AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, October 18, 2018, 7:00 p.m.
399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

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. Joanne Vanderheyden (Chair)
Ms. Trish Fulton (Vice Chair)
Ms. Maureen Cassidy
Mr. Michael Clarke
Mr. Jesse Helmer
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

September 20, 2018 – Board of Health meeting

DELEGATIONS

7:05 – 7:15 p.m.	Chair, Relocation Advisory Committee - Verbal Update, re: Item #1 Relocation Advisory Committee meeting, October 18, 2018

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Delegations and Committee Reports						
1	Relocation Advisory Committee Meeting – Verbal Update	October 18, 2018 Agenda	x	x	x	To receive information and consider recommendations from the October 18, 2018 Relocation Advisory Committee meeting.
Information Reports						
2	Submission to Environmental Registry Ontario on Bill 4: Cap and Trade Cancellation Act 2018 (Report No. 066-18)	Appendix A			x	To provide an update on the submission to the Environmental Registry Ontario regarding Bill 4, Cap and Trade Cancellation Act 2018.
3	Prenatal Health Planning Initiative: Process, Recommendations and Implications (Report No. 065-18)				x	To provide an update on the planning process related to prenatal health in an effort to strengthen evidence-informed resource allocation in the area of prenatal health, cohesion in prenatal health programs, and compliance with the 2018 Healthy Growth and Development Standard.
4	Middlesex-London Community Drug and Alcohol Strategy – A Foundation for Action (Report No. 061-18)	Appendix A			x	To provide an update on the Community Drug and Alcohol Strategy report with recommendations to prevent and address substance related harms in London and Middlesex.
5	Support for Plain and Standardized Tobacco Products and Packaging (Report No. 062-18)	Appendix A			x	To provide an update on the plain and standardized products and packaging legislation which will result in removing all tobacco product design features.
6	Summary Information Report for October (Report No. 063-18)				x	To provide an update on Health Unit programs and services for October.

7	Medical Officer of Health/Chief Executive Officer Activity Report for October (Report No. 064-18)				x	To provide an update on the activities of the MOH/CEO for October.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: November 1, 2018 @ 9:00 a.m.
- Next Board of Health Meeting: November 15, 2018 @ 7:00 p.m.
- Next Governance Committee Meeting: November 15, 2018 @ 6:00 p.m.

CORRESPONDENCE

CONFIDENTIAL

The Board of Health will move in-camera to approve Confidential minutes from its September 20, 2018 meeting.

ADJOURNMENT

CORRESPONDENCE – OCTOBER 2018

a) Date: 2018 September 6
Topic: Ontario Basic Income Pilot
From: Huron County Health Unit
To: The Honourable Doug Ford

Background:

On September 6, 2018, the Huron County Board of Health wrote to Premier Doug Ford urging the Ontario government to reconsider the decision to cancel the Ontario Basic Income Pilot. This request supports similar requests made by other public health agencies across the province. These are referenced in the Board of Health agenda for September 20, 2018, correspondence items j), m), o), p), r), s), t), and u).

Recommendation:

Receive.

b) Date: 2018 September 14
Topic: Email from the Premier of Ontario re: Dedicated Funding for local Public Health Agencies from Cannabis Sales
From: Premier Doug Ford
To: Ms. Joanne Vanderheyden, Chair, Middlesex-London Board of Health

Background:

On September 14, 2018, Premier Doug Ford responded to a letter from Middlesex-London Health Unit's Board of Health regarding the Board's endorsement of dedicated funding for local public health agencies from cannabis sales. The endorsed correspondence item can be referenced in the Board of Health agenda for May 17, 2018, correspondence item a). Premier Ford indicated that the issue falls under the responsibility of the Minister of Finance, Honourable Vic Fedeli, and that the Board of Health's views will be taken into consideration.

Recommendation:

Receive.

c) Date: 2018 September 17
Topic: St. Joseph's Health Care London Community Partner of Distinction Award
From: Office of the President, St. Joseph's Health Care London
To: The Middlesex-London Health Unit Outreach Team

Background:

On September 17, 2018, the President of St. Joseph's Health Care London notified MLHU staff that the Health Unit's Outreach Team was selected as this year's recipient of the St. Joseph's Health Care London Community Partner of Distinction Award. This award recognizes partnership and

collaboration, and is a result of the positive impact the Outreach Team has had on the delivery of good and safe patient care in the midst of an HIV and Hep C challenge.

Recommendation:

Endorse.

d) Date: 2018 September 20
Topic: *Smoke-Free Ontario Act, 2017*
From: Haliburton, Kawartha, Pine Ridge District Health Unit
To: The Honourable Christine Elliott

Background:

On September 20, 2018, the Board of Health for Haliburton, Kawartha, Pine Ridge District Health Unit wrote to Minister Christine Elliott expressing concern over the delay in implementing the *Smoke-Free Ontario Act, 2017*. Haliburton, Kawartha, Pine Ridge District Health Unit joins other Ontario boards of health in supporting the placement of restrictions on vaping to reinforce ongoing efforts to reduce the use of tobacco and its associated or analogous products.

Recommendation:

Receive.

e) Date: 2018 September 17
Topic: Ontario Basic Income Pilot
From: Chatham-Kent Public Health Unit
To: The Honourable Lisa MacLeod

Background:

On September 17, 2018, the Chatham-Kent Public Health Unit Board of Health wrote to Minister Lisa MacLeod expressing concern over the announcement to cancel the Ontario Basic Income Pilot. The Chatham-Kent Public Health Unit joins the other public health agencies as referenced in the above correspondence item a).

Recommendation:

Receive.

f) Date: 2018 July 3 [received September 27]
Topic: *Smoke-Free Ontario Act, 2017*
From: Peterborough Public Health
To: The Honourable Christine Elliott

Background:

On July 3, 2018, Peterborough Public Health's Board of Health wrote to Minister Christine Elliot urging the Ontario government to reconsider the pause in implementing *Smoke-Free Ontario Act, 2017* regulations that were to come into effect. The Board of Health for Peterborough Public Health was encouraged by the Executive Steering Committee's "Smoke-Free Ontario Modernization" report, and recognizes the range of strategies that are critical to meeting Ontario's goal of having the lowest rates of commercial and tobacco use in Canada.

Recommendation:

Receive.

g) Date: 2018 September 28
Topic: One-month extension for Overdose Prevention Site
From: Office of the Honourable Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care
To: Ms. Joanne Vanderheyden, Chair, Middlesex-London Board of Health

Background:

On September 28, 2018, Minister Christine Elliott advised the Middlesex-London Health Unit's Board of Health that the Ministry of Health and Long-Term Care approved a one-month extension, to October 31, 2018, for the Overdose Prevention Site. Minister Elliott advised that she is in the process of finalizing her recommendations following a review of the latest data, evidence, current site models, and period of consultation.

Recommendation:

Receive.

h) Date: 2018 September 27
Topic: Report: "Prevention Matters: Why Ontario Needs a Chronic Disease Prevention Strategy"
From: KFL&A Public Health
To: Office of the Honourable Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care

Background:

At its September 26, 2018, meeting the KFL&A Public Health Board of Health endorsed the report "Prevention Matters: Why Ontario Needs a Chronic Disease Prevention Strategy," including the recommendations made in this report. The report recommends: 1) investment in a comprehensive provincial chronic disease prevention strategy, 2) creation of a chronic disease prevention council to provide leadership and advice, and 3) creation of an inter-ministerial council to plan and coordinate actions across provincial government agencies.

Recommendation:

Receive.

i) Date: 2018 September 27
Topic: Drug Policy Reform
From: KFL&A Public Health
To: The Right Honourable Justin Trudeau, Prime Minister of Canada

Background:

At its September 26, 2018 meeting, the KFL&A Public Health Board of Health passed a motion to urge the federal government to strike a national advisory committee to consider drug policy reform, including a full spectrum of decriminalization options, which may have the potential to address the opioid overdose crisis. KFL&A Public Health supports a harm reduction approach to substance use and maintains that illicit drug decriminalization needs to be considered as a fundamental element of drug policy reform.

Recommendation:

Receive.

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, September 20, 2018, 8:00 p.m.

MEMBERS PRESENT:	**Ms. Joanne Vanderheyden, Chair** Ms. Trish Fulton Ms. Tino Kasi Mr. Jesse Helmer Mr. Trevor Hunter Mr. Marcel Meyer Mr. Kurtis Smith
REGRETS:	Mr. Michael Clarke Ms. Maureen Cassidy Mr. Ian Peer
MEDIA:	Mr. Christian D'Avino, 980 CFPL
OTHERS PRESENT:	Dr. Christopher Mackie, Secretary-Treasurer Dr. Alexander Summers, Associate Medical Officer of Health Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Ms. Muriel Abbott, Public Health Nurse Mr. Jordan Banninga, Manager, Program Planning and Evaluation Ms. Laura Di Cesare, Director, Healthy Organization Ms. Shaya Dhinsa, Manager, Sexual Health Mr. Dan Flaherty, Communications Manager Mr. Brian Glasspoole, Manager, Finance Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance Ms. Kim Loupos, Dietitian Ms. Linda Stobo, Manager, Chronic Disease and Tobacco Control Ms. Kendra Ramer, Manager, Strategic Projects Ms. Maureen Rowlands, Director, Healthy Living Ms. Ruth Sanderson, Epidemiologist Mr. Stephen Turner, Director, Environmental Health and Infectious Diseases Mr. Alex Tyml, Online Communications Coordinator Ms. Deena Ruston

Chair Vanderheyden called the meeting to order at 8:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Vanderheyden inquired if there were any disclosures of conflicts of interest to be declared.

Mr. Hunter declared a conflict with regard to Governance Committee item number 4.2 (Board Development Activities) and advised that he abstained from discussion and voting on this matter at the Governance Committee meeting earlier this evening.

No other conflicts of interest were declared.

APPROVAL OF AGENDA

It was moved by Mr. Smith, seconded by Mr. Meyer, *that the **AGENDA** for the September 20, 2018 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Hunter, seconded by Ms. Kasi, *that the **MINUTES** of the July 19, 2018 Board of Health meeting be approved.*

Carried

DELEGATIONS AND COMMITTEE REPORTS

Finance & Facilities Committee (FFC) Meeting – September 6, 2018 (Report No. 051-18)

Ms. Fulton introduced, provided context for, and summarized the following reports, which were considered at the September 6 FFC meeting.

Q2 Financial Update and Factual Certificate (Report No. 033-18FFC)

It was moved by Ms. Fulton, seconded by Mr. Meyer, *that the Board of Health approve Report No. 033-18FFC re: "Q2 Financial Update and Factual Certificate."*

Carried

Middlesex-London Health Unit – March 31 Draft Financial Statements (Report No. 034-18FFC)

It was moved by Ms. Fulton, seconded by Ms. Kasi, *that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31, 2018, as recommended by the Finance & Facilities Committee.*

Carried

The Finance & Facilities Committee received the following reports for information:

Location Project – Status Update (Report No. 035-18FFC)

This report outlined the estimated timeline for the move and contained other updates regarding the current status of the location project.

Location Project – Architectural Services (Report No. 036-18FFC-R)

Ms. Fulton noted that there was much discussion in the minutes regarding Report 036-18FFC and that the Committee asked for further information regarding the architect. This information is provided in the revised report (036-18FFC-R).

Discussion ensued on the following items:

- Dr. Mackie walked the Board through Revised Report No. 036-18FFC-R, as well as the context behind the request for a single-source contract, namely to expedite the build and move schedule to reduce financial risk to MLHU. The current build schedule is for 14 to 15 months. Some efficiencies have been identified in terms of timing, such as selecting a single-source architect, which would speed up the process for the build schedule.

- That the Health Unit sought quotes from other high-quality architects in the area, as requested by the Finance & Facilities Committee. Other quotes were received; however, they did not provide a fixed bid, which could pose financial risks for the Health Unit. Staff have confidence in the current bid before the Board this evening.
- That selecting this architect would allow work to begin immediately, and that the architect already has knowledge of the building, having completed work in it for the landlord.
- That entering into a competitive process would not only push back the start date for this work by another two to three months, but would be unlikely to yield any bids as competitive as this one, which is well below published industry standards.
- Mr. Meyer noted his concerns regarding a single-source contract and thanked staff for adding additional information to the revised report.

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

1) *Receive Report 036-18FFC-R re: "Location Project – Architectural Services" for information; and*
2) *Approve entering into a single-source contract with Endri Poletti Architect Inc. for the purpose of providing architectural services at Citi Plaza.*

Carried

Location Project – Project Management Services (Report No. 037-18FFC-R)

Ms. Fulton introduced this revised report and outlined the information that had been added since the September 6 Finance & Facilities Committee meeting.

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

1) *Receive Report No. 037-18FFC re: "Location Project – Project Management Services" for information; and*
2) *Approve entering into a contract with BES Project Consulting for the purpose of providing construction project management services at Citi Plaza.*

Carried

The Committee's next meeting will be on Thursday, October 4, at 9:00 a.m., in Room 3A, 50 King Street.

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that the Board of Health receive the MINUTES of the September 6, 2018 Finance & Facilities Committee meeting, including the revised reports 036-18FFC-R and 037-18FFC-R.*

Carried

Mr. Trevor Hunter, Chair, Governance Committee re: Item #2 **Governance Committee Meeting September 20, 2018**

It was moved by Mr. Hunter, seconded by Mr. Smith, *that the Board of Health receive the **MINUTES** of the June 21, 2018 Governance Committee meeting.*

Carried

Ad Hoc Committee – Location Project (Report No. 010-18GC)

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

1) *Receive Report No. 010-18GC re: "Ad Hoc Committee – Location Project"; and*
2) *Approve the creation of an Ad Hoc Committee and the Terms of Reference for this Committee (Appendix A).*

Carried

Board Development Activities (Report No. 009-18GC)

Mr. Hunter noted that this was where he declared a conflict, and accordingly, after introducing the item, did not participate in the discussion or vote on the matter at the Governance Committee meeting.

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

1) *Receive Report No. 009-18GC re: "Board Development Activities" for information; and*
2) *Approve the "Leading Through Transition/Change Management" session delivered by Your Latitude as a Board development opportunity, as recommended by the Governance Committee.*

Carried

Governance Policy Review (Report No. 008-18GC)

Mr. Hunter ran through the policies that were reviewed and considered at the Governance Committee meeting, which included: G-B30 Proceedings of the Board of Health, G-205 Borrowing, G-290 Standing and Ad Hoc Committees, G-340 Whistleblowing, and G-395 LHIN Relationships.

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

1) *Receive report No. 008-18GC re: "Policy Review" for information; and*
2) *Approve the new and revised governance policies outlined in Appendix A.*

Carried

The next Governance Committee meeting will be on Thursday, November 15, 2018, at 6:00 p.m.

Chair Vanderheyden opened the floor for nominations to the Relocation Advisory Committee. She outlined the Committee's membership as per the Terms of Reference, which stipulate that membership must include: the Chair of the Board of Health and at least one City, one County, and one provincial representative.

Chair Vanderheyden advised that Mr. Peer and Mr. Clarke have already agreed to let their names stand, should they be nominated to this committee.

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that Mr. Jesse Helmer be nominated to the Relocation Advisory Committee.*

Carried

Mr. Helmer agreed to let his name stand.

It was moved by Mr. Smith, seconded by Ms. Kasi, *that Mr. Meyer be nominated to the Relocation Advisory Committee*.

Carried

Mr. Meyer agreed to let his name stand.

It was moved by Mr. Hunter, seconded by Mr. Meyer, *that Mr. Clarke be nominated to the Relocation Advisory Committee.*

Carried

Mr. Clarke agreed to let his name stand in advance of the meeting.

It was moved by Mr. Hunter, seconded by Ms. Kasi, *that Mr. Hunter be nominated to the Relocation Advisory Committee*.

Carried

Mr. Hunter agreed to let his name stand.

It was moved by Ms. Kasi, seconded by Mr. Meyer, *that Mr. Peer be nominated to the Relocation Advisory Committee*.

Carried

Mr. Peer agreed to let his name stand in advance of the meeting.

Since two names were brought forward for the single remaining seat on the Relocation Advisory Committee, a vote of Board of Health members was held.

Ms. Milne distributed the ballots.

Dr. Mackie, Secretary-Treasurer, collected the ballots and tallied the votes.

Dr. Mackie advised that Mr. Peer was selected to take the remaining seat

Mr. Helmer said he would resign his seat and allow Mr. Hunter to take over his seat on the Committee as City representative.

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

1) *Accept Mr. Helmer's resignation from the Relocation Advisory Committee; and*
2) *Appoint Mr. Hunter to sit as City Representative on the Relocation Advisory Committee.*

Carried

Chair Vanderheyden invited nominations three more times. Hearing none, it was moved by Mr. Meyer, seconded by Ms. Kasi, *that nominations be closed and that Mr. Hunter, Mr. Meyer, Mr. Clarke, and Mr. Peer be appointed to the Relocation Advisory Committee*

Carried

It was moved by Mr. Meyer, seconded by Mr. Smith, *that the ballots be destroyed.*

Carried

Dr. Alex Summers and Ms. Ruth Sanderson re: Plan to Update the Online Community Health Status Resource

Dr. Summers introduced Board of Health members to the Community Health Status Resource and how it relates to the Board's work. Ms. Ruth Sanderson provided background on the resource and outlined the steps that will be taken to update the data and align the resource with the new 2018 Public Health Standards.

Discussion ensued on the following items:

- Who the audiences for this information are, how these audiences will be considered when rebuilding the resource, and if testing will be carried out, once rebuilding is complete, to ensure that audiences are able to interact with the data.
- That the Health Unit's Senior Leadership Team will assist in identifying high-impact audiences for the resource as it is built and through each of the planning cycles.
- Where the data will be collected from, and that the update will also help to identify some of the gaps in data sources.

It was moved by Mr. Meyer, seconded by Mr. Hunter, *that the Board of Health receive the presentation and plan to update the online Community Health Status Resource.*

Carried

Mr. Jordan Banninga re: Item No. 6 – Review of Public Health Services in Middlesex County – Findings (Report No. 055-18)

Mr. Banninga outlined the findings, key highlights, and considerations that came out of the Review of Public Health in Middlesex County.

Discussion ensued on the following items:

- The survey method's limitations, the value of engaging councillors at council meetings, and the number of councillors that responded to the surveys to help inform this report.
- That the Health Unit's move would not negatively impact the health of the County, per the considerations outlined in this report.
- If there was there a difference in health outcomes between different areas in the County.
- That this report represents just the beginning of a conversation with municipalities about Health Unit programs and services.
- Next steps in the process, namely to request delegation status at Middlesex County Council, to bring forward the report, and then to begin finalizing recommendations.

It was moved by Mr. Hunter, seconded by Ms. Kasi, *that the Board of Health receive Report No. 055-18 re: "Review of Public Health Services in Middlesex County – Findings" for information.*

Carried

RECOMMENDATION REPORTS

Organizational Plan for Reconciliation (Report No. 052-18)

Dr. Mackie introduced this report and provided context, noting that it will assist the Health Unit in playing an important role in reconciliation.

Discussion ensued on the following items:

- That when education is provided to staff, it be provided to Board of Health members at the same time.
- The reconciliation process through PBMA.

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

1) *Receive Report No. 052-18 re "Organizational Plan for Reconciliation" for information;*
2) *Approve implementation of the organizational plan for reconciliation in principle; and*
3) *Direct that the Senior Leadership Team consider these recommendations as well as the data from Our Health Counts, and bring any resource requirements forward through the PBMA process; and*
4) *Direct staff to share this report with other public health units and others.*

Carried

Nutritious Food Basket (Report No. 053-18)

Dr. Mackie introduced this report and provided context. He noted that the report's authors were in attendance to answer questions, if needed.

Discussion ensued on how the findings from this report are the same every year, and what might be done to change the outcomes detailed in the report.

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

1) *Request that the federal Minister of Families, Children and Social Development commit additional funding for poverty reduction in Budget 2019, and report the marginal food insecurity category separately from the food secure category within the Canadian Community Health Survey Household Food Security Survey Module;*

2) *Request that the Ontario Minister of Children, Community and Social Services consider reinstating the Ontario Basic Income Pilot study to support completion of the evaluation, and to increase social assistance rates to reflect the cost of nutritious food and safe housing; and*

3) *Forward Report No. 053-18 re: "2018 Nutritious Food Basket Survey Results and Implications for Government Public Policy and Action" to Ontario boards of health, the City of London, Middlesex County, and appropriate community agencies.*

Carried

Public Health Considerations for the 2018 Municipal Election (Report No. 059-18)

Dr. Mackie introduced this report. Ms. Rowlands advised that this primer will help municipal election candidates highlight some of the critical areas where they may play a role to help improve the health of their communities.

Board of Health members noted that this document is a great introduction to public health for new candidates.

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

1) *Receive Report No. 059-18 re: "Public Health Considerations for the 2018 Municipal Election" for information; and*

2) *Direct the Medical Officer of Health to send the "Healthy People, Healthy Communities" primer, attached as Appendix A, to all municipal candidates in the Middlesex-London area in advance of the election to profile the role that municipal councils play in influencing individual and community health.*

Carried

INFORMATION REPORTS

Hepatitis A in Homeless/Under-Housed Population (Report No. 054-18)

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that the Board of Health receive Report No. 054-18 re: "Hepatitis A in Homeless/Under-Housed Populations" for information.*

Carried

2017-18 School-Based Dental Screening Results (Report No. 058-18)

Discussion ensued on why there is such a high rate of refusal of dental services as indicated in the report.

It was moved by Mr. Helmer, seconded by Ms. Kasi, *that the Board of Health receive Report No. 058-18 re: "2017–2018 School-Based Dental Screening Results" for information.*

Carried

Summary Information Report for September (Report No. 056-18)

It was moved by Ms. Kasi, seconded by Mr. Smith, *that the Board of Health receive Report No. 056-18 re: "Summary Information Report for September 2018" for information.*

Carried

Medical Officer of Health/Chief Executive Officer Activity Report for September (Report No. 057-18)

It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Board of Health receive Report No. 057-18 re: "Medical Officer of Health Activity Report for September" for information.*

Carried

CORRESPONDENCE

It was moved by Ms. Kasi, seconded by Mr. Hunter, *that the Board of Health receive correspondence items a) through u).*

Carried

OTHER BUSINESS

Chair Vanderheyden reviewed the next meeting dates of the Finance & Facilities Committee, the Board of Health, and the Governance Committee, and requested approval of the draft 2019 meeting dates.

It was moved by Ms. Kasi, seconded by Mr. Hunter, *that the Board of Health approve the draft 2019 Board of Health, Governance Committee, and Finance & Facilities Committee meeting schedule.*

Carried

- Next Finance & Facilities Committee meeting: October 4, 2018 @ 9:00 a.m.
- Next Board of Health meeting: October 18, 2018 @ 7:00 p.m.
- Next Governance Committee meeting: November 15, 2018 @ 6:00 p.m.

Dr. Mackie flagged some additional items of note under "other business":

1) The Health Unit's Outreach Team has been selected as this year's recipient of the St. Joseph's Health Care London Community Partner of Distinction Award, which recognizes partnership and collaboration.
2) The response to a procedural question regarding abstention from voting and how it is to be handled, which was raised at the September 6, 2018 Finance & Facilities Committee meeting. Per the Board of Health Procedural Bylaw, for a motion to be successful, it requires a majority vote; therefore abstention is considered a negative vote.
3) That the Health Unit will be making a submission to the national pharmacare process based as much as possible on previous Board of Health positions. If the Board of Health wishes to review the submission before it is sent in, please contact Dr. Mackie or Ms. Milne.

Mr. Hunter noted that he had an opportunity to tour the Temporary Overdose Prevention Site (TOPS) with Mr. Peer, which helped them learn more about the importance of harm reduction services in the community. Mr. Hunter urged all municipal election candidates to visit the site to learn more about the service it provides and the lives it saves.

Dr. Mackie noted that his door is always open to any candidate who wishes to tour the facility.

A brief discussion ensued about who the audience is for the Business Case for Supervised Consumption in London, Ontario.

CONFIDENTIAL

At 9:40 p.m., it was moved by Mr. Hunter, seconded by Mr. Helmer, *that the Board of Health move in-camera to discuss matters regarding identifiable individuals and potential litigation affecting the Middlesex-London Board of Health.*

Carried

At 10:09 p.m., it was moved by Mr. Helmer, seconded by Mr. Hunter, *that the Board of Health rise and return to public session.*

Carried

At 10:09 p.m., the Board of Health returned to public session.

ADJOURNMENT

At 10:09 p.m., it was moved Ms. Kasi, seconded by Mr. Hunter, *that the meeting be adjourned.*

Carried

JOANNE VANDERHEYDEN
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 066-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 October 18

SUBMISSION TO ENVIRONMENTAL REGISTRY ONTARIO ON BILL 4: CAP AND TRADE CANCELLATION ACT 2018

Recommendation

It is recommended that Report No. 066-18 Re:* "Submission to Environmental Registry Ontario on Bill 4: Cap and Trade Cancellation Act 2018"** ***be received for information.

Key Points

- In 2014, MLHU commissioned a report entitled "Assessment of Vulnerability to the Health Impacts of Climate Change in Middlesex-London."
- With the release of the International Panel on Climate Change's Global Warming at 1.5 C report, the threat posed by climate change is even more clear. impacts of climate change on population health, MLHU provided comments on the need for robust climate change policies at the provincial level.
- The provincial government has announced its intent to repeal Cap and Trade carbon policies in Ontario. With a short comment period for public submissions on the legislation, MLHU staff have submitted comments based on past Board of Health discussions and decisions.

Background

Recently, the provincial government introduced Bill 4, The Cap and Trade Cancellation Act, 2018, which will eliminate Cap and Trade carbon policies in Ontario. Environmental Registry Ontario (ERO) opened a 30-day comment period for citizens and agencies to provide input into this proposed legislation. This comment period ended on October 11.

Given the demonstrated and anticipated effects of climate change on population health, it was important that public health agencies submit comments summarizing these effects and emphasizing the need to ensure that the provincial government develop a comprehensive plan to reduce greenhouse gas emissions and take mitigative measures against the effects of climate change, should Cap and Trade be repealed.

The Middlesex-London Health Unit prepared and submitted comments to the ERO review process that identified the mandate public health has been given to identify and plan for the effects of climate change (Appendix A). These comments also included an attachment of the 2014 MLHU report referenced above.

This report was prepared by the Food Safety & Healthy Environments Team, Environmental Health and Infectious Disease Division.

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

Appendix A to Report No. 066-18

Dear Minister Phillips,

In response to the call for public comments to Bill 4, the Cap and Trade Cancellation Act, 2018, the Middlesex-London Health Unit has prepared a short submission to contribute to the review process.

The Middlesex-London Health Unit (MLHU) believes strongly in promoting a healthy environment and protecting the health of our communities consistent with our legislative mandates laid out by the Ministry of Health and Long Term-Term Care. Recent changes to these mandates include the introduction of the *Healthy Environments and Climate Change Guideline* which seeks to assist boards of health in developing approaches for promoting healthy built and natural environments to enhance population health and mitigate environmental health risks. Specifically, the Guideline presents existing and new population-based activities to address the health impacts of environmental health issues, which include climate change and environmental exposures of public health significance.

The Guideline supports the development of strategies that raise public awareness and reduce environmental health risks, allowing for evidence-informed program delivery to address the needs of priority populations within local communities. The objective of this guideline is to identify approaches for boards of health that must be used or considered to achieve the following:

- Enhance public health capacity to address risk factors in the environment, including the impacts of climate change, using population-based activities (e.g. Vulnerability Assessments).
- Identify and enable mitigation of risk factors related to environmental exposures that can contribute to the burden of illness.
- Facilitate upstream, preventative strategies for advancing healthy built and natural environment initiatives using standard provincial approaches.
- Align existing public health initiatives across boards of health to ensure optimum delivery from both the Healthy Environments and Chronic Disease Prevention Standards.

The MLHU has been actively addressing actual and anticipated risks to public health associated with climate change. In 2014, a comprehensive report, titled "*Assessment of Vulnerability to the Health Impacts of Climate Change in Middlesex-London*", was completed to identify these risks associated with climate change in our region. The MLHU collaborated with representatives from most sectors in the community, identified local threats, vulnerable populations, and associated community resources and susceptible to the effects of climate change**.** The go-forward plan resulting from this assessment remains consistent with the Guideline. This work includes seeking collaboration with community partners at all levels to develop effective community-based strategies that reduce exposure to health hazards and promote healthy built and natural environments. These strategies must also support the collection of objective evidence to monitor the value of adaptive and mitigative strategies, the identification of changing risks and hazards, and the facilitation of effective knowledge transfer (education) at all levels of the population.

In this regard, the MLHU has shown leadership in developing formal strategies to address extreme weather events and in seeking strategies as to how best to engage and support community partners. The MLHU acknowledges the importance of the provincial government's leadership role in recognizing the public health impacts of climate change by supporting efforts to reduce greenhouse gas emissions and the need for adaptive strategies.

The work done to produce the Middlesex-London Health Unit's Vulnerability Assessment has helped to illustrate the need for a provincial climate change strategy that reduces greenhouse gas emissions, improves air and water quality, and protects ecosystems sensitive to the effects of climate change. While it is recognized that the provincial government's intent is to discontinue the 'Cap and Trade' program, we encourage the Province to strive to ensure similar carbon reductions are nonetheless achieved. The Middlesex-London Health Unit also recommends that the Province ensure comprehensive prevention and mitigation strategies continue to be developed and enacted to help safeguard Ontarians from the population health risks associated with climate change including food-, water-, and vector-borne diseases, air pollution, environmental health hazards, extreme weather events, and food and water scarcity.

We thank you for the opportunity to present comments and we hope that you will find the attached report valuable to your review.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 065-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / Chief Executive Officer

DATE: 2018 October 18

PRENATAL HEALTH PLANNING INITIATIVE: PROCESS, RECOMMENDATIONS AND IMPLICATIONS

Recommendation

It is recommended that the Board of Health receive Report No. 065-18 re "Prenatal Health Planning Initiative: Process, Recommendations and Implications" for information.

Key Points

- Healthy Start engaged in an evidence-informed planning process related to prenatal health in an effort to strengthen evidence-informed resource allocation in the area of prenatal health, cohesion in prenatal health programs, and compliance with the 2018 Healthy Growth and Development Standard.
- Prioritized prenatal health outcomes and priority populations were identified.
- The planning process provided helpful direction and resulted in program recommendations which will optimize public health programming related to prenatal health.

Background

Teams across Healthy Start provide a number of universal and targeted interventions related to prenatal health. A comprehensive program planning process related to prenatal health was undertaken by the division, in an effort to strengthen evidence-informed resource allocation in the area of prenatal health, cohesion in prenatal health programs and services, and compliance with directives. The applicable standards and guidelines are the 2018 Healthy Growth and Development Standard, and the Healthy Growth and Development, Health Equity, and Mental Health Promotion Guidelines.

Planning Process

The project team consisted of the Healthy Start Leadership team, seven Public Health Nurses from across the division, two Program Evaluators, and one Epidemiologist. They team used the MLHU Planning and Evaluation Framework to guide the planning process. Evidence was gathered from a variety of sources, including public health mandate, population health status, current allocation of resources in prenatal health, research and grey literature (on universal group prenatal education, and prenatal mental health promotion), prenatal education community resources, and other health units. Prioritized prenatal outcomes of interest, based primarily on population health status in London and Middlesex County, included mental wellbeing, smoking, substance use, alcohol use, and maternal weight gain. Based on population health status and literature, populations identified as priority for our catchment area included the following: low income; youth (24 years of age and under); Indigenous; and newcomers. A facilitator supported the project team in gathering information and in developing program recommendations related to prenatal health.

Program Recommendations

The following program recommendations resulted from this planning process:

- Continue providing prenatal information and support universally through online e-learning, up-to-date and credible website content, and Health Connection.
- Continue to offer universal group prenatal education on preparing for parenthood.
- Shift group prenatal education to focus on enhancing existing programs for priority populations (Smart Start for Babies, Prenatal Immigrant Program, targeted home visiting, support for Wholistic Prenatal Program at SOAHAC). Incorporate prenatal topic information from literature review into existing interventions.
- Explore needs and opportunities for staff capacity-building in the areas of prenatal health, community resources, prenatal mental health screening, and prenatal mental wellness promotion.
- Promote use of prenatal mental health self-assessment tool and provide self-help mental wellness resources on MLHU website.
- Promote universal prenatal mental health screening and confirm screening tools for MLHU use.
- Enhance consistency of prenatal health and wellness messaging, and coordination of MLHU efforts.

Conclusion

This evidence-informed planning process has provided helpful direction to support optimal public health programming related to prenatal health. Through this process, prenatal health outcomes have been prioritized, priority populations identified, and evidence from various sources used to develop prenatal health program recommendations. Implications will be considered through the 2019 budget process, including further consultations.

This report was prepared by the Healthy Start Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 061-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 October 18

MIDDLESEX-LONDON COMMUNITY DRUG AND ALCOHOL STRATEGY: A FOUNDATION FOR ACTION

Recommendation

It is recommended that report No. 061-18 re: "Middlesex-London Community Drug and Alcohol Strategy" be received for information.

Key Points

- The Middlesex-London Community Drug and Alcohol Strategy is a collaboratively developed, long-term strategy to prevent and reduce the harms of substance use in London and Middlesex County.
- The Strategy consists of 23 recommendations and 98 associated actions, with 59 of those actions prioritized for the next three years.
- Ongoing commitment of partners, and continued and strengthened collaboration among and between sectors, will be critical to success.

Background

In late 2015, the Middlesex-London Health Unit brought together more than eighty diverse community stakeholders to share information and discuss concerns regarding the impacts of substance use in our community. Although considerable work was already being done to assist those using substances, it was recognized that a long-term comprehensive strategy was required to support collaboration across sectors to bring about positive long-term change. Development of a local drug and alcohol strategy began in the spring of 2016, with a four-pillar approach—prevention, treatment, harm reduction, and enforcement. Board of Health Report No. 046-16 (July 2016) describes some of the early work in the development of the Middlesex-London Community Drug and Alcohol Strategy (CDAS).

The CDAS was developed through the dedicated involvement of numerous community partners. The process was guided by a Steering Committee, co-chaired by MLHU and Regional HIV/AIDS Connection, with support and input from four work-groups, each representing a pillar of the strategy. The development of the strategy was grounded in a collaboratively developed mission, vision, and guiding principles, and required intentional consultation with a broad range of stakeholders, including service providers and the wider community, as well as focused input from LGBTQ2+ youth, Indigenous persons, and women with lived experience of substance use.

Move to Implementation

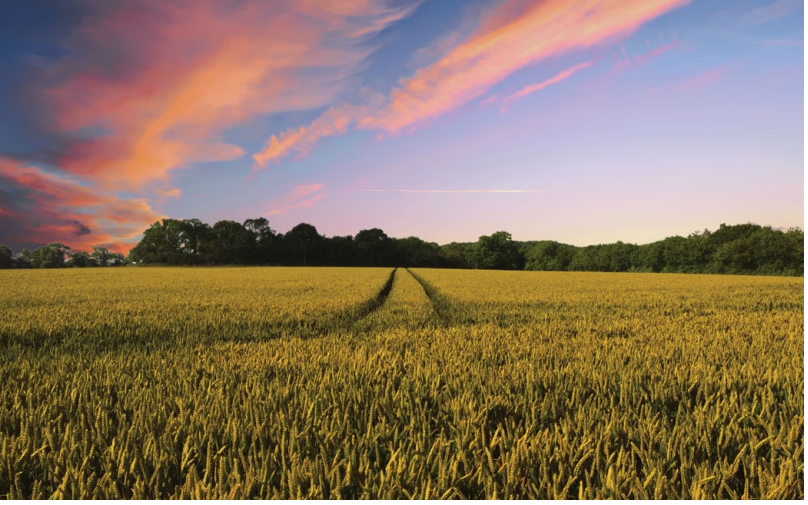
The release of the report, *Middlesex-London Community Drug and Alcohol Strategy – A Foundation for Action*, attached as Appendix A, marks the official shift to implementation. Overall, the Strategy consists of 23 recommendations, with 98 associated actions. Of these actions, 59 were identified for priority focus over the next three years. These comprise both new actions and actions that build upon and strengthen initiatives currently underway in our communities.

Next Steps

The CDAS lays out recommendations and actions that, when implemented, will prevent and reduce harms of substance use in London and Middlesex County. Many actions will depend on effective leveraging of existing resources, and some will require new sources of funding. Progress in implementing the Strategy will be monitored and reported on at regular intervals, with the CDAS website (https://www.mldncdas.com/) serving as a source of information. As the CDAS shifts to implementation, the structure and composition of CDAS governance and workgroups will shift somewhat, the better to support implementation. The ongoing commitment of the CDAS partners, together with continued and enhanced collaboration among and between sectors, will be critical for success. As implementation moves forward, everyone in the community will have a role to play. Any resource implications for MLHU will come forward in the 2019 budget process.

This report was prepared by the Healthy Living Division.

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



Middlesex-London

COMMUNITY DRUG & ALCOHOL STRATEGY

A Foundation For Action

September 2018

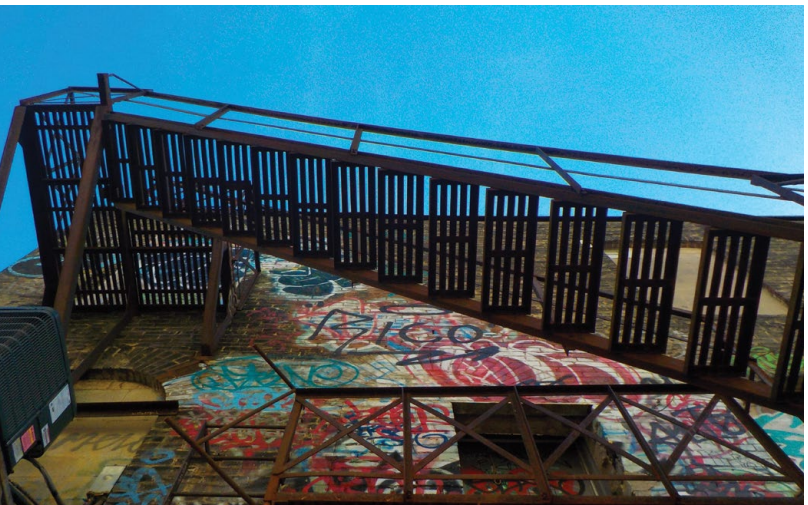


TABLE OF CONTENTS

We would like to thank our community for many of the images used in this report including photos courtesy of the London Arts Council's Culture City photo archive, taken by Gr. 7/8 students from Antler River School and University Heights Public School, as well as other photos courtesy of Middlesex County.

A CALL TO ACTION

The Middlesex-London Community Drug and Alcohol Strategy (CDAS) is the result of the commitment and collaboration of many stakeholders. The CDAS lays out recommendations and actions that, when implemented, will prevent and reduce harms of substance use in London and Middlesex County.

This Strategy is a roadmap for long-term action. Ongoing commitment of partners, and continued and strengthened collaboration among and between sectors will be critical to success.

Furthermore, our community as a whole has a vital role to play.

The financial impacts of substance use to our communities in costs related to healthcare, lost productivity, criminal justice and other direct costs are in the millions. The negative social impacts of substance use on the lives of people in our community - our families, friends and neighbours – is incalculable. We are losing loved ones to opioid poisoning, families are being torn apart, and community organizations and agencies are struggling to meet needs; we must change this trajectory.

We also know that there are groups of people who are disproportionately affected by the harms of substance use. Indigenous peoples and communities, related to histories of colonization and systemic racism, experience higher rates of substance related harms. Other people, including those identifying as LGBTQ2+ and people experiencing mental illness, are also likely to experience more harms from substances. Layered onto this, is the effect of stigma which leads to isolation, creates barriers to accessing support and causes harm to vulnerable individuals and the community as a whole.

Johann Hari, an award-winning British journalist and playwright has stated;

> “The opposite of addiction isn’t sobriety. It’s connection. It’s all I can offer. It’s all that will help [you] in the end. If you are alone, you cannot escape addiction. If you are loved, you have a chance.”

People connecting creates powerful energy. The development of this strategy began with connection. Organizations and individuals concerned about the health of Middlesex-London connected with the goal to solve a problem. Through this connection trust was built, understanding was deepened and solutions emerged.

Moving forward, we all have a role to play. The communities within and surrounding Middlesex and London are strong and vibrant. Reaching out, challenging stigma and connecting with our fellow citizens is something each of us can do.

ACKNOWLEDGEMENTS

The development of a long-term and comprehensive community drug and alcohol strategy is a complex, time-intensive process that requires the dedication and support of many organizations and individuals. As we deliver the Middlesex-London Community Drug and Alcohol Strategy, we wish to express our sincere thanks and appreciation to all those who have been involved in its creation. Without the sharing of expertise, passion, and commitment of many, this work would not have been possible.

To the Steering Committee and Pillar workgroup co-chairs and members, thank you for your commitment and continued efforts in making this important work come to life. We extend our appreciation to the multiple organizations and agencies who have supported and will continue to support this work.

To the community members and service providers across London and Middlesex who have provided input, thank you. Your feedback has helped shape the final Strategy and will inform the actions that will make a difference in the years ahead.

Thanks are also due to the health promotion, nursing, program evaluation, epidemiology, and program support staff at the Middlesex-London Health Unit (MLHU). Your time and expertise throughout the development of this strategy, from logistical support of committee work, to community consultation planning and data analysis, to providing surveillance data, has been essential to the development of this Strategy. Additionally, is it important to acknowledge the overall backbone support of MLHU. Without their investment in time and resources we would not be at this stage in the process.

Finally, and most importantly, thank you to the people with lived experience who have, with dedication and passion, shared stories, insights and input. Your wisdom is integral to this Strategy and the important work that will unfold in the coming years.

Early in the process, the Steering Committee for the Strategy committed to a vision that our work would be collaborative, inclusive, and based on the existing strengths in our community. We have steadfastly worked to stay true to this vision.

The development of the Community Drug and Alcohol Strategy truly has been a community effort.

***Rhonda Brittan**, Manager, Healthy Communities and Injury Prevention, Middlesex-London Health Unit &*
***Brian Lester**, Executive Director, Regional HIV/AIDS Connection,*
Middlesex-London Community Drug and Alcohol Strategy Steering Committee Co-Chairs.

Executive summary

Substance use is part of our social culture. People from all walks of life use substances and do so for a variety of reasons. Not all substance use is problematic. However, all substances have the potential for negative effects, and for some people there can be substantial risks and harms.

The harmful outcomes of substance use are a significant issue in London and Middlesex. Whether alcohol, prescription medications or illegal drugs, problematic substance use negatively impacts individuals, families and our communities as a whole.

In late 2015, local stakeholders came together confirming the need for a long-term comprehensive strategy to prevent and reduce harms related to substance use in Middlesex-London. It was identified that despite much positive work happening in our community, strengthened coordination, new solutions, and a long-term focus was needed to influence meaningful change. From this, the Middlesex-London Community Drug and Alcohol Strategy (CDAS) was created.

The CDAS has been built on the internationally recognized "Four Pillar" approach of Prevention, Treatment, Harm Reduction, and Enforcement and focuses on all substances, with the exception of tobacco.

A Steering Committee and four Pillar workgroups, made up of service providers and individuals representing health, education, social services, law enforcement, the non-profit sector, the private sector, municipal government, and people with lived experience, began the work of developing the Strategy in the Spring of 2016. A list of CDAS members can be found in **Appendix A**.

A vision, mission and set of guiding principles, outlined on page 9, were collaboratively developed and have served as a foundation for this work. The guiding principles, which are fully defined in **Appendix B**, have grounded the development of the Strategy and are intended to guide the future actions and initiatives during implementation.

An important part of developing the CDAS involved obtaining broad input from our communities. This occurred in two phases:

Phase 1: An environmental scan of service providers and organizations across London and Middlesex was completed during late 2016 into 2017 to gain input and insight on current substance use issues and needs. Questions asked were related to each organization's:

- existing substance use-related services and programs,
- insights on barriers to service delivery and service gaps,
- ideas on the urgent issues regarding problematic substance use in London and Middlesex County, and
- perspectives on opportunities for collaboration and integration of services to manage substance use.

Phase 2: Consultation with the broader community took place in the Spring of 2018 to obtain feedback and input on a set of draft recommendations. This consisted of:

- five in-person, drop-in style community consultations, two in Middlesex County and three in London,
- an online survey through the CDAS website,
- focus sessions with specific groups including LGBTQ2+ youth, Indigenous persons, and women with lived experience of substance use.

Following the community consultations, all feedback gained was analyzed, collated and incorporated to produce the recommendations and actions of the CDAS.

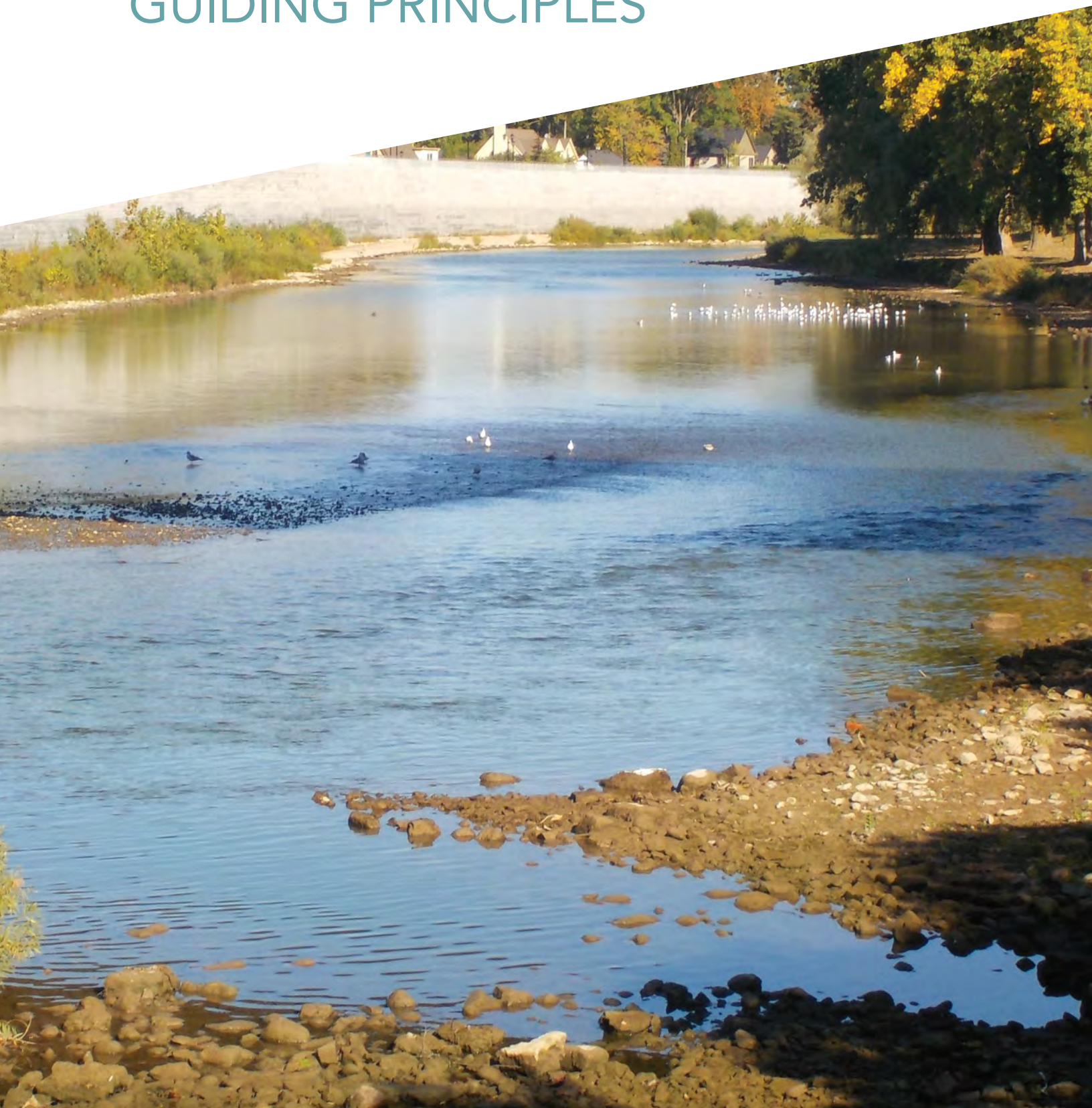
The Strategy outlines a total of 23 recommendations with 98 associated actions in the pillars of treatment, prevention, harm reduction, and enforcement, including some "overarching" recommendations and actions that cross all pillars.

While all are important, 59 priority actions have been identified for focus over the next 3 years of the CDAS. These broad and comprehensive actions are directed toward:

- education and awareness,
- programs and services,
- supportive environments and collaboration, and
- policy and advocacy.

The CDAS is a locally developed strategy for preventing and addressing substance use-related harms in our community. It is the result of the expertise of local partners as well as the diverse voices of hundreds of citizens who are invested in the health and wellness of Middlesex-London. The vision of the CDAS is a caring, inclusive, and safe community that works collaboratively to reduce and eliminate the harms associated with drugs and alcohol. While the work of implementation is already underway, reaching this vision will be dependent on the long-term involvement, dedication and support of citizens, community agencies, service providers, and governments.

VISION, MISSION, AND GUIDING PRINCIPLES



Early work of the Steering Committee was dedicated to building a shared understanding and a strong foundation for the development of a local strategy. A collaborative process, a collective vision, and strong relationships were identified as essential elements. A vision, mission and guiding principles were developed to ground and guide the work.

Vision

A caring, inclusive, and safe community that works collaboratively to reduce and eliminate the harms associated with drugs and alcohol.

Mission

Create, implement, and evaluate a comprehensive drug and alcohol strategy to reduce problematic substance use and harm that reflects the needs of the entire community, through the use of a person centred, equity-focused approach based on the four pillars of prevention, harm reduction, treatment, and enforcement.

Guiding Principles

The following guiding principles were collaboratively developed and have grounded the work of the Steering Committee and the development of recommendations. It is intended that the guiding principles be frequently referenced and continue to support the Strategy's implementation. A full explanation of the Guiding Principles can be found in **Appendix B**.

- Community Strengths Based
- Evidence Informed
- Non-stigmatizing
- Accessible
- Locally Relevant
- Collaborative
- Hopeful
- Responsive to Barriers
- Action-oriented & Results Driven
- Culturally Safe
- Inclusive
- Equity Focused
- Reconciliation Aware

THE NEED FOR A DRUG AND ALCOHOL STRATEGY IN MIDDLESEX AND LONDON

London and Middlesex, like many communities throughout Ontario and Canada, are experiencing significant impacts related to substances, including alcohol, prescription medications, and illegal drugs. Whether directly or indirectly, individuals, families, and our communities as a whole are experiencing negative effects on health, personal relationships, safety, and overall community wellness. Furthermore, we know that the impacts of stigma and marginalization on people who use substances only serve to intensify negative consequences.

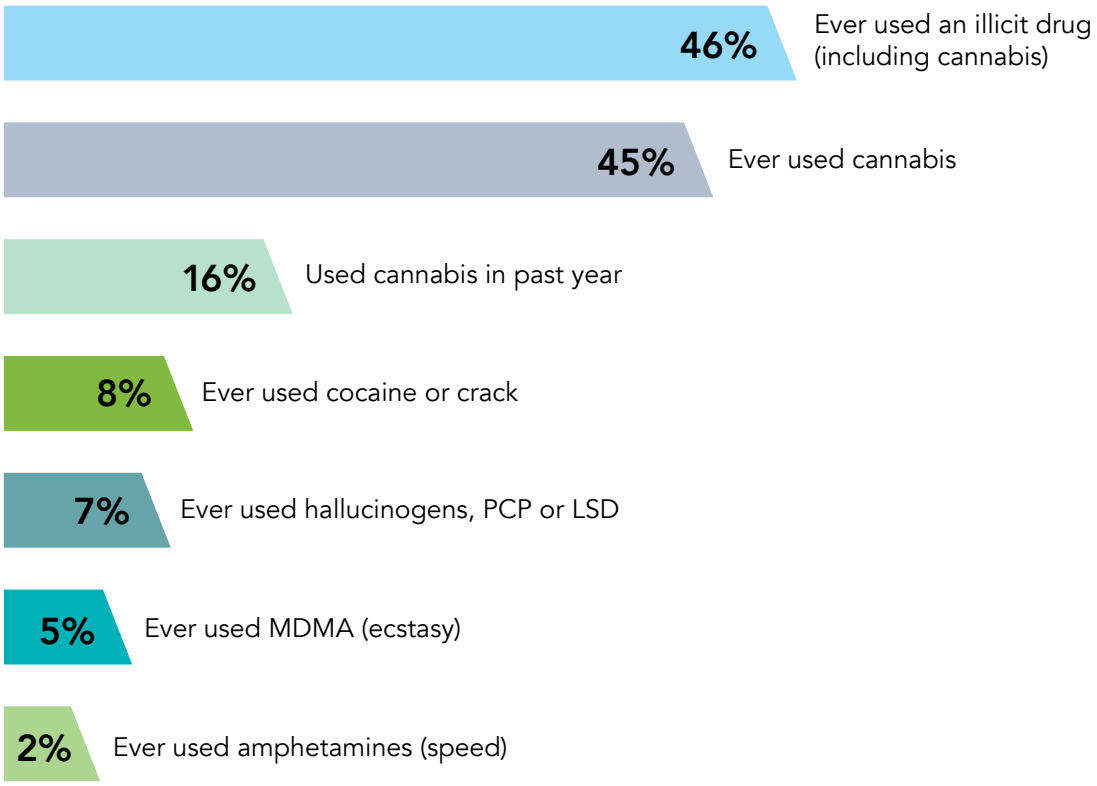
Substance use is a complex issue with no single solution that any one organization or sector can provide. In London and Middlesex County, many organizations are actively working to prevent and reduce the harms of substance use. While there has been, and continues to be significant benefits to many, we know that more must be done. Strengthened coordination, new solutions, and a long-term focus is needed to impact meaningful change. As a community, we must also do more to build opportunities for community connectedness and inclusion for all citizens, notably our youth.

In late 2015 organizations and stakeholders came together and, with an almost unanimous voice, agreed that a community-focused, long-term comprehensive strategy to prevent and reduce the harms related to substance use and misuse was needed in Middlesex-London. From this, the Middlesex-London Community Drug and Alcohol Strategy was born. We know from other communities that such an approach has many benefits including increasing coordination of services, promoting collaboration and actions across sectors, and ensuring the voices of the community – including those with lived experience – are heard.

Substance use in Middlesex-London

The data on the following pages provides a high level snapshot of some of the substance use related issues in our community. Data sources can be found in the reference list.

Substances used in Middlesex-London[1]:



Substances for which people seek local treatment support

- Alcohol and opioids were the top "problem substances" identified by clients in both Middlesex County and London at their initial in-take to receive addiction services.[2]
- 50% of people seeking addiction treatment services self-reported being diagnosed with a mental health concern.[2]

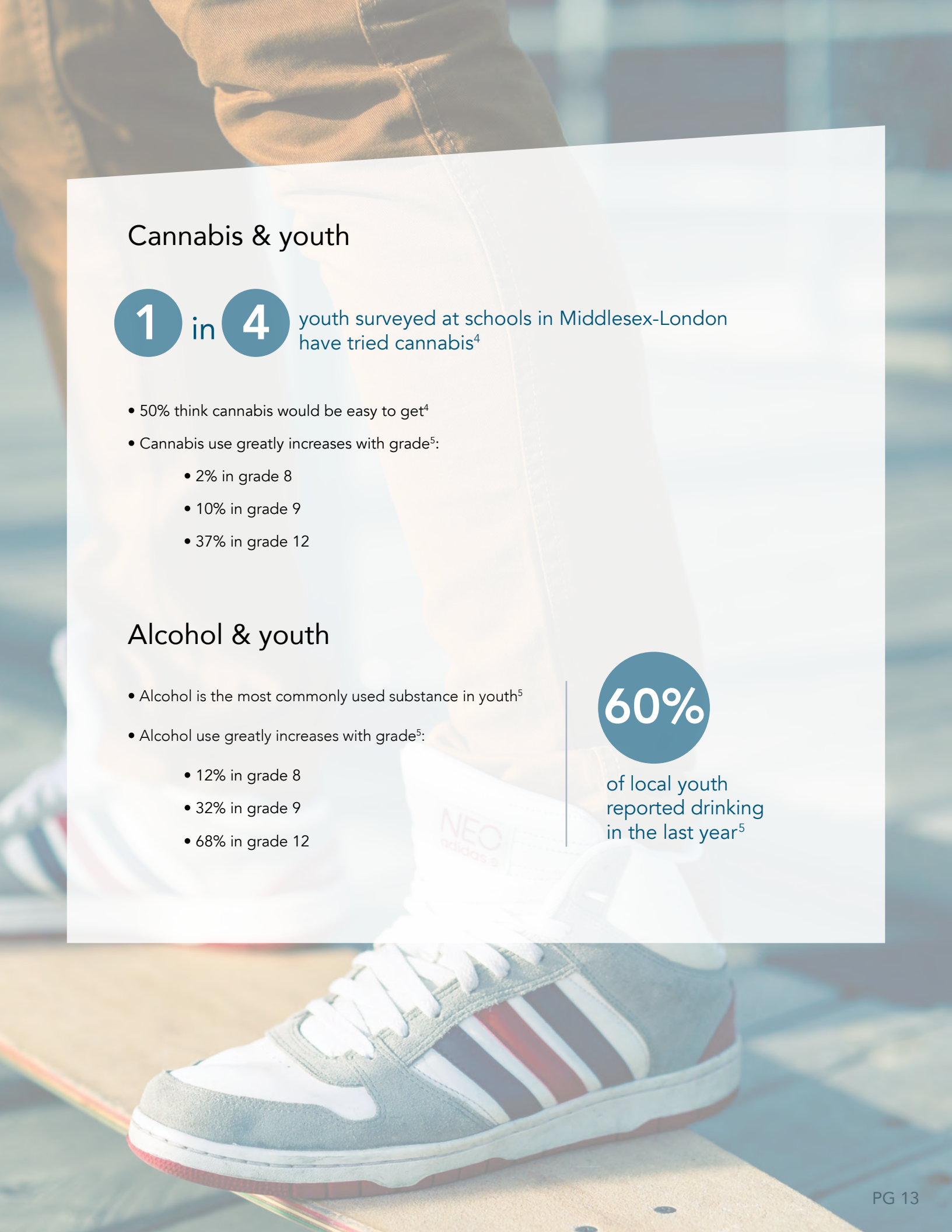
Alcohol use in Middlesex-London[3]

24% of those 19 years and older reported heavy drinking (five or more drinks for males, four or more drinks for females).

49% of those 19 years and older reported exceeding the low-risk alcohol drinking guidelines (increasing the risk of chronic disease and/or injury).

Reproduced with permission from the Canadian Centre on Substance Use and Addiction.

Canada's Low-Risk Alcohol Drinking Guidelines (LRADGs) recommend specific limits in number of drinks for men and women to help Canadians moderate their alcohol consumption and reduce their immediate and long-term alcohol-related harms. For more information on Canada's LRADGs refer to the Canadian Centre on Substance Use and Addiction's website.



Cannabis & youth

1 in 4 youth surveyed at schools in Middlesex-London have tried cannabis[4]

- 50% think cannabis would be easy to get[4]
- Cannabis use greatly increases with grade[5]:
    - 2% in grade 8
    - 10% in grade 9
    - 37% in grade 12

Alcohol & youth

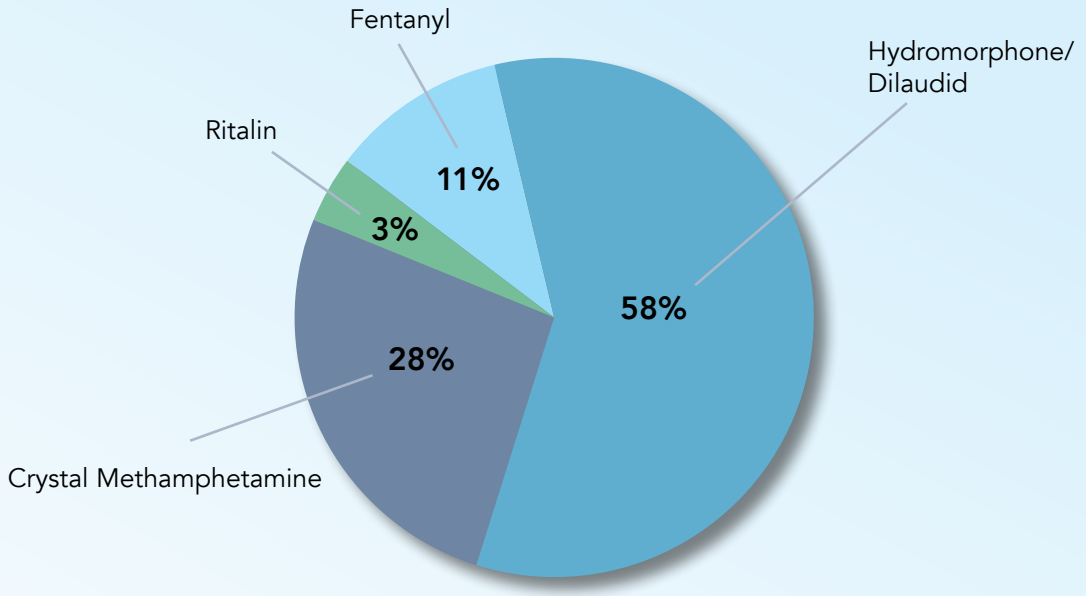
- Alcohol is the most commonly used substance in youth[5]
- Alcohol use greatly increases with grade[5]:
    - 12% in grade 8
    - 32% in grade 9
    - 68% in grade 12

60% of local youth reported drinking in the last year[5]

PEOPLE WHO INJECT DRUGS IN MIDDLESEX-LONDON

It has been estimated by those working in harm reduction that up to 6,000 people in London and Middlesex use injection drugs. It is typical for people who inject drugs to use more than one substance and it is known that substances used change over time based on availability and other factors.

Top reported substances at London's Temporary Overdose Prevention Site
February 12, 2018 to August 31, 2018



A 2016 research study[6] of 199 people in London who inject drugs found that 79% reported injecting hydromorphone and 64% reported injecting morphine in the past 6 months. Over half of those injecting opioids reported that they did so daily. Crystal methamphetamine was reported to be used by 83% of people over the past 6 months, with 35% reporting daily use.

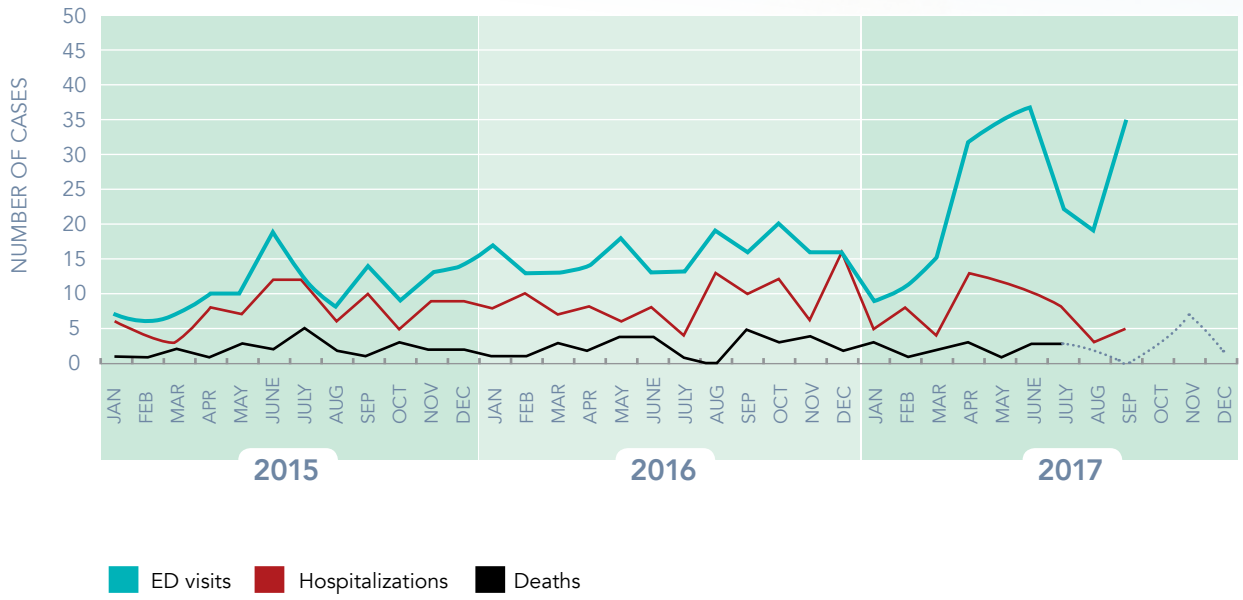
> "…A focused Drug and Alcohol Strategy will only enhance our response to community safety concerns, leading to a community that thrives."
>
> (A SERVICE PROVIDER PERSPECTIVE)

Opioid poisoning

Deaths related to opioids continue to occur in Middlesex-London.

- Visits to the emergency department (ED) for opioid poisonings increased in 2017.[7]
- There were 30 deaths reported in both 2016 and 2017.[7]

Diagnosed cases of opioid poisoning in ED visits, hospitalizations and deaths, Middlesex-London residents, January 2015 to December 2017



Source: Ontario Opioid-Related Death database, Office of the Chief Coroner for Ontario **Death data preliminary after 07/2017 and subject to charge; Discharge Abstract Database (DAD), Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario; National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario

WHAT IS KNOWN ABOUT SUBSTANCE USE

Continuum of substance use

Adapted from the Canadian Mental Health Association's (Ontario) website "Substance Use and Addiction". Retrieved on June 1, 2018 from http://ontario.cmha.ca/addiction-and-substance-misuse/

Substance use is part of social culture. People from all walks of life use substances and do so for a variety of reasons. Substance use is not always problematic. It exists along a continuum, ranging from an individual having never used substances to chronic dependence and addiction (also known as a substance use disorder). Some substances, such as prescription medications, have well-established benefits when taken correctly. However, all substances have the potential for negative effects, and for those individuals that develop a dependence (physical or psychological), there can be significant risks and harms to them as well as their families and friends.[8]

Casual substance use often starts as a way to relax, have fun, or experiment.[8] For many people, trying substances begins in their youth. The 2017 Ontario Student Drug Use and Health Survey cites that 43% of Ontario students grade 7 to 12 reported drinking in the past year (with 17% reporting binge drinking in the last month) while 19% of students reported smoking cannabis in the past year.[5] For some people, substance use may never become problematic. For others, using a substance just once may lead to addiction.

Risk factors for problematic substance use and addiction

There are known risk factors that may influence the likelihood of someone using substances and developing a substance use disorder. Risk factors include those related to biological, physical, and psychological changes that occur during a person's lifetime, or factors in their environment.[9] Having a risk factor does not guarantee someone will develop a substance use disorder; it only indicates there is a higher possibility.[10] Many risk factors are linked with one another. Some of the more common known risk factors are discussed below:

Early initiation of substance use

One of the most commonly cited risks for developing a future substance use disorder is starting to use substances during adolescence or as a young adult. Throughout development, a young person's brain is undergoing many changes. Substance use can be very damaging to this development, and result in a higher likelihood of addiction later in life.[11,12]

Mental health issues

Mental health issues are often linked to problems with substance use.[9] The reasons for this are complex and not completely clear; however, three relationships between mental health and substance use are often used to explain this connection:

1. Both substance misuse and mental health problems have common risk and protective factors.
2. Mental health issues can lead to problematic substance use. People may use alcohol or drugs to help cope with mental health symptoms.
3. Problematic substance use may trigger mental health issues.[13]

Genetic predisposition

Genetic predisposition, or inherited traits, have been found to account for at least 50% of a person's risk for developing an addiction.[14] This means that a person with a relative who has a substance addiction is at a higher risk for also developing an addiction. This link also may result in becoming addicted more quickly to a substance, or an addiction progressing more rapidly.[15]

Exposure to trauma and/or violence

Exposure to trauma and/or violence is often associated with substance use and addiction. Substances can be used as a way to cope with trauma, numbing a person's feelings or helping them to forget what happened. Using substances in this way can increase risk of developing an addiction. It is vital that all health, social, and other services are trauma- and violence-informed in providing care.[16,17]

Societal norms related to substance use

Alcohol in particular has become normalized in our society, with approximately 80% of Ontarians aged 18 and older reporting consumption of alcohol.[18] Positive media messaging, the loosening of protective alcohol policies, and the lack of public understanding regarding the true harms associated with alcohol have served to reinforce its normalcy. Alcohol consumption is a causal factor in more than 200 diseases and injuries and statistics indicate that at least 3.1 million Canadians drink enough to put themselves and others at risk for injury or harm.[19,20]

The normalization of cannabis use is also a growing concern. Currently, Canadians have some of the highest rates of cannabis use worldwide with youth being the top users, compared to their counterparts in other developed countries.[21] Research has found that youth tend to have more misconceptions around the harms associated with cannabis which can put them at greater risk of harm.[22] While the legalization and regulation of cannabis is consistent with a public health approach, it also brings yet unknown factors related to public perception and normalization.

Addiction

Addiction is more common than many people think and can affect anyone, regardless of sex, race, income or social standing. Over 20% of Canadians meet the criteria for substance use disorder in their lifetime. According to 2012 Statistics Canada data, youth have the highest reported rates of substance use disorder at 12%, while the lowest rate is among those 45 years and older at about 2%.[23]

A good way to understand addiction is to think of the four Cs:

1. Craving.

2. Loss of **control** of amount or frequency of use**.**

3. Compulsion to use.

4. Use despite **consequences.**[24]

> “Seize opportunities to explore people’s narrative and allow them to share their experiences with those who don’t understand poverty and substance use.”
>
> (COMMUNITY MEMBER PERSPECTIVE)

Populations at-risk for problematic substance use

Due to a host of issues, such as risk factors discussed previously and inequities influenced by the social determinants of health, certain groups are more at-risk for problematic substance use and disproportionate harm. Acknowledging these impacts is important to ensuring a more equitable approach through focusing resources and developing tailored solutions. Honouring these voices of lived experience will strengthen the response to their unique needs. Some examples of higher-risk populations are discussed below.

People who are unstably housed or homeless are some of the most underserved and vulnerable populations in Canada. Because of this, coupled with higher rates of mental health issues, feelings of shame, fear, hunger, pain, and the stresses of living on the streets, a much higher proportion of people who are homeless experience addictions and harms of substance use. Substance use and addiction can also be a cause of homelessness for some people, as it can impact relationships, finances, work, and other necessities of life.[25]

Lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ2+) youth are found to use substances at a rate that is 2-4 times higher than that of the rest of the population. Often, they are dealing with stigma of homophobia, biphobia and transphobia or using substances as a coping mechanism for dealing with difficult feelings and experiences. Like with many youth, substance use may also be part of cultural acceptance, and be seen as a way to socialize with others.[26]

Indigenous persons within Canada have a lengthy and complex history with colonization and the resulting ongoing impacts. This history has led to extreme inequities in all aspects of life, including culturally unsafe healthcare, inadequate education systems, sub-standard housing, and mental and physical abuse experiences. Additionally, many communities do not have access to appropriate services to assist in managing these stressors due to geographic and financial barriers, as well as discriminatory experiences with service providers, often times resulting in substance use as the most accessible alternative to cope. In a survey done by the federal government, issues relating to alcohol and drug use were found to be the number one challenge for wellness within First Nations communities.[27]

Populations in correctional facilities report high rates of substance use. Upon admission, nearly 70% of people who are incarcerated have a substance use issue requiring intervention, and 34% of people used injection drugs prior to coming to a correctional facility. People in correctional facilities are more likely to also have mental health concerns and histories of trauma, thus increasing their risk for problematic substance use. Furthermore, discharge from a correctional facility is an extremely high risk time for overdose.[28,29]

Protective factors for problematic substance use and addiction

Providing accurate information about substances and harms is important, but education alone is not sufficient or effective in preventing problematic substance use.

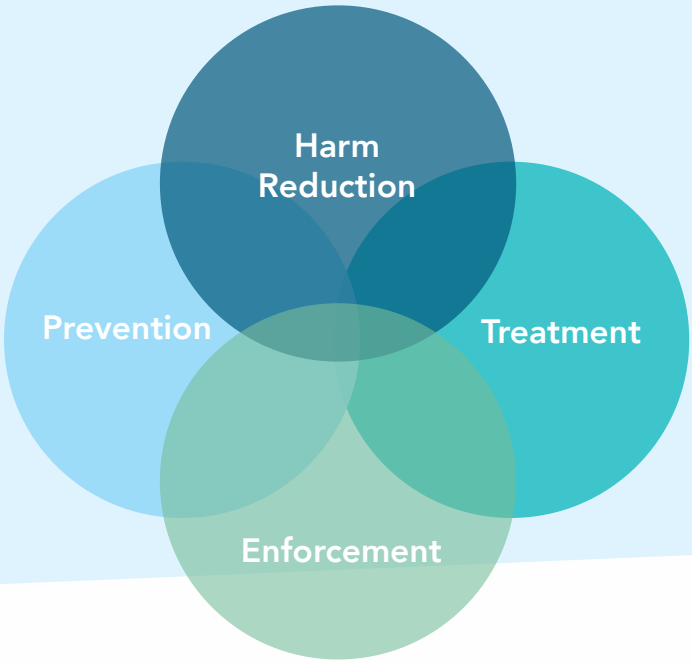
During the last decade, Iceland has done significant evidence-based work to reduce adolescent substance use. Working with local partners has been critical in reducing risk factors and strengthening school and community-level protective factors for adolescent substance use.[30]

Research shows that there are many known factors, often referred to as protective factors, that can play a role in preventing the development of problems with substances, particularly among children and youth.

Examples of protective factors:

- Strong attachment to neighbourhood
- Strong and positive family bonds
- Parent monitoring of children's activities and peers
- Time spent with parents
- Clear rules of conduct that are consistently enforced within the family
- Parent support (caring and warm) and involvement
- Ability to self-regulate
- Problem-solving skills
- Success in school
- Strong bonds with institutions (e.g., school and religious organizations)
- Participation in organized teams or clubs[30,31]

FOUR PILLAR APPROACH



Substance use is a complex issue. There is no one solution to address substance use and no one sector can do it on its own. A Four Pillar approach includes strategies and actions that incorporate prevention, treatment, harm reduction, and enforcement. The four pillar approach first originated in Europe and has been utilized and proven to be successful in countries and cities across the world, including in Canada. While often symbolized as four separate pillars, there is much overlap. For success, cooperation and coordination of efforts is imperative.

Prevention

Prevention refers to efforts that aim to prevent or delay substance use or limit the development of problems associated with using substances. As such, alcohol and other drug prevention exists along a continuum.

- Early prevention: seeks to improve social, economic and cultural protective factors of substance use.
- Primary prevention: seeks to prevent or delay use of alcohol and other drugs.
- Secondary prevention: seeks to limit alcohol and other drug use before harms occur.
- Tertiary prevention: seeks to minimize problems resulting from alcohol and other drugs.

Treatment

Substance Use Addiction Treatment refers to interventions and activities that seek to improve the physical, emotional, psychological and spiritual health and well-being of people who use or have used substances (and family or key supports). Treatment services provide options along a continuum of care that support the differing needs of individuals. Services may include withdrawal management services, outpatient and peer-based counselling, opioid substitution programs, daytime or residential treatment, harm reduction supports, supportive housing services and ongoing medical care.

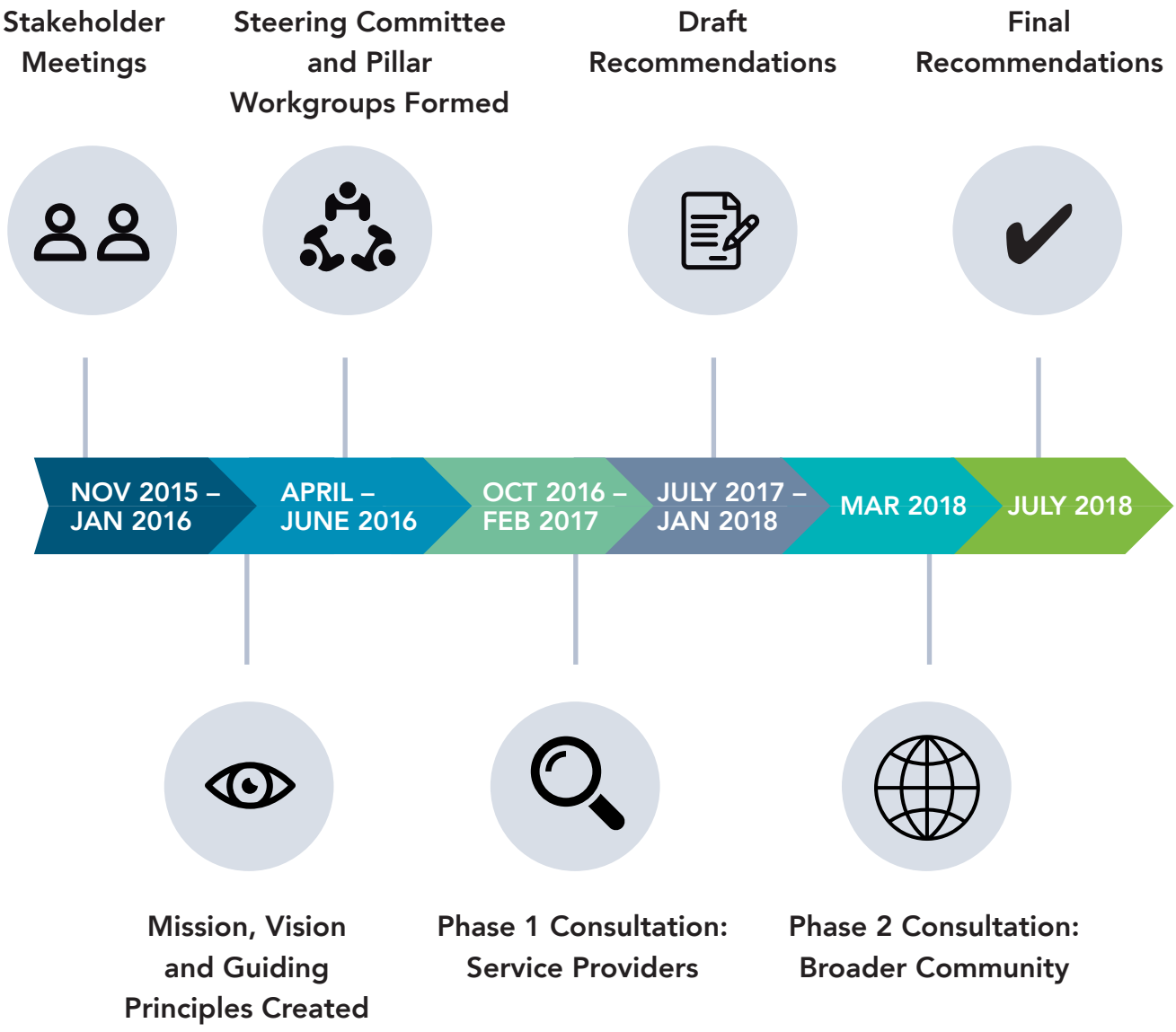
Harm Reduction

Harm Reduction refers to any policies, programs and practices that aim to reduce the health, social and economic harms associated with drug use without requiring the person to stop using substances. Harm Reduction is an evidence-based and cost-effective approach – bringing benefits to the individual, community and society.

Enforcement

Enforcement refers to interventions that seek to strengthen community safety by responding to the crimes, provincial legislation and community disorder issues associated with legal and illegal substances. Enforcement includes the broader justice system of the courts, probation, parole and other health and social services.

CREATION OF OUR LOCAL STRATEGY



Stakeholder meetings

In November 2015 and January 2016, over 80 diverse community stakeholders came together over two meetings hosted by the Middlesex-London Health Unit (MLHU). Attendees reviewed local data and shared perspectives on current substance use issues in our community. During these meetings, it was confirmed that there was both interest in and a need for a collaborative and collective effort to address problematic substance use within the community.

A decision was made to base the strategy's development on a Four Pillar framework of Prevention, Treatment, Harm Reduction, and Enforcement. The Four Pillar approach is recognized internationally as an effective way to prevent and respond to harms associated with problematic substance use.

From the outset, the intent was to develop a comprehensive, long-term drug strategy inclusive of all substances, with the exception of tobacco, and to consider the issue from multiple perspectives grounded in collaboration, shared decision making, and community strengths. Early in the process, a decision was made to explicitly name alcohol as part of the strategy.

As a comprehensive strategy, the Community Drug and Alcohol Strategy (CDAS) recognizes not only that addiction is a significant issue, but additionally other adverse outcomes associated with substance use must also be addressed and prevented. The Strategy acknowledges the importance of a continuum of responses based on multi-sector involvement and support. The Strategy also acknowledges that substance use exists across our communities and that issues experienced by those living in Middlesex County may be different than those living in London.

Steering Committee and Pillar Workgroups

A Steering Committee and four workgroups representing the pillars of Prevention, Treatment, Harm Reduction, and Enforcement were formed and began working together in the Spring of 2016 (for a list of members, see **Appendix A**).

Over 50 partners have been involved in the Middlesex-London Community Drug and Alcohol Strategy partnership and played a role in the development of the Strategy. The Steering Committee and Pillar workgroups have consisted of individuals representing service providers, community organizations, the business sector and people with lived experience.

The Steering Committee has provided support, guidance and oversight to the development of the Strategy.

The Pillar workgroups have provided expertise into the creation of the recommendations and action items for the Strategy.

COMMUNITY INPUT

An important step in developing the Strategy was obtaining input from diverse stakeholders within our community. This occurred in two phases. Phase 1 involved conducting an environmental scan of service providers and organizations in order to gain input and insight on current substance use issues and needs. Phase 2 involved broadly consulting community members in London and Middlesex to obtain feedback and input on draft recommendations.

Phase 1 consultation: service provider environmental scan

The environmental scan of Middlesex and London service providers was conducted during late 2016 into 2017. The primary purpose of this scan was to obtain a comprehensive understanding of service providers' perspectives related to substance use/misuse. Input was received from 37 organizations.

The service provider environmental scan asked about each organization's:

- Existing substance use-related services and programs
- Insights on barriers to service delivery and service gaps
- Ideas on the urgent issues regarding problematic substance use in London and Middlesex County
- Perspectives on opportunities for collaboration and integration of services to manage substance use

Response themes:

- Priority substance use issues were identified for both organizations themselves and the broader community. Issues identified included: access to services and support, the need for more access and understanding of harm reduction, the need for substance education and awareness, and the importance of considering the role of the social determinants of health in substance use.
- Substances that were identified as particularly challenging at that time included Crystal Methamphetamine, Opioids/Opiates, Alcohol, Cannabis, and other prescribed medications or unclassified drugs.
- Organizations shared perspectives on who was not being well reached by existing programs and services. Populations identified included youth, Aboriginal/First Nations people, LGBTQ2+ youth, individuals struggling with addiction, people who lack basic necessities, individuals who are inmates/paroled, people with complex mental and physical issues, rural communities, women, and other populations.
- Five main areas for action were identified: increasing education, increasing access to services, more collaboration, the development of laws and policies, and increasing funding.

Draft recommendations

Following phase 1 consultation, pillar workgroups began the work to develop draft recommendations. Stakeholder input, the local expertise of CDAS members, and findings from a review of other community drug strategies led to potential recommendations and action items that would be reflective and responsive to local needs. Draft recommendations were reviewed and added-to by the Steering Committee and further refined through a facilitated half-day session of both Steering Committee and Pillar workgroup members. During this session, the alignment of the service provider environmental scan results, collective expertise of the group, CDAS Guiding Principles, and local data were all considered. The results were collated and used to finalize the draft version of the CDAS recommendations and actions.

> "The issues that impact our organization are those that affect our community…We are cognizant of the fact that community issues are our issues – we reflect on the needs and concerns of our community and attempt to identify them in time to provide not only a reactive response but a proactive response as well."
>
> (A SERVICE PROVIDER PERSPECTIVE)

Phase 2 consultation: broader community

Following the development of draft recommendations and actions, the community was consulted more broadly. Community members had the opportunity to participate through either in-person sessions or an online survey.

The purpose of these consultations was to confirm that the draft recommendations were reflective of community needs and to obtain further input. Additionally, consultations provided opportunities to share information about local substance use issues, the CDAS and discuss next steps.

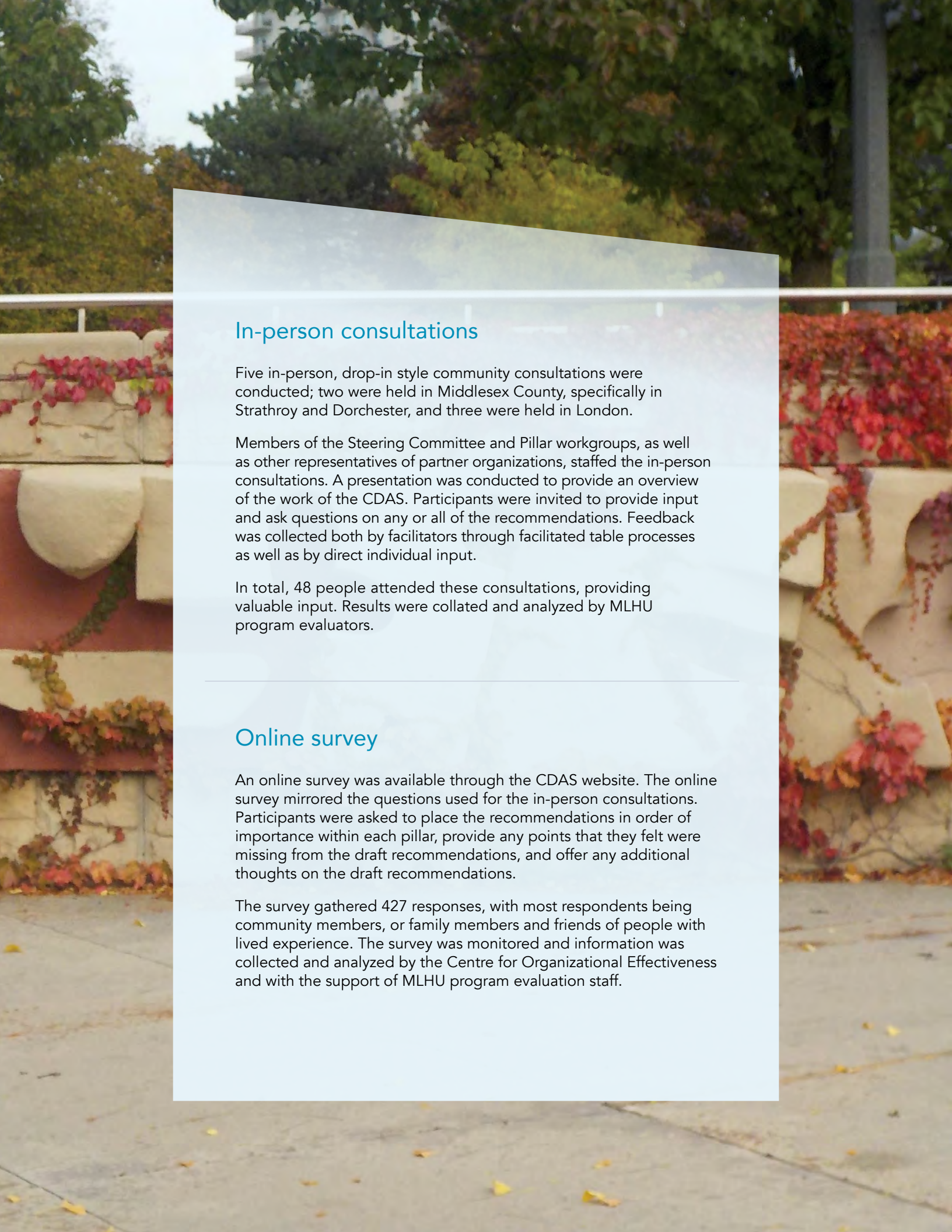
Those who participated in the consultations were asked to identify if anything was missing from the recommendations identified under each of the pillars, and provide any additional thoughts that should be considered. Participants were also asked to rank the recommendations in order of importance.

The in-person and online community consultations were promoted through the use of local media channels, social media, poster advertisements and community partners.

Focus sessions were also held with specific groups including Indigenous persons, LGBTQ2+ youth, and women with lived experience of substance use.

Following the community consultations, all feedback gained was analyzed, collated and incorporated into the recommendations.

> “This Community Drug and Alcohol Strategy is a great beginning. We need to learn from one another, network better, share resources and knowledge more freely. We are stronger together than in our individual silos.”
>
> (A SERVICE PROVIDER PERSPECTIVE)



In-person consultations

Five in-person, drop-in style community consultations were conducted; two were held in Middlesex County, specifically in Strathroy and Dorchester, and three were held in London.

Members of the Steering Committee and Pillar workgroups, as well as other representatives of partner organizations, staffed the in-person consultations. A presentation was conducted to provide an overview of the work of the CDAS. Participants were invited to provide input and ask questions on any or all of the recommendations. Feedback was collected both by facilitators through facilitated table processes as well as by direct individual input.

In total, 48 people attended these consultations, providing valuable input. Results were collated and analyzed by MLHU program evaluators.

Online survey

An online survey was available through the CDAS website. The online survey mirrored the questions used for the in-person consultations. Participants were asked to place the recommendations in order of importance within each pillar, provide any points that they felt were missing from the draft recommendations, and offer any additional thoughts on the draft recommendations.

The survey gathered 427 responses, with most respondents being community members, or family members and friends of people with lived experience. The survey was monitored and information was collected and analyzed by the Centre for Organizational Effectiveness and with the support of MLHU program evaluation staff.

FOCUS SESSIONS

Focus sessions were also conducted with populations that were deemed as important stakeholders. These populations included Indigenous persons, LGBTQ2+ youth, and women with lived experience. Each focus session used different methodology for gathering information that was tailored to the specific population or setting. It is important to note that there was a small sample size for each of the focus sessions and the information received may not be reflective of the entire target population. It is acknowledged that as the Strategy moves to implementation, further input and involvement of these voices will be important. Results from each focus session were collated and analyzed by program evaluators at the Middlesex-London Health Unit.

Indigenous persons

Prior to conducting community consultations, a meeting was held with Indigenous leaders to discuss and review the high level recommendations with a goal of ensuring that a more inclusive, Indigenous lens was included. Recommendations then moved forward to broader community consultations.

Focus sessions with Indigenous people were done one-to-one with a facilitator. Participants were asked to identify what was missing that could help them achieve success and what were some of the barriers they have experienced that have prevented them from achieving success. These focus sessions gathered 12 responses.

There were five emerging, overarching themes that were apparent in the consultations with Indigenous persons. These themes were:

- There are barriers to accessing services/ support/treatment
- More services/supports are needed
- Stigma and racism are barriers
- Lack of basic necessities in life (that can impede the ability to get sober/recover)
- Need for meeting people where they are at

LGBTQ2+ youth

A facilitated focus group was held with LGBTQ2+ youth. They were asked if there were recommendations missing that would help them or their friends achieve success in finding, accessing, or using information and services that relate to substance use. They were also asked about issues that have prevented people from finding/accessing and/or using information and services that relate to drug and alcohol use.

There were three emerging, overarching themes that were apparent in the consultations with LGBTQ2+ youth. These themes were:

- There are barriers to accessing services/ support/treatment
- More services/supports are needed
- Stigma and racism are barriers

Women with lived experience of substance use

Focus sessions were conducted with women of lived experience, including those who experience gender- based violence, trauma, chronic mental and physical health challenges, homelessness or housing instability, substance use and extreme poverty. These focus sessions were conducted by either allowing participants to independently fill out the forms that were provided at the in-person consultations, or filling them out with a volunteer. This information was combined with the results from the in-person consultations.

> “More needs to be done to get help for people living with addiction, [who] are also living with mental health issues as well as living in poverty.”
>
> (COMMUNITY MEMBER PERSPECTIVE)

Alignment with other community strategies and initiatives

While the Community Drug and Alcohol Strategy sets a long-term comprehensive four pillar approach to address substance use in our communities, it is acknowledged that there is much existing important work being done. An important role of the CDAS is to support and strengthen existing work.

There are other strategies and initiatives in London and Middlesex that have alignments with the vison and goals of the CDAS.

One example of this is the Community Mental Health and Addiction Strategy (CMHAS), developed through a facilitated process led by the City of London. The CMHAS focuses on improving the experiences and outcomes of people in London who are experiencing mental health and/or addiction challenges. Several of the recommendations within this strategy complement those of the CDAS. As we move into implementation phase, both strategies will address a range of gaps and service needs. Leveraging opportunities for collaboration will strengthen our impact.

Temporary overdose prevention site & supervised consumption facilities

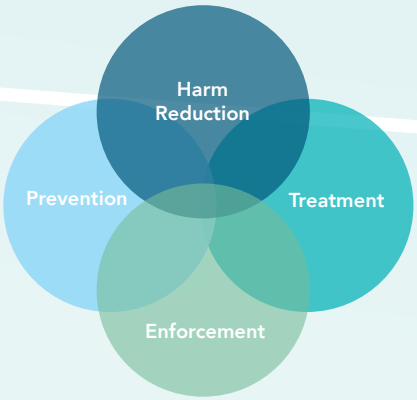
The work to develop supervised consumption services has been a significant project demonstrating the strength of partnerships in our community. London opened a Temporary Overdose Prevention Site (TOPS) on February 12, 2018. In alignment with the CDAS, many agencies moved quickly to bring this site to reality. TOPS shares space with Regional HIV/AIDS Connection (RHAC), sharing the site of the Counterpoint Needle and Syringe Program, which is already familiar for people who inject drugs. Staffing is provided by the two main partners: RHAC and Middlesex-London Health Unit (MLHU). RHAC provides the day to day operational management of the TOPS program. Wrap-around services are provided in-kind by five additional partners: Southwest Ontario Aboriginal Health Access Centre; Addiction Services of Thames Valley; the Canadian Mental Health Association; London Intercommunity Health Centre; and London Cares Homeless Response Services – all members of CDAS. The work of the Opioid Crisis working group, made up of several partners including people with lived experience was integral in making TOPS a reality. In the first 29 weeks of operation, TOPS had a total of 7,347 visits by over 2,000 unique individuals. During this time, 34 opioid poisonings occurred with successful treatment and no deaths.

RECOMMENDATIONS

Overall, the Middlesex-London Community Drug and Alcohol Strategy consists of 23 recommendations with 98 actions. These recommendations incorporate both new actions and those that will build on and strengthen initiatives currently happening in our community.

The CDAS was built on a four pillar model of Prevention, Treatment, Harm Reduction and Enforcement. As such, the recommendations are organized by these pillars in addition to a broader category of "Overarching" for those recommendations that have a broader scope. Because there is overlap between pillars, implementation of the strategy must focus across pillars and across recommendations.

Together, these recommendations aim to prevent, reduce and eliminate the harms of problematic substance use in Middlesex-London.



OVERARCHING

Recommendations / Actions

Recommendation 1:

Advocate for policies and programs that address poverty, homelessness, housing and other social determinants of health including Indigenous determinants of health.

Actions

1.1 Advocate to increase access and availability of efficient, attainable, scattered and diverse housing stock.

1.2 Advocate for financial support programs (e.g., Ontario Works, Ontario Disability Support Program) to increase rates that better reflect cost of living.

1.3 Advocate for financial support for medical expenses not covered by OHIP or non-insured health benefits (e.g., transportation to health related appointments).

1.4 Advocate for expanded supportive housing approaches and promote Housing First programs to assist people experiencing chronic and persistent homelessness to secure permanent housing with support.

1.5 Promote a range of supports and services to support people and families experiencing or at risk of homelessness and/or food insecurity.

1.6 Advocate for Emergency Shelter specialization (i.e., youth shelter).

1.7 Work alongside Indigenous communities to identify and address Indigenous-specific determinants of health, such as colonization and cultural continuity, that contribute to problematic substance use.

Recommendation 2:

Ensure programs and services in Middlesex-London are person focused.

Actions

2.1 Advocate for and support cultural safety and trauma-informed care training to agencies and organizations and embed policies and practices to ensure services are culturally safe.

2.2 Work in purposeful partnership with diverse populations to enhance access to culturally safe prevention, treatment, harm reduction and enforcement related programs and services.

2.3 Ensure information is communicated using accessible and targeted language to reflect the needs of diverse populations.

2.4 Advocate to ensure training for service providers and programs for the community reflect the needs of diverse populations that exist throughout Middlesex-London.

Recommendation 3:

Encourage participation of people with lived experience during development and implementation of programs, services, and campaigns.

Actions

3.1 Advocate for new Peer Training programs that are specific to people who have lived experience with addiction.

3.2 Integrate personal stories of substance use experience, including recovery, into messaging and education about substance use.

Recommendation 4:

Work to reduce stigma related to substance use and addictions.

Actions

4.1 Promote an inclusive, compassionate community that understands substance use and addictions as health concerns and supports families.

4.2 Provide opportunities for community members and organizations to learn about substance use, harm reduction, addictions and stigma around drug use.

4.3 Share positive messaging and continue to help people tell their personal stories in a non-stigmatizing way.

4.4 Continue to challenge the continuum of service providers and media to not perpetuate stigma.

4.5 Support training opportunities for health and other professionals about addiction, harm reduction, and injection drug use.

4.6 Work towards shifting language to reduce stigma (e.g., overdose to poisoning).

4.7 Advocate for substance use content to be included in the education curriculum of professionals who work with people who use drugs (i.e., health and social services workers, police, educators, etc.).

Recommendation 5:

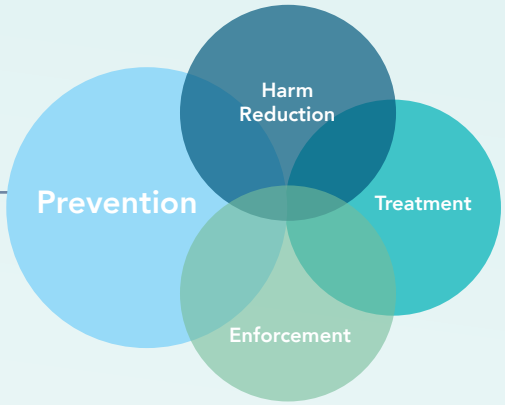
Increase response to public space challenges related to drugs and alcohol.

Actions

5.1 Increase collaboration between services, organizations, business groups, and community members with a mechanism for ongoing feedback to work together towards the goal of achieving public spaces that are non-stigmatizing and safe for all.

5.2 Services, businesses, institutions, and community members work together to foster mutual public respect and understanding in public spaces.

5.3 Improve communication between stakeholders to utilize models of service delivery which recognize and address the impact in surrounding community spaces and plan accordingly to address issues.



PREVENTION

Recommendations / Actions

Recommendation 6:

Provide accurate substance related information and prevention messaging to the community about the facts, protective factors and impact of substance use.

Actions

6.1 Support schools by providing up-to-date and evidence-based information and resources to inform curriculum and school policy and aid in the implementation of comprehensive school health.

6.2 Use and promote national and provincial education campaigns and materials related to alcohol, cannabis, and other drugs. Develop local messages to fill any gaps.

6.3 Use workplaces as a place to share information and encourage workplaces to support substance use prevention and treatment programs (e.g., Employee Assistance Programs).

6.4 Support primary care as a valuable partner in prevention by providing up-to-date and evidence-based information, resources, and tools for working with patients including families, children, youth, adults, and older adults (e.g., screening and brief intervention tools, Low-Risk Alcohol Drinking Guidelines).

Recommendation 7:

Advocate for and implement targeted strategies and programs to reduce known substance use risk factors and increase protective factors that help to prevent problematic substance use.

Actions

7.1 Collaborate with existing systems to create opportunities for positive community involvement and participation in meaningful leisure and recreational activities, for children of all ages and abilities, to foster feelings of inclusion and social capital among children and youth.

7.2 Enhance school and community partnerships to build a sense of personal and group belonging within schools and the community.

7.3 In collaboration with existing strategies, projects and plans, acknowledge that education and success at school are key protective factors. Support supplementary school success programs such as free tutoring, mentoring, wrap-around supports.

7.4 In collaboration with existing strategies, projects and plans, continue to implement and advocate for targeted programs that provide early supports, such as basic life skills and healthy coping, to children, youth, parents and families who may be at higher risk.

7.5 Collaborate with existing systems to enhance positive parenting programs, resources, and supports in the community.

7.6 Advocate for increased capacity for children's mental health and early supports for people with mental health concerns.

7.7 Promote programs that enhance wellbeing and resiliency through stressful life transitions (e.g., elementary school to high school, high school to college, retirement).

7.8 Collaborate with existing systems to create opportunities for positive social involvement and community connectedness for all residents (e.g., increase opportunities and reduce barriers to participate in local social and recreational activities).

Recommendation 8:

Ensure supportive built environments and social environments in our communities.

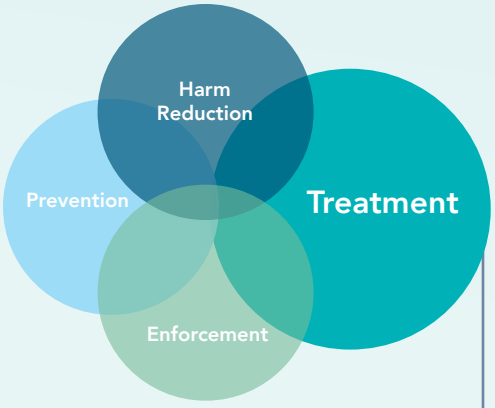
Actions

8.1 Work with municipal decision-makers to include evidence-based substance prevention considerations in municipal planning and policies (e.g., Municipal Alcohol Policies, bylaws related to cannabis legalization).

8.2 Advocate for provincial policy that reduces substance-related harms (e.g., cannabis and alcohol pricing and taxation, drug impaired driving laws).

8.3 Offer the necessary supports needed for accessing services and programs (e.g., transportation to and from programs, child minding services, free services).

8.4 Encourage workplaces to develop and implement policies that support work-life balance and flexible working hours for parents.



TREATMENT

Recommendations / Actions

Recommendation 9:

Enhance community awareness of services within Middlesex and London.

Actions

9.1 Increase awareness of existing treatment information and pathways to treatment services in Middlesex-London, including awareness of existing sources of information such as Healthline and ConnexOntario.

9.2 Increase awareness of services and supports available to families of children and youth using substances.

Recommendation 10:

Reduce system barriers and create greater access to treatment and recovery services.

Actions

10.1 Explore and advocate for new models of treatment to meet community need (e.g., daytox, Indigenous model, full-day non-residential programs, low-threshold treatment and service options, a recovery community/centre, sobering centre).

10.2 Explore the extent to which transportation and location of services is a barrier, notably in rural areas, and develop strategies to address.

10.3 Identify barriers and create new strategies to help support people using drugs and/or alcohol to access services (e.g., childcare, mobility issues, etc.).

10.4 Advocate to all levels of government to provide funding for a full continuum of treatment and care for individuals using substances and for their families and friends, including involvement in the recovery process.

10.5 Implement "pre-treatment beds/stabilization housing" between withdrawal and residential treatment and/or other recovery programming.

10.6 Advocate to close the gap between short term programs and longer term residential program wait times.

10.7 Promote self-managed treatment and recovery options as appropriate (e.g., guided self change program).

10.8 Increase the hours of operation, availability (including reducing wait times) and options for treatment services.

Recommendation 11:

Enhance coordination of treatment service and improve linkages and collaboration among the continuum of services.

Actions

11.1 Explore and improve the different models of withdrawal management care (i.e., daytox clinic) and how they fit into the continuum of services.

11.2 Strengthen capacity for service providers to work together to share best practices and common processes.

11.3 Enhance relapse prevention supports and services.

11.4 Collaborate with institutions and community agencies to implement discharge planning and transition protocols to improve care for individuals leaving hospitals and jails.

11.5 Enhance collaboration between services that address substance use and mental health services.

11.6 Advocate for training for service providers across different services including primary care, hospital care, and community based treatment for the purpose of coordinating services.

11.7 Strengthen engagement with treatment organizations across different funding sectors (e.g., private/public).

11.8 Advocate for enhanced linkages and collaboration across Ministries at the provincial level.

Recommendation 12:

Develop a coordinated service response specific to Crystal Methamphetamine (drug induced psychosis).

Actions

12.1 Support existing efforts to provide evidence-based information and training to those in contact with people who use crystal methamphetamine including local businesses.

12.2 Provide education and supports to people who use crystal methamphetamine as well as their peers (e.g., user guide).

12.3 Investigate the efficacy of separate treatment entrance paths for people using crystal methamphetamine.

12.4 Investigate and develop both evidence-based residential and community treatment models specific to crystal methamphetamine.

HARM REDUCTION

Recommendations / Actions

Recommendation 13:

Work collaboratively to address the opioid crises within Middlesex-London.

Actions

13.1 Advocate for more access to Suboxone as a means of treatment, including through primary care physicians, and enhancement of counselling service availability at opioid substitution clinics.

13.2 Support existing efforts to implement Supervised Consumption Facilities in London including a comprehensive model of care.

13.3 Advocate for continued provincial attention to the opioid crises including continued policy commitment under Ontario Narcotics Strategy.

13.4 Advocate for provision of naloxone kits, information and training to anyone being treated for an overdose at point of care and other access points.

13.5 Support organizations to have naloxone available as standard first aid measure (i.e., support with policies and procedures).

13.6 Explore and remove barriers that prevent naloxone being used.

13.7 Develop a community overdose awareness campaign (i.e., Stop Overdose Ottawa campaign).

13.8 Enhance collaboration between opioid substitution therapy providers and community services.

13.9 Explore and advocate for new treatment options for those addicted to opioids.

Recommendation 14:

Ensure people who are using drugs have access to accurate and timely information.

Actions

14.1 Continue to ensure people are informed of locations where to access naloxone.

14.2 Develop a coordinated way to inform people of contaminated/"bad" drugs within the community.

14.3 Develop a coordinated way to inform people about infection outbreaks.

Recommendation 15:

Expand harm reduction services.

Actions

15.1 Establish a managed alcohol program/facility for people with severe chronic alcohol addiction to address overall health and wellbeing.

15.2 Advocate for extended hours of services and locations of harm reduction services and distribution of harm reduction supplies in London and Middlesex.

15.3 Determine need and explore strategies to expand availability of harm reduction services and supplies in rural communities (e.g., expansion of mobile services).

15.4 Enhance participation in research and evaluation of harm reduction services.

15.5 Advocate for organizations across the continuum of care (e.g., treatment services, family health teams, hospitals etc.) to integrate harm reduction philosophies and strategies within their organizations (e.g., lower risk use and overdose prevention education, access to harm reduction supplies and supports).

Recommendation 16:

Develop a comprehensive community needle syringe recovery strategy.

Actions

16.1 Expand the availability of portable needle disposal kits and needle disposal bins throughout Middlesex-London.

16.2 Empower and educate the public regarding safe handling of sharps.

16.3 Explore and advocate for models of comprehensive needle recovery that support the effective and safe management of discarded sharps for citizens and property owners within London and Middlesex which does not rely on a fee for service.

16.4 Advocate for increased funding for a syringe recovery strategy.

Recommendation 17:

Monitor substance use trends in Middlesex-London.

Actions

17.1 Enhance surveillance and monitoring of local level substance use trends as well as risk and protective factors.

17.2 Use data and information to identify new drugs and new drug use trends to minimize negative impacts.

Recommendation 18:

Advocate for policy and legal change within the correctional system that supports both harm reduction and treatment.

Actions

18.1 Advocate for evidence-based programs and services for both harm reduction and treatment support in federal and provincial correctional facilities.

18.2 Advocate that harm reduction equipment, treatment support, and general health information (i.e., understanding substance use, wound care, education) be made available in both federal and provincial prisons.

18.3 Improve discharge planning, aftercare, and continued community treatment – including harm reduction – upon release through enhanced collaboration between services.

Recommendation 19:

Advocate for evidence-based reform of current drug laws and policy.

Actions

19.1 Research evidence of the benefits of changing legislation related to criminalizing possession of substances.

ENFORCEMENT

Recommendations / Actions

Recommendation 20:

Improve collaboration between police, health and social services.

Actions

20.1 Expand the coordination of police service activities with activities of health and social service agencies to develop long-term solutions that improve the health and safety of people living in Middlesex-London.

Recommendation 21:

Support education and training for those working within the justice system about substance use, harm reduction, and treatment.

Actions

21.1 Assess and evaluate gaps in training related to substance use, harm reduction and treatment that may exist for those working in the justice system.

21.2 Facilitate access and support training based on identified need.

Recommendation 22:

Advocate for recovery-focused solutions for people involved with the criminal justice system (e.g., drug court).

Actions

22.1 Support the reinstatement of diversion programs that combine treatment with a problem-solving lens that addresses diverse and unique needs.

22.2 Advocate for key influential stakeholders to support and sustain diversion programs at a systems-level.

22.3 Review similar recovery focused programs occurring elsewhere to inform successful implementation.

Recommendation 23:

Enhance the community's understanding of the "right" responder to contact in situations where addiction crisis is apparent and increase community knowledge about reporting incidences.

Actions

23.1 Support the development of an information campaign (e.g., when to go to a walk-in crisis centre; when to go to the emergency department; when to call 911).

23.2 Influence coordination and collaboration among first responders to work in a manner to ensure the right resource and care is mobilized.

23.3 Foster service provider, business and workplace awareness of crisis response resources and choices to make other than 911.

23.4 Facilitate knowledge transfer to community members about crisis response resources in London.

While all recommendations in the Strategy are important, through deliberate discussion and consensus of the CDAS Steering Committee, a total of 59 priority actions for a 1-3 year focus were identified.

These 1-3 year priority recommendations are organized for implementation within a comprehensive health promotion approach incorporating:

- Education & Awareness
- Programs & Services
- Supportive Environments & Collaboration
- Policy & Advocacy

Implementation of the Strategy will require the collaboration and efforts of many, including the community as whole. While the following recommendations have been prioritized, there is also a recognition for the need to be flexible and responsive to changing local needs.

The identified priority actions for the first 1-3 years of the Strategy follow.

COMMUNITY DRUG AND ALCOHOL STRATEGY PRIORITY ACTIONS

Overarching priority actions (years 1-3)

Education/ Awareness	4.2. Provide opportunities for community members and organizations to learn about substance use, harm reduction, addictions and stigma around drug use.
	4.4. Continue to challenge the continuum of service providers and media to not perpetuate stigma.
	4.5. Support training opportunities for health and other professionals about addiction, harm reduction, and injection drug use.
Programs/ Services	1.5. Promote a range of supports and services to support people and families experiencing or at risk of homelessness and/or food insecurity.
Supportive Environments/ Collaboration	1.7 Work alongside Indigenous communities to identify and address Indigenous-specific determinants of health, such as colonization and cultural continuity, that contribute to problematic substance use.
	3.2. Integrate personal stories of substance use experience, including recovery, into messaging and education about substance use.
	4.1. Promote an inclusive, compassionate community that understands substance use and addictions as health concerns and supports families.
	4.3. Share positive messaging and continue to help people tell their personal stories in a non-stigmatizing way.
	4.6. Work towards shifting language to reduce stigma (e.g., overdose to poisoning).
	5.1. Increase collaboration between services, organizations, business groups, and community members with a mechanism for ongoing feedback to work together towards the goal of achieving public spaces that are non-stigmatizing and safe for all.
Policy/ Advocacy	1.1. Advocate to increase access and availability of efficient, attainable, scattered and diverse housing stock.
	1.2. Advocate for financial support programs (e.g., Ontario Works, Ontario Disability Support Program) to increase rates that better reflect cost of living.
	1.3. Advocate for financial support for medical expenses not covered by OHIP or non-insured health benefits (e.g., transportation to health related appointments).
	1.4. Advocate for expanded supportive housing approaches and promote Housing First programs to assist people experiencing chronic and persistent homelessness to secure permanent housing with support.
	1.6. Advocate for Emergency Shelter specialization (i.e., youth shelter).
	2.1. Advocate for and support cultural safety and trauma-informed care training to agencies and organizations and embed policies and practices to ensure services are culturally safe.
	3.1. Advocate for new Peer Training programs that are specific to people who have lived experience with addiction.

Prevention priority actions (years 1-3)

Education/ Awareness	6.1. Support schools by providing up-to-date and evidence-based information and resources to inform curriculum and school policy and aid in the implementation of comprehensive school health.
	6.2. Use and promote national and provincial education campaigns and materials related to alcohol, cannabis, and other drugs. Develop local messages to fill any gaps.
	6.3. Use workplaces as a place to share information and encourage workplaces to support substance use prevention and treatment programs (e.g., Employee Assistance Programs).
	6.4. Support primary care as a valuable partner in prevention by providing up-to-date and evidence-based information, resources, and tools for working with patients including families, children, youth, adults, and older adults (e.g., screening and brief intervention tools, Low Risk Alcohol Drinking Guidelines).
Programs/ Services	7.3. In collaboration with existing strategies, projects and plans, acknowledge that education and success at school are key protective factors. Support supplementary school success programs such as free tutoring, mentoring, wrap-around supports.
Supportive Environments/ Collaboration	7.1. Collaborate with existing systems to create opportunities for positive community involvement and participation in meaningful leisure and recreational activities, for children of all ages and abilities, to foster feelings of inclusion and social capital among children and youth.
	7.2. Enhance school and community partnerships to build a sense of personal and group belonging within schools and the community.
Policy/ Advocacy	8.1. Work with municipal decision-makers to include evidence-based substance prevention considerations in municipal planning and policies (e.g., Municipal Alcohol Policies, bylaws related to cannabis legalization).
	8.2. Advocate for provincial policy that reduces substance-related harms (e.g., cannabis and alcohol pricing and taxation, drug impaired driving laws).

Treatment priority actions (years 1-3)

Education/ Awareness	9.1. Increase awareness of existing treatment information and pathways to treatment services in Middlesex-London, including awareness of existing sources of information such as Healthline and ConnexOntario.
	12.1. Support existing efforts to provide evidence-based information and training to those in contact with people who use crystal methamphetamine including local businesses.
	12.2. Provide education and supports to people who use crystal methamphetamine as well as their peers (e.g., user guide).
Programs/ Services	10.1. Explore and advocate for new models of treatment to meet community need (e.g., daytox, Indigenous model, full-day non-residential programs, low-threshold treatment and service options, a recovery community/centre, sobering centre).
	10.2. Explore the extent to which transportation and location of services is a barrier, notably in rural areas, and develop strategies to address.
	10.3. Identify barriers and create new strategies to help support people using drugs and/or alcohol to access services (e.g., childcare, mobility issues, etc.).
	11.1. Explore and improve the different models of withdrawal management care (i.e., daytox clinic) and how they fit into the continuum of services.
	11.3. Enhance relapse prevention supports and services.
Supportive Environments/ Collaboration	11.2. Strengthen capacity for service providers to work together to share best practices and common processes.
	11.4. Collaborate with institutions and community agencies to implement discharge planning and transition protocols to improve care for individuals leaving hospitals and jails.
	11.5. Enhance collaboration between services that address substance use and mental health services.
Policy/ Advocacy	10.4. Advocate to all levels of government to provide funding for a full continuum of treatment and care for individuals using substances and for their families and friends, including involvement in the recovery process.

Harm Reduction priority actions (years 1-3)

Education/ Awareness	14.1. Continue to ensure people are informed of locations where to access naloxone.
	14.2. Develop a coordinated way to inform people of contaminated/"bad" drugs within the community.
	14.3. Develop a coordinated way to inform people about infection outbreaks.
	16.2. Empower and educate the public regarding safe handling of sharps.
Programs/ Services	13.2. Support existing efforts to implement Supervised Consumption Facilities in London including a comprehensive model of care.
	15.1. Establish a managed alcohol program/facility for people with severe chronic alcohol addiction to address overall health and wellbeing.
	15.3. Determine need and explore strategies to expand availability of harm reduction services and supplies in rural communities (e.g., expansion of mobile services).
	16.1. Expand the availability of portable needle disposal kits and needle disposal bins throughout Middlesex-London.
	16.3. Explore and advocate for models of comprehensive needle recovery that support the effective and safe management of discarded sharps for citizens and property owners within London and Middlesex which does not rely on a fee for service.
Supportive Environments/ Collaboration	15.4. Enhance participation in research and evaluation of harm reduction services.
	17.1. Enhance surveillance and monitoring of local level substance use trends as well as risk and protective factors.
	17.2. Use data and information to identify new drugs and new drug use trends to minimize negative impacts.
Policy/ Advocacy	13.1. Advocate for more access to Suboxone as a means of treatment, including through primary care physicians, and enhancement of counselling service availability at opioid substitution clinics.
	13.3. Advocate for continued provincial attention to the opioid crises including continued policy commitment under Ontario Narcotics Strategy.
	13.4. Advocate for provision of naloxone kits, information and training to anyone being treated for an overdose at point of care and other access points.
	15.2. Advocate for extended hours of services and locations of harm reduction services and distribution of harm reduction supplies in London and Middlesex.

Enforcement priority actions (years 1-3)

Education/ Awareness	21.1. Assess and evaluate gaps in training related to substance use, harm reduction and treatment that may exist for those working in the justice system.
	23.1. Support the development of an information campaign (e.g., when to go to a walk-in crisis centre; when to go to the emergency department; when to call 911).
Programs/ Services	22.1. Support the reinstatement of diversion programs that combine treatment with a problem-solving lens that addresses diverse and unique needs.
Supportive Environments/ Collaboration	20.1. Expand the coordination of police service activities with activities of health and social service agencies to develop long-term solutions that improve the health and safety of people living in Middlesex-London.
Policy/ Advocacy	22.2. Advocate for key influential stakeholders to support and sustain diversion programs at a systems-level.

NEXT STEPS

The release of this report marks the beginning of the implementation phase of the Middlesex-London Community Drug and Alcohol Strategy. As we reach this milestone, many actions are already underway and many partners are committed to this collaborative work.

The Steering Committee and four Pillar workgroups, through collective dedication and expertise, have developed this Strategy. As we move to implementation, the structure and composition of the CDAS governance and workgroups will shift to better support the Strategy's implementation.

Consistent with other community drug strategies across Ontario, the need for a dedicated strategy coordinator has been identified as essential to coordinate implementation of the many recommendations and actions. Work is underway for a strategy coordinator to be put into place.

An implementation plan will be developed for priority actions. Many actions will depend on leveraging of existing resources, and some will require new sources of funding. This Strategy can serve to guide decision making of leaders and funders as the priorities and most immediate needs and actions are identified.

Progress of the Strategy will be monitored and reported on at regular intervals, with the CDAS website, **www.mldncdas.com**, being a source of information and reporting progress.

The CDAS is a long term strategy. While priority actions have been identified, there is a need to be nimble and responsive to changing local needs. Ongoing commitment of partners and collaboration among sectors is essential to success. Each member of our community has a role to play.

REFERENCES

1 Ontario Agency for Health Protection and Promotion (Public Health Ontario). Self-reported illicit drug use snapshot: self-reported proportion of the population who have ever used an illicit drug>> age standardized rate (both sexes combined)>> 2009-2012>>Middlesex-London [Internet]. Toronto (ON): Queen's Printer for Ontario; 2013 [updated 2013 November 20; cited 2018 April 6]. Available from: https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Illicit-Drug-Use.aspx

2 Addiction Services of Thames Valley. Annual general meeting – a ten year vision [PowerPoint presentation]. London (ON): [publisher unknown]; 2017 [cited 2018 Mar 20]. Available from: http://adstv.on.ca/wp-content/uploads/2017/06/AGM2017_loop.pdf

3 Canadian Community Health Survey [2015/16], Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

4 Leatherdale, ST. The COMPASS study: London district catholic school board summary of results for 2016-2017 [Internet]. Waterloo (ON): University of Waterloo; 2018. Available from: https://uwaterloo.ca/compass-system/information-researchers by using the data usage application form.

5 Boak A, Hamilton HA, Adlaf EM, Mann RE. Drug use among Ontario students, 1977-2017: detailed findings from the Ontario Student Drug Use and Health Survey (OSDUHS). Toronto, ON: Centre for Addiction and Mental Health; 2017. 341 p. Report No.: 46

6 Kerr T, Scheim A, Bardwell G, Mitra S, Rachlis B, Bacon J, Murray K, Rourke S. Ontario integrated supervised injection services feasibility study - study report: London, ON. London (ON): [Ontario HIV Treatment Network]; 2017. 17 p. Available from: http://www.ohtn.on.ca/wp-content/uploads/2017/02/OISIS-London-Report-Online.pdf

7 Public Health Ontario. Opioid-related morbidity and mortality in Ontario: interactive opioid tool [Internet]. Toronto (ON): Ontario Agency for Health Protection and Promotion; 2018 [updated 2018 May 23; cited 2018 Mar 20]. Available from: https://www.publichealthontario.ca/en/dataandanalytics/pages/opioid.aspx

8 Canadian Mental Health Association. Substance use and addiction [Internet]. Toronto (ON): Canadian Mental Health Association, Ontario;2018. Available from: http://ontario.cmha.ca/addiction-and-substance-misuse/

9 U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. Facing addiction in America: the Surgeon General's report on alcohol, drugs, and health [Internet]. Washington (DC): HHS; November 2016. Available from: https://addiction.surgeongeneral.gov/

10 Center on Addiction. Who develops addiction? Addiction risk factors [Internet]. New York (NY): Center on Addiction; 2017 [updated 2017 April 14; cited 2018 Mar 28]. Available from: https://www.centeronaddiction.org/addiction/addiction-risk-factors

11 Substance Abuse and Mental Health Services Administration. The TEDS report: age of substance use initiation among treatment admissions aged 18 to 30. Rockville (MD): Center for Behavioral Health Statistics and Quality; 2014 Jul 17. 6 p. Available from: https://www.samhsa.gov/data/sites/default/files/WebFiles_TEDS_SR142_AgeatInit_07-10-14/TEDS-SR142-AgeatInit-2014.pdf

12 National Institute on Drug Abuse Principles of substance abuse prevention for early childhood: a research-based guide [Internet]. [Bethesda (MD)]: National Institute on Drug Abuse; 2016 [cited 2018 Apr 4]. 94 p. Available from: https://www.drugabuse.gov/publications/principles-substance-abuse-prevention-early-childhood/introduction

13 Canadian Centre on Substance Abuse. When mental health and substance abuse problems collide. [Ottawa (ON)]: Canadian Centre on Substance Abuse; 2013. 8 p. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Mental-Health-and-Substance-Abuse-2013-en.pdf

14 The National Centre on Addiction and Substance Abuse at Columbia University. Addiction medicine: closing the gap between science and practice [Internet]. New York (NY): The National Centre on Addiction and Substance Abuse at Columbia University; 2012 Jun. 586 p. Available from: https://www.centeronaddiction.org/sites/default/files/Addiction-medicine-closing-the-gap-between-science-and-practice_1.pdf

15 Mayo Clinic [Internet]. [place unknown]: Mayo Foundation for Medical Education and Research; 2017 Oct 26. Drug addiction (substance use disorder); 2017 Oct 26 [cited 2018 Apr 4]. Available from: https://www.mayoclinic.org/diseases-conditions/drug-addiction/symptoms-causes/syc-20365112

16 The National Child Traumatic Stress Network. Making the connection: Trauma and substance abuse [Internet]. [place unknown]: The National Child Traumatic Stress Network; 2008. 8 p. Available from: http://www.nctsn.org/sites/default/files/assets/pdfs/SAToolkit_1.pdf

17 Canadian Centre on Substance Abuse. The essentials of…series: trauma-informed care [Internet]. [place unknown]: Canadian Centre on Substance Abuse; 2014. 7 p. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf

18 Ialomiteanu AR, Hamilton HA, Adlaf EM, Mann RE. CAMH monitor e-report: substance use, mental health and well-being among Ontario adults, 1977–2015. Toronto (ON): Centre for Addiction and Mental Health; 2016. 299 p. Report No.: 45.

19 World Health Organization. Global status report on alcohol and health 2014 [Internet]. Luxembourg: WHO Press; 2014. 392 p. Available from: http://apps.who.int/iris/bitstream/handle/10665/112736/9789240692763_eng.pdf;jsessionid=36E9161A7C2ACE-5806400C8DB7653F5D?sequence=1

20 Government of Canada. The chief public health officer's report on the state of public health in Canada, 2015: alcohol consumption in Canada. Ottawa (ON): Public Health Agency of Canada; 2015. 76 p. Available from: http://healthycanadians.gc.ca/publications/department-ministere/state-public-health-alcohol-2015-etat-sante-publique-alcool/alt/state-phac-alcohol-2015-etat-aspc-alcool-eng.pdf

21 UNICEF Office of Research. Innocenti Report Card 11 - Child well-being in rich countries: a comparative overview. Florence (IT): UNICEF Office of Research; 2013. 60 p. Available from: https://www.unicef-irc.org/publications/pdf/rc11_eng.pdf

22 McKiernan A, Fleming K. Canadian youth perceptions on cannabis. Ottawa (ON): Canadian Centre on Substance Abuse; 2017. 69 p. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Youth-Perceptions-on-Cannabis-Report-2017-en.pdf

23 Pearson C, Janz T, Ali J. Health at a glance - mental and substance use disorders in Canada [Internet]. Ottawa (ON): Statistics Canada; 2012 [updated 2015 November 27; cited 2018 Mar 27]. Available from: http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.htm

24 Centre for Addiction and Mental Health. Addiction [Internet]. Toronto (ON): Centre for Addiction and Mental Health; 2012. [cited 2018 Mar 27]. Available from: https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/addiction

25 Didenko E, Pankratz N. Substance use: Pathway to homelessness? Or a way of adapting to street life? Visions Journal [Internet]. 2007 Summer [cited 2018 Apr 5]; 4(1):9-10. Available from: http://www.heretohelp.bc.ca/sites/default/files/visions_housing_homelessness.pdf

26 Rainbow Health Ontario. LGBTQ people, drug use, & harm reduction. Toronto (ON): Rainbow Health Ontario; 2014. 17 p. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2015/06/RHO_FactSheet_LGBTDRUGUSEHARMREDUCTION_E.pdf

27 Canadian Centre on Substance Use and Addiction. First Nations, Inuit and Métis [Internet]. [Ottawa (ON)]: Canadian Centre on Substance Use and Addiction; 2018 [cited 2018 Mar 28]. Available from: http://www.ccdus.ca/Eng/topics/First-Nations-Inuit-and-Metis/Pages/default.aspx

28 McVie F. Drugs in federal corrections – the issues and challenges [Internet]. Ottawa (ON): Correctional Services Canada; 2015 [updated 2015 Mar 5; cited 2018 Mar 28]. Available from: http://www.csc-scc.gc.ca/research/forum/e133/e133c-eng.shtml

29 World Health Organization. Preventing overdose deaths in the criminal-justice system [Internet]. Copenhagen (DK): WHO Regional Office for Europe; 2014. 32 p. Available from: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf?ua=1

30 Sigfusdottir ID, Kristjansson AL, Gudmundsdottir ML, Allegrante JP. Substance use prevention through school and community based health promotion: a transdisciplinary approach from Iceland. Global Health Promotion. 2011 Sep; 18(3):23-26

31 National Drug Institute on Drug Abuse. What are risk factors and protective factors? [Internet]. [Bethesda (MD)]: National Institutes of Health; 2003 [updated 2003 Oct; cited 2018 26]. Available from: https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors

APPENDIX A

CDAS Steering Committee

Co-Chair, Rhonda Brittan, Middlesex-London Health Unit

Co-Chair, Brian Lester, Regional HIV/AIDS Connection

Joe Antone, Southwest Ontario Aboriginal Health Access Centre

Anne Armstrong, London Cares Homeless Response Services

Laura Cornish and Jan Richardson, Neighbourhood, Children and Fire Services, City of London

Scott Courtice, London InterCommunity Health Centre

Jon DeActis, Mission Services of London

Casey Donkers, Community Member

Tracey Law, London Area Network of Substance Users

Daryl Longworth, London Police Service

Janette MacDonald, Downtown London

Catherine McInnes, London Arts Council

Beth Mitchell, Canadian Mental Health Association Middlesex

Jen Pastorius, Old East Village Business Improvement Area

Michelle Quintyn, Goodwill Industries

Linda Sibley, Addiction Services of Thames Valley

Jack Smit and Sandra Datars Bere, Housing, Social Services and Dearness Home, City of London

Michael van Holst, Councillor Ward 1, City of London

1 co-chair from each pillar workgroup

Prevention Pillar Co-Chairs:	Pauline Andrew, Social Services, County of Middlesex
	Anita Cramp, Middlesex-London Health Unit
Treatment Pillar Co-Chairs:	Michael Annett, Salvation Army Centre of Hope
	Pam Hill, Addiction Services of Thames Valley
Harm Reduction Pillar Co-Chairs:	Sonja Burke, Regional HIV/AIDS Connection
	Natalie Meade, Middlesex-London Health Unit
Enforcement Pillar Co-Chairs:	Chris Auger, Ontario Provincial Police
	Bruce Rankin, Regional HIV/AIDS Connection

Past Steering Committee Members:

Muriel Abbott, Middlesex-London Health Unit – Steering Committee Co-chair

Al Edmondson, Mayor, Middlesex Centre

Lori Hassall, Canadian Mental Health Association Middlesex

Sharon Koivu, London Health Sciences Centre

Heather Lumley, St. Leonard's Community Services London and Region

Janet McAllister, Centre for Addiction and Mental Health

Suze Morrison, London Diversity and Race Relations Advisory Committee

Kelly Simpson, South West Local Health Integration Network

Pillar Workgroups

People from the following organizations and affiliations have been members of Pillar workgroups during the development of the CDAS.

Prevention

Co-Chair, Social Services, County of Middlesex
Co-Chair, Middlesex-London Health Unit
Children's Aid Society
African Canadian Federation of London & Area
Beth Emanuel Church
Canadian Council of Muslim Women
Community Member
IMPACT Program - London Health Sciences Centre
London District Catholic School Board
London Police Service
Middlesex-London Emergency Medical Services
Middlesex-London Health Unit
Mothers Against Drunk Driving
St. Leonard's Community Services London and Region
Thames Valley District School Board
Youth Opportunities Unlimited

Treatment

Co-Chair, Salvation Army Centre of Hope
Co-Chair, Addiction Services of Thames Valley
Canadian Mental Health Association London-Middlesex
City of London
Craigwood Youth Services
Family Service Thames Valley
Local Physician
London InterCommunity Health Centre
Mission Services of London
St. Joseph's Health Care
St. Leonard's Community Services London and Region
Teen Challenge

Harm Reduction

Co-Chair, Regional HIV/AIDS Connection
Co-Chair, Middlesex-London Health Unit
Addiction Services of Thames Valley
Anova
Children's Aid Society
London Area Network of Substance Users
London InterCommunity Health Centre
Local Physician
Mission Services of London
Old East Village Business Improvement Area
St. Joseph's Health Care

Enforcement

Co-Chair, Ontario Provincial Police
Co-Chair, Regional HIV/AIDS Connection
Children's Aid Society
Ethno Cultural Council of London
John Howard Society
London Police Service
Old East Village Community Association
Ontario Provincial Police
St. Leonard's Community Services London and Region

APPENDIX B

Guiding Principles

1. Community Strengths Based

- Recognize that Middlesex-London neighborhoods, institutions, and families and individuals have unique gifts to share, i.e. lived experience
- Draw on community and individual strengths as well as successes to further develop community assets
- Draw on community better practices from other community models that work

2. Evidence Informed

- Sound decision-making based on diverse forms of evidence from multiple sources, including best and promising practices, and persons with lived experience

3. Non-stigmatizing

- People first and all people matter
- Challenge harmful labels, stereotypes, discrimination and oppression
- Use language that is free of judgment and dignifying (not hurtful or derogatory)
- Share facts and positive attitudes about people who use substances, including addressing myths about use and behavior change
- Use of community and public education, including at a system level

4. Accessible

- Promote and ensure programs, services, communities and resources are accessible and appropriate to help reduce inequities faced by individuals who use substances and their supports in all environments (e.g. hospitals, clinics, business, women who are street involved)

5. Locally Relevant

- Tailor solutions to the diversity and uniqueness of, and local context found within all communities in Middlesex-London (i.e. consider local economy, drug use trends)

6. Collaborative

- Enhance inter-sectoral collaboration
- Nurture partnerships between citizens/residents, community groups, service providers, government, business, and persons with lived experience
- Engage community members in a full and meaningful way

7. Hopeful

- Build on our shared expectations, ambitions, and optimism for improvements in the impacts of substance use on our community
- Cultivate a realistic hope that acknowledges the challenges we face and persists in offering options outside of those already considered in resolving problems
- Embrace the language that fosters hope such as “when”, and “we believe”
- Mentorship/peer support with lived experience

8. Responsive to Barriers

- Provide community wide responses designed to identify and eliminate attitudinal, structural or systemic barriers to full participation in civic life and society as well as barriers to accessing the community's resources
- Educate the community to remove stigma
- Encourage/invite community participation

9. Action-oriented & Results Driven

- Set goals and develop indicators to track progress and evaluate the performance of selected approaches against the results we seek
- Use champions with expertise related to specific tasks
- Assess unintended outcomes/impacts (both positive & negative) at process and outcome level (e.g. Health Equity Impact Assessment)
- Publish the community's successes along the way

10. Culturally Safe

- Recognize that it is impossible to be thoroughly knowledgeable about cultures other than one's own
- Regard citizens as experts of their own culture and access their cultural expertise when engaging the community (e.g. those with lived experience)
- Recognize that mainstream approaches can lead to stress in marginalized communities (e.g. ethno-stress in ethnic communities)
- Use tailored approaches that are relevant to the needs of individuals who use substances, as well as to families and communities affected by substance use
- Trauma informed

11. Inclusive

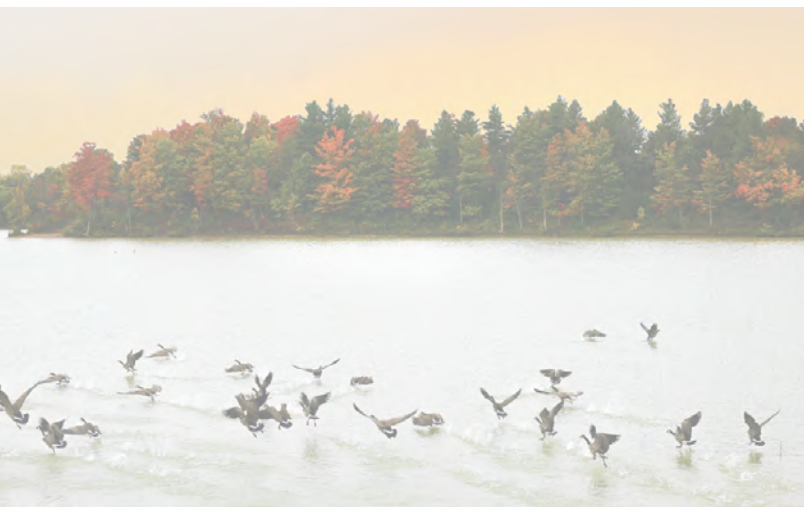
- Seek meaningful involvement, participation, and contribution of all people regardless of drug usage history, age, gender, ethnicity, race, income, and mental, cognitive or physical ability
- Apply inclusive approaches to all aspects of the drug strategy planning, implementation, and evaluation process

12. Equity Focused

- The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (definition from World Health Organization)
- Take into account the inter-relationships and impact of social determinants of health (SDOH), including how determinants of health and inequities reinforce each other
- Collaborate with committees/groups working to address SDOH in other areas
- Utilize culturally appropriate models of social determinants of health (e.g. Indigenous-informed model by the National Collaborating Centre for Indigenous Health)

13. Reconciliation Aware

- To contribute to reconciliation by honouring the uniqueness of the relationship between settlers and Indigenous peoples
- Establish and maintain a mutually respectful relationship with Indigenous peoples and communities
- Recognize the role of our own colonial history, power and privilege in shaping community interactions so as to mitigate/eliminate adverse effects of that power and privilege



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 062-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2018 October 18

SUPPORT FOR PLAIN AND STANDARDIZED TOBACCO PRODUCTS AND PACKAGING

Recommendations

It is recommended that the Board of Health receive Report No. 062-18 re: "Support for Plain and Standardized Tobacco Products and Packaging."

Key Points

- In November 2015, the Government of Canada introduced plain and standardized tobacco products and packaging legislation ("plain packaging", a key priority to strengthen current tobacco control measures across the country.
- Plain packaging will result in the removal of all tobacco product design features, such as colours, fonts, and logos, which reinforce the tobacco brand and undermine the graphic health warnings on the package.
- In May 2016, the Middlesex-London Health Unit Board of Health signed the *Plain and Standardized Packaging Endorsement Form* to recommend that the Government of Canada implement plain and standardized tobacco packaging.
- In September 2018, MLHU submitted a letter to a Health Canada consultation in support of plain packaging, and providing feedback on the federal government's proposed *Tobacco Products Regulations (Plain and Standard Appearance).*

Background

Tobacco use is the leading preventable cause of illness and premature death in Canada, killing more than forty-five thousand Canadians annually. Preventing initiation of tobacco use is one of the most effective means of reducing tobacco use and its associated health risks.

The tobacco industry understands the value of their packaging, and designs them for making their products attractive and appealing to youth. Colourful and eye-catching logos and sleek, sculpted packages reinforce the brand to tobacco users. These undermine graphic health warnings that are already required on packages.

Plain packaging was first initiated in Australia in 2012. Since then, eight countries have adopted plain packaging measures, and at least sixteen more are in the process of, or considering implementing, plain packaging for tobacco products.

There is an extensive body of evidence in support of implementing plain packaging, and additional studies have further documented the Australian experience. Evidence shows that plain packaging reduces the appeal of tobacco products, and reduces the prevalence of smoking. After plain packaging was introduced in Australia, a significant decline in smoking prevalence and an increase in call-to-quit lines was observed.

In Canada in 2015, the federal government committed to implementing plain packaging, and recognized it as a top priority in order to strengthen tobacco control measures across Canada and protect youth and others from being exposed and targeted via appealing tobacco packages.

Health Canada 2018 Consultation

In June 2018, the Government of Canada released its proposed regulations for plain and standardized products, including measures to standardize the appearance of tobacco product packs, as well as the product itself. This includes removing brand colours, logos, and other distinctive or appealing features associated with the tobacco brand. All packs and products would have a similar appearance, and the same ordinary, bland colour. Standardizing the product, as well as the packaging, goes above and beyond plain packaging efforts in other countries, and positions Canada as a leader in tobacco control.

In September 2018, the Middlesex-London Health Unit participated in a public consultation by writing a letter in support of plain packaging, and providing feedback on the Canadian Government's proposed *Tobacco Products Regulations (Plain and Standard Appearance)*. The letter to the Tobacco Control Directorate, Health Canada, titled "Support for Plain and Standardized Tobacco Products and Packaging," is included in Appendix A.

This report was prepared by the Healthy Living Division.

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

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

September 6, 2018

Appendix A to Report No. 062-18

Tobacco Control Directorate
Health Canada
150 Tunney's Pasture Driveway
Ottawa, Ontario
K1A 0K9

RE: Support for Plain and Standardized Tobacco Products and Packaging

At its May 19, 2016 meeting the Middlesex-London Board of Health reviewed Report No. 033-16 re *Plain and Standardized Packaging – Reducing the Impact of Tobacco Marketing on Smoking Behavior*, attached, and recommended that the Government of Canada implement plain and standardized tobacco product packaging. Plain and standardized packaging should apply to all tobacco products, and the slide and shell package format should be required for cigarettes. These regulations should be adopted as soon as possible without being weakened. The Middlesex-London Health Unit applauds the Government of Canada's plan to introduce plain and standardized tobacco products and packaging in Canada, and fully supports the proposed Tobacco Products Regulations (Plain and Standard Appearance).

The Government of Canada has committed to achieving 5% tobacco use rate by 2035. In order to achieve this goal, bold and innovative measures are necessary such as implementing plain and standardized packaging for commercial tobacco products with the strongest regulations possible. Tobacco companies often challenge plain and standardized packaging stating it is an ineffective intervention. However, evidence shows that plain and standardized packaging reduces the appeal of tobacco products and reduces the prevalence of smoking. For example, after plain packaging was introduced in Australia, a significant decline in smoking prevalence and increase in calls to quit lines was observed.[1] In addition, with plain and standardized packing in place, Canadian youth will no longer be exposed and targeted by appealing tobacco packages.

With many forms of tobacco advertising prohibited, the tobacco pack has become the main form of advertising to current and potential users. Colours, logos and images reinforce the brand and undermine graphic health warnings. The tobacco pack serves as a mini billboard, travelling everywhere with the customer and coming into view multiple times a day. Tobacco companies are very protective and vehemently oppose plain and standardized tobacco packaging. Industry documents explain: "With tobacco advertising bans, the only thing left is the pack. You have to put your entire brand image into the pack to draw new customers to you." [2]

Plain and standardized packaging is a key priority to strengthen tobacco control measures already in place across Canada and one of the most important measures that can be undertaken to lower our nation's smoking rate. The Middlesex-London Health Unit commends the Government of Canada for their leadership in introducing this legislation, and their commitment to protecting the health of Canadians.

Sincerely,

Christopher Mackie MD, MHSc, CCFP, FRCPC
Medical Officer of Health/CEO
Middlesex London Health Unit
50 King St.
London, ON
N6A 5L7

References:

[1] Smoke-Free Ontario Scientific Advisory Committee. Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2016). Evidence to guide action: comprehensive tobacco control in Ontario. Toronto, ON: Queen's Printer for Ontario.
[2] Frans van Heertum, as quoted in S. Rossel, "The cigarette pack has just begin it's life": Interview with ciarette packaging designers", *Tobacco Journal International*, 8 May 2008.

MIDDLES4EX-LONDON HEALTH UNIT

REPORT NO. 033-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2016 May 19

PLAIN AND STANDARDIZED PACKAGING-REDUCING THE IMPACT OF TOBACCO MARKETING ON SMOKING BEHAVIOUR

RECOMMENDATIONS

It is recommended that:

1. ***The Board of Health sign the endorsement, attached as Appendix A, recommending that the Government of Canada implement plain and standardized tobacco product packaging; and,***
2. ***In support of the National Campaign, the members of One Life One You visit local MPs to provide education and promote the importance of plain and standardized tobacco product packaging prior to proposal submission to Cabinet, anticipated for fall 2016.***

Key Points

- In Nov. 2015, the Federal Government committed to implement plain packaging and to make it a top priority as stated in a letter to the Minister of Health.
- The tobacco package is one of the only remaining marketing tools that the tobacco industry has to promote its deadly product, serving as a mini billboard, using colours, images, logos, slogans and distinctive fonts, finishes, and sizing configurations to make their product appealing and attractive to tobacco users and to recruit new tobacco users.
- An extensive body of evidence has shown that that plain and standardized packaging enhances the effectiveness of the graphic health warnings and curbs deceptive messages about tobacco products, reducing tobacco use.
- Several national health agencies led by the Heart and Stroke Foundation, the Non-Smokers' Rights Association and the Canadian Cancer Society (CCS) are developing a coordinated national campaign to support the Federal Government's plan.

Background

Legislation prohibiting how and where tobacco companies can advertise tobacco products has necessitated the development of tobacco packaging that is, in essence, a mini billboard to promote tobacco companies' deadly products in compelling ways. Clever marketing that uses colourful and eye-catching logos and graphics, and sleek, sculpted packages containing monogrammed or stylized cigarettes appeals to tobacco users and potential new smokers alike.

Replacing the flashy tobacco package with a plain package containing only the brand name and health warning would eliminate tobacco brand promotion, curb deceptive messaging using descriptors such as "light" or "mild", strengthen the impact of the graphic health warnings and reduce tobacco use overall.

Plain packaging of tobacco products is not a new idea. Australia was the first country to mandate plain packaging in Dec. 2012, and the UK and France are implementing plain packaging in May 2016. Ireland has enacted legislation and is currently waiting on an implementation date. Plain packaging is being formally considered in 9 other countries including Canada, Sweden, South Africa, Finland, Norway and

Belgium. In Canada in 2015, the Federal Government committed to implementing plain packaging as part of its electoral platform and referred to it as a top priority in a letter to the Minister of Health.

There is an extensive body of evidence in support of implementing plain packaging and additional studies that have documented the Australian experience. As expected, the tobacco industry has responded through legal action; however, both a constitutional challenge and tobacco industry legal claim against the Australian government have been dismissed.

The National Campaign for Plain and Standardized Packaging

Several national health agencies led by the Heart and Stroke Foundation, the Non-Smokers' Rights Association and the Canadian Cancer Society (CCS) are developing a national campaign to support the Federal Government's plan to require plain and standardized packaging. The proposal put forth to the Canadian government would require that packages are void of colour, logos, branding, slogans, images and/or stylized fonts. Further, all packages would have standardized dimensions (size and shape), and would not include any distinctive finishes or specialty formats. With campaign support and health agency endorsement across Canada, the Government of Canada has the opportunity to address the remaining forms of tobacco marketing. The inclusion of standardization goes above and beyond plain packaging efforts in other countries and will position Canada as a leader in tobacco control once again. Throughout this process there will be ongoing opportunities for involvement at the regional and local level. A provincial coalition comprised of representatives from public health units and Smoke-free Ontario provincial partners is developing a social marketing campaign to raise awareness of the tobacco industry's practices with respect to branding, packaging and design, and to promote the impact that tobacco packaging has on youth initiation. The Tobacco Prevention Health Promoter and Youth Development Specialist from the Health Unit and SW TCAN are active members of this provincial coalition.

Opportunities for Action

To show support for plain and standardized packaging, the Canadian Cancer Society has prepared an endorsement form for signature by as many national, provincial and regional health agencies as possible. Collecting a large number of these endorsements is an essential part of the effort to demonstrate to the Canadian Government that there is widespread support for plain and standardized packaging. Signing the *Plain and Standardized Packaging Endorsement Form*, attached as Appendix A, is an opportunity for the Middlesex-London Board of Health to communicate its support to the national campaign and to recommend the implementation of plain and standardized packaging by the Federal Government. To support the campaign at the local level, members of *One Life One You* will visit local MPs to provide education and promote the importance of plain and standardized packages, prior to the proposal submission to Cabinet in the fall of 2016.

This report was prepared by Mrs. Lori Fellner, Youth Development Specialist, South West Tobacco Control Area Network (SWTCAN), Ms. Jacqueline Uprichard, Health Promoter for the Chronic Disease Prevention and Tobacco Control (CDPTC) Team, Ms. Donna Kosmack, SWTCAN Manager and Ms. Linda Stobo, CDPTC Program Manager.

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

This report addresses the following requirements of the Ontario Public Health Standards (2015): Foundational Standard 1, 9; Chronic Disease Prevention 1, 7, and 11.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Endorsement of Plain and Standardized Packaging

Plain and standardized packaging would prohibit all promotional features on all tobacco packaging, including the use of colours, images, logos, slogans, distinctive fonts, and finishes. Only the brand name would be allowed. Health warnings would remain on packages. The size and shape of the package would be standardized, thus prohibiting specialty package formats, such as slim and superslim cigarette packages that reduce warning size and overtly target women. The appearance of cigarettes would also be standardized, at a minimum prohibiting the use of branding, logos, colours and special finishes, and establishing standards for cigarette length and diameter.

Our organization endorses a requirement in Canada for plain and standardized packaging, as outlined above.

Name of organization: Middlesex-London Board of Health

Name of organization representative: Mr. Jesse Helmer

Title: Chair, Middlesex-London Board of Health

Signature: _____

Date: 19 May 2016

Name and email for organization contact: Dr. Christopher Mackie, Medical Officer of Health and CEO
Email: christopher.mackie@mlhu.on.ca

London Office
50 King St., London, ON N6A 5L7
tel: (519) 663-5317 • fax: (519) 663-9581

www.healthunit.com
health@mlhu.on.ca

Strathroy Office - Kenwick Mall
51 Front St. E., Strathroy, ON N7G 1Y5
tel: (519) 245-3230 • fax: (519) 245-4772

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 063-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie Medical Officer of Health / CEO

DATE: 2018 October 18

SUMMARY INFORMATION REPORT FOR OCTOBER

Recommendation

It is recommended that Report No. 063-18 re: Summary Information Report for October be received for information.

Key Points

- After a competitive request for proposals a contract was awarded to Cinnamon Toast New Media Inc. in the amount of $36,7500 to assist the Southwest Tobacco Control Area Network in the development of a social marketing campaign to address the high smoking rate among young adult male population.

Procurement for Social Marketing Materials for Tobacco Prevention Campaign

The Southwest Tobacco Control Area Network (SW TCAN) is developing a social marketing campaign to address the high smoking rate observed in the young adult male population. Request for Proposal 18-03 entitled Marketing Materials for Tobacco Prevention Campaign was issued on September 3rd, 2018. Five proposals were received by the deadline and underwent an extensive evaluative process that consisted of proposal scoring, follow up questions being asked and interviews conducted for the top two proponents. Cinnamon Toast New Media Inc. was awarded the contract in the amount of $36,750 as they received the top score during this process. The SW TCAN will work with Cinnamon Toast to ensure all deliverables are provided to the Middlesex-London Health Unit by December 21, 2018.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 064-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 October 18

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR OCTOBER

Recommendation

It is recommended that the Board of Health receive Report No. 064-18 re: "Medical Officer of Health Activity Report for October" for information.

The following report presents activities of the Medical Officer of Health for the period of September 7, 2018, to October 5, 2018.

September 10 Participated in planning meeting with Western University staff in regard to an Opioids Panel event for Western Homecoming

September 12 Participated on the COMOH Executive Team conference call
Interviewed on video for the nomination of the Temporary Overdose Prevention Site's for the Pillar Community Innovation Award for Community Collaboration at Gotham Studios

September 13 Attended the Community Health Collaborative Steering Committee meeting at Goodwill Industries

September 14 Teleconference with alPHa Executive Committee
Attended the Our Health Counts London launch event

September 17 Phone call with Dr. Roumeliotis to discuss cannabis issues
Met with Ward 13 candidate Kevin Wilbee
Met with Ward 13 candidate Jonathan Hughes

September 18 Interviewed by Darryl Newcombe, CTV, and Norm DeBono, *London Free Press* (LFP), in regard to opioids, the Supervised Consumption Facilities (SCF) Business Case, and Temporary Overdose Prevention Sites (TOPS)

September 19 Participated in interview for Public Health Ontario, titled "Situational Assessment on Healthy Eating and Food Environment Public Health Practice: Needs, Challenges, and Opportunities"
Interviewed live by Craig Needles, 980 CFPL, commenting on mayoral remarks about SCF and current realities of London's opioid crisis

September 20 Attended the Youth Opportunities Unlimited (YOU) Finance Committee meeting
Interviewed by the CBC; Mike Stubbs, AM 980, and Dan Brown (LFP) regarding the Business Case for SCF.
Attended United Way Harvest Lunch
Interviewed at Fanshawe College in regard to the Health Unit's nomination for the Annual Pillar Award
Attended the Board of Health meeting

September 21	Attended the City Manager's Breakfast at the London Convention Centre
September 26	Participated in the COMOH Section teleconference
September 27	Met on behalf of COMOH with Jeff Yurek, MPP Elgin-Middlesex-London, in Toronto
September 28	Attended alPHa Board of Directors meeting in Toronto
October 1	Delivered opening remarks at the Canadian Institute of Public Health Inspectors (CIPHI) conference, held in London and hosted by MLHU Participated in Ministry conference call with all health units in regard to Infectious Disease Outbreak Management Surge Capacity Policy
October 3	Met with members of the Opioid Crisis Working Group to discuss strategies for commencing implementation of an SCF in London Attended the Ward 13 all-candidates meeting at Central Library
October 4	Conference call with Peter Fragiskatos, MP London North Centre, about SCFs Participated in a TOPS tour with Dr. Alam, President, Ontario Medical Association Phone call with Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
October 5	Interviewed by Camille Ross, CTV News, about recent TOPS extension announcement Led a class of Public Health master's students, Western University

This report was submitted by the Office of the Medical Officer of Health.

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