AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2016 January 21

MISSION - MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Patricia Fulton
Mr. Jesse Helmer
Dr. Trevor Hunter
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Mark Studenny
Mr. Stephen Turner
Ms. Joanne Vanderheyden

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

Public Session - December 10, 2015 Board of Health meeting
Confidential - December 10, 2015 Board of Health meeting

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:30 – 7:40 p.m.	Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item #2 - Finance and Facilities Committee Meeting January 14, 2016
7:40 – 7:50 p.m.	Mr. Mark Studenny, Chair, Governance Committee re Item #3 Governance Committee Meeting January 21, 2016

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Meeting Procedures						
1	Election of 2016 Board of Health Executive and other Procedures (Report 001-16)	Appendix A Appendix B Appendix C Appendix D		x		To fulfill the requirements of the first Board of Health meeting of each year, e.g., election of Chair/Vice Chair for 2016
Committee Reports						
2	Finance and Facilities Committee Meeting January 14, 2016 (Report 002-16)		x	x		To receive information and consider recommendations from the January 14th FFC meeting
3	Governance Committee Meeting January 21, 2016 (Verbal)		x	x		To receive information and consider recommendations from the January 21st meeting
Delegations and Recommendation Reports						
4	Cannabis: A Public Health Approach (Report 003-16)	Appendix A	x	x		To request that the Board of Health consider reccomendations to develop an evidence-based public health approach to cannabis policy in the context of legalization, including strict regulations to minimize health and social harms
5	Patients First – Proposed Changes to Public Health & Ontario's Health System (Report 004-16)	Appendix A			x	To receive information and consider the proposed changes to Public Health and Ontario's Health System
Information Reports						
6	Columbia Sportswear Donations (Report 005-16)	Appendix A			x	To inform the Board of Health that the Emergency Management program will continue to cover minor repair and cleaning costs to assist in the distribution of clothing and footwear donations
7	Medical Officer of Health Activity Report – January (Report 006-16)				x	To provide an update on the activities of the MOH for January 2016

CONFIDENTIAL

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, January 28, 2016 @ 9:00 a.m. in Boardroom
- Next Board of Health Meeting: Thursday, February 18, 2016 @ 7:00 p.m.
- Board of Health meeting schedule

CORRESPONDENCE

a) Date: 2015 November 20 (Received 2015 November 27)
Topic: Healthy Babies Healthy Children Program Funding
From: Copy of correspondence from Mr. Norm Gale, Chair, Thunder Bay District Board of Health
To: The Honourable Tracy MacCharles, Ministry of Children and Youth Services

Background:
The Healthy Babies Healthy Children Program helps children get a healthy start in life by providing screening, assessment and referral to community programs and services, supporting new parents and helping to find community resources for breastfeeding, nutrition, health services, parenting programs and family literacy programs.

The Board of Health endorsed correspondence regarding HBHC funding challenges from Dr. Penny Sutcliffe, MOH & CEO, Sudbury and District Health Unit at the September 17th meeting.

Recommendation:
Receive.

b) Date: 2015 November 27 (Received 2015 December 02)
Topic: Basic Income Guarantee
From: Premier Kathleen Wynne
To: Mr. Ian Peer Chair, Middlesex London Board of Health

Background:
The Board of Health considered a report at the September 17th meeting and approved that the Board: 1) Send a letter to the Prime Minister of Canada, the Premier of Ontario and the Ontario Minister Responsible for the Poverty Reduction Strategy requesting they prioritize consideration and investigation into a joint federal-provincial basic income guarantee; 2) Send a letter to the Premier of Ontario requesting the province increase social assistance rates to reflect the rising cost of nutritious food & safe housing; 3) Send a letter to all London and Middlesex County federal election candidates requesting they take Food Secure Canada's Eat Think Vote candidate pledge; and 4) Forward Report No. 50-15 re 2015 Nutritious Food Basket Survey Results and Implications for Government Public Policy to the City of London, Middlesex County & appropriate community agencies.

Recommendation:
Receive.

c) Date: 2015 December 03 (Received 2015 December 06)
Topic:Middlesex-London Board of Health Supporting Changes to the *Municipal Act* to Authorize Electronic Participation in Meetings for Local Boards of Health.
From: Honourable Ted McMeekin
To: Mr Ian Peer, Chair Middlesex-London Board of Health

Background:
At the September 17th, 2015 meeting, the Middlesex-London Board of Health passed a motion to endorse a letter from the Chair of Wellington-Dufferin-Guelph Public Health and drafted correspondence to the Ministry of Health and Long-Term Care requesting changes to the Municipal Act to authorize the use of electronic means for participating in board of health meetings.

The Ministry of Urban Affairs and Housing is currently reviewing the Municipal Act and the recommendations submitted by the Board of Health will be integrated into the considerations.

Recommendation:

Receive.

d) Date: 2015 December 4 (Received 2015 December 22)
Topic: Public Health Funding
From: Copy of Correspondence from Mr. Lee Mason, Chair, Algoma District Board of Health
To: The Honourable Eric Hoskins, Ministry of Health and Long-Term Care

Background:
A funding review workgroup was struck in 2010 to investigate the status of public health funding in Ontario and to advise the ministry on a potential funding model and principles to guide its implementation. The report produced by the workgroup was accepted and the Ministry began to implement the new model in 2015. Two percent growth funding (approx. $11 million) for mandatory programs is being distributed to public health units who have not reached their model-based share – the Middlesex-London Health Unit is one of these health units.

Several health units across the province have expressed concern for the new funding model and called for the Ministry of Health and Long-Term Care to revise the funding formula. This new funding formula has been seen as biased against smaller, northern and rural health units. At the September 17th meeting, the Board of Health approved writing a letter to the Minister of the Ministry of Health and Long-Term Care expressing the Health Unit's appreciation for supporting a more equitable approach to public health funding.

Recommendation:
Receive.

e) Date: 2015 December 21 (Received 2015 December 22)
Topic: Basic Income Guarantee
From: Copy of Correspondence from Anne Warren, Chair, Leeds, Grenville and Lanark District Board of Health
To: The Honourable Jean-Yves Duclos, Ministry of Family, Children and Social Development.
The Honourable Kevin Daniel Flynn, Ministry of Labour
The Honourable Eric Hoskins, Ministry of Health and Long-Term Care
The Honourable Tracy MacCharles, Ministry of Children and Youth Services
The Honourable Deborah Matthews, Minister Responsible for the Poverty Reduction Strategy
The Honourable MaryAnn Mihychuk, Ministry of Labour
The Honourable Jane Philpott, Ministry of Health

Background:
A basic income guarantee is a governmental assurance that no one's income will fall below a level that is sufficient to meet their basic necessities and to live with dignity, regardless of employment status. There is a strong association between socioeconomic status and health outcomes. The basic income guarantee has the potential to prevent poverty and to improve health outcomes in our population. The Middlesex-London Health Unit endorsed correspondence from the Simcoe Muskoka District Health Unit at the June 18th, 2015 Board of Health meeting.

Recommendation:
Receive.

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

ADJOURNMENT

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2015 December 10

MEMBERS PRESENT:	Mr. Ian Peer (Chair) Mr. Jesse Helmer (Vice Chair) Ms. Trish Fulton Dr. Trevor Hunter Mr. Marcel Meyer Ms. Nancy Poole Mr. Kurtis Smith Mr. Mark Studenny Mr. Stephen Turner
REGRETS:	Ms. Viola Poletes Montgomery Ms. Joanne Vanderheyden
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health & CEO (Secretary Treasurer of the Board) Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder) Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services Mr. Jordan Banninga, Manager, Strategic Projects Ms. Shaya Dhinsa, Manager, Sexual Health Services Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy Mr. Dan Flaherty, Manager, Communications Dr. Gayane Hovhannisyan, Associate Medical Officer of Health Ms. Heather Lokko, Associate Director, Oral Health, Communicable Disease & Sexual Health Services Ms. Brenda Marchuk, Acting Chief Nursing Officer Mr. John Millson, Director, Finance and Operations Mr. Alex Tyml, Online Communications Coordinator Ms. Suzanne Vandervoort, Acting Director, Family Health Services

Board of Health Chair, Mr. Ian Peer, called the meeting to order at 6:00 p.m.

Dr. Christopher Mackie, Medical Officer of Health & CEO welcomed all in attendance and introduced Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Mr. Peer inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by, Mr. Meyer, seconded by Mr. Studenny *that the AGENDA for the December 10, 2015 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by, Ms. Fulton, seconded by Dr. Hunter *that the MINUTES of the October 15, 2015 Board of Health meeting be approved.*

Carried

DELEGATIONS and COMMITTEE REPORTS

1. Finance and Facilities Committee Meeting – November and December (Report 67-15)

Chair of the Finance and Facilities Committee, Ms. Trish Fulton, reported on the outcomes of the November and December Finance and Facilities Committee meetings.

Recommendations arising from November meeting:

November

Draft Factual Certificate (No. 25-15FFC)

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

1) *Approve the draft Factual Certificate template as appended to Report No. 25-15FFC ; and*
2) *Approve the process outlined in Report No. 25-15FFC.*

Carried

Third Quarter Financial Update (No. 26-15FFC) – FFC received for information

Proposed Resource Reallocation for the 2016 Budget (No. 27-15FFC) – FFC received for information

Funding for Panorama Implementation (No. 28-15FFC)

It was moved by Ms. Fulton, seconded by Mr. Helmer *that the Board of Health accept the terms and conditions to receive $203,900 in one-time Panorama funding as detailed in the funding letter appended to Report No. 028-15FFC.*

Carried

December

2016 Budget – PBMA Proposals (No. 31-15FFC)

The Finance and Facilities Committee reviewed the 2016 PBMA proposals for new one-time investments and disinvestments in the amounts that are listed below. It was noted that the committee had substantial discussions about the relevant proposals.

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

1) *Approve in principle PBMA investments totaling $527,289 as identified in Appendix A to Report No. 31-15FFC, and further*
2) *Approve in principle PBMA one-time investments totaling $206,953 as identified in Appendix B to Report No. 31-15FFC, and*
3) *Approve in principle PBMA disinvestments totaling $281,597 as identified in Appendix C to Report No. 31 – 15FFC.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Meyer *that the minutes of the November 5, 2015 Finance and Facilities Committee meeting be received.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Helmer *that the draft minutes of the December 3, 2015 Finance and Facilities Committee meeting be received.*

Mr. Helmer noted that his first name was missing in the draft December minutes and asked that this be addressed before these minutes go to FFC for approval.

Carried

RECOMMENDATION REPORTS

2. Middlesex-London Health Unit Organizational Structure (Report 68-15)

Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy presented a summary of the process and comprehensive assessment that was conducted by the Organizational Structure and Location Committee to inform the findings and structural change recommendations outlined in this report.

Dr. Mackie outlined the recommended changes to the current organizational structure and noted that staff feedback was vital in helping to shape the new organizational structure. Dr. Mackie identified the importance of divisional collaboration and the improved alignment of services that will allow programs to have a greater impact on clients.

Mr. Helmer inquired about Part 3 of the Report's recommendation to delegate decision-making for organizational structure to the Medical Officer of Health and CEO, and direct the MOH and CEO to keep the Board of Health informed about the organizational structure of the Health Unit. Discussion ensued about the delegation of decision making for organizational structure to the Medical Officer of Health and CEO.

Ms. Di Cesare explained that other Board structures were reviewed and considered through the Organizational Restructuring process and that such delegation is standard for this and other industries.

Dr. Mackie explained that any changes to the core programs of the Health Unit would be put through the normal budget process, going to the Board for approval and formalized at that time. Dr. Mackie committed to revising program-related policies to reflect existing practice whereby substantive service-level changes are approved by the Board of Health. The Board of Health acknowledged their confidence in Dr. Mackie, Medical Officer of Health & CEO.

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

1) *Receive Report No. 68-15 re Middlesex-Health Unit Organizational Structure; and further*

2) *Approve revisions to the Middlesex-London Health Unit organizational structure; and further*

3) *Delegate decision-making for organizational structure to the Medical Officer of Health and CEO, and direct the MOH and CEO to keep the Board of Health informed about the organizational structure of the Health Unit.*

Carried

3. Middlesex London Health Unit and Ontario Nurses' Association (ONA) Pay Equity Plan (Report 73-15)

Ms. Di Cesare, Director, Human Resources and Corporate Strategy advised that no pay equity adjustments were required and that the Ontario Nurses' Association (ONA) Pay Equity Plan had been ratified by ONA members.

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

1) *Receive Report No. 73-15 re Middlesex-London Health Unit Ontario and Ontario Nurses' Association (ONA) Pay Equity Plan; and further*

2) *Approve the ONA MLHU Pay Equity Plan.*

Carried

INFORMATION REPORTS

4. Sexual Health Services Review (Report 69-15)

This report was provided as information on the enhanced services for Sexual Health Services.

It was moved by Mr. Helmer seconded Mr. Smith by *that Report No. 69-15 re Sexual Health Services Review be received for information.*

Carried

5. Summary Information Report for December (Report 70-15)

It was moved by, Mr. Helmer, Mr. Turner seconded by *that Report No. 70-15 re Summary Information Report for December be received for information.*

Carried

6. Medical Officer of Health Activity Report – December (Report 71-15)

Dr. Mackie provided some context to his activity report. Dr. Mackie presented the Pillar Nonprofit Network Community Collaboration award that was received on November 25th for the Middlesex-London Health Unit's collaboration of the Naloxone program with the Regional HIV/AIDS Connection (RHAC), the London Intercommunity Health Centre (LIHC) and the London Area Network of Substance Users (LANSU). Dr. Mackie outlined the benefits of the Naloxone program and thanked the Board for their support in playing a crucial role to bring the Naloxone program to Middlesex-London.

It was moved by Mr. Helmer, seconded by Mr. Turner, *that Report 71-15 re Medical Officer of Health Activity Report – December be received for information.*

Carried

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At 7:01p.m. it was moved by Mr. Studenny, seconded by Dr. Hunter *that the Board of Health move in camera to discuss matters concerning an identifiable individual.*

Carried

All visitors and Mr. Mark Studenny left the room.

At 7:21 p.m. it was moved by Mr. Meyer, seconded by Mr. Helmer *that the Board of Health rise and return to public session to report that progress was made in matters concerning an identifiable individual.*

Carried

Mr. Mark Studenny returned.

It was requested by Mr. Turner that the Board of Health review the remaining term appointments at the next Governance Committee meeting. It was requested that correspondence be prepared for a future meeting to discuss these items.

CORRESPONDENCE

It was moved by, Mr. Helmer, seconded by Mr. Turner, *that correspondence items a) through g) and i) through n) be received for information.*

Carried

It was moved by Mr. Helmer, seconded by Mr. Turner *that the Board of Health endorse item h) – a copy of correspondence from Mr. Lorne Coe, President, Association of Local Public Health Agencies, to the Honourable Eric Hoskins, Minister of Health and Long-Term Care re the Public Health Funding Model.*

Carried

OTHER BUSINESS

Upcoming meetings:

- Next Finance and Facilities Committee Meeting: Thursday, January 14, 2016 @ 9:00 a.m.
- Next Governance Committee Meeting: Thursday, January 21, 2016 @ 6:00 p.m.
- Next Board of Health Meeting: Thursday, January 21, 2016 @ 7:00 p.m.

Mr. Helmer noted a conflict with the Board of Health meeting scheduled for Thursday January 21st @ 7:00pm. This meeting conflicts with the City's Strategic Priorities and Policy – Budget meeting being held the same night.

It was requested that the 2016 Proposed Board of Health Meeting dates be recirculated to the Board members at the next meeting.

ADJOURNMENT

At 7:24 p.m. it was moved by Mr. Meyer, seconded by Mr. Helmer *that the meeting be adjourned.*

Carried

IAN PEER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 001-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

ELECTION OF 2016 BOARD OF HEALTH EXECUTIVE AND OTHER PROCEDURES

Recommendations

It is recommended that the Board of Health:

1. ***Elect a Chair and Vice-Chair for the current term;***
2. ***Appoint the Medical Officer of Health as Secretary-Treasurer for 2016;***
3. ***Recognize and appoint members to the Finance and Facilities Committee and the Governance Committee.***

Board Membership Update

The current Board of Health consists of the following Members:

1. **Five (5) Provincial Appointees:** Ms. Trish Fulton, Mr. Ian Peer, Ms. Viola Poletes Montgomery, Ms. Nancy Poole and Mr. Mark Studenny.
2. **Three (3) City of London Appointees**: Mr. Jesse Helmer, Mr. Stephen Turner, and Dr. Trevor Hunter
3. **Three (3) Middlesex County Appointees:** Mr. Marcel Meyer, Mr. Kurtis Smith and Ms. Joanne Vanderheyden

The terms of Board of Health Members can be found in Appendix A.

Procedures for the First Meeting of the Year

Bylaw No. 3 of the Board of Health regulates the proceedings of the Board. Section 18.0 of this Bylaw addresses Elections and Appointment of Committees. It reads as follows:

18.1 *At the first meeting of each calendar year, the Board shall elect by a majority vote a Chair and a Vice-Chair for that year.*

18.2 *The Chair of the Board shall rotate on an annual basis to one of the representatives of the City of London, the County of Middlesex and the Province of Ontario. The Chair of the Board of Health shall be elected for one year by majority vote. The Chair may serve as Chair for a second year, if approved by a majority vote.*

18.3 *At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other boards, bodies or commissions where appropriate.*

18.4 *The Board may appoint committees from time to time to consider such matters as specified by the Board. (e.g., Human Resources, Planning, etc.).*

Election of Executive Officers

Chair: As per the current Bylaw No. 3 Section 18, as stated above, the Chair is elected for one year, with a possible renewal of one additional year, and rotates among the three representative bodies. The Chair for 2015, Mr. Ian Peer, is a Provincial appointee.

Vice-Chair: Bylaw No. 3 Section 18 stipulates that the Vice-Chair is elected for a one year term. Mr. Jesse Helmer, City of London appointee, was the 2015 Vice-Chair.

Secretary-Treasurer: Traditionally, the Secretary-Treasurer functions have been performed by the Medical Officer of Health and CEO.

Establishment of Standing Committees

In Section 1.3 (ii) of Board of Health Policy No. 1-010 Structure and Responsibilities of the Board of Health, the Board determines whether it wishes to establish one or more Standing Committees at its inaugural meeting of the year. In 2013, the Board of Health created the Finance and Facilities Standing Committee which meets the first Thursday of the month and/or at the call of the Committee Chair. At the December 2013 meeting, the Board created the Governance Committee which has been meeting quarterly or at the call of the Committee Chair, immediately preceding the Board of Health meeting.

1. Finance and Facilities Committee (The Terms of Reference is attached as Appendix B)

   The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

2. Governance Committee (The Terms of Reference is attached as Appendix C)

   The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

All Board of Health members are able to attend the Finance & Facilities and Governance Committees, but only Committee members can vote.

Meeting Schedule for 2016

The 2016 Proposed Meeting Schedule was sent electronically on October 27, 2015 to Board members for their review. This Schedule is attached as Appendix D for approval by the Board of Health.

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

This report addresses Bylaw #3 as outlined in the MLHU Administration Policy Manual.

MIDDLESEX-LONDON HEALTH UNIT

2016 Middlesex London Board of Health

Appendix A to Report 001-16

Title	First Name	Last Name	Appointed By	First Appointed	Term Expires on
Ms.	Viola	Poletes Montgomery	Province of Ontario	March 1, 2006	February 29, 2016
Mr.	Mark	Studenny	Province of Ontario	April 11, 2006	April 10, 2016
Ms.	Nancy	Poole	Province of Ontario	July 28, 2010	July 27, 2016
Mr.	Marcel	Meyer	County of Middlesex	January 12, 2011	December 31, 2018
Mr.	Ian	Peer	Province of Ontario	November 14, 2012	November 13, 2016
Ms.	Patricia	Fulton	Province of Ontario	January 9, 2013	January 8, 2017
Mr.	Stephen	Turner	City of London	December 1, 2014	November 30, 2018
Mr.	Jesse	Helmer	City of London	December 1, 2014	November 30, 2018
Mr.	Kurtis	Smith	County of Middlesex	December 17, 2014	December 31, 2018
Ms.	Joanne	Vanderheyden	County of Middlesex	December 17, 2014	December 31, 2018
Dr.	Trevor	Hunter	City of London (Citizen Appointee)	March 10, 2015	November 30, 2018

Last updated 1/13/2016

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

FINANCE & FACILITIES COMMITTEE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer (MOH/CEO), and the Director of Finance & Operations in the administration and risk management of matters related to the finances and facilities of the organization.

REPORTING RELATIONSHIP

The Finance & Facilities Committee is a committee reporting to the Board of Health of the Middlesex-London Health Unit. The Chair of the Finance & Facilities Committee, with the assistance of the Director, Finance and Operations and the MOH/CEO, will make reports to the Board of Health as a whole following each of the meetings of the Finance & Facilities Committee.

MEMBERSHIP

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

The Secretary-Treasurer will be an ex-officio member

Staff support: - Director, Finance and Operations
- Executive Assistant to the Board of Health

Other Board of Health members are able to attend the Finance & Facilities Committee but are not able to vote.

CHAIR

The Committee will elect a Chair at the first meeting of the year to serve at least one year, and optimally two years.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as he or she remains a Board of Health member.

DUTIES

The Committee will seek the assistance of and consult with the MOH/CEO and the Director of Finance & Operations for the purposes of making recommendations to the Board of Health on the following matters:

1. Reviewing detailed financial statements and analyses.
2. Reviewing the annual cost-shared and 100% funded program budgets, for the purposes of governing the finances of the Health Unit.
3. Reviewing the annual financial statements and auditor's report for approval by the Board.
4. Reviewing annually the types and amounts of insurance carried by the Health Unit.
5. Reviewing periodically administrative policies relating to the financial management of the organization, including but not limited to, procurement, investments, and signing authority.
6. Monitoring the Health Unit's physical assets and facilities.
7. Reviewing annually all service level agreements.
8. Reviewing all funding agreements.

FREQUENCY OF MEETINGS

The Committee will meet monthly between Board of Health meetings, if a meeting is deemed to be not required it shall be cancelled at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director of Finance & Operations and the Medical Officer of Health & Chief Executive Officer (MOH/CEO), will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the Executive Assistant to the Board of Health.
4. Agenda & minutes will be made available at least 5 days prior to meetings.
5. Agenda & meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable.
This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every 2 (two) years.

Implementation Date: June 20th, 2013

Revision Dates:

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

GOVERNANCE COMMITTEE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer (MOH/CEO), and the Director of Human Resources & Corporate Strategy in the administration and risk management of matters related to board membership and recruitment, board self-evaluation and governance policy.

REPORTING RELATIONSHIP

The Governance Committee is a committee reporting to the Board of Health of the Middlesex-London Health Unit. The Chair of the Governance Committee, with the assistance of the Director, Human Resources & Corporate Strategy and the MOH/CEO, will make reports to the Board of Health as a whole following each of the meetings of the Governance Committee.

MEMBERSHIP

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

The Secretary-Treasurer will be an ex-officio member

Staff support: - Director, Human Resources & Corporate Strategy
- Executive Assistant to the Board of Health or the Executive Assistant to the Medical Officer of Health, depending on availability

Other Board of Health members are able to attend the Governance Committee but are not able to vote.

CHAIR

The Committee will elect a Chair at the first meeting of the year to serve at least one year, and optimally two years.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as he or she remains a Board of Health member.

DUTIES

The Committee will seek the assistance of and consult with the MOH/CEO and the Director of Human Resources & Corporate Strategy for the purposes of making recommendations to the Board of Health on the following matters:

1. Recruitment and nomination of suitable Board members.
2. Orientation and training of Board members.
3. Performance evaluation of individual members, the Board as a whole, and committees of the Board.
4. Compliance with the Board of Health Code of Conduct.
5. Performance evaluation of the MOH/CEO.
6. Governance policy and bylaw review and development.
7. Compliance with the Organizational Standards.
8. Strategic Planning.

FREQUENCY OF MEETINGS

The Committee will meet quarterly or at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director of Human Resources & Corporate Strategy and the MOH/CEO, will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the Executive Assistant to the Board of Health.
4. Agenda & minutes will be made available at least 5 days prior to meetings.
5. Agenda & meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable. This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every 2 (two) years.

Implementation Date: January 16th, 2013

Revision Dates:

Proposed Board of Health Meeting Dates for 2016

Board of Health	Notes
Thurs. Jan. 21/16	
Thurs. Feb. 18/15	Family Day is Monday, February 15, 2016
Thurs. Mar. 17/15*	Good Friday is March 25, 2016 March Break is March 14-18, 2016 ***Recommendation to move this meeting to March 10, 2016***
Thurs. April 21/15	
Thurs. May 19/15	
Thurs. June 16/15	
Thurs. July 21/15	
Thurs. Aug. 18/15	Have cancelled this meeting in the past if not needed
Thurs. Sept. 15/15	
Thurs. Oct. 20/15	
Thurs. Nov. 17/15	
Thurs. Dec. 8/15	

Finance & Facilities Committee	Notes
Thursday, Jan 14	
Thursday, Jan 28	
Thursday, Feb 11*	***Finance to discuss this meeting related to quorum***
Thursday, Mar 3	Have cancelled this meeting in the past if not needed
Thursday, Apr 7	
Thursday, May 5	
Thursday, June 2	
Thursday, July 7	
Thursday, Aug 4	Have cancelled this meeting in the past if not needed
Thursday, Sept 1	
Thursday, Oct 6	
Thursday, Nov 3	
Thursday, Dec 1	

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 002-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

FINANCE AND FACILITIES COMMITTEE: JANUARY 14, 2016 MEETING

The Finance and Facilities Committee (FFC) met at 9:00 a.m. on January 14 (Agenda). The Committee approved minutes from December 3, 2015 available on the Health Unit website. The following items were discussed at the meeting and recommendations made:

Reports	Summary of Discussion	Recommendations for Board of Health's Consideration
2016 Budget Process Report 01-16FFC	The Committee and other Board members in attendance discussed the 2016 Planning and Budget Templates for the following services areas:	
	Human Resources and Corporate Strategy (Appendix A to Report No. 01-16FFC)	It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance & Facilities Committee review the 2016 Planning and Budget Templates for Human Resources and Corporate Strategy attached as Appendix A to Report No. 01-16FFC.*
	Finance & Operations Services (Appendix B to Report No. 01-16FFC)	It was moved by Mr. Meyer, seconded by Ms.Vanderheyden *that the Finance and Facilities Committee review the 2016 Planning and Budget Templates for Finance & Operations Services attached as Appendix B to Report No. 01-16FFC.*
	Information & Technology Services (Appendix C to Report No. 01-16FFC)	It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee review the 2016 Planning and Budget Templates for Information & Technology Services attached as Appendix C to Report No. 01-16FFC.*

	Office of the Medical Officer of Health (Appendix D to Report No. 01-16FFC)	It was moved by Ms. Vanderheyden, seconded by Mr. Peer *that the Finance and Facilities Committee review the 2016 Planning and Budget Templates for the Office of the Medical Officer of Health attached as Appendix D to Report No. 01-16FFC.*
	Oral Health, Communicable Disease and Sexual Health Services (Appendix E to Report No. 01-16FFC)	It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the Facilities Committee review the 2016 Planning and Budgeting Templates for Oral Health, Communicable Disease and Sexual Health Services attached as Appendix E to Report No. 01-16FFC.* It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the Finance and Facilities Committee report to the January 21, 2016 Board of Health meeting recommending that the Board of Health defer approval of these components of the 2016 budget until all budget proposals are available at the February 18, 2016 meeting of the Board of Health.*

The Committee will receive the remaining Planning and Budget Templates at its January 28, 2016 meeting, cancelling the February 11, 2016 meeting due to quorum.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

CANNABIS: A PUBLIC HEALTH APPROACH

Recommendation

It is recommended that the Board of Health:

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

Key Points

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

Background

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

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

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

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

Public Health Approach

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

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

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

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

Conclusion

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

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

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

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

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

Appendix A to Report # 003-16

Cannabis: A Public Health Approach

January 8, 2016

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Table of Contents

1.0 Introduction

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

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

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

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

2.0 Cannabis: What Is It?

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

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

3.0 Prevalence of Use

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

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

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

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

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

4.0 History of Law Related to Cannabis

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

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

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

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

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

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

5.0 Current Canadian Law Related to Cannabis

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

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

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

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

5.1 Medical Marijuana in Canada

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

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

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

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

6.0 Harms

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

6.1 Direct Health Harms

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

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

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

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

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

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

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

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

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

6.2 Indirect Harms

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

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

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

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

7.0 A Public Health Approach…What Is It?

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

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

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

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

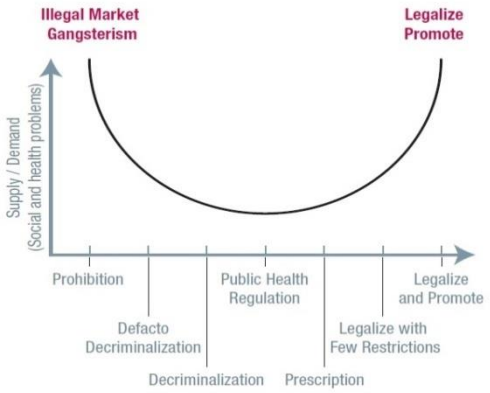

Figure 1: Paradox of Prohibition. Health Officers Council of British Columbia (2011). Reprinted with permission.

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

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

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

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

8.0 Trends Away From Prohibition

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

8.1 The Netherlands

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

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

- While purchase and use of cannabis is permitted, production is illegal. Thus, cannabis sold in coffeeshops comes from an illegal and unregulated production system (CCSA, 2014; Roles, 2014).

- There has been success in separating cannabis from the market for other illegal drugs (Room et al., 2010).

- During early commercialization, prior to advertising and age restrictions, there was evidence of more cannabis use by youth and an earlier age of first use. This trend reversed when increased regulations for coffeeshops were implemented in the mid-90's (Room et al., 2010).

- Evidence suggests that prevalence of cannabis use is lower in the Netherlands than in several neighboring countries as well as Canada and the US (MacCoun, 2011).

8.2 Portugal

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

- Offenders are referred to a Commission for the Dissuasion of Drug Addiction (CDT) who provide a range of sanctions ranging from a fines and community service to treatment (Hughes & Stevens, 2010).

- Early evidence suggests small increases in reported illicit substance use by adults, however reductions have been seen in problematic use, adolescent use, substance related harms, and criminal justice system burden (Hughes & Stevens, 2010).

8.3 Uruguay

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

8.4 United States

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

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

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

8.4.1 Colorado

- Colorado took 1 year from voted legalization to implementation.

- Licensing body is Colorado Department of Revenue.

- Age restriction is 21 and over.

- Personal production of up to 6 plants permitted that must be in an enclosed locked space.

- Early legalization has been market driven, with new products and commercial branding.

- The extent of the edibles market was unanticipated and has become a large part of the market resulting in the need to address high potencies, child enticing packaging, and overconsumption.

- The Colorado Department of Public Health and the Environment (CDPHE) is responsible for monitoring changes in drug use patterns and health effects of marijuana. The CDPHE is also involved in the development of policies and regulations to protect public health and safety.

- Data on first year patterns of use and health outcomes is extremely limited. However, early data has shown increasing trends of poison centre calls, hospitalizations and emergency room visits possibly related to marijuana, and increase in hospitalization rates for children with possible marijuana exposure.

- The Rocky Mountain High Intensity Drug Trafficking Area (RMHIDTA) is concurrently tracking impact of marijuana legalization. While reported findings have been fairly widely quoted, this data should be interpreted with caution. RMHIDTA is a US Federally funded agency whose stance is to uphold US federal drug policy.

8.4.2 Washington State

- Washington took 18 months from voted legalization to implementation.

- Licensing body is Washington State Liquor and Cannabis Board.

- Age restriction is 21 and over.

- Personal production not permitted.

- In comparison to Colorado, Washington has stricter licensing laws: e.g. growers cannot sell and sellers cannot grow, limits on farm sizes, limited large corporate operations.

- Taxes are higher than in Colorado.

- The Washington State Institute for Public Policy (WSIPP) is responsible for evaluating legalization outcomes under the categories of public health, public safety, youth and adult rates of use and maladaptive use, economic impacts, criminal justice impacts and state and local administrative costs and revenues. While an evaluation plan is in place, initial outcome results are not expected until September 2017 (Darnell, 2015).

8.5 What are Canadians saying?

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

9.0 Policy Recommendation: A Public Health Approach

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

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

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

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

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

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

9.1 Recommended considerations for public health focused regulations:

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

9.2 Additional considerations:

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

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

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

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

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Appendix I - Glossary of Terms

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

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

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

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

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

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

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

Appendix II – Positions of Others

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

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

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

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 004-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

PATIENTS FIRST – PROPOSED CHANGES TO PUBLIC HEALTH & ONTARIO'S HEALTH SYSTEM

Recommendation

It is recommended that the Board of Health receive Report No. 004-16: "Patients First – Proposed Changes to Public Health & Ontario's Health System" for information.

Key Points

- On December 17, 2015 the Ministry of Health and Long-Term Care released the *"Patients First – A Proposal to Strengthen Patient-Centred Health Care in Ontario"* discussion paper.
- The proposed changes will impact public health, changing the current relationship between public health units and the Local Health Integration Networks.
- The proposal requires legislative changes which are expected to be tabled by the spring of 2016.
- The Board of Health will be kept apprised as further information becomes available.

Patients First – Discussion Paper

On December 17, 2015, Dr. Eric Hoskins, Minister of Health and Long-Term Care released a discussion paper titled *"Patients First – A Proposal to Strengthen Patient-Centred Health Care in Ontario"*. The discussion paper recommends expanding the role of the Local Health Integration Networks in four areas. The proposed model would require changes to legislation. The ministry is reviewing relevant Acts and intends to propose draft legislation for consideration by the Legislative Assembly in the spring of 2016.

Both the Ontario Public Health Association (OPHA) and the Association of Municipalities of Ontario (AMO) have provided an initial analysis of the discussion paper and the potential areas of impact on public health. These analyses are attached as Appendix A. The Association of Local Public Health Agencies (alPHa) Board of Directors has begun to develop a response process for the discussion paper. As a first step, alPHa developed a short survey to collect members' initial reactions which closed January 8, 2016.

The Ministry has identified a number of questions about how to successfully plan for and implement the proposed changes and hopes to receive feedback on those questions. Feedback and further questions can be sent to health.feedback@ontario.ca or submitted at http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20151217.aspx.

This report was prepared by Mr. John Millson, Associate Director of Finance.

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

Dear Member,

Please find below the links to a just released discussion paper from Ontario's Minister of Health and Long-Term Care outlining proposals to transform Ontario's health system. Highlighted below are the proposed changes related to public health, in particular changes in the relationship between Boards of Health, Medical Officers of Health, public health units and LHINs.

The discussion paper describes four main proposals focussed on: strengthening population and public health and integration at the local level; improving access to primary care; strengthening and standardizing home and community care; and putting patients first and reducing inequities.

The Minster is looking for input and advice. Our Board President Larry Stinson and I have been invited to a stakeholder session this afternoon with the Minister and Deputy Minister. We'll keep you posted as we learn more.

Feedback on the discussion paper can be submitted to health.feedback@ontario. Possible changes to legislation is being considered for the spring of 2016. OPHA will no doubt be reviewing these proposals more closely and developing a submission to the ministry in the coming weeks.

Proposals related to Public Health:

Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.

To better integrate population health within our health system, we propose that LHINs and public health units build on the collaborations already underway, and work more closely together to align their work and ensure that population and public health priorities inform health planning, funding and delivery.

To support this new formal relationship:

- The ministry would **create aformal relationship between the Medical Officers of Health and each LHIN**, empowering the Medical Officers of Health to work with LHIN leadership **to plan population health services.**
- The ministry would **transfer the dedicated provincial funding for public health units to the LHINs** for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.
- The **LHINs** would **assume responsibility for the accountability agreements** with public health units.
- Local **boards of health** would continue to **set budgets**.

- The respective **boards of health**, as well as land ambulance services, would continue to be **managed at the municipal level.** As part of a separate initiative to support more consistent public health services across the province, the ministry is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.
- The ministry would also appoint an **Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units**, and **how to further improve public health capacity and delivery.**

Questions for feedback include:

1. *How can public health be better integrated with the rest of the health system?*
2. *What connections does public health in your community already have?*
3. *What additional connections would be valuable?*
4. *What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system*

Links to the Discussion Paper:

- http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf
- http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20151217.aspx

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From: AMO Communications [mailto:communicate@amo.on.ca]
Sent: Thursday, December 17, 2015 4:46 PM
To: Bennett, Karyn
Subject: AMO Breaking News - Ontario's Consultation on Primary, Home, and Community Health Care

December 17, 2015

Ontario's Consultation on Primary, Home, and Community Health Care

Today, the Minister of Health and Long-Term Care, the Honourable Dr. Eric Hoskins, launched a consultation process on primary, home and community health care, and to strengthen population and public health.

The provincial government in their discussion paper, "Patients First: A Proposal to Strengthen Patient Centred Health Care in Ontario", set out a series of proposals for public consultation. This will potentially involve a restructuring of primary and public health service delivery which may have implications for public health. There may also be an opportunity to explore the delivery of community paramedicine as a form of primary care, although this is not included in the scope of the discussion paper.

For public health, there are two major proposals being floated out in the Ministry's discussion paper. The first is to require Public Health Units to participate in formalized planning and joint initiatives with the Local Health Integration Networks (LHINs).

The second proposal is that public health funding be flowed through the LHINs to Public Health units. This raises a number of significant municipal questions about funding and governance relationships. AMO will assess the appropriateness of such a transfer of responsibility, and if it occurs, provide advice so that it is done under the right conditions. AMO and its members will want to be assured that the Ministry provides a guarantee of current level of public health funding with growth funding within a designated envelope. Further, AMO will want to be satisfied that the LHINs will not be overly prescriptive and still allow for effective Boards of Health functioning and governance.

AMO expects to be involved throughout the Ministry's transformative strategy development and implementation discussions. AMO will be seeking the inclusion of an elected official on any consultation or advisory groups as municipal governments are the cofunders, and in some cases, the employers of Public Health Units.

AMO will be establishing its own municipal officials group to make recommendations directly to the Minister on the consultation paper questions.

The government's discussion paper and information on how to provide your council's input into the consultation are found on the Ministry website. If commenting, we would ask you to provide AMO with your input by contacting Michael Jacek, Senior Advisor, so that it can inform our analysis and proposed approach.

In other health related news, the government also announced that the Province is investing $16.2 million in 1,000 supporting housing units across the province, including $4 million for 248 supportive housing units in 2016-17. For more information, see the news release.

AMO Contact: Michael Jacek, Senior Advisor, E-mail: mjacek@amo.on.ca, 1-877-426-6527 (toll free) or 416.971.9856 (local) ext. 329.

PLEASE NOTE: AMO Breaking News will be broadcast to the member municipality's council, administrator, and clerk. Recipients of the AMO broadcasts are free to redistribute the AMO broadcasts to other municipal staff as required. We have decided to not add other staff to these broadcast lists in order to ensure accuracy and efficiency in the management of our various broadcast lists.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 005-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

COLUMBIA SPORTSWEAR DONATIONS

Recommendation

It is recommended that Report No. 005-16 re "Columbia Sportswear donations" be received for information.

Key Points

- Columbia Sportswear Canada donated large amounts of surplus clothing to the MLHU.
- Some items required minor repairs and cleaning, which was covered by MLHU.
- The Emergency Management program plans to continue to support this extraordinary opportunity to clothe newcomers and at-risk clients.

Background

In 2015, the MLHU was approached by partners at Middlesex-London Emergency Medical Services (M-L EMS) to assist in the distribution of Columbia Sportswear Canada's generous donation of clothing and footwear.

These items are deemed surplus by Columbia Sportswear, and may be season ends, returns, damaged goods, mislabeled or otherwise gently used.

Since the health unit's programs and services assist the citizens of Middlesex County and the City of London who are in need, and that MLHU is well connected to other social support services, it was a logical fit. MLHU staff supports new immigrants, single parents and families with young children where the annual income may not ever allow them the luxuries of new coats or boots.

In the spring and fall, the CERV team (Community Emergency Response Volunteers) sorted and distributed approximately 500 fleece sweaters, 350 coats, 100 pairs of boots and numerous other clothing items.
The Health Unit paid two newcomers to repair 75 zippers on coats and had to dry-clean 6 coats, which altogether cost about $800.00. Attached as Appendix A is a photo of the materials and the set-up for distribution.

In addition to supporting some at-risk clients, MLHU also provided much needed items to:

1) Clients of the Social Services Department at Middlesex County
2) The Salvation Army for the Night-time street outreach program
3) Single boots were donated to Bio Ped for their amputee support program at Parkwood Hospital
4) St. Michaels Elementary and Roosevelt Public Schools received coats for many immigrant children
5) Disabled male residents in a Public Guardian/Trustee group home in Strathroy received coats, fleece and boots each

Columbia has another 40 large boxes of items to donate to MLHU and will likely have more in the future. This is an extraordinary opportunity to support people of this region who are touched by poverty.

Next Steps

MLHU will continue to cover the minor costs associated with this exercise, to a maximum of $2,000.00 per year, using existing program dollars.

This report was prepared by Patricia Simone, Emergency Manager.

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

Appendix A to Report No. 005-16 - Columbia Sportswear Donations

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – JANUARY

Recommendation

It is recommended that Report No. 006-16 re Medical Officer of Health Activity Report – January be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the December Medical Officer of Health Activity Report to January 6, 2016.

On December 3rd, the MOH along with Kim Leacy, Public Health Dietician, hosted a "Conversation in a Box" event for MLHU staff. The conversation had 2 primary goals; to get staff feedback on the Shared Understanding of Poverty and; gather staff input on gaps, barriers, and solution to poverty in London. This event is part of the engagement strategy of the Mayor's Advisory Panel on Poverty (MAPOP). The next step in this process will be for the panel members to check in with the community to ask if the recommendations are on the right track.

Similar to the December 3rd Conversation in a Box event that was held for MLHU staff, the MOH, Joanne Simpson and Kim Leacy hosted an event for health professionals in the community. The conversation was attended by approximately 15 people and the feedback was positive.

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

December 2	Attended a meeting with Chairs of the Mayor's Advisory Panel on Poverty (MAPOP) Did a radio interview with Craig Needles in regards to Safe Injection Sites
December 3	Attended the Middlesex County Inaugural Meeting
December 4	Via Skype, presented at McMaster University – the topic was Management Skills within Public Health Units
December 7	Delivered opening remarks at the Healthy Kids Community Challenge event
December 8	Participated in a United Way allocation meeting
December 9	Attended a meeting of MAPOP at London Public Library Central Branch to hear delegations for formal presentation to the panel Attended a farewell gathering for Shaun Elliott, formally of YMCA Western Ontario
December 10	Participated in 2 days of Change Management Training Attended a Community Conversation event with MAPOP Attended the Board of Health meeting and dinner

December 14	Participated in an interview with CBC Radio about the Health Minister's announcement regarding vaccine exemptions
December 15	Attended the MLHU Preceptor Recognition Reception Met with Michael Harkins, Acting Executive Director, London Bridge Child Care Services Met with Joanne Sherin, ED at Vanier Children's Services to discuss the Mental Health Transformation agenda
December 17	Attended a YOU Board meeting Attended the farewell celebration for Michelle Hurtubise, outgoing Executive Director for London InterCommunity Health Centre Participated in a teleconference meeting with the South West LHIN and Public Health Units - Patients First: Proposal to Strengthen Patient-Centred Health Care in Ontario
December 21	Attended a meeting with UWO staff in regards to drug resistance testing
January 4	Was interviewed by Mike Stubbs, CJBK radio in regards to an article about vaccines in Australia
January 5	Interview with Phil McLeod - McLeod Report CJBK in regards to red light cameras Attended The Collaborative Champion meeting at LHSC Attended a MAPOP meeting Met with City and County staff to discuss health unit funding

This report was prepared by Lynn Guy, Executive Assistant to the Medical Officer of Health.

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