Shannon et al. (2008) demonstrated that HCV prevalence among those who engaged in crack use was 43%.

Malchy et al., (2011) make reference to evidence that indicates that pneumonia and tuberculosis can also be contracted when inhalation equipment is shared.

Barriers to Safer Crack Smoking:

The social, political, economic and physical environment all play a role in risks associated with smoking crack cocaine. This literature review focuses largely on strategies to mitigate the physical risk environment. People who smoke crack consistently report sharing crack pipes, a clear route of transmission of disease (Ivsins et al., 2011). This has been attributed to the limited availability of safer smoking supplies and/or confiscation of supplies by police (Ti et al., 2011; Persaud et al. 2013). Leonard et al. (2011) note that by increasing the accessibility of harm reduction supplies, sharing of drug smoking paraphernalia decreases. This is also supported by the work of Persuad et al. (2013) who also suggest that the way of mitigating the physical risk environment is by increasing safer crack smoking supply distribution.

Literature Review

Objectives 2: Best practice recommendations about supplies for safer crack smoking

To reduce the transmission of disease and prevent injury from makeshift equipment, safer smoking programs may offer the following supplies to those who engage in crack smoking.

Overview of best practice safer smoking supplies

Stems (crack pipes): Stems are used to channel vapors. Borosilicate glass "Pyrex®" stems are a safer alternative to regular glass stems because they are more resistant to heat and do not break as easily.

Screens (metal): Provide a barrier on which pieces of crack are placed and then heated. In community, steel wool or Brillo® is commonly used; however, pieces of steel wool products break off and when inhaled can burn lips and cause pulmonary problems if ingested.

Push Sticks: Are used to push screens into place within the stem. Wooden push sticks are preferred over metal because they are less likely to crack or chip stems.

Mouthpieces: A small length of vinyl tubing that covers the stem and prevents saliva and/or blood from being passed onto others when individuals use their own mouthpiece. Mouthpieces also prevent burns to lips that may be caused by heat conduction, and cuts from sharp stems.

Alcohol swabs: To clean equipment after use and to clean hands and surfaces before use. Please remember that cleaning supplies with alcohol swabs do not sterilize supplies or make them safe for sharing.

Optional items:

Lighter: Are a safer alternative to matches because a person is less likely to burn themselves. Malchy et al. (2011), also state that not having one's own "light" is also associated with unsafe circumstances (e.g. forced to share crack or experience harassment from others).

Bandages: To cover/protect open wounds.

Condoms/Lubricant: To encourage safer sex practices.

Information/resource cards: Offer harm reduction tips and a list of local resources relevant to the population.

*Commonly used terms: crack kits, safer crack use kits, or safer inhalation kits are used to make reference to the package of supplies that is distributed in a safer smoking program.
** This information is adapted from: the Harm Reduction Journal (Boyd et al., 2008), the Canadian Journal of Public Health (Malchy et al., 2011), and the Best Practices Recommendations for Canadian Harm Reduction Programs (Strike et al., 2013).

Up until 2014 in Ontario, the distribution of safer smoking supplies varied among programs as a result of there being no established provincial distribution program. The programs that have been distributing safer smoking supplies have been sourcing and purchasing their own supplies. According to best practices, supplies that should be made available include borosilicate glass stems, food grade rubber/vinyl mouthpieces, wooden push sticks and metal screens. These are the products now available to order through OHRDP by Ontario's 36 core NSPs.

There may be reluctance among service users to use screens as opposed to Brillo®. Boyd et al. discovered that only 42% of survey respondents who received safer crack kits used screens while 91% indicated that they usually or always use Brillo®. Reynolds et al., (2011) found similar practices among their study participants as did Ivsins et al., (2011). Brillo® is easy to manipulate when packing a stem; therefore, despite the fact that Brillo® disintegrates and is sometimes inhaled, service users prefer to use it. This indicates that this particular behaviour might be difficult to change. Some crack kits have had info cards explaining the dangers associated with using Brillo® (Boyd, et al., 2008). Demonstrating and offering hands-on practice on how to insert screens was found to be effective at increasing the frequency of which participants used the screen (Boyd et al. 2008).

Literature Review

Objectives 3: Effectiveness of safer smoking programs

Safer Smoking Program Findings:

- There was a decrease in sharing previously used supplies and an increase in using safer supplies following the implementation of safer smoking programming in Ottawa (Leonard et al., 2011; Medd et al., 2011).
- The proportion of study participants sharing pipes "every time" fell from 37% to 13% (Leonard et al., 2007).
- Smoking from a previously used pipe declined from 65% to 53% ($p<0.01$) (Leonard et al., 2011).
- The frequency of re-using a stem decreased from 288 times down to 40 times, 11 months after safer smoking programming was implemented (Leonard et al., 2011).
- Using metal pipes (as opposed to glass stems) decreased by 29%, the use of inhalers (as opposed to mouthpieces) by 27%, the use of pop cans (as opposed to glass stems and mouthpieces) by 27%, and using car antennae (as opposed to wooden push sticks) from 7% to 1%. All declines were found to be highly statistically significant (Medd et al. 2011).
- In 2006 at the 1 year evaluation point after the safer smoking programming was implemented in Ottawa, almost 94% of participants had accessed the safer smoking program (Leonard et al., 2007).
- Offering safer smoking supplies can create the opportunity to engage the sub-population who use crack through existing health services including income assistance, addiction treatment and health care (DeBeck et al., 2009).
- Contact with people who use crack by way of distributing safer smoking supplies presents the opportunity to teach people who use crack about safer smoking and crack use practices (Boyd et al. 2008).

This literature review highlights the need for safer smoking programs. Seven studies focused directly on the efficacy of such programs and initiatives. In one study conducted in Vancouver in 2007, qualitative interviews were completed with those who received safer smoking supplies. It was found that those surveyed had an interest in reducing harms associated with crack smoking practices (Boyd, et al., 2008). Participants in Boyd's study employed safer smoking practices by modeling what others were doing and what they had seen. Using brass screens instead of Brillo® was one example. Between demonstrations from outreach staff and peers, and hearing about the fact that screens are safer to use than Brillo®, participants reported that they used screens more often, especially so when the message and demonstrations were repeated (Boyd et al., 2008).

Another cross-sectional survey was done before and after safer smoking kits were distributed among recipients in Vancouver. The purpose of the study was to examine how the kits were used and to see what effects distributing the kits had on behaviours and crack-smoking practices. The authors indicated that 71% of the post-survey participants confirmed that they had received a kit. Among those who received a kit, stems and lighters were used by 98% of respondents and mouthpieces were used by 79%.

Three studies focused on evaluating the implementation of safer smoking programming in Ottawa in 2005. Each study investigated whether or not unsafe crack-smoking practices (e.g. sharing supplies or using unsafe supplies) declined following the enactment of the program. Interviewing and a cross-sectional design were the methods used. A significant decline in sharing was demonstrated in the first study (37% pre-implementation to 13% 12-months post, $p=0.001$). What was highlighted was the decline in injecting behaviour given the availability of safer smoking supplies. A supplementary increase in crack use via inhalation was also found; however, because a decrease in injection drug use had accompanied this change, researchers indicated that this was a positive behaviour given numerous other risks associated with intravenous drug use (Leonard et al. 2007). In another study it was found that smoking from a previously used crack pipe declined from 65% to 53% ($p<0.01$) (Leonard et al., 2011). In the same study, frequency of re-using a stem before discarding it was shown to decline as well. Two months after the implementation of the programming, participants reported re-using a glass stem 288 times; however, eleven months post-programming implementation, participants reported re-using a glass stem 40 times before throwing it away.

Literature Review

> ***"Many people who engage in crack use were aware that sharing paraphernalia carries the risk of spreading diseases"*** -Ivsins et al., 2011

> ***"Many attributed their reduction in injection frequency and increase in crack smoking to the new availability of safer crack-smoking supplies"*** *-Leonard et al., 2007*

In a study by Medd et al., 2011 based in Ottawa, the use of metal pipes (as opposed to glass stems) declined 29%, the use of inhalers (as opposed to mouthpieces) dropped 27%. Using pop cans (as opposed to glass stems and mouthpieces) dropped 27%, and using car antennae (as opposed to wooden push sticks) dropped from 7% to 1%. Overall, the use of unsafe equipment declined at a highly statistically significant level ($p<0.001$). It was concluded that the safer smoking program in Ottawa demonstrated effectiveness at reducing harms associated with crack use, and the need to continue implementing and evaluating this program was suggested by all researchers and their affiliates (Leonard et al., 2007; Leonard et al., 2011; Medd et al., 2011). Access to the program increased significantly during the 12-month study period, with 94% of participants indicating that they, or a person on their behalf, had accessed the program (Leonard et al., 2007). This was taken as an indicator that the safer smoking programming was meeting the previously unmet needs of the population engaging in crack use.

In another study, which took place in Victoria BC, benefits and barriers to safer smoking program implementation were assessed through interviews. Eligibility criteria for this study included crack use on at least half of the 30 days prior to the interview and crack use for longer than 6 months. Benefits revealed were categorized as: health, economic and social level benefits. Health benefits included a decreased need to share after having received a crack kit. Economic benefits included a decreased need to engage in sex work to be able to buy supplies. Social benefits included a decreased need to become hostile or physically aggressive with another person who engaged in crack use, when both had their own supplies to use. Another benefit revealed, at the societal level, was that increased access to equipment resulted in fewer participants having to vandalize property to make crack smoking supplies. (Ivsins et al., 2011)

Ti et al. (2011) conducted research regarding factors that were associated with accessing stems with two established study cohorts in Vancouver. Over a third (33%) of their study participants related difficulty gaining access to stems. What was more concerning was the fact that this was reported in places where the participants could access stems at either a low cost or for free if supply was available. The factors associated with difficulty in access were sharing stems ($p=0.01$), access to services ($p=0.02$), police presence ($p=0.01$) and sex trade involvement ($p=0.03$). These findings indicated that difficulty accessing stems is a strong predictor of having to share. The findings also support what has been stated previously: that those who engage in crack use experience barriers to many services, especially in this case, as "services" were defined to include any harm reduction, counselling, housing, police or health service. The authors hypothesized that this finding was likely due to stigmatization this group faces, referencing numerous other studies that support this notion. The fact that the presence of police interfered with access to pipes was unsurprising to the researchers.

Literature Review

Objective 4*: *Findings from a survey conducted by OHRDP of interest for safer smoking programs or programs currently underway in Ontario

OHRDP conducts annual surveys with its 36 core NSPs across Ontario to ensure that distributed supplies are meeting community needs and current trends. In the most recent Environmental Scan conducted in 2013, these sites were asked several questions about safer smoking; 33 of the 36 sites answered the section on safer smoking.

Results of the annual survey:

- 88% (29/33 sites) stated that they saw a need to distribute safer smoking supplies.
- 74% (23/31 sites) indicated that they required information on risks associated with crack smoking.
- 49% (16/36 sites) indicated that they would consider distributing safer smoking supplies.
- 36% (12/33 sites) indicated that they were already in the process of distribution.
- Of the remaining seven NSP's that indicated they would not distribute safer smoking supplies, they explained that they could not due to financial and political barriers.

Comments from respondents as to the importance of distributing smoking supplies:

"The safer crack smoking equipment program is very limited as it is run solely on donations and is not supported or funded by Public Health"
"There is an increase in the amount of safer smoking going out through the NSP. Ordering of supplies has doubled in the past year"
"The need to stop the spread of blood borne diseases"
"Common sense"

The results of this survey are not unexpected. OHRDP is helping to meet the fiscal needs of safer smoking programs by supplying safer smoking supplies free of charge to the 36 core NSPs. The need for educational resources has also been identified through the 2013 Environmental Scan. OHRDP is helping to meet the education needs by having produced a manager's resource along with service user's resources on safer smoking. Currently, there are at least 14 programs supplying safer inhalation supplies in some capacity in Ontario (either a core NSP or satellite site). As OHRDP roles out the safer smoking program, staff at the 36 NSP sites will be key players in implementing the program at a local level.

Objective 5: Program implementation and considerations

Program model:

- In a harm reduction model, safer smoking supplies would be made available in a non-judgmental manner. The ways in which supplies are delivered might vary depending on program resources; however, the supplies can be offered through harm reduction programs such as needle and syringe programs, methadone clinics, or outreach workers who are either professional or peer. Outreach services are commonly employed, as they are known to be effective at reaching vulnerable populations such as those who engage in crack use (Ti et al., 2011).

Literature Review

Supplies:

- As of July 2014, OHRDP will be providing safer smoking supplies: borosilicate glass stems (crack pipes), brass screens, wooden push sticks, food grade vinyl mouthpieces, and alcohol swabs. Other supplies that sites may consider purchasing on their own include: lighters and bandages.

- Some programs provide condoms and lubricant with safer smoking supplies. Malchy et al. (2011) noted that condoms provided in the crack kits were used by 59% of the survey respondents. Harm reduction programs and outreach teams often distribute condoms, though the majority of the kit-recipients indicated that they had used the condoms that were provided with the safer smoking supplies specifically. Including condoms and/or other items that protect against STIs is a consideration for program design.

Kits vs. individual pieces:

- Pre-packed kits can be beneficial and may encourage recipients to use all components needed for safer smoking. Leonard et al. (2007) discovered that distribution of complete kits decreased during their study period; however, accessing individual pieces of equipment increased which included screens, mouthpieces and glass stems (2007).

Size of supplies:

- The need to be vigilant about police detecting equipment on the person was expressed as a concern in the study conducted by Boyd et al. (2008). Participants admitted that they would throw equipment away if it was not practical and useable (e.g. push sticks that were conspicuous and could not be transported easily, were discarded by participants).

Information cards:

- Just under three quarters of survey respondents in the study conducted by Malchy et al. (2011) indicated that information cards listing local resources were useful. In the study conducted by Boyd et al. (2008) those who received the cards indicated that they either used them or gave them to a peer in need of resources listed. Literacy levels of the population and amount of information would need to be considered as well as font size for those in need of glasses.

> ***"…When distribution of harm reduction equipment is part of a comprehensive program within a spectrum of health services, risk behaviours decline significantly..."*** *-Malchy et al., 2011*

Other high-risk populations:

- Shannon et al (2008) found women who engage in crack use experience increased exploitation, violence and vulnerability compared to their male counterparts. Ti et al. (2011) also demonstrated that females are more likely than males to have difficulty accessing stems. Shannon et al. (2008) discussed higher risks associated with STIs and HCV among women; therefore, offering gender-specific harm reduction programming is important. This could include efforts to discuss STI prevention with women who engage in crack use.

- Youth are another vulnerable sub-population. Younger populations report being taken advantage of by those engaging in crack use who are older, or those who sell crack cocaine (Reynolds, et al. 2011). Reynolds et al. (2011) also discovered that younger crack cocaine users were more likely to engage in risk behaviours such as sharing crack pipes. Leonard et al. (2007), also discuss that many studies indicate that injection drug users under age 30 engage in stem sharing as well. An additional effort to support the needs of youth is another consideration when implementing this type of programming.

Literature Review

- Those who engage in crack use discuss the ever-present need to move continuously from one place to another, given the vigilance of police patrolling (Ivsins, et al., 2011). This finding impacts the amount of time outreach efforts will have to spend with potential clientele.

Other concerns:

- Accessibility: location, hours and availability were the main reasons why participants in some studies had difficulty accessing safe smoking equipment (Ti et al., 2011). This study also discussed the need to ensure resources are available at night, due to the fact that sex trade work was associated with difficulty in accessibility.

- Police interference was reported as an issue, primarily in accessing equipment (Ivsins et al., 2011; Ti et al, 2011). Participants in the Ivsins (2011) study discussed the fact that police often break or confiscate crack pipes, and that sometimes those who engage in crack use cannot have supplies on them due to conditions of probation or parole. Capacity building with service providers and authorities, and tackling general political resistance, may be an important component of safer smoking program success. For more information about safer smoking kit distribution and the law, please see the September 2008 Canadian HIV/AIDS Legal Network Report: Distributing Safer Crack Use Kits in Canada.

- A few participants felt it was disrespectful for those distributing safer smoking supplies to demonstrate how to load a pipe, especially when the person who used crack had pride associated with their use (Boyd et al., 2008). Consideration in best ways to build rapport will be an essential component of program success.

Literature Review

Conclusion

There are many benefits to supplying safer smoking supplies, which are summarized below:

Individual level

1. Decreases in risky health behaviours
- With the availability of safer smoking supplies one can decrease the frequency of sharing supplies.
- There is some evidence that the availability of safer smoking supplies might reduce the frequency of injecting (Leonard et al., 2007; Persaud et al., 2013; Reynolds et al., 2011)
- If condoms and lubricant are made available as part of safer smoking kits, this can decrease risk of STI transmission.

2. Increases in positive health behaviours
- The ability to provide brief intervention counseling and/or referrals when offering safer smoking supplies to a person can increase the likeliness that they might decide to get tested for STIs, HIV, and HCV.
- The person may also choose to access other health services outlined on resource cards if they are made available as part of an entire kit.

3. Psychological impact
- The act of making safer smoking supplies available was found to impact some study participants positively as they reported feeling cared for by this simple gesture (Boyd, et al., 2008).
- Providing harm reduction interventions can lessen feelings of social exclusion, shame, low self-esteem and feelings of marginalization.

Population level

4. Community/Society/Population impacts
- Decreased transmission of communicable diseases associated with crack use in a community where safer smoking programs exist, translates into less risk of disease transmission within the larger community.
- Safer disposal of crack supplies can take place at sites or with outreach workers resulting in lessened associated risks within the community at large.
- Incidences of vandalism, theft and physical violence associated with acquiring makeshift equipment may decrease when safer smoking supplies are made available (Ivsins et al., 2011).
- Given the high incidence rates of HIV and HCV among those who engage in crack use (Shannon et al., 2008), preventing disease from distribution of safer smoking supplies may reduce costs to our healthcare system.

All information shared in this literature review exemplifies causes to intervene specifically with those who engage in crack use by way of a safer smoking program. Supplies that are essential for safer smoking need to be available and accessible. Furthermore, Fisher et al. (2007) pointed out that there is a disparity between interventions for substance users based on the drug that is used. He stated that there is a "focal bias in interventions in favour of IDU" and that there has been no therapeutic intervention made available to those who engage in crack smoking comparable to NSPs in Canada, or heroin prescription programs. He states that "safer crack kit" interventions, as "rudimentary" as they are as preventative interventions, have not been given the opportunity to demonstrate their effectiveness.

> ***"Despite this widespread prevalence of smoking crack among Canadians who inject drugs, the HCV and HIV related prevention needs of crack smokers have largely been ignored in the development and implementation of harm reduction programmes for people who inject drugs"*** *-Leonard et al., 2007*

Literature Review

Limitations

Most studies in this review used a cross-sectional design; therefore temporality and thus causation could not be assured. Surveys and self-reported data were often methods of data collection used in the studies implicating the fact that findings were subject to social desirability bias. However, there is strong evidence that self-reported information among illicit drug users has high validity (Fisher et al., 2008). This also implies that the findings were underestimates of some of the reported risk behaviours, meaning that in some cases, results reported would be strengthened.

The majority of studies were conducted in Vancouver's downtown eastside, one of the poorest neighbourhoods in Canada (Boyd, et al., 2008). Vancouver has been found to have the highest proportion of people who use crack among illicit drug users (Fischer et al., 2008). Therefore, results of such studies can reliably be generalizable only to the study area. Findings of studies conducted in Ottawa might have more generalizability to other Ontario communities. This can be taken as an indication of the need for a situational assessment of areas local to the 36 core NSPs in Ontario. Such an assessment can highlight opportunities and barriers that might exist in the implementation of safer smoking programming.

It should also be noted that many injection drug user cohort studies engage with participants who also smoke crack. In those cases, the applicability of the findings to people who only smoke crack (and do not inject) are unknown and caution should be taken when extrapolating findings to this group (Webb & Bain, 2011).

Snowball sampling methods was employed to recruit study participants in all studies reviewed. This technique results in non-probability samples (Groves et al., 2009). However, due to the established fact that the majority of people who misuse drugs are hidden in society, this selection method has been proven as highly effective at obtaining a representative sample among this particular population (Watters et al., 1989).

This literature review was completed within a limited time period; therefore, this could have restricted the amount of associated literature and reports that could be incorporated in the discussion regarding efficacy of safer smoking programs.

Literature Review

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 040-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 June 19

MLHU INPUT TO "THE LONDON PLAN"

Recommendation

It is recommended that the Board endorse Report No. 040-14 re MLHU Input to "The London Plan" and direct staff to provide public health input to City of London Planning Department staff.

Key Points

- Public health has an important role to play in designing healthy communities, which is reaffirmed by the Ontario Public Health Standards.
- Our health is affected by the physical design of our community.
- MLHU staff members recommend the Board direct staff to review "The London Plan" and provide public health input to City of London planning process.

Background

It is impossible to ignore that the community around us impacts our health and mental well-being. The Ontario Public Health Standards 2008 require health units to support healthy public policy and the creation or enhancement of supportive environments related to the built environment. Public health has an important role to play in designing healthy communities. To do so, public health must work in partnership with many agencies and levels of government. The physical and mental health and social well-being of residents in Middlesex and London is affected by the natural and built environment in which we live, work and play. Every time we step out our doors, our health is affected by the physical design of our community. Research shows that promoting healthy community design facilitates a productive healthy lifestyle leading to happiness and a sense of well-being and security.

ReThink London was established in 2012 as the process to review the City of London Official Plan. Health Unit staff were actively engaged in providing input into the ReThink London process providing presentations, attending events and submitting recommendations in the following two reports: Healthy City Active London and *City of London Official Plan Recommendations* (See Board Report 084-13). In addition, staff maintain collaborative relationships that support the promotion of healthy communities including the Child and Youth Network; in Motion® Middlesex-London; Healthy Communities Partnership Middlesex-London; London Middlesex Road Safety Committee; Active and Safe Routes to School Committee; Transportation Advisory Committee; and many others. And in 2012, the Healthy Communities Partnership was successful in obtaining London City Council's endorsement of the International Toronto Charter for Physical Activity.

Health Unit staff also promote healthy built environments in Middlesex County. They co-authored Linking Health and the Built Environment in Rural Settings: Evidence and Recommendations for Planning Healthy Communities in Middlesex County, submitted recommendations as part of the Middlesex County, Thames Centre and Lucan Biddulph Official Plan review and supported six municipal councils of Middlesex County to endorse the International Toronto Charter for Physical Activity.

The London Plan

As a result of the Rethink London process, on May 22, 2014 at the Strategic Planning and Priorities Committee, city staff announced the new draft Official Plan – The London Plan. A preliminary review of The London Plan revealed that public health can provide meaningful input in several areas. For example:

- Physical Activity – active transportation and recreational opportunities; and compact pattern of growth
- Social Determinants of Health and Health Equity – affordable housing; social environments; accessibility; and cultural diversity
- Safety and Injury Prevention – road safety; safe mobility; design of parks; and complete streets
- Mental Well-being and Social Capital – urban design principals; mixed housing; sense of place; and communities and neighbourhoods
- Access to Healthy Foods – Food Charter; and community gardens
- Environment – green and natural areas; surface and ground water features; water quality; environmental management and impact studies; natural hazards; and urban forestation

The London Plan supports the planning and designing of communities that make it easier for people to live safe, healthy lives. One of the "big ideas" from the Rethink London process that has been incorporated into the Plan is 'Planning for a healthy city'. Thus, it makes sense that public health continue to be involved in advocating for healthy community design and principles.

Next Steps

City of London Planning Department Staff is now seeking additional input from residents and agencies to further improve the content of The London Plan. This is an excellent opportunity for MLHU staff to provide further public health input into the policies that will govern how we develop our built environment. Staff in most areas of MLHU can provide important and meaningful input into the London Plan that will result in a positive impact on the public's health for years to come. Therefore, Health Unit staff members recommend that the Board direct them to review the London Plan closely and provide their expert public health input to City of London Planning Department staff.

Options that the Board of Health could choose instead would be to take no action at this point, or to officially endorse The London Plan.

This report was prepared by Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention Team, Environmental Health and Chronic Disease Prevention Services.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 041-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 June 19

LONDON ROAD SAFETY STRATEGY

Recommendation

It is recommended that the Board endorse Report No. 041-14 re London Road Safety Strategy endorse the London Road Safety Strategy Charter.

Key Points

- London Road Safety Strategy identifies 6 key priority areas: intersections; distracted/aggressive driving; young drivers ages 16-25; pedestrians; cyclists; and red light running.
- The London-Middlesex Road Safety Committee will implement the London Road Safety Strategy and work towards a 10% reduction in injury and fatal collisions over the next 5 years.
- MLHU staff recommend that the Board endorse the London Road Safety Strategy Charter.

Background

The Ontario Public Health Standards 2008 - Prevention of Injury Program Standard requires MLHU staff to address road safety. The requirement includes: increasing public awareness; working with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs; and the creation or enhancement of safe and supportive environments.

Road safety continues to be a public health issue. Provincial (Ontario Road Safety Annual Report, 2010) and local data indicate that motor vehicle traffic collisions continue to cause injuries and deaths. In Middlesex-London there were 55 deaths between 2008 and 2011 and approximately 6000 injuries related to collisions. Seatbelts have been linked to a substantial decline in fatalities and serious injuries since 1980, however preventable injuries and deaths continue. Nationally, the goal of Canada's Road Safety Strategy 2015 is "to continue to reduce fatalities and serious injuries caused by collisions on Canada's roads". This national strategy is expected to result in safer road users, safer road infrastructure and safer vehicles through: raising public awareness and commitment to road safety; improving communication, cooperation and collaboration among all stakeholders; enhancing enforcement; and improving road safety information in support of research and evaluation. Locally, the London Road Safety Strategy (LRSS) will parallel the national Strategy and will include the 3 E's of injury prevention: Engineering, Enforcement and Education.

The London Road Safety Strategy

In August 2012, the City of London initiated the London Road Safety Strategy study. The study was carried out by hired consultants, CIMA, with the final technical report being completed in March 2014. The Middlesex-London Health Unit chairs the London-Middlesex Road Safety Committee (LMRSC) and worked with partners to utilize the results of the study to create a Vision, Mission, and Goal for the London Road Safety Strategy:

- **Vision**: A path to a safer road environment for all transportation users in London and Middlesex County
- **Mission**: To save lives and reduce serious injuries to all transportation users through leadership, innovation, coordination, and program support in partnership with other public and private organizations
- **Goal**: A non-linear 10% reduction in injury and fatal collisions over 5 years

The top 6 specific target areas identified for the Strategy include: intersections; distracted and aggressive driving; young drivers ages 16-25; pedestrians; cyclists; and red light running.

All LMRSC members reviewed their current activities and considered new and/or enhanced programming that would work towards achieving the identified goal of a 10% reduction in injury and fatal collisions within 5 years. The LMRSC will focus their efforts on the London Road Safety Strategy's identified priority issues to achieve the projected outcome of approximately 155 fewer motor vehicle collisions by 2020. The MLHU contributions to the Strategy will predominantly be the provision of education programs and advocating for road safety policy development. Other Strategy partners will add engineering and enforcement programs as their focus. The LMRSC will now focus their efforts on the LRSS plan.

As co-chair of the LMRSC, MLHU will: continue to play a key role in the coordination and collaboration of all the sectors; advocate for a safe built environment that encourages active transportation and; lead educational campaigns about distracted driving, cycling and pedestrian safety.

London Road Safety Strategy Charter

The London Road Safety Strategy has not only set clear goals based on the CIMA Report, for the road safety partners to work towards, it has also created the London Road Safety Strategy Charter (Appendix A) to allow the partners to formally express their commitments to the success of the Strategy. By signing the London Road Road Safety Strategy Charter, the Middlesex-London Health Unit commits to fulfilling its role in implementing the Strategy and to continuing to work with all of its road safety partners to ensure that the Strategy is successful. Board of Health endorsement of the London Road Safety Strategy Charter will help advance this important work.

This report was prepared by Ms. Joyce Castanza, PHN, Healthy Communities and Injury Prevention Team, Environmental Health and Chronic Disease Prevention Services.

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

Program Charter

London Road Safety Strategy

City of London and County of Middlesex, Ontario

By and Among:

City of London
County of Middlesex
London Police Service
Middlesex-London Health Unit
London Health Sciences Centre
London Block Parent Program
……

WHEREAS, from 2008 to 2011, the City of London experienced 30712 reported motor vehicle collisions and the County of Middlesex experienced 3228 reported motor vehicle collisions, resulting in overall estimated costs of $815 million; and

WHEREAS, the City of London has corporate strategic goals to increase the health and well-being of all citizens, and to promote safety in all neighbourhoods; and

WHEREAS, City officials have endorsed the development, implementation and ongoing management of a Road Safety Strategy (LRSS) that includes goals, emphasis area priorities and actions that the London-Middlesex Road Safety Committee (LMRSC) can stand behind and act upon to reduce traffic collisions; and

WHEREAS, as traffic safety management is a shared responsibility, the LRSSC includes representatives from civic government, enforcement agencies, educational institutions, public health providers, hospitals, emergency services, private agencies and the provincial government.

THEREFORE, IT IS AGREED THAT the members of the Steering Committee agree to support the development and ongoing LRSS effort to achieve its Vision, Mission and Goal:

Vision: A path to a safer road environment for all transportation users in London and Middlesex.

Mission: To save lives and reduce serious injuries to all transportation users through leadership, innovation, coordination, and program support in partnership with other public and private organizations.

Goal: 10% reduction in injury and fatal collisions over the next five years.

NOW, THEREFORE, the signatories below hereby jointly agree to the following eight conditions:

1. We accept and endorse the goals, priorities and actions of the LRSS; and
2. We commit to promoting road safety and the LRSS within our organization; and
3. We commit to integrating the LRSS actions into our current strategic plans and programs, whenever possible; and
4. Our representatives will bring new and modified road safety initiatives, not currently identified in the LRSS action plan, forward to the LMRSC for consideration, approval and integration into the LRSS action plan, as appropriate; and
5. We will provide technical advice and resource support and commitment to manage and deliver those LRSS action plan activities that each of us are responsible for; and
6. We will attend and participate in quarterly meetings to inform the members of our safety initiative progress, assess the overall progress of the LRSS, address any service delivery gaps, make program changes as required, resolve issues, and remove any implementation barriers; and
7. We will support all cross-emphasis area programs, actions and public communications; and
8. We will abide by the terms of reference, roles and responsibilities as contained in the Terms of Reference for the LMRSC.

BY SIGNING BELOW, I agree that my organization supports the LRSS, and that it will provide a committed and active member to the LRSSC to participate in accomplishing the LRSS Vision, Mission, Goals and Action Plan.

_____ _____

City of London Date County of Middlesex Date

_____ _____

London Police Service Date Middlesex-London Health Unit Date

_____ _____

London Health Sciences Centre Date London Block Parent Program Date

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 042-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 June 19

SUMMARY INFORMATION REPORT FOR JUNE 2014

Recommendation

It is recommended that Report No. 042-14 re Information Summary Report for June and the attached appendices be received for information.

Key Points

- This years' International Nursing Week (May 12-18) was marked at MLHU with a workshop and luncheon attended by ninety Public Health Nurses.
- The Preparation for Parenthood Project, launched in May 2014, addresses the impact of parenting practices on families.
- The Ministry of Children & Youth Services (MCYN) has provided funds for enhanced hearing screening equipment in order to more accurately screen the hearing of over 10,000 infants in our region each year.
- The One Life One You Youth Leaders developed and implemented the "Tobacco and the Environment" initiative to educate environmentally conscious youth about the severe environmental impacts of harvesting, manufacturing and packaging tobacco products.

Background

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

International Nursing Week May 12-18, 2014

Health Unit nurses celebrated National Nursing Week on Tuesday May 13th with a professional development workshop and celebratory luncheon. (Appendix A). Public Health Nurses welcomed the President of the Registered Nurses' Association of Ontario (RNAO), Dr. Vanessa Burkoski, and she spoke to of the importance of nurses as change agents and advocates for community health. Dr. Shannon Sibbald of the Faculty of Health Sciences and the Shulich Interfaculty Program at Western University presented a thought-provoking presentation on public health practice and ethics. Funding for the celebratory luncheon was paid for through fund-raising activities by the nurses. Event planning was supported by the Nursing Practice Council and the Nursing Week Committee. For more information about National Nursing Week see http://www.cna-aiic.ca/en/events/national-nursing-week .

Preparation for Parenthood Project/iParent Campaign

The transition to parenthood brings about more profound changes than any other developmental stage of the family life-cycle. A MLHU evaluation completed in 2013 supported earlier reports that prior to the birth of a first baby 44% of parents felt prepared for parenthood. Following the birth of their child, the percentage of parents who felt confident about their parenting abilities dropped to 18%. The "Life's About to Change" iParent campaign, launched in May 2014, aims to engage parents in contemplating the impact of parenthood prior to the arrival of their baby and to actively prepare for parenthood. The campaign drives the community to the MLHU hosted www.iparent.net where parents are encouraged to "find answers together". The

campaign also includes county newspaper ads, transit shelter advertising, Facebook ads, and the use of twitter (Appendix B).

Infant Hearing Program – Enhanced Hearing Screening Equipment

In 2013/2014, the Ministry of Children and Youth Services (MCYS) provided $52,608 to upgrade the hearing screening equipment in our region. The Finance and Facilities Committee reviewed this funding proposal and the Board approved it in March of this year. The new equipment is more portable, easier to use and has greater accuracy. As part of the rollout we are re-training hospital nurses and community hearing screeners in the use of the new equipment and in the new protocols. This past year we have been able to increase hearing screening at LHSC over the weekends so that more families can leave the hospital having their babies' hearing screened. In 2013/2014 10,691 infants were screened and 35 were identified with permanent hearing loss.

One Life One "Tobacco and the Environment" Initiative

Throughout the month of April and in conjunction with Earth Day (April 22nd), the Health Unit's One Life One You targeted environmentally conscious youth, profiling the negative impact that the tobacco industry has on the environment. Youth were encouraged to take the pledge to be tobacco-free because they care about the environment. Harvesting, manufacturing and packaging tobacco products contribute to a number of severe environmental impacts including deforestation and pollution.

Cigarette butts are the most littered product in the world, leaching chemicals into the ground and water systems. They can take up to 25 years to fully decompose. Cigarette butts are often consumed by animals and birds, causing illness or death. Using creative messages, infographics, interactive displays, school announcements and banners to collect youth pledges to be tobacco-free, One Life One You exposed how the tobacco industry is harming the environment. Engaging and working with youth who care about the environment is a unique strategy to help shift tobacco use behaviours and social norms.

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

MIDDLESEX-LONDON HEALTH UNIT

Appendix A

NURSING WEEK

ALL NURSES WORKSHOP & LUNCHEON

Tuesday May 13, 2014 8:30am-12:30pm

BMO Centre, 295 Rectory Street, London, Ontario

8:30-9:00	Networking and Coffee
9:00-9:15	Welcome & Introduction from ***Diane Bewick***, Chief Nursing Officer ***Brenda Marchuk,*** Community Health Nursing Specialist
9:15-10:15	***Nursing – Future, Strengths; Future Challenges*** ***Dr. Vanessa Burkoski,*** President, RNAO and Vice President, Professional Practice and Chief Nurse Executive, LHSC
10:15-10:30	Break
10:30-11:30	***Ethics and Public Health Practice*** ***Dr. Shannon Sibbald,*** Assistant Professor in the Faculty of Health Sciences & the Schulich Interfaculty Program in Public Health, Western University
11:30-12:30	Luncheon/Raffle

choose health


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Finding answers together
Becoming a parent is about more than having a baby.
It's natural to have questions about being a parent.
Contact us today to find answers together.
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BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com
www.iparent.net

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 043-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 June 19

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – JUNE

Recommendation

It is recommended that Report No. 043-14 re Medical Officer of Health Activity Report – June be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the May Medical Officer of Health Activity Report to June 6, 2014.

The MOH continued to be involved in negotiations with CUPE the week of May 5th. The final negotiations with CUPE occurred on June 2nd. Negotiations with ONA began on May 22nd. Proposals were exchanged. The next meeting is June 23rd.

During the week of May 5th, the Medical Officer of Health led the interview process to recruit the Associate Medical Officer of Health.

On May 29th, the MOH delivered opening remarks at a Share the Road press conference. The event was held to launch an awareness campaign to prevent collision-related injuries and deaths. The campaign encourages drivers and cyclists to be respectful and to provide a one meter clearance when passing.

On June 3rd the MOH co-facilitated an all staff meeting to launch the Health Unit's Strategic Planning Process for 2015-2018. The guest speaker was Glen Pearson who delivered an inspiring message to staff.

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

May 5	Participated in two teleconferences: - PHO Rounds: Measles in Ontario: A multidisciplinary presentation to answer commonly asked questions from the field - Urban Public Health Network (UPHN) working group - smoke free movies
May 6	Attended an Emergency Preparedness Week Barbecue co-hosted by MLHU and County of Middlesex in support of the Salvation Army
May 7	Meeting with Maria Sánchez-Keane to give input for the City of London Community Plan Regarding Street Involved Sex Workers
May 8	Meeting with Dick Foster to discuss his quotation for a generator at 50 King St
May 12	All Our Sister National Forum on Security of Housing and Safe Communities for Women Coast to Coast, at the London Convention Centre

May 13	All Nurses meeting held at the BMO Centre to celebrate National Nursing Week. United Way Campaign Fundraising Cabinet meeting
May 15	Provincial/Public Health Unit Conference Call Spoke to the Public Health Interest Group for Medical Students at Western University about the role of a Medical Officer of Health, what training is involved, and the positive and negative aspects of specializing in public health Board of Health Governance Committee meeting and the Board of Health meeting
May 20	Visit from Dr. Paul Roumeliotis, MOH, Eastern Ontario Health Unit, to discuss the Board of Health approved Provincial Poverty Project
May 21	Met with Oxford County Public Health staff in Woodstock to discuss a joint communications campaign
May 23	Southwest Medical Officer of Health meeting at the Chatham-Kent Public Health Unit
May 26	Teleconference regarding Panorama implementation Along with Dr. David Colby and Dr. Bryna Warshawsky, the MOH met with three McMaster medical students to practice for their upcoming oral exams
May 28	Attended the Father's Day Breakfast at the Marconi Club. This annual event is organized by the Centre for Research & Education on Violence Against Women & Children Videoconference – SW LHIN System Leadership Council Meeting
May 29	Attended the United Way Middlesex Wrap Up event. This was held in Komoka to wrap up the needs assessment in Middlesex County that the United Way led over the past two years with the support of the Ministry of Training, Colleges & Universities and community partners
May 30	Met with Linda Sibley, Executive Director, Addiction Services of Thames Valley to discuss harm reduction programming Met with Glen Pearson, guest speaker for Strategic Planning Launch
June 4	Attended the annual alPHa *Prevent More to Treat Less Public Health and Primary Health Care Joint Conference* held in Richmond Hill
June 5	In response to a Health Unit letter to all three provincial party leaders about opioid overdose deaths, met with Dani Peters of the provincial Progressive Conservative party to discuss opportunities for provincial policy to address prescription opioid abuse.

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