AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, April 18, 2024 at 7 p.m.
Microsoft Teams

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

Matthew Newton-Reid
Michael Steele
Peter Cuddy
Aina DeViet
Skylar Franke
Michael McGuire
Selomon Menghsha
Howard Shears
Michelle Smibert
Dr. Alexander Summers (Medical Officer of Health, ex-officio member)
Emily Williams (Chief Executive Officer, ex-officio member)

SECRETARY

Emily Williams

TREASURER

Emily Williams

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: March 21, 2024 – Board of Health meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1		X	X	Performance Appraisal Committee Meeting Summary (Verbal Report)	April 18, 2024 Agenda	To provide an update from the April 18, 2024 Performance Appraisal Committee meeting. Lead: Incoming 2024 Performance Appraisal Committee Chair
2		X	X	Governance Committee Meeting Summary (Verbal Report)	April 18, 2024 Agenda	To provide an update from the April 18, 2024 Governance Committee meeting. Lead: Incoming 2024 Governance Committee Chair
3		X	X	2024 Annual Service Plan (Report No. 25-24)	Appendix A Appendix B Appendix C	To review and seek endorsement from the Board of Health on the 2024 Annual Service Plan submitted on April 2, 2024. Leads: Sarah Maaten, Director, Public Health Foundations and David Jansseune, Associate Director, Finance and Operations
4			X	2023 Occupational Health and Safety Report (Report No. 26-24)	Appendix A	To review the 2023 Middlesex-London Health Unit Occupational Health and Safety Report. Lead: Cynthia Bos, Associate Director, Human Resources and Labour Relations Presenting: Lilka Young, Health and Safety Advisor

5			**X**	OAGO Performance Audit – Non-Municipal Water (Report No. 27-24)		To discuss a request received by the Middlesex-London Health Unit from the Auditor General of Ontario regarding small drinking water systems in the jurisdiction. Lead: Mary Lou Albanese, Director, Environmental Health, Infectious Disease and Clinical Services Presenting: Ryan Fawcett, Manager, Privacy, Risk and Client Relations and Andrew Powell, Manager, Safe Water, Tobacco Enforcement and Vector Borne Disease
6			**X**	Vector-Borne Disease Program: Contract Award (Report No. 28-24)		To provide the Board of Health with information on community larvaciding contract awards. Lead: Emily Williams, Chief Executive Officer Presenting: Andrew Powell, Manager, Safe Water, Tobacco Enforcement and Vector Borne Disease and Warren Dallin, Manager, Procurement and Operations
7			**X**	The Evolving Food Safety Landscape (Report No. 29-24)		To provide an update on the current food safety landscape in Middlesex-London. Lead: Mary Lou Albanese, Director, Environmental Health and Clinical Services Presenting: David Pavletic, Manager, Food Safety and Health Hazards and Jordan Banninga, Manager, Infectious Disease Control
8			**X**	Current Public Health Issues (Verbal Update)		To provide an update on current public health issues in the Middlesex-London region. Leads: Dr. Alexander Summers, Medical Officer of Health and Dr. Joanne Kearon, Associate Medical Officer of Health

9			**X**	Medical Officer of Health Activity Report for March (Report No. 30-24)		To provide an update on external and internal meetings attended by the Medical Officer of Health since the last Board of Health meeting. Lead: Dr. Alexander Summers, Medical Officer of Health
10			**X**	Chief Executive Officer Activity Report for March (Report No. 31-24)		To provide an update on external and internal meetings attended by the Chief Executive Officer since the last Board of Health meeting. Lead: Emily Williams, Chief Executive Officer
Correspondence						
11			**X**	April Correspondence		To receive items a) through e) for information: a) 2023 Chief Medical Officer of Health of Ontario Annual Report - *Balancing Act: An All-of-Society Approach to Substance Use and Harms* b) Association of Local Public Health Agencies re: *2024 Summary of the Ontario Budget* c) Middlesex-London Board of Health External Landscape for April d) Association of Local Public Health Agencies re: *2023 Chief Medical Officer of Health of Ontario Annual Report* e) Haliburton, Kawartha, Pine Ridge District Public Health Unit re: *National Framework for a School Food Program Act*

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, May 16, 2024 at 7 p.m.

CLOSED SESSION

The Middlesex-London Board of Health will move into a closed session to approve previous closed session Board of Health minutes and to discuss matters which pertain to one or more of the following, as per section 239(2) of the *Municipal Act, 2001, S.O. 2001, c. 25*:

(a) the security of the property of the municipality or local board;
(b) personal matters about an identifiable individual, including municipal or local board employees;
(c) a proposed or pending acquisition or disposition of land by the municipality or local board;
(d) labour relations or employee negotiations;
(e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
(g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
(h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or
(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, March 21, 2024, 7 p.m.
MLHU Board Room – Citi Plaza
355 Wellington St. London, ON, N6A 3L7

MEMBERS PRESENT:
Matthew Newton-Reid (Chair)
Michael Steele (Vice-Chair)
Selomon Menghsha (attended virtually)
Skylar Franke
Michelle Smibert
Peter Cuddy
Michael McGuire (attended virtually)
Howard Shears
Emily Williams, Chief Executive Officer (ex-officio) (Secretary and Treasurer)
Dr. Alexander Summers, Medical Officer of Health (ex-officio)

REGRETS:
Aina DeViet

OTHERS PRESENT:
Stephanie Egelton, Executive Assistant to the Board of Health (recorder)
Sarah Maaten, Director, Public Health Foundations
Jennifer Proulx, Director, Family and Community Health and Chief Nursing Officer
Dr. Joanne Kearon, Associate Medical Officer of Health
Mary Lou Albanese, Director, Environmental Health, Infectious Disease and Clinical Services
Cynthia Bos, Associate Director, Human Resources and Labour Relations
David Jansseune, Associate Director, Finance and Operations/Chief Financial Officer
Ryan Fawcett, Manager, Privacy, Risk and Client Relations
Angela Armstrong, Program Assistant, Communications
Abha Solanki, End User Support Analyst, Information Technology
Morgan Lobzun, Communications Coordinator
Linda Stobo, Manager, Social Marketing and Health Systems Partnerships
Andrew Powell, Manager, Safe Water, Tobacco Enforcement and Vector Borne Disease
Donna Kosmack, Manager, Oral Health and Clinical Support Services
Warren Dallin, Manager, Procurement and Operations
Jessica Wijesundera, Health Promotion Specialist, Social Marketing and Health Systems Partnerships
Daniel Neamtu, Nursing Student, Social Marketing and Health Systems Partnerships

Chair Matthew Newton-Reid called the meeting to order at **7 p.m.**

DISCLOSURE OF CONFLICT OF INTEREST

Chair Newton-Reid inquired if there were any disclosures of conflicts of interest. None were declared.

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APPROVAL OF AGENDA

Chair Newton-Reid noted that due to a recent announcement from Health Canada, there is a proposed updated Appendix B to Report No. 16-24 to be added to the agenda.

It was moved by **S. Franke, seconded by M. Smibert,** *that the **AGENDA** for the March 21, 2024 Board of Health meeting be approved as amended.*

Carried

APPROVAL OF MINUTES

It was moved by **H. Shears, seconded by M. Smibert,** *that the **MINUTES** of the February 15, 2024 Board of Health meeting be approved.*

Carried

It was moved by **M. Smibert, seconded by P. Cuddy,** *that the **MINUTES** of the February 15, 2024 Finance and Facilities Committee meeting be received.*

Carried

NEW BUSINESS

alPHa Resolution: Permitting Applications for Automatic Prohibition Orders under the Smoke Free Ontario Act, 2017 for Vapour Product Sales Offences (Report No. 15-24)

Andrew Powell, Manager, Safe Water, Tobacco Enforcement and Vector Borne Disease introduced a proposed resolution for the Board of Health's consideration at the Association of Local Public Health Agencies Annual General Meeting in June 2024.

A. Powell provided background information on automatic prohibitions within the *Smoke Free Ontario Act*. The *Smoke Free Ontario Act* is provincial legislation that regulates the sale, supply, display, and promotion of commercial tobacco and vapour products at retail outlets, as well as provisions for designated locations for smoking and vaping. Currently, the Health Unit is seeing a large increase of non-compliance by vapour product retailers despite the provisions under the legislation. Under the *Smoke-free Ontario Act*, routine non-compliance (two or more convictions) with tobacco sales offences results in the issuance of an automatic prohibition order for further tobacco sales under Section 22 of the *Smoke-Free Ontario Act.* At this time, there is no provision for automatic prohibitions under the legislation for vapour product violations.

Currently, test shopping and inspection practices by Health Unit staff are critical to promote and monitor retailer compliance, however, opportunity exists to strengthen controls within the retail space. A. Powell noted that operators (of vapour product retailers) have shared with the Health Unit's Tobacco Enforcement Officers that the large revenue from sales of vapour products far exceeds both the fine amounts and the risk of product seizures. Operators have stated that this aspect is a cost of doing business.

In addition, the Health Unit's Tobacco Enforcement Officers have noted the following:

- That there is an increase in the number of facilities selling vapour products within the Middlesex-London jurisdiction;
- There is an overall decrease in compliance with provisions of the *Smoke Free Ontario Act* for vapour product;
- There has been an increase in warning and charges issues against vapour product retailers for sale to people under the age of 19;
- That retailers continue to offer for sale prohibited flavours of vapour products and e-cigarettes with nicotine concentrations more than 20mg/L; and
- That the fines and product seizures seem to be an insufficient deterrent.

A. Powell provided a recent example of the process of issuing an offence to a non-compliant vapour product retailer. A local convenience store had a history of non-compliance, which included selling flavoured vapour products containing nicotine concentrations more than 20 mg/mL, selling prohibited flavours of vapour products, selling of vapour products to youth without requesting age and identification, and non-compliance with display and promotion of vapour products. With the absence of being able to issue an automatic prohibition order for vapour related offences, the Health Unit issued a Section 13 order under the *Health Promotion and Protection Act* on January 9, 2024 to the convenience store. A Section 13 order can only be made by a Medical Officer of Health, Associate Medical Officer of Health or Public Health Inspector to cease activities that pose health risks to the community. A. Powell noted that while a Section 13 order is a necessary action at a specific time, a Tobacco Enforcement Officer is not designated under the *Health Promotion and Protection Act* to issue such order and must rely on their Public Health Inspector colleagues, Dr. Summers or Dr. (Joanne) Kearon.

The next steps on bringing awareness to the Province of Ontario on this matter is to bring a Board of Health supported resolution to the upcoming Association of Local Public Health Agencies Annual General Meeting (through Dr. Summers) to request an amendment to Section 22 of the *Smoke-Free Ontario Act* to include vapour product sales convictions within automatic prohibition order applications.

Board Member Michelle Smibert inquired on the monetary offence amount for a tobacco and vapour product offence under the *Smoke Free Ontario Act*. A. Powell noted that depending on the type of offence, the starting fine is $250 and increases up to thousands of dollars.

Board Member Skylar Franke inquired on the process for a Board of Health to bring a resolution to the Association of Local Public Health Agencies Annual General Meeting. Dr. Alexander Summers, Medical Officer of Health explained that the Association of Local Public Health Agencies (alPHa) represents all 34 health units in Ontario, and the Annual General meeting is an opportunity to review and pass resolutions from its members. Resolutions assist the association with supporting advocacy for healthy public policy development of certain topics, with 3-4 resolutions passed each year. Members debate discuss and vote on resolutions. Dr. Summers noted the eagerness of supporting this resolution in front of the Board as it is a concrete solution, and the ask is for tools of enforcement for vaping to be the same as tobacco violations. With a resolution such as this one, the Health Unit and members of alPHa can mobilize through the Province of Ontario to request to change policy and legislation.

Chair Newton-Reid noted the importance of the context within this resolution regarding automatic prohibitions and that it is a clear gap in legislation.

It was moved by **M. Steele, seconded by S. Franke,** *that the Board of Health:*

1) *Receive Report No. 15-24 re: "alPHa Resolution: Permitting Applications for Automatic Prohibition Orders under the Smoke Free Ontario Act, 2017 for Vapour Product Sales Offences"; and*
2) *Direct staff to submit the draft resolution, attached as Appendix A, to the Association of Local Public Health Agencies (alPHa) for consideration at the Annual General Meeting on June 5, 2024.*

Carried

Recommendation for Provincial and Federal Restrictions on Nicotine Pouches (Report No. 16-24)

Linda Stobo, Manager, Social Marketing and Health Systems Partnerships provided information on recommendations for federal and provincial restrictions on nicotine pouches.

L. Stobo provided an overview of newly available nicotine products in the marketplace. There is a growing range of available nicotine products which include "Sesh+" gum and "Zonnic" nicotine pouches. These products are currently approved for sale as natural health products. "Zonnic" nicotine pouches were

authorized for sale by Health Canada on July 18, 2023, under the Natural Health Products Regulations and do not contain any tobacco. The nicotine pouch classification as a natural health product are not regulated under the *Tobacco and Vaping Products Act* or the *Smoke-Free Ontario Act* and are sold at convenience stores and gas stations without restrictions. L. Stobo added that these products are still harmful as a natural health product and harmful marketing is catered towards youth.

L. Stobo noted that nicotine pouches are incredibly harmful to youth. Use of these products could impact brain development, mood, learning and attention, impulse control, heart health and will lead youth to become addicted to nicotine as 1 pouch can have the nicotine level of 4 cigarettes. Currently, "Zonnic" is the only brand of nicotine pouches currently approved for sale in Canada, but other brands are being openly sold illegally in specialty vapour product stores. Schools are reporting increased nicotine sickness, symptoms of nicotine withdrawal, and nicotine pouch litter to public health. There are also emerging lawsuits with brands such as "Zyn" sold in the United States due to their addictive nature and the use of "Zynfluencers" to target youth on social media.

L. Stobo informed the Board of Health that there was an announcement on March 20 from Health Canada that they are pursuing legislative and regulatory mechanisms in the short term to put in place safeguards to address youth access and appeal to nicotine replacement products, including restrictions on advertising, flavours, and place of sale. As a result of this recent announcement, staff has drafted a proposed letter from the Board to the Minister of Health outlining support for these short-term measures.

Vice-Chair Michael Steele sought confirmation if smoking cessation gum (such as "Nicorette" nicotine gum) is regulated under different legislation than nicotine pouches. L. Stobo explained that smoking cessation gum is located in a pharmacy and considered a drug due to the amount of nicotine within the product and its purpose and are legislated under food and drug legislation. The nicotine pouches are considered a natural health product, potentially due to the documentation that was provided to Health Canada when seeking licensing. Dr. Summers added that the marketing of these types of products is profoundly different today than when smoking cessation gum was first introduced and marketed.

It was moved by **M. Smibert, seconded by P. Cuddy,** *that the Board of Health:*

1) *Receive Report No. 16-24 re: "Recommendation for Provincial and Federal Restrictions on Nicotine Pouches" for information;*
2) *Endorse the Windsor-Essex County Board of Health Resolution Report, attached as Appendix A; and*
3) *Direct staff to submit a letter to Health Canada on behalf of the seven public health units in southwestern Ontario, attached as Appendix B.*

Carried

Q4 2023 Risk Register Update (Report No. 17-24)

Ryan Fawcett, Manager, Privacy, Risk and Client Relations provided an update on the Middlesex-London Health Unit's Risk Registry for Q4 2023.

R. Fawcett noted that there were ten (10) risks identified in Q3 of 2023, with no new risks being identified or removed from the registry in Q4. For residual risks in Q4, five (5) were classified as being minor risks and five (5) were classified as being moderate risks. One (1) political risk related to public health modernization and mergers was changed from significant risk to moderate risk.

There were no questions or discussion.

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It was moved by **S. Franke, seconded by H. Shears,** *that the Board of Health:*

1) *Receive Report No. 17-24 re: "MLHU Q4 2023 Risk Register Update" for information; and*
2) *Approve the Q4 Risk Register (Appendix A).*

Carried

Privacy Program – Information and Privacy Commissioner (IPC) Statistical Reports (Report No. 18-24)

R. Fawcett provided an update on the Middlesex-London Health Unit's privacy program and submission of 2023 privacy information statistical reports submitted to the Information and Privacy Commissioner of Ontario.

R. Fawcett provided a brief overview of the framework of legislation and reporting within the Privacy Office. The applicable legislation includes the *Personal Health Information Protection Act* (PHIPA), the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA), the *Health Protection and Promotion Act* and the Ontario Public Health Standards. The Privacy Office (at the Health Unit) completes annual statistical reporting to the Information and Privacy Commissioner of Ontario in accordance with the requirements set out in the *Personal Health Information Protection Act* (PHIPA), O. Reg 329/04, and the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA).

The Health Unit's Privacy Office submits three (3) annual statistical reports to the Information and Privacy Commissioner of Ontario: confirmed privacy breaches under the *Personal Health Information Protection Act*, access and correction requests under the *Personal Health Information Protection Act*, and access and correction requests under the *Municipal Freedom of Information and Protection of Privacy Act*. In 2023, there were zero (0) privacy breaches, twenty-one (21) access requests under the *Personal Health Information Protection Act* and seven (7) access requests under the *Municipal Freedom of Information and Protection of Privacy Act.*

Statistical reporting to the Information and Privacy Commissioner of Ontario is due on March 1 of each year. The Privacy Office submitted the Health Unit's reporting on February 16. R. Fawcett noted that all staff and Board Members have completed their annual privacy attestations, and the Privacy Office will continue to audit and provide education throughout the year.

Board Member S. Franke inquired to R. Fawcett how the Health Unit learns that a privacy breach has occurred. R. Fawcett explained that through the Privacy Office, regular audits are conducted on systems with sensitive information, such as client personal health information. R. Fawcett provided an example of the Clinical Connect program, where searches of same surnames by authorized users would be flagged for the Privacy Office. R. Fawcett noted that the Privacy Office works with program leaders to confirm access and added that all searches in Clinical Connect in 2023 were legitimate.

Chair Newton-Reid inquired on statistics from the previous year compared to 2023. R. Fawcett noted that access requests have increased in 2023, noting that metric scoring has changed since 2022. Personal health information access requests (under the *Personal Health Information Protection Act*) increased by 10 requests from the previous year, and the privacy breach metrics decreased.

It was moved by **P. Cuddy, seconded by M. Smibert,** *that the Board of Health receive Report No. 18-24 re: "Privacy Program – Information and Privacy Commissioner (IPC) Statistical Reports" for information.*

Carried

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2024 Insurance Policies (Report No. 19-24)

R. Fawcett provided an update on the Middlesex-London Health Unit's general liability and cyber insurance.

R. Fawcett noted that the Health Unit has acquired its general liability and cyber insurance packages for 2024. The general insurance costs have increased by 7%, with a cost of approximately $155,000. Cyber insurance costs have decreased by 8%, with a cost of approximately $46,000. Total costs are just over $200,000 for the year. It is noted that within the public sector that there is limited ability to go to market for insurance providers as there are limited providers that serve the sector. Cyber insurance is also difficult to obtain and maintain within the public sector.

General liability insurance is provided through Intact Public Entities Incorporated and the term is March 31, 2024 to March 31, 2025. Cyber insurance is provided by CFC (United Kingdom) and the term is March 1, 2024 to March 1, 2025.

Chair Newton-Reid noted that it was positive to see insurance premiums decrease, especially cyber insurance which generally does not decrease year to year. Emily Williams, Chief Executive Officer noted that there are a few factors assisting with obtaining and maintaining cyber insurance. The Information Technology team has been leading training activities for staff, such as fake phishing and scam attempts. The Information Technology team has also assisted with having a penetration test, where a legitimate and proficient hacker attempts to gain access to the Health Unit's information technology systems. This activity had good results and provided risks to be addressed, which to date have been addressed by the Health Unit. E. Williams noted that the cyber insurance provider requests documentation of training activities and risk management to maintain coverage. The Health Unit also has fewer staff which has also factored into decreased cyber insurance costs.

It was moved by **S. Franke, seconded by M. Smibert,** *that the Board of Health receive Report No. 19-24 re: "2024 Insurance Policies" for information.*

Carried

MLHU Citi Plaza Dental Operatory Addition (Report No. 20-24)

Warren Dallin, Manager, Procurement and Operations and Donna Kosmack, Manager, Oral Health and Clinical Support Services provided the Board of Health with an update on the Citi Plaza Dental Operatory Addition.

D. Kosmack and W. Dallin provided background information to the Ontario Seniors' Dental Care Program and the capital funding received by the Middlesex-London Health Unit. The Ontario Seniors' Dental Care Program is a government-funded dental care program where free, routine dental services are provided for low-income adults who are 65 years and older. Middlesex-London has a waiting list, and to address these wait times, capital funding was provided in the amount of $348,170 from the Ministry of Health to expand from 2 (two) dental operatories to four (4). In November 2023, a project team was created with the Strategy, Planning and Performance, Oral Health and Clinical Support Services, and Procurement and Operations teams to retrofit and renovate the dental clinic in London (at Citi Plaza). CCS Engineering and Construction Inc. was selected through a formal Request for Proposal (RFP) procurement process and were the firm that built the Strathroy Dental Clinic.

W. Dallin noted that the dental clinic build would have two (2) phases. The first phase is to retrofit the existing operatories with new dental chairs to support client needs, patching flooring, and creating door windows. The length of this phase is expected to take the full week of March 18, with no dental clinics operating during this construction. The Oral Health and Clinical Support Services Team will be renting space from the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) Dental Clinic for the week

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of March 18. Therefore, no appointments will be cancelled, and all patients will be seen at the SOAHAC clinic.

The second phase is to build (2) new operatories. The two (2) clinical rooms will be converted into two dental operatories, along with creating a supplies storage room. Construction will consist of adding plumbing, lead lining of the walls, changing the room sizes, and installation of cabinets and new dental equipment. All clinics will continue to operate during construction and patients will be rerouted from the reception area to the clinical space to avoid the construction area. Building permits have been submitted to the City of London, with this phase of the project to begin at the end of April and take five (5) weeks.

D. Kosmack noted that the retrofit of the existing operatories will allow for increased safety with glass inserts being added to the doors and new chairs that allow for enhanced client comfort and better ergonomics for staff. There are approximately 518 people on the waiting list and the additional operatory space will help to reduce this list. D. Kosmack noted that one of the new operatories that is being built will be larger in size to allow staff to see clients who need to remain in their wheelchair and cannot transfer to a dental chair.

Chair Newton-Reid inquired on what the current waitlist of 518 means for the operation of the dental clinics. D. Kosmack explained that the Strathroy Clinic was opened in July 2023, and 500 clients have been seen over a 9-month period.

Board Member Howard Shears inquired if the Strathroy Dental Clinic construction project was delivered on time and on budget. W. Dallin confirmed that it was and noted that it is not anticipated that the final costs of the current project will exceed what was funded by the Province of Ontario.

Board Member Selomon Menghsha inquired what would be an acceptable number on a waitlist for public health dental services in Middlesex-London. D. Kosmack noted that while ideally no waitlist for the public is desired, it is uncertain at this time if this is attainable. D. Kosmack added that the Middlesex-London community’s waitlist is on par with the size of the jurisdiction, noting in comparison that Toronto’s waitlist is very high and Northern Ontario does not have a waitlist – a couple of months for a waitlist would be appropriate for the Middlesex-London area. Dr. Summers noted that the Seniors’ Dental (Care) program remains a big program. The original client needs assessment was approximately 3000, and now it is approximately 6000 and growing. Health units have had to start from scratch to build the program and are now looking to re assess wait times. In addition, with the recent announcement of the Canadian Dental Care Program, there will be potential policy changes, and re-applying for additional capital and operating funds for the Middlesex-London program may be necessary. Dr. Summers added that private dental care wait times tend to be 2-3 weeks, and ideally the Health Unit would like to replicate this.

Chair Newton-Reid inquired if 4 operatories will be enough to serve the community. Dr. Summers noted that at this point, information is unknown due to unknown statistics and lack of being able to market the program broadly due to capacity. As previously stated, the details of the Canadian Dental Care Plan are also unknown and further based on how the private sector will see clients under the program.

Board Member H. Shears inquired on the staffing at the dental clinics. D. Kosmack noted that there are two (2) Dentists at 1.5 FTE, twelve (12) Dental Assistants with two (2) positions currently posted, 10 Registered Dental Hygienists, one (1) Program Assistant, two (2) Associate Managers and 1 (one) Manager.

It was moved by **S. Franke, seconded by H. Shears,** *that the Board of Health receive Report No. 20-24 re: “MLHU Citi Plaza Dental Operatory Addition” for information.*

Carried

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Current Public Health Issues (Verbal)

Dr. Summers provided a verbal update on current public health issues within the region.

Respiratory Season Update

The Middlesex-London Region is in a non-high-risk period for respiratory illness. COVID-19 trends have decreased since the previous week, and COVID-19 activity in wastewater is decreasing. Influenza rates are the same as the previous week, with both influenza A and B present in the community. Influenza A rates are showing an increase in wastewater. Other respiratory viruses are stable, with a slight increase of coronavirus (not COVID-19). Dr. Summers emphasized the importance of masking in crowded spaces and continuing appropriate infection, prevention, and control measures.

Measles Update

On March 9, the Health Unit received confirmation of a positive measles case. A media release was issued due to the number of potential exposure sites in the City of London. Case and contact management was performed and post exposure prophylaxis (PEP) was provided to high-risk close contacts of the individual. Dr. Summers emphasized the infectious nature of measles – if an infected individual is in a room and leaves, the virus could be present for up to 2 hours after the individual leaves the room.

Vaccination continues to be the best protection against measles. If you were born after 1970:

- Check if you received 2 doses of a measles-containing vaccine (MMR or MMRV) – check your vaccination record or contact your primary health care provider; and
- If you haven't received 2 doses or are unsure, contract your primary care provider about receiving a second dose.

Measles is still a dangerous illness throughout the world, with 2 million deaths per year. During the Ebola crisis in Congo, 2200 died of Ebola while 7800 died of measles during the same time.

Visit to Citi Plaza Dental Clinic from Minister Filomena Tassi, Federal Economic Development Agency for Southern Ontario and Member of Parliament for London North Centre, Peter Fragiskatos

On March 13, Minister Tassi (Federal Economic Development Agency for Southern Ontario) and MP Peter Fragiskatos (London North Centre) visited the Citi Plaza Dental Clinic to learn more about the work conducted and clients served.

Dr. Summers noted that as the preliminary details of the Canadian Dental Care Plan have been released, there are still questions on how this plan will coordinate with those served under the Ontario Seniors' Dental Care Program. Oral health is health, and preventative services continue to be a struggle for many members of the community.

MLHU in the News

Since the previous Board of Health meeting, there has been media attention on the recent measles case, non-compliance by vapour product retailers, vaccination status while travelling, and nutritious food for low-income families.

Board Member H. Shears inquired on the status of follow-up for clients diagnosed with measles in the community. Dr. Summers noted that testing through primary care and hospital settings are occurring. Dr. Joanne Kearon, Associate Medical Officer of Health added that the Vaccine Preventable Disease Team is seeing a large increase in the ordering of the measles, mumps, and rubella (MMR) vaccine from health care providers.

Vice-Chair Steele inquired on the level of immunity of those who have been vaccinated against measles. Dr. Summers noted that there has been little activity of measles in 35 years and a lot has been put to the test in recent months. If a client has received 2 doses of vaccine, they are significantly less impacted by the spread of measles and those born before 1970 are even less likely to spread measles having likely been exposed to the disease prior to that date.

Board Member S. Franke noted that she had seen in the media that London is continuing to see residents without family doctors, and if there is any involvement with public health. Dr. Summers noted that within the community, there is a group (Middlesex-London Ontario Health Team Coordinating Council) of health system partners from the hospital, primary care, social services, and health unit partners, that has a physician recruiter. Dr. Summers noted the lack of family physicians means some Middlesex-London residents do not have a choice but to go to the emergency room for care. While public health is not responsible for physician recruitment, through the Coordinating Council the need is recognized. Dr. Summers added that L. Stobo's team (Social Marketing and Health System Partnerships) can be involved in support efforts with health system partners on this matter.

It was moved by **P. Cuddy, seconded by S. Franke,** *that the Board of Health receive the verbal report re: Current Public Health Issues for information.*

Carried

Medical Officer of Health Activity Report for January and February (Report No. 21-24)

Dr. Summers presented his activity report for January and February.

There were no questions or discussion.

It was moved by **S. Franke, seconded by M. Steele,** *that the Board of Health receive Report No. 21-24 re: "Medical Officer of Health Activity Report for January and February" for information.*

Carried

Chief Executive Officer Activity Report for January and February (Report No. 22-24)

E. Williams presented her activity report for January and February.

There were no questions or discussion.

It was moved by **P. Cuddy, seconded by S. Franke,** *that the Board of Health receive Report No. 22-24 re: "Chief Executive Officer Activity Report for January and February" for information.*

Carried

Board of Health Chair Activity Report for January and February (Report No. 23-24)

Chair Newton-Reid presented his first activity report for January and February. Chair Newton-Reid noted that this report would be presented to the Board of Health every other month.

There were no questions or discussion.

It was moved by **S. Franke, seconded by H. Shears,** *that the Board of Health receive Report No. 23-24 re: "Board of Health Chair Activity Report for January and February" for information.*

Carried

DRAFT

CORRESPONDENCE

It was moved by **S. Franke, seconded by M. Smibert,** *that the Board of Health receive items a) and b) for information:*

a) Public Health Sudbury & Districts re: Gender-based and Intimate Partner Violence
b) Middlesex-London Board of Health External Landscape for March

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, April 18, 2024 at 7 p.m. on Microsoft Teams.

CLOSED SESSION

At **8:04 p.m.,** it was moved by **M. Steele, seconded by S. Franke,** *that the Board of Health will move into a closed session to consider matters regarding litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board; advice that is subject to solicitor-client privilege, including communications necessary for that purpose; labour relations or employee negotiations, personal matters about an identifiable individual, including municipal or local board employees, and to approve previous closed session Board of Health minutes.*

Carried

At **8:27 p.m.,** it was moved by **P. Cuddy, seconded by M. Smibert,** *that the Board of Health return to public session from closed session.*

Carried

ADJOURNMENT

At **8:27 p.m.,** it was moved by **P. Cuddy, seconded by H. Shears,** *that the meeting be adjourned.*

Carried

MATTHEW NEWTON-REID
Chair

EMILY WILLIAMS
Secretary

DRAFT

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 25-24

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2024 April 18

2024 ANNUAL SERVICE PLAN

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 25-24 re: "2024 Annual Service Plan" for information; and*
2) *Approve the 2024 Annual Service Plan for submission to the Ministry of Health.*

Report Highlights

- The Annual Service Plan includes program descriptions and a budget submission for shared funded programs and the Ontario Seniors Dental Care Program (excludes all other 100% funded programs).
- The budget submission is identical to the Board approved budget, but the format has been restated from Division/Department to Health Standard/Program.
- Appendix A is a summary of the Board approved budget totaling $38,613,100.
- Appendix B is a summary of the ASP budget totaling $34,324,307. It also includes a reconciliation to the Board approved budget of $38,613,100.
- Appendix C includes the Annual Service Plan submitted to the Ministry of Health on the due date of April 2, 2024.

Background

Each year, the Ministry of Health requires local public health units to communicate their program plans and budgeted expenditures through the Annual Service Plan (ASP). The ASP includes a narrative component to describe the programs planned to be delivered in accordance with the Ontario Public Health Standards (OPHS) and related budget information. The Ministry of Health provides each health unit with a standard template for the ASP. This plan is the start of the ministry reporting cycle, which includes quarterly Standard Activity Reports (SAR) and concludes with the Annual Report and Attestation (ARA).

2024 Annual Service Plan

The ASP reflects the recent restructuring changes as described in Report No. 80-23 presented in December 2023.

In summary, the re-structuring carried out the organization's commitment to 'do what we do well'. Certain program areas required additional investment to strengthen the agency's capacity and meet provincial and community expectations. Local public health agencies build credibility and political capital by responding effectively to acute and emerging risks. This allows for work further 'upstream' to advance solutions that can address more distant and long-term health outcomes. Minor investments were made in:

- Vaccine preventable disease to ensure ongoing ability to maintain compliance with the Immunization of School Pupils Act (ISPA), as well as to support moderate vaccine administration (including COVID-19) to prioritized populations with minimal access to other health care sources.
- Infectious disease control to ensure readiness and responsiveness to emerging threats.
- Strengthening of presence with health sector partners, notably the Middlesex-London Ontario Health Team.

Disinvestments are consistent with the objective of discontinuing work that may not have the appropriate dose and intensity to generate a reasonable impact. In the context of limited resources, interventions broadly categorized as skill development, strengthening community action, and media campaigns have the least evidence with regards to impact, particularly compared to healthy public policy development and building supportive environments. Significant reductions were made in:

- Comprehensive school health nursing and dietitians, with a shift to supporting boards and 'families' of schools. Immunization and oral health programming continue.
- Public health nursing capacity and dietitians in healthy public policy development and community mobilization, with a shift to prioritized issues and partners at the municipal level.
- Social marketing work, particularly public awareness campaigns, except for regional and sustained initiatives.

No plan has been made to complete vision screening as described in the School Standard of the OPHS. This program has been discontinued given the limited dose and intensity of the interventions over the past few years.

The ASP also includes a community assessment section completed by the Population Health Assessment and Surveillance (PHAS) Team that provides a high-level description of the local community's population health needs and priorities.

The Finance team ensured the budget and staffing information reconciled to the Board approved budget. The program plans and budget information are organized by the Ontario Public Health Standards (OPHS).

Appendix A is a summary of the Board Approved budget totaling $38,613,100.

Appendix B is a summary of the ASP budget totaling $34,324,307. It also includes a reconciliation to the Board approved budget for accuracy and transparency.

As required by the Ministry, the 2024 ASP was submitted on the due date of April 2, 2024. The ASP, with associated program and budget information, is found in Appendix C.

Next Steps

The Board of Health must provide endorsement of the submitted Annual Services Plan for 2024. The 2024 Annual Service Plan was submitted on April 2, 2024.

This report was prepared in collaboration with the Strategy, Planning & Performance and Finance teams.

EWilliams

Alexander T. Summers

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Organizational Requirements as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Define what we do and do it well (Direction under the Program Excellence Priority area)

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Foundational Standards section in the Annual Service Plan describes activities to coordinate the implementation of both plans.

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 26-24

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2024 April 18

2023 OCCUPATIONAL HEALTH AND SAFETY REPORT

Recommendation

It is recommended that the Board of Health receive Report No. 26-24 re: "2023 Occupational Health and Safety Report" for information.

Report Highlights

- The Occupational Health and Safety (OHS) annual report summarizes the health, safety and wellness accomplishments, challenges, incidents and activities of the Joint Occupational Health and Safety Committee (JOHSC) and Be Well Committee from the previous calendar year (Appendix A).
- In 2023, OHS completed 16 ergonomic reviews (19% of employee incident reports) following employee questions and/or concerns about their workstation.
- 85 employee incident reports were submitted in 2023, a 21% reporting rate amongst the total number of employees.
- Key OHS accomplishments include improved safety and security measures in the Citi Plaza Office location, including the needle syringe program area and policy review of 63% of the current OHS policy section.

Background

Occupational health and safety are an integral aspect of any successful organization. Ensuring that all workplace parties are aware of their roles and responsibilities under the *Occupational Health and Safety Act* (OHSA) is at the foundation of any health and safety program. This is further codified in the organizational requirements within the legislative Public Health Accountability Framework, in which the "board of health shall comply with all legal and statutory requirements".

As part of the Occupational Health and Safety Program, the Occupational Health and Safety team submits an annual report (Appendix A) summarizing health, safety and wellness initiatives, employee-reported incidents, and the activities of the Joint Occupational Health and Safety

Committee (JOHSC) and the Be Well Committee. This annual report is shared with staff at all levels of the organization.

Occupational Health, Safety and Wellness Program Summary

From policy review to the introduction of a new virtual wellness program, 2023 was a year focused on new initiatives, education, and continuous quality improvement.

Two new policies were released to staff and the incident reporting policy underwent a large revision, including the development of a new report form and new incident reporting and investigation resources. Following two incidents and associated staff concerns, OHS, program teams and Operations worked to implement security and safety enhancements, including the installation of a new panic button, a remote lock on the front public access doors at Citi Plaza and various furniture (locker, cabinets) in the Needle Syringe Program to support staff safety and address employee concerns.

Near miss reporting continued to make up 15% of all employee incident reports. Near miss reporting is encouraged and allows for a proactive approach for addressing and anticipating health and safety concerns and/or hazards. Appendix A provides a summary of employee reported injuries and incidents in 2023.

OHS continued to offer training to employees, including first aid, basic lifesaving CPR, Workplace Hazardous Materials Information System (WHMIS) and verbal and nonviolent crisis intervention training. The focus on continuous quality improvement will continue as work progresses in to 2024.

Next Steps

The Occupational Health and Safety program at the MLHU and the work of the JOHSC and Be Well Committee continue to make improvements for the health, safety, and wellness of all employees through awareness campaigns, ongoing education opportunities, and ensuring legislative compliance. Continued focus on policy development, employee education, infection prevention and control, workplace violence prevention and employee wellbeing are anticipated over the course of 2024.

This report was written by the Human Resources Team, Corporate Services Division.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The *Occupational Health and Safety Act and the applicable regulations.*
- The following goal or direction from the Middlesex-London Health Unit's Provisional Plan:
    - 3.1 Develop and implement strategies to support staff mental health and wellbeing, including addressing systemic factors contributing to burn out.
    - 3.2 Develop and implement comprehensive training, learning and development, and professional development opportunities for staff and leaders

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendations related to processes to engage and include diverse voices from the MLHU community in shared decision-making and in the planning, implementation and evaluation of safety, health and wellness programs and collaboration with the Health Equity and Indigenous Reconciliation Team (HEART) to collaborate on communications and key messaging.

Annual Report of the Middlesex-London Health Unit's Occupational Health and Safety Program

2023

March 22, 2024

For information, please contact
Occupational Health and Safety

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MIDDLESEX-LONDON HEALTH UNIT – Annual Report of The Middlesex-London Health Unit's Occupational Health and Safety Program

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Introduction

The following report is submitted to the Board of Health and is available for all employees to review on an annual basis by the second quarter of the following year as per policy 8-010 Occupational Health and Safety as agency best practice. The information included in this report includes a summary of the activities and initiatives related to occupational health, safety and wellness that were completed over the course of 2023.

The Occupational Health and Safety Team

Reporting to the Associate Director, Human Resources and Labour Relations, the Health and Safety Advisor with the support of a Human Resources Coordinator, Health and Safety oversees the occupational health, safety and wellness programming for MLHU. The Occupational Health and Safety team, with the support of the Joint Occupational Health and Safety Committee (JOHSC) monitor and support the Internal Responsibility System by reinforcing legislative requirements, promoting continuous quality improvement, and consulting with teams to ensure that the appropriate safety measures are in place. The team also leads the follow up for employee incident reporting, employee immunization and reports quarterly to the Senior Leadership Team.

Activities and Initiatives

2023 Policy Review

Over the course of 2023, ten policies were reviewed, including the Workplace Violence, Occupational Health and Safety, Incident Reporting and Infection Prevention and Control policies.

The incident reporting policy in the OHS section of the administrative policy manual was reviewed and revised in 2023 to include not only Health and Safety incidents but also clinical and medication events. Through this review, a new online health and safety incident report form was developed to allow for documentation for incident investigation, follow up and corrective actions. Like the incident report form that was launched in late 2021, the new form allows for customizable notifications to leaders, which provides incident information to be shared in a timelier manner.

The Infection Prevention and Control policy underwent massive revisions to align and document current practices. Future work will be completed to recommend and develop more formal infection prevention and control training for all levels of staff based on a risk assessment.

Two new policies were developed in 2023. In collaboration with Emergency Management, a policy was developed to document and implement the procedures in place for a newly launched internal mass notification system (IMNS). The business and personal contact information for all employees, students and Board of Health Members are entered into the IMNS to support timely communications during emergency situations. In addition, a new policy focused on appropriate and safe attire and footwear was introduced, in collaboration with the Human Resources Team. This policy documents safety and attire requirements based on the type of work being performed and includes a situational assessment and risk assessment to guide leaders and employees for what is appropriate and safe attire in the workplace.

To prepare for the development of a Lone Worker Safety policy, OHS and the Manager, Privacy, Risk and Client Relations hosted a focus group with employees who work alone. Results from the focus group will inform the development of the policy and will be reviewed with focus group participants in 2024. Four policies will require review in 2024 and two new policies will be developed (Needle Safety

and Lone Worker Safety). There are currently 16 health and safety policies in the administrative policy manual.

Citi Plaza Security and Safety Enhancements

Following an investigation into staff safety concerns in the needle syringe program (NSP) room at Citi Plaza, the following changes were made in consultation with affected staff:

- Elimination of evening service hours;
- Installation of a secondary panic alarm;
- Installation of cabinets to provide a separation barrier in the NSP room;
- Installation of door lock to allow for secure half door;
- Installation of locker for client bags and weapons; and
- Relocation of panic alarm in NSP room.

Following an event that involved the locking of the public facing entrance doors and internal response following the activation of a panic alarm, the following recommended changes were made to bolster employee safety and security. Previously, entrance doors had to be locked from the mall corridor, potentially putting an employee at risk if there is a risk of violence outside of MLHU facilities at Citi Plaza. Interventions following this incident included:

- Adding a remote electronic lock on the front doors; and
- Updating the panic alarm protocol to clarify roles when the panic alarm is triggered.

Employee Immunization Program

Occupational Health and Safety continues to manage the Employee Immunization Program, which includes the tracking of employee immunization status for 6 vaccinations for all staff and TB Skin Testing for select employees. During respiratory season, defined in the policy as November 1 – March 31 under the directive of the Medical Officer of Health, employees who were not up to date with their influenza and/or COVID-19 vaccines and those working in clinical environments were required to wear a medical mask.

At the end of 2023, 89% of staff were compliant with the COVID-19 vaccine reporting requirements, in that they had either reported receiving a recent dose (65%) or were exempt from/ declined receiving an additional dose of the COVID-19 vaccine (22%). Rates for influenza uptake was 68% and the compliance rate (86%) was lower in comparison to COVID-19 as indicated in Table 1.

Table 1: 2023 Employee Immunization Uptake and Compliance Rates for COVID-19 and Influenza Vaccines

Vaccine	Employee Uptake Rate	Employee Compliance Rate
COVID-19	65%	89%
Influenza	68%	86%

The compliance rate for submission of immunization history among new hires in 2023 continues to be 100%. The compliance rate for submission of immunizations history among current staff in 2023 was 93%. Linking employee vaccine status to job hazard analysis and confirming exposure risks among teams will continue in 2024.

Ergonomics

Over the course of 2023, OHS conducted sixteen ergonomic reviews for employees, accounting for 18% of employee incident reports, up from 6% in 2022. These proactive reviews were conducted following employee questions and/or concerns about their workstations. Three employees also reported musculoskeletal injuries in relation to awkward postures, carrying equipment, and assisting a client following a fall. Ergonomics and musculoskeletal disorders continue to make for the majority of employee interactions with OHS. Proactive reviews and supports assist in mitigating risk of severe injuries requiring medical attention and/or lost time.

Supporting a Return to The Office

Occupational Health and Safety continues to support employees returning to the office as part of the Hybrid Work policy in-office requirements through ergonomic review and consultation with leaders and employees.

To illustrate and educate employees on the various pieces of safety equipment available to them at MLHU office locations, a new safety video was filmed by Communications in collaboration with OHS. This video has been shared at the team level as well as through the virtual townhall. This video will also support and orient employees to the measures in place to summon immediate assistance, such as the panic alarm system.

Training

Anti-Harassment and Anti-Discrimination All Staff Training

In collaboration with Human Resources, an internal online module was introduced to educate employees on the procedures in place when a staff member experiences or witnesses harassment or discrimination. In addition to this training, supporting the Employment Systems Review, a Respect in the Workplace module was also introduced to all staff. These modules together support MLHU's legislative compliance under the OHSA and bolster MLHU's efforts for inclusivity and a supportive workplace.

Standard First Aid, CPR and Basic Life Saving (BLS) Training

In 2023, eligibility for Standard First and CPR and Basic Life Saving (BLS) CPR training was reviewed to align with agency, medical directives, regulatory college, or legislative requirements. There are approximately 115 MLHU employees who are eligible for training. In 2023, 49 employees were certified or re-certified in BLS or Standard First Aid and CPR. Of the 115 eligible employees, 22 act as designated first aid responders to support legislative compliance for the *Workplace Safety and Insurance Act.*

Verbal and Nonviolent Crisis Intervention Training

Offering de-escalation education to staff was a key priority in 2023 following high rates of reports of verbal aggression during the pandemic. Over the course of late 2022 and 2023, 200 (51% of active employees as of December 15, 2023) employees completed de-escalation training. The training was offered in two levels, based on level of risk for violence and type of work conducted by position (administrative positions vs. client/public facing roles). Efforts to train remaining employees will continue in 2024.

Fostering Well-being Through Leadership

In response to the Employment Systems Review (ESR), five leadership sessions on fostering well-being through leadership were offered to the leadership team, those participating in the leadership development program as well as union, JOHSC and Be Well members. These sessions are specifically designed for people leaders (e.g., supervisors, managers, senior leaders, etc.) and aim to increase leaders' confidence in supporting employees who may be experiencing mental health challenges. It also provides a foundation for fostering psychological health and safety at all levels of an organization.

Workplace Hazardous Materials Information System (WHMIS) Program Enhancements and Compliance

For the fifth year, OHS hosted a student from the Occupational Health and Safety Management Diploma program at Western Continuing Studies. During the months of May-August 2023, the practicum student assisted with the re-development and maintenance of a refresher training module for all staff to support legislative compliance and capacity building for staff knowledge as it relates to WHMIS. The agency wide product inventory and safety data sheets were also reviewed to ensure that all supporting documentation was up-to-date and accessible to all employees. At the end of 2023, an additional all-staff e-module was developed for a 2024 launch, covering materials for products stored and handled by the majority of MLHU employees. Additional product specific, team level training will be finalized and assigned to select staff in 2024.

Employee Reported Injuries and Incidents

There were 85 employee incident reports submitted in 2023. The reporting rate per 100 employees for the number of incident reports submitted remained the same (21%) compared to the reporting rate per 100 in 2022. Incident reporting is regularly encouraged with staff to ensure that the MLHU is aware of the employee experience to inform and enhance OHS programming as well as to ensure the appropriate hazard controls are in place to prevent incidents from occurring. Near miss reporting continued to make up 20% of all employee incident reports.

Of the 85 employee incident reports, the most reported incidents were related to ergonomics (23% of reports), workplace violence (18%) and struck with/ caught by/ contact with (13%).

The ergonomics category includes requests for equipment and/or ergonomic consultation, such as a proactive ergonomic review following concerns about discomfort. In addition to these reports, injury reports related to musculoskeletal accounted for 4% of received incident reports. MSD-related reports, including proactive consultations and reviews were reported at a rate of 5% per 100 employees based on an employee count of 390 staff at the end of 2023, returning to a similar rate pre-pandemic, where more staff were working in the office.

Examples of workplace violence incidents, as defined at MLHU, include any situation that involves a worker in the workplace that may result in actual or potential harm/ injury, including mental stress from a violent incident. This may include reports of acts or attempts or threats of physical violence, verbal aggression/ abuse, and harassment. Interactions may be with other workers, clients, individuals with no connection to MLHU or a personal connection to a worker (i.e., intimate partner violence/domestic violence). Workplace violence reports, including those that do not meet the *Occupational Health and*

Safety Act's definition of workplace violence[1] were reported at a rate of 3% per 100 employees, a decrease from 7% in 2022.

Examples of contact with/ struck by incidents include when an object strikes, pinches, or contacts an employee causing injury, including pokes with sterile syringes, hitting head, dog bite, etc. These types of reports were reported at a rate of 2% per 100 employees, the same rate as 2022.

All employee incident reports are depicted in Figure 1 and 2 below.

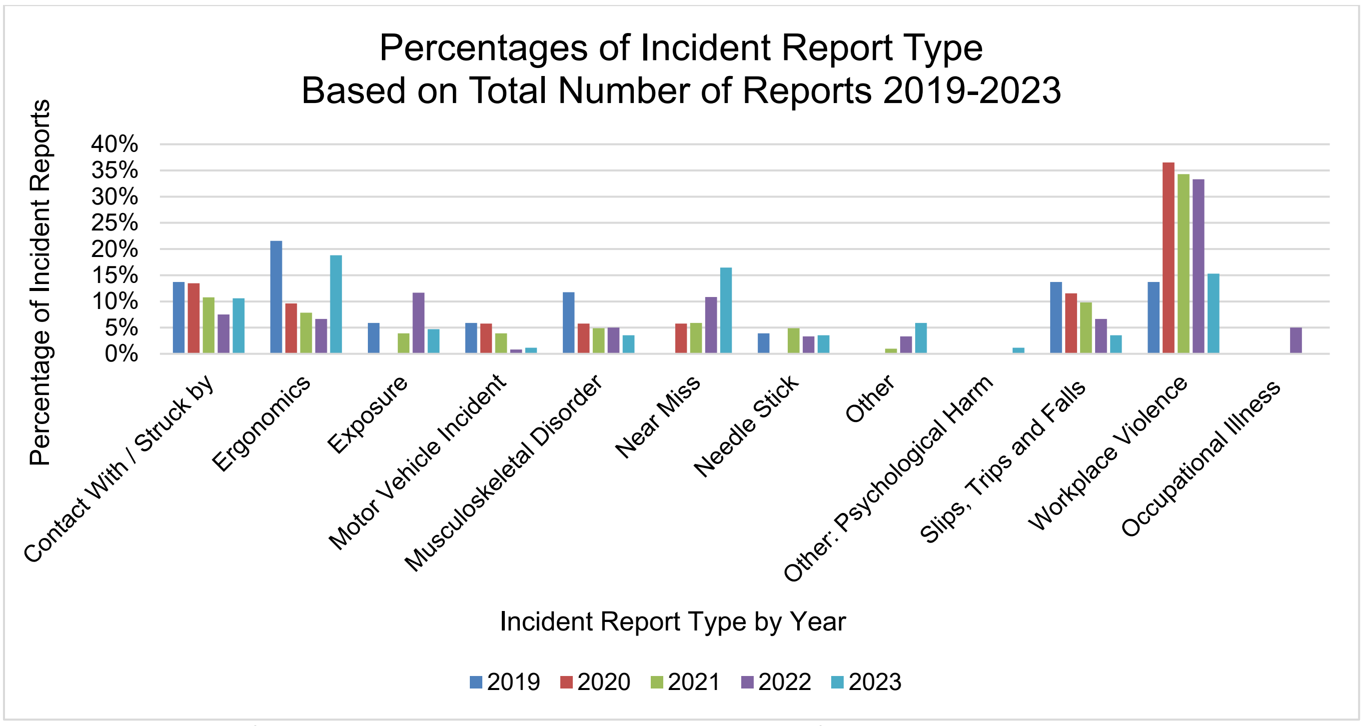


Figure 1: Percentage of Employee Incident Report Types by Total Number of Reports 2019-2023

[1] Workplace violence is defined in the OHSA as:

- the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker,
- an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker,
- a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker [subsection 1(1)].

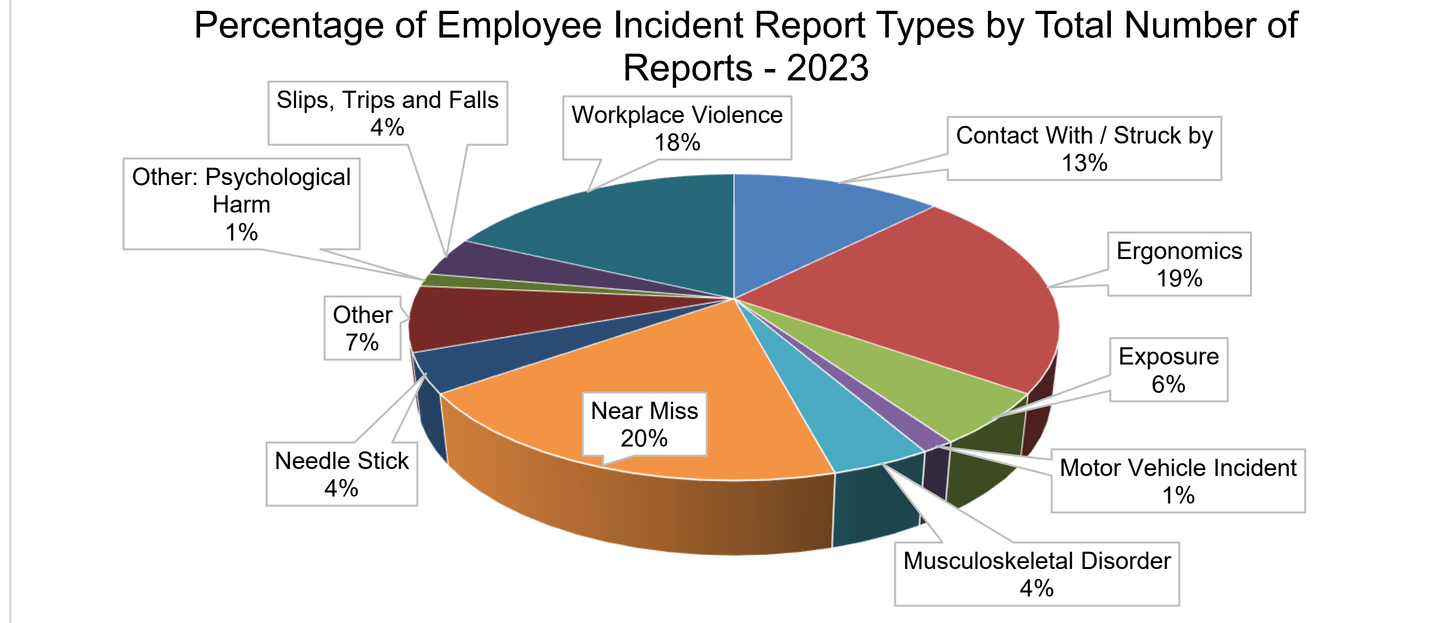
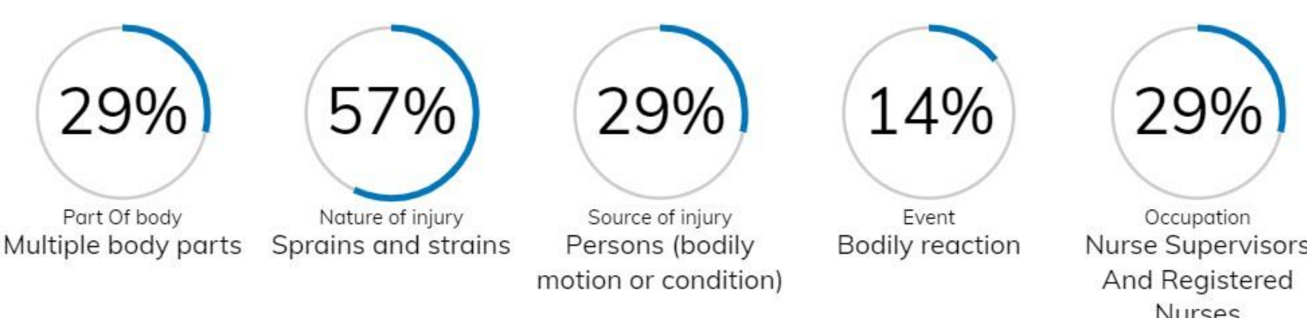


Figure 2: Percentage of Employee Incident Report Types by Total Number of Reports 2023

In addition to the 85 employee incident reports received in 2023, MLHU receives incident reports from and/or about visitors, clients, contractors, unpaid students, and volunteers. These assist in identifying and determining factors involved in non-employee incidents to ensure the appropriate corrective actions are in place when a hazard is identified to prevent further incidents from occurring. Over the course of 2023, there were 16 non-employee reported incidents related to client incidents or injuries and 13 employee reports that occurred outside of work hours and/or were not work-related. All incident reports are welcomed as it provides insight into the employee experience as well as informs the organization about possible hazards and risks.

Workplace Safety and Insurance Board (WSIB) Reporting and Claims

According to the WSIB publicly accessible Safety Check tool (Figure 3), 57% of the MLHU's lost time injuries between 2019-2023 were sprains and strains (MSD Other) and 29% of WSIB-reported injuries were sustained by nurses. In 2023, approximately 34% of the MLHU workforce was made up of nurses.



WSIB generated report for MIDDLESEX-LONDON HEALTH UNIT
Data source: Workplace Safety and Insurance Board
Data maturity: As of January 31, 2024
This data is licensed to you under the Government of Ontario's Open Data License https://www.ontario.ca/page/ontarios-open-data-directive#section-8 and subject to the provisions described therein.
Data downloaded from WSIB Safety Check tool.
Report downloaded on 2024-02-29 12:02:55

Figure 3: WSIB Safety Check - Leading Types of Lost Time Injuries 2019-2023

The following statistics (Figure 4 and Table 5) are accessible from the Workplace Safety and Insurance Board (WSIB) e-services Compass portal tool and provide a summary of the organization's claim counts and the number of days lost (lost time) over the course of the year.

Of all lost time claims, zero percent of claims have continued to receive loss of earnings benefits one year post injury.

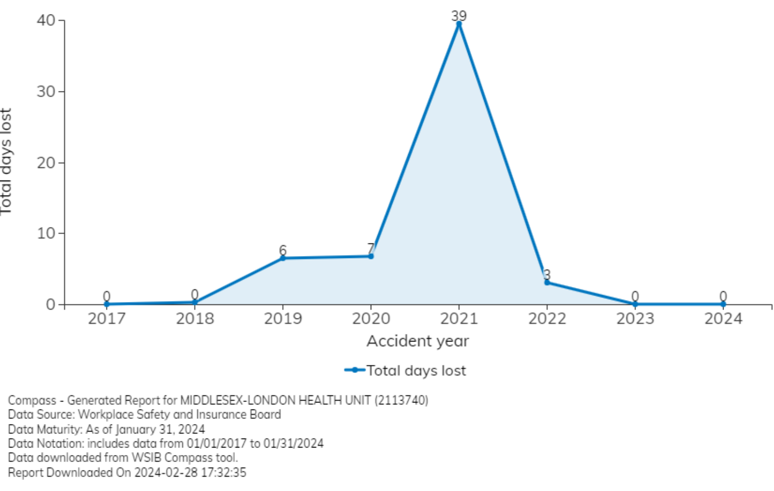


Figure 4: WSIB Summary of Lost Time (Days Lost) 2017-2023

Over the course of 2023, eight reports (9% of employee incident reports) were submitted to WSIB. Of those eight reports, three claims, representing 3.5% of all employee incident reports (down from 12) were approved by WSIB in 2023 compared to previous years as indicated in Table 2.

Table 2: Lost time and No Lost Time Summary with WSIB Data

Category	2019	2020	2021	2022	2023
MLHU Employee Count[1]	308	392	814	561	390
Total Number of MLHU Employee Incident Reports	51	52	102	120	85
WSIB Lost Time Injuries Count[2]	1	2	1	3	0
WSIB No Lost Time Injuries Count[3]	7	1	6	9	3
WSIB Recordable Injuries Total	8	3	7	12	**3**
WSIB Year-to-date Days Lost	6.46	6.78	39.41	3	0

[1]The employee count reflects full-time, part-time, temporary, and casual employees, including those on leave of absence on December 15, and does not account for employees who left MLHU during the year.
[2]Lost time injuries as per approved WSIB claims. An LTI (Lost-Time Injury) is a serious injury that results in time off work beyond the day of the incident, a loss of wages, or a permanent disability.
[3]No lost time injuries as per WSIB claims. An NLTI (No Lost Time Injury) is any injury in which no time is lost from work other than on the day of the incident, but medical attention/health care is sought (this does not include first aid that is received).

MLHU continues to encourage employees to report injuries and/or incidents in a timely fashion. During follow up of incidents, employees are encouraged to seek medical attention and/or report any lost time in relation to the injury, if required. This may impact the number of reports submitted to WSIB when employees seek medical attention or take time off in relation to an injury they have sustained.

Be Well Committee

Employee Wellness Programming and Initiatives

Over the course of 2023, the Be Well Committee (also referred to as "Be Well") continued to offer virtual and hybrid wellness programming to support the hybrid work environment. Be Well also continued to provide the monthly Be Well highlights newsletter, and weekly wellness content/ activities during virtual town hall meetings and regularly scheduled wellness workshops. In addition, the Be Well Committee also coordinates two annual all staff social/appreciation events.

Three wellness workshops were well attended by staff and covered topics such as social media and mental health, building resilience, and how to create and maintain healthy habits. In addition to these sessions, to support recovery and foster resilience from MLHU restructuring and lay offs, three change management sessions were held for both employees and leaders with information on self-care, change management, and supporting employees/ individuals through change.

Staff participation varied by event and to support the varied schedules, some were recorded and posted on the Be Well Website for employees to access when conducive to their schedule. MLHU allows employees to attend Be Well sanctioned events on worktime as part of its commitment to employee wellbeing.

Introduction of Virtual Wellness Programming - Cyno

A new initiative was launched in 2023, partnering with a new wellness provider, Cyno. Cyno is a virtual wellness platform that provides direct access to a variety of service providers and practitioners, such as therapists, registered dietitians, fitness professionals and much more. Programming is available in three different modes: on demand, live group programming, and one-on-one services. All permanent staff were

provided with 8 credits to use towards one-on-one services over the calendar year. Cyno programming was promoted via Be Well Highlights, e-mail, magic monitor screens and at town hall. Utilization continued to increase throughout the year, with approximately 35% of staff participating on the platform. Following the request for proposal process in late 2023, the contract with Cyno was extended for an additional three years with the opportunity for extension beyond the third year.

Employee Family and Assistance Program: Homewood Health

Homewood Health's Employee and Family Assistance Program services run on an annual calendar that spans from April to March. By the third quarter, MLHU began to see lower utilization rates 13% (41 cases) in comparison to 2022 rates, which were above the contracted 20% utilization rate at 30%. The third quarter report shows a decrease of 31.67 cases in comparison to the same period in 2022 (72.67 cases). The projected annualized utilization rate for 2023-2024 is 13.02%, still well above the sector benchmark of 8.95%. MLHU employees have used a range of the programs available through the Homewood Health offerings, including clinical counselling, pro-active coaching, and online services.

In May 2022, Homewood Health launched a new tool on their online platform homeweb.ca called Pathfinder. This tool assists employees or their family members to find the resources, tools or counselling that align with their specified need through their website. To date, 37 employees have registered for this service (up 7 from 2022).

Joint Occupational Health and Safety Committee

JOHSC Membership Updates

In 2023, the following three members left the committee: Mabel Kane (ONA), Shelley Hylmbicky (ONA) and Sarah Webb (Management). With vaccination clinic locations closing, the JOHSC is working to return to a committee consisting of nine or ten members (down from 12). The current committee operates as a multi-site committee, representing all MLHU facilities and has eight worker members and two management members.

Every Joint Health and Safety Committee (JHSC) must have at least two certified members: one representing workers, and one from management. A certified member is a JOHSC member who has completed both Part One (Basic Certification) and Part Two (Workplace-specific Hazard Training) of the Joint Health and Safety Committee Certification program. In 2023, one member received certification training. Of the 10 members, eight hold JHSC Certification. The MLHU's commitment to training JOHSC members beyond the OHSA requirements allows for the JOHSC to act effectively when it comes to identifying workplace hazards and advocating for employee health and safety. Those who completed the training after March 1, 2016, require refresher training every three years. Five members are due for re-certification training in 2025.

Safety and Health Week

Each May, the JOHSC celebrates Safety and Health Week. In 2023, OHS and the JOHSC partnered with the Emergency Management Specialist to host a brief meet and greet coffee break that included refreshments and educational trivia. The JOHSC will continue to provide both in person and virtual education for Safety and Health Week in 2024 in partnership with Emergency Management, as both Safety and Health Week and Emergency Preparedness Week happen to fall on the same dates.

Workplace Inspections

The JOHSC conducts monthly inspections of all MLHU locations (includes offices and vaccination clinics) to identify hazards, make recommendations to management for corrective actions, and monitor progress of corrective actions and measures undertaken. The overarching goal of the worksite inspections is to monitor and evaluate the effectiveness of the Internal Responsibility System. Over the course of 2023, 43 inspections were conducted across 4 locations, and 102 items (including new and repeated findings) were identified. The most common hazards identified are safety hazards, which includes items associated with equipment or materials, risk of slip, trips, and falls, etc. See Table 4 below for a summary of the results from the 2023 worksite inspections.

Employees are encouraged to raise concerns with their leader first; however, the JOHSC will follow up and discuss concerns raised by employees during worksite inspections. These types of concerns may require engagement of the JOHSC in discussion, consultation, monitoring or the development of recommendations to address them. Contributing factors associated with incidents/injuries, identified hazards, and near misses are expected to be resolved satisfactorily by the employee's immediate leader, sometimes in consultation with Human Resources, Occupational Health and Safety, or Operations.

Management responses to identified hazards and observations were routinely and promptly received in writing by the applicable leader. Most hazards or operational issues were resolved expeditiously, or a plan to address them was put in place and communicated to the employees and the JOHSC within a 21-day timeframe, based on the legislative requirement for formal recommendations. At the end of 2023, one item remains outstanding due to the ongoing monitoring of the heating and cooling concerns throughout Citi Plaza.

Table 3: Summary of Outstanding Items Identified During Worksite Inspections

Hazard Category	Description	Year	Status
Physical	Employee concerns related to thermal comfort (both in cool and warmer temperatures) in various areas of Citi Plaza. Monitored temperatures are above 18 degrees.	2023	Continue to monitor and adjust as needed.

Table 4: Summary of 2023 Worksite Inspections

2023 Workplace Inspections	Citi Plaza	Strathroy Dental Clinic	Strathroy	Western Fair	Total
Number of inspections	**12**	**7**	**12**	**12**	**43**
Types of items identified					
Biological	9	1	2	3	15
Chemical	3	0	0	0	3
Compliance	1	2	10	2	15
Musculoskeletal	4	1	1	1	7
Physical	1	0	0	0	1
Psychosocial	0	0	0	0	0
Safety	33	8	10	10	61
Total:	**51**	**12**	**23**	**16**	**102**

Biological – includes hazards that come from living organisms.

Chemical – includes hazards associated with chemicals / chemical use.
Compliance – includes practices or conditions that are not in compliance with relevant legislation/ regulations.
Musculoskeletal (MSD) – includes hazards that may result in Musculoskeletal Disorders.
Physical – includes hazards that come from forms of energy that can result in bodily harm.
Psychosocial – includes hazards that affect the mental and physical wellbeing of people
Safety – includes hazards associated with equipment, as well as slips, trips and falls.

Employees are encouraged to review the posted worksite inspection reports on the newly established OHS SharePoint page or on the dedicated OHS bulletin board in each MLHU location. Occupational Health and Safety information was migrated to an updated internal SharePoint site in 2023.

Quarterly Meetings

The JOHSC is required to meet at least once every three months under the OHSA; the MLHU JOHSC conducted five meetings over the course of 2023. The JOHSC regularly discusses incident reports and statistics, worksite inspections, and program/ policy updates at each scheduled meeting. Minutes of the JOHSC meetings are made available to all staff on the OHS SharePoint page and are also posted on the OHS bulletin boards at each MLHU location, including the vaccine clinic. In addition to regular meeting agenda items, the following topics were discussed by the JOHSC in 2023:

- 2024 Communication calendar
- Needle Syringe Program (NSP) safety concerns
- Policy Review:
  Inclement Weather, First Aid, Appropriate and Safe Attire and Footwear, Infection Prevention and Control (IPAC), Incident Reporting
- Strathroy dental clinic opening
- Strathroy site improvements
- WHMIS
- Lone Worker Safety Policy
- Review of JOHSC Terms of Reference
- IPAC Review of clinic spaces
- Panic alarm response
- Fire Drill Outcomes

Conclusion

The MLHU continues to build its safety culture through continued consultation and collaboration, open dialogue, regular communications, and education opportunities. Encouraging reporting of incidents, including near misses, concerns and injuries allows for more a proactive safety culture which is supported by regular reporting to the Senior Leadership Team (SLT). Further dedication to employee wellness, policy review, employee education, infection prevention and control, workplace violence prevention, and formal risk assessments are planned for 2024.

References

Occupational Health and Safety Act R.S.O. 1990, c. O.1. https://www.ontario.ca/laws/statute/90o01

Workplace Safety and Insurance Board. (2024, March 20) *Safety Check*. WSIB Ontario. https://safetycheck.onlineservices.wsib.on.ca/safetycheck/explore/profile/10396624

Workplace Safety and Insurance Board. (2024, January 31) *Compass.* WSIB Ontario. https://compass.onlineservices.wsib.on.ca/compass/compass

Workplace Safety and Insurance Board. (2024, January 31) *Business Profile.* WSIB Ontario. https://compass.onlineservices.wsib.on.ca/compass/compass/businessReports/profile/2113740

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 27-24

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2024 April 18

OAGO PERFORMANCE AUDIT – NON-MUNICIPAL WATER

Recommendation

It is recommended that the Board of Health receive Report No. 27-24 re: "OAGO Performance Audit – Non-Municipal Water" for information.

Report Highlights

- Under the *Health Promotion and Protection Act* (HPPA) the Middlesex-London Health Unit is responsible for upholding and enforcing Regulation 319 – Small Drinking Water Systems.
- On March 25, 2024 the Medical Officer of Health received notice that the Office of the Auditor General of Ontario (OAGO) is conducting a performance audit related to Non-Municipal Drinking Water (including small drinking water systems and private well water regulated under the HPPA and the *Safe Drinking Water Act*). Each local public health agency in the province received this notice.
- The MLHU submitted a response letter and corresponding documentation on April 8, 2024 – the deadline set by the OAGO.

Background

The Small Drinking Water Systems – Regulation 319 under the *Health Protection and Promotion Act* sets out requirements that must be followed by owners and operators of each small drinking water system (SDWS), such as minimum water testing for Escherichia coli and total coliforms. Owners and operators of SDWS are responsible for keeping drinking water safe and meeting their regulatory requirements (such as within the *Safe Drinking Water Act*).

Public Health Inspectors (PHIs) are responsible for conducting site-specific risk assessments of every SDWS in the province. Based on the assessment, PHIs determine what owners and operators must do to keep their drinking water safe, and issue a directive for each system, which may include requirements such as water testing, treatment, and training. This reflects the

use of a customized approach for each SDWS depending on the level of risk, rather than a 'broad brush' approach.

OAGO Request

The Auditor General requested the past five (5) years of data/documentation on the following:

1. Inventory of all drinking water systems in the health unit that are regulated under the HPPA and *Safe Drinking Water Act* (SDWA);
2. Small drinking water system notifications of intent to provide water or stop providing water and permission to operate the system;
3. Small drinking water system directives, their contents, and revisions to them;
4. Adverse drinking water incident responses to system operators (not limited to small drinking water systems);
5. Compliance (e.g., inspections, warnings, orders, fines) activities related to safe drinking water (not limited to small drinking water systems);
6. Public health inspector credentials/training.

Additional information regarding private well water drop off locations, local performance indicators related to safe drinking water, epidemiological analysis, educational material, and local assessments related to increasing public awareness of water-borne illnesses and safe drinking water was also requested.

Of note, the MLHU performance indicators related to safe drinking water are as follows:

- With regards to the number and/or percentage of adverse water quality incidents (AWQI) that had an initial response within 24 hours over the last 5 years, **the MLHU has responded to 100% of the AWQIs received within 24 hours.**
- With regards to the percentage of Small Drinking Water Systems (SDWS) inspected within the prescribed timeline set out by the Ministry of Health over the last 5 years, **100% of all SDWS were inspected by the MLHU within the prescribed timelines.**

Next Steps

The MLHU submitted a response letter and corresponding documentation on April 8, 2024, the deadline set by the OAGO. Staff will await further requests or need for clarification.

This report was co-written by the Manager of Privacy, Risk and Client Relations and the Manager of Safe Water, Tobacco Enforcement and Vector Borne Disease.

EWilliams

Alexander T. Summers

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Safe Water standard as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The Health Promotion and Protection *Act* – Regulation 319 Small Drinking Water System
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Program Excellence – our public health programs are effective, grounded in evidence and equity.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendation Governance.

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 28-24

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2024 April 18

VECTOR-BORNE DISEASE PROGRAM: CONTRACT AWARD

Recommendation

It is recommended that the Board of Health receive Report No. 28-24 re: "Vector-Borne Disease Program: Contract Award" for information.

Report Highlights

- Since prior contracts have expired, a Request for Proposal (RFP) was issued in 2024 to deliver select services for the Vector-Borne Disease program for the next 3 years.
- The lowest-cost compliant bids have increased substantially from prior contracts due to inflation. The 2024 budgeted amount is $100,000 for Part A. The recommended supplier's negotiated starting rate is $107,500 for 2024. Costs for Part B have gone up from $21,025 in prior years to $22,748 for each of the next two years.
- These services are required under the Infectious and Communicable Diseases Prevention and Control Standard of the Ontario Public Health Standards, Requirements for Programs, Services and Accountability.

Background

The Vector Borne Disease (VBD) Team delivers a surveillance and control program to monitor West Nile Virus (WNV), Eastern Equine Encephalitis (EEE), Zika Virus (ZV) and Lyme disease (LD) activity in Middlesex London. This program is made up of the following components: mosquito larval surveillance, larviciding, adult mosquito trapping, human surveillance, responding to public inquiries, public education, and active and passive tick surveillance. The tasks of larval mosquito surveillance and control, along with mosquito identification and viral testing, are performed by contracted agencies on behalf of the MLHU.

These activities are completed in accordance with the Ministry of Health's (MOH) West Nile Virus Preparedness and Prevention Plan for Ontario, and Regulation 199/03 (Control of West Nile Virus) of the *Health Protection and Promotion Act*.

Contract Award

On January 5th, 2024, staff issued a Request for Proposals (RFP) for both Larval Mosquito Surveillance and Control (Part A), and Mosquito Identification and Viral testing (Part B). Notice of the procurement opportunity was posted publicly and provided to known service providers.

For Part A, the successful proponent is the Canadian Centre for Mosquito Management (CCMM) in the amount of $107,500 (exclusive of HST). For Part B, the successful proponent is GDG Canada Inc. in the amount of $22,748 (excluding HST).

Next Steps

Health Unit staff will be moving forward with the lowest-cost compliant bids, issuing contracts to CCMM Inc and GDG Canada Inc. with the understanding that it is slightly over the current 2024 allocated budget. This discrepancy between the contract pricing and current budget amount will be managed through internal savings on other corporate expenses (eg. Cyber Insurance).

This report was prepared by the Safe Water, Tobacco Control and Vector Borne Disease team and the Procurement and Operations team.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Infectious and Communicable Disease Prevention and Control standard as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The Regulation 199/03 (Control of West Nile Virus) of the *Health Protection and Promotion Act*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
    - Our public health programs are effective, grounded in evidence and equity

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 29-24

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2024 April 18

THE EVOLVING FOOD SAFETY LANDSCAPE

Recommendation

It is recommended that the Board of Health receive Report No. 29-24 re: "The Evolving Food Safety Landscape" for information.

Report Highlights

- This report provides an update on Report No. 64-22 that the Board of Health received on November 10, 2022 regarding the changing landscape for food safety in Middlesex-London.
- Recent trends, including special events, manufactured products, and shared / rented kitchens, present unique scenarios for Public Health Inspectors to understand and inspect.
- These trends are continuously risk-assessed and monitored to ensure the appropriate public health response is taken to protect the Middlesex-London community from harms associated with food-borne illness.

Background

The food safety program assists in the prevention and reduction of food-borne illnesses through the delivery of local, comprehensive food safety programs. As part of the program, the Food Safety and Health Hazards (FSHH) and Infectious Disease Control (IDC) Teams are responsible for monitoring emerging trends related to food safety. Increasingly, Middlesex London Health Unit (MLHU) Public Health Inspectors have observed changing trends, such as more frequent special events, manufactured products, shared kitchen spaces, and home-based businesses. The novelty associated with these trends requires planning and consultation to adequately provide risk-based and meaningful interventions to mitigate food-borne illnesses. The work associated with understanding these emerging trends, investigating, and inspecting the new premises places pressure on traditional food safety inspection work.

To monitor enteric illness in the Middlesex-London region, the MLHU continues to participate in the Public Health Agency of Canada (PHAC) program, FoodNet Canada, as one of three

sentinel FoodNet Canada sites across Canada. The initiative examines trends in enteric illness and public health impact. FNC considers enteric illnesses from a unique perspective by integrating enhanced follow-up of human cases of selected enteric diseases, testing of retail food products of interest, sampling of manure from local farms and collection of surface water for pathogens that can cause illnesses. A memorandum of understanding along with the funding for this program has been confirmed through 2027.

Food Safety Emerging Trends

There has been a steady increase in the number of special events in Middlesex-London. These events include many 'first-time' operators. Public Health Inspectors have observed a lack of operator familiarity with regulatory requirements along with the need to provide increased education to equity deserving populations. The Health Unit has a requirement for operators to submit a notice of operation. Often these are either not submitted or submitted at the last minute making it challenging for the inspectors to provide early consultation and complete a proper risk assessment.

Facilities, such as restaurants, inspected by the MLHU produce manufactured food products. The MLHU's inspections are largely focused on safe food handling and sanitation related to these 'food service' facilities. However, there is an increase in operators producing food products for retail that require a knowledge of food processing and packaging. These products are being distributed through online sales, farmers markets, special events and smaller retail outlets. Food processing and manufacturing falls under the Canadian Food Inspection Agency (CFIA) or the Ontario Ministry of Agriculture and Rural Affairs (OMAFRA). However, due to either scope of distribution, type of food and / or location of preparation, these smaller venues are not supported/inspected by these agencies.

The popularity of renting kitchen spaces is an emerging trend that is presenting additional challenges. Operators require an inspected kitchen in order to manufacture food products or produce food for take-out or retail. Considerations for inspection work are significant and include food storage on-site (delineation of businesses) and responsibility for matters of regulatory compliance, along with logistical challenges related to hours of operation, file management, disclosure, and reporting of inspection results.

Current provincial regulatory exemptions introduced in 2020 permit operators to prepare low-risk foods from home and require annual risk assessment and inspection work. The City of London does not permit home-based food businesses due to zoning restrictions. However, discussions are underway to potentially align with provincial direction. There are several home-based businesses in Middlesex County, as municipal bylaws provide these allowances.

Next Steps

The Food Safety & Health Hazards and Infectious Disease Control teams have consulted with partner agencies and other health units, as well as the food industry, in order to better understand this new landscape. Oftentimes, emerging trends are identified through field inspection work which precedes the availability of Ministry direction. Without Ministry direction, there is an environment of uncertainty for the Public Health Inspectors. The MLHU continues to navigate these new emerging trends through ongoing consultations, risk assessments, and prioritization of interventions with the goal to prevent and reduce food-borne illnesses.

This report was co-written by the Managers of Food Safety & Health Hazards and Infectious Disease Control.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Food Safety Program Standard as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The *Health Protection and Promotion Act, R.S.O. 1990, c.H.7 and O. Reg. 493/17 Food Premises.*
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
    - Facilitate meaningful and trusting relationships with prioritized equity-deserving groups, specifically Black and Indigenous communities
    - Define what we do and do it well

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendation:

- 21. Create and strengthen relationships and partnerships with ACB organizations, including the diverse faith institutions within the ACB community, in London and Middlesex County, to collaboratively enhance population health outcomes.

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 30-24

TO:	Chair and Members of the Board of Health
FROM:	Dr. Alexander Summers, Medical Officer of Health
DATE:	2024 April 18

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR MARCH 2024

Recommendation

It is recommended that the Board of Health receive Report No. 30-24 re: "Medical Officer of Health Activity Report for March 2024" for information.

The following report highlights activities of the Medical Officer of Health for the period of March 8 to April 4, 2024.

The Medical Officer of Health provides oversight of all public health programs at the Middlesex-London Health Unit and co-chairs the Senior Leadership Team. The Medical Officer of Health participates in a wide range of external and internal meetings, along with liaising with community partners and municipal and provincial stakeholders.

The Medical Officer of Health, along with other team members, continues to host a weekly Middlesex-London Health Unit (MLHU) Staff Town Hall.

The Medical Officer of Health also participated in the following meetings:

Client and Community Impact – *These meeting(s) reflect the MOH's representation of the Health Unit in the community:*

March 8	Attended the Council of Medical Officers of Health (COMOH) Executive meeting.
March 11	Participated in a regional call to discuss measles preparedness.
March 12	Attended a UPHN Strategic Planning meeting.
March 13	With Emily Williams, CEO, Dr. Joanne Kearon, Associate Medical Officer of Health, Mary Lou Albanese, Director, Environmental Health, Infectious Disease and Clinical Services, and Donna Kosmack, Manager, Oral Health and Clinical Support Services, hosted Honourable Filomena Tassi, Minister, Federal Economic Development Agency for Southern Ontario, and MP Peter Fragiskatos for a tour of the Citi Plaza dental operatories.

Attended the quarterly meeting with the London Middlesex Primary Care Alliance.

Attended the Anti-Black Racism Plan Advisory Committee meeting.

March 14 Participated in a call with a student interested in public health and preventive medicine.

March 18 Participated in a call with Dr. Charles Gardner, Medical Officer of Health, Simcoe Muskoka District Health Unit.

Participated in the monthly Southwest Medical Officer of Health/Associate Medical Officer of Health meeting.

March 19 Met with Dr. Maxwell Smith, Assistant Professor, Western University.

March 20 Interview with Andrew Lupton, CBC News London, regarding the Board of Health report on an alPHa resolution for permitting applications for automatic prohibition orders under the *Smoke Free Ontario Act* for vapour product sales offences.

March 21 Participated in a call with Dr. Mehdi Aloosh, Medical Officer of Health, Windsor-Essex County Health Unit.

March 22 Participated in a call with Dr. Natalie Bocking, Medical Officer of Health, Haliburton, Kawartha, Pine Ridge District Health Unit.

March 25 Interview with Devon Peacock, Global News 980 CFPL, regarding illegal vape sales and the emerging challenge with nicotine pouches.

March 26 Interview with Alessio Donnini, CBC News London, regarding HPV vaccination rates.

March 27 Met with Scott Courtice, Executive Director, London InterCommunity Health Centre.

March 28 Attended a Middlesex-London Ontario Health Team Coordinating Council meeting.

With Scott Courtice, Executive Director, London InterCommunity Health Centre, co-chaired a meeting of the Community Drug and Alcohol Strategy Steering Committee.

April 4 With Emily Williams, CEO, Dr. Joanne Kearon, Associate Medical Officer of Health, and Sarah Maaten, Director, Public Health Foundations, hosted Dr. Michael Sherar, President and CEO of Public Health Ontario for a meeting.

Participated in a call with Dr. Deepika Lobo, Medical Officer of Health, Halton Region.

Participated in a meeting to discuss local measles preparedness within the acute health care system.

Employee Engagement and Learning – *These meeting(s) reflect on how the MOH influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

March 12 Participated in a planning meeting for vaccinations and suspensions as part of the *Immunization of School Pupils Act*.

March 14 With Emily Williams, CEO, Dr. Joanne Kearon, Associate Medical Officer of Health, and Cynthia Bos, Associate Director, Human Resources and Labour Relations, participated in a meeting to discuss an on-call policy.

March 18 Attended the MOS/IDID Steering Committee meeting.

March 19 Attended a meeting to discuss the draft Emergency Response Plan for Middlesex-London Health Unit.

With Emily Williams, CEO and Emily Van Kesteren, Acting Manager, Communications, participated in a planning meeting for Canadian Public Health Week.

March 20 Attended the unveiling of the quilt created during the 2023 Community Art Event.

March 21 Attended a Social Marketing and Health System Partnerships team meeting to support transitioning to the new organizational structure.

Attended a union grievance meeting.

March 22 Participated in a meeting to discuss Model of Service Delivery reviews at the Middlesex-London Health Unit.

March 26 Attended the Environmental Health, Infectious Diseases and Clinical Support Services Divisional meeting.

March 27 With Jennifer Proulx, Director, Family and Community Health and Darrell Jutzi, Manager, Municipal and Community Health Promotion, met to discuss the Community Drug and Alcohol Strategy.

March 28 With Jennifer Proulx, Director, Family and Community Health and Darrell Jutzi, Manager, Municipal and Community Health Promotion, met to plan action items for the Middlesex-London Health Unit from the meeting of the Community Drug and Alcohol Strategy Steering Committee.

April 2 Participated in a meeting to discuss staffing for the vaccine preventable diseases program for May with regards to that month's round of suspensions per the *Immunization of School Pupils Act*.

April 4 Participated in a meeting to discuss the cultivation of a failure-friendly culture at the Middlesex-London Health Unit.

Participated in an internal meeting to discuss the Chief Medical Officer of Health's Annual Report in relation to the work of the Middlesex-London Health Unit.

Personal Development – *These meeting(s) reflect on how the MOH develops their leadership, skills and growth to define their vision and goals for the Health Unit.*

April 3 Attended the virtual sessions of The Ontario Public Health Conference (TOPHC).

Governance – *This meeting(s) reflect on how the MOH influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This also reflects on the MOH's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

March 12 Attended the monthly Board of Health agenda review and Executive meeting with the Chair and Vice-Chair of the Board of Health, Chief Executive Officer and Executive Assistant to the Board of Health.

March 19 Attended the Board of Health and leadership team social.

March 21 Attended the monthly one-on-one meeting with the Board Chair.

March 25 Attended a meeting of the Public Health Sector Coordination Table.

March 26 Attended a special meeting of the Public Health Sector Coordination Table.

March 28 Attended the Ontario Public Health Standards Review Table meeting.

This report was prepared by the Medical Officer of Health.

Alexander T. Summers

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Good Governance and Management Practices Domain as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Governance and Leadership (ABRP) section.

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 31-24

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2024 April 18

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR MARCH

Recommendation

It is recommended that the Board of Health receive Report No. 31-24 re: "Chief Executive Officer Activity Report for March" for information.

The following report highlights activities of the Chief Executive Officer (CEO) for the period of March 8 – April 4, 2024.

Standing meetings include weekly Corporate Services leadership team meetings, Senior Leadership Team meetings, MLHU Leadership Team meetings, Virtual Staff Town Hall meetings, bi-weekly R3 meetings, and weekly check ins with the Corporate Services leaders and the Medical Officer of Health. The Chief Executive Officer took vacation on March 15.

The Chief Executive Officer also attended the following meetings:

Client and Community Impact – *These meeting(s) reflect the Chief Executive Officer's representation of the Health Unit in the community:*

March 13 With the Medical Officer of Health and Associate Medical Officer of Health, hosted the Minister of Federal Economic Development Agency for Southern Ontario, Filomena Tassi and Member of Parliament for London North Centre, Peter Fragiskatos to tour MLHU Citi Plaza Dental Clinic.

April 3 With the Associate Director, Human Resources and Labour Relations attended a meeting with the Association of Local Public Health Agency (AOPHBA) representatives to discuss leadership opportunities for AOPHBA members.

Employee Engagement and Learning – *These meeting(s) reflect on how the Chief Executive Officer influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

March 11 With the Medical Officer of Health and Associate Director, Human Resources and Labour Relations, participated in the Manager, Corporate Communications interviews.

March 12 Attended the Vaccine Preventable Disease meeting to discuss staffing for school suspensions regarding immunizations.

March 14 Attended a meeting to discuss the on-call policy.

Attended the Employment Systems Review Steering Committee.

March 18 Greeted employees at the MLHU agency orientation.

With the Medical Officer of Health and Associate Director, Human Resources and Labour Relations, participated in the Manager, Corporate Communications interview.

March 19 Attended/chaired the MLHU Leadership Team meeting.

Attended the MLHU Leadership Team and Board of Health Social.

March 20 Attended a meeting to discuss the Canadian Public Health Week communications content.

March 22 Attended a meeting to discuss the process for conducting Model of Service Delivery reviews.

April 2 Attended a meeting to discuss Vaccine Preventable Disease team staffing for May.

Governance – *This meeting(s) reflect on how the Chief Executive Officer influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the Health Unit's mission and vision. This also reflects on the Chief Executive Officer's responsibility for actions, decision and policies that impact the Health Unit's ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

March 12 Attended the Board of Health agenda review and Executive meeting.

March 18 Attended meeting with Ministry of Health partners to discuss public health funding regarding measles.

March 21 Attended the Board of Health meeting.

April 4 With the Medical Officer of Health and Associate Medical Officer of Health, and Public Health Foundations, Director hosted the President and Chief Executive Officer, Public Health Ontario for a meeting.

This report was prepared by the Chief Executive Officer.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Good Governance and Management Practices Domain as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Governance and Leadership (ABRP) section.

Correspondence A

Balancing Act

An All-of-Society Approach to Substance Use and Harms

Focus on
Tobacco/Vaping Products, Cannabis, Alcohol, and Opioids

2023 ANNUAL REPORT
Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

Land Acknowledgement

We wish to acknowledge the land on which the Office of the Chief Medical Officer of Health is working. For thousands of years, it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today this place is still home to many Indigenous people from across Turtle Island, and we are grateful to have the opportunity to work on this land.

Dedication

Each year, too many members of our communities are lost due to the harmful effects of substances like tobacco, cannabis, alcohol and opioids. This report is dedicated to the family members and friends of those lost far too soon, and to the public health, health care, social service and other providers who strive each day to support those experiencing substance use harms.

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Correspondence A

Letter from Dr. Moore

Dear Mr. Speaker,

I am pleased to share with you my 2023 Annual Report, "Balancing Act: An All-Of-Society Approach to Addressing Substance Use and Harms," in fulfillment of the requirements of the independent Chief Medical Officer of Health for Ontario, and as outlined in section 81. (4) of the *Health Protection and Promotion Act, 1990*.

Our collective experiences during recent challenges, notably the COVID-19 pandemic, have showcased the resilience and strength of Ontario's communities. Today, we face another challenge – the rise in substance use and related harms, which threatens the health of Ontarians and the well-being of our communities.

Opioids have claimed over 2,500 lives each year in Ontario in the past few years through toxicity deaths alone, indicating the need for urgent intervention. We have also seen concerning changes in substance use patterns and harms more broadly, including higher rates of vaping among non-smokers, increased unintentional poisonings in children from cannabis ingestion, and an ongoing high burden of hospitalizations and cancers caused by alcohol. It is our duty to take action now both to address today's challenges and to lay the foundations for a future state where everyone in Ontario can live longer and healthier lives.

With this report, I am adding my voice to the voices of many professional, public health, and community organizations, and of people with lived experience of substance use and substance use harms, who have identified the need to take collective action urgently to address the harms of substance use in Ontario.

To address these challenges, I am recommending that we invest in what we know works, which includes health promotion efforts, strategies to prevent harms from drug use, access to evidence-based treatment, and regulatory measures and enforcement. Recognizing that substance use is often rooted in early life experiences and intergenerational trauma, the report advocates for comprehensive interventions—both upstream investments to address structural factors and downstream strategies to mitigate acute risks. This approach is crucial to fostering healthier individuals, communities, and societies. And, as reflected in the report title, "Balancing Act," I recognize the need to strike a balance between individual autonomy and political interests with the overall health of our populations to achieve these goals.

Substance use cannot be addressed by the health sector alone. In this report, I call for collaboration between communities, all levels of government, health and social services, organizations at all levels, the public health sector, the healthcare system, and Ontario residents.

I wish to express my appreciation to all contributors who have played an important role in shaping this report, and I invite partners at all levels to engage in meaningful dialogue, including people with lived experiences of substance use, on how we can collectively do better. By working together, we can find that critical balance to an all-of-society approach that will lead to a healthier future for all Ontarians.

Yours truly,

Dr. Kieran Moore

Correspondence A

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Executive Summary

Mood-altering substances like cannabis, alcohol, opioids, and tobacco and vaping products that contain nicotine are widely used in Ontario. Some people use them for enjoyment. Others use them to reduce anxiety, relieve depression, manage pain, and cope with stress and trauma. Most Ontarians who use these substances do so without seeming to harm their health or wellbeing, but some people experience real damage to their health, lives, and relationships.

Measuring Substance Use Harms

There are currently between 2,500 and 3,000 opioid toxicity deaths in Ontario each year – or one tragic, preventable death every three hours, largely due to the toxic unregulated drug supply. Thousands more Ontarians are also treated for accidental overdoses in our emergency departments each year.

But substance-related harms are not limited to unregulated substances. Every year, the use of regulated substances, like tobacco/vaping products, alcohol, and cannabis, results in thousands of emergency department visits, hospitalizations, and deaths.

The use of these four substances costs the province billions of dollars each year in health care, lost productivity, criminal justice, and other direct costs.

Harms and Estimated Costs Attributable to Substance Use in Ontario, 2020

Substance use attributable harms	Tobacco	Alcohol	Cannabis	Opioids
Deaths	16,296	6,201	108	2,415
Hospitalizations	54,774	47,526	1,634	3,042
Emergency Department Visits	72,925	258,676	16,584	28,418
Total Costs	**$4.18 billion**	**$7.11 billion**	**$0.89 billion**	**$2.73 billion**

Source: Canadian Substance Use Costs and Harms Scientific Working Group. (2023). Canadian substance use costs and harms 2007–2020. (Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction.) Ottawa, Ont.: Canadian Centre on Substance Use and Addiction. Available from https://csuch.ca/explore-the-data/

During the COVID-19 pandemic, Ontario saw disturbing trends in substance use and harms, including:

- more people, who had not previously smoked tobacco, using vaping products that contain nicotine (the highly addictive substance in tobacco)
- more adults using cannabis and more cannabis-related emergency department visits
- a significant increase in alcohol toxicity deaths
- more polysubstance use (i.e. alcohol and cannabis, opioids with benzodiazepine, alcohol and/or cannabis), which increases the risk of death
- the growing number of youth in grades 7 to 12 who reported using alcohol and cannabis more frequently, and the growing number using toxic unregulated opioids.

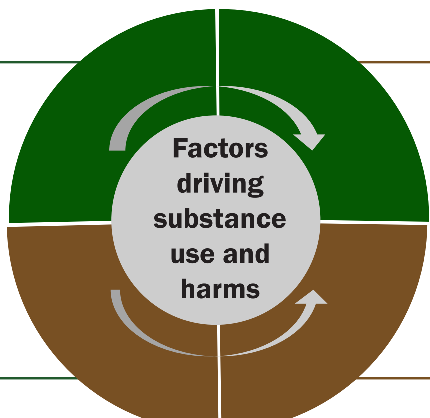
It is time to focus attention on substance use and harms.

The Upstream and Downstream Drivers of Substance Use

Why are some people able to use substances without any apparent harm to their health or well-being, while others experience serious harms?

The likelihood that someone will develop a substance use disorder or addiction is strongly influenced by:

Upstream factors, such as early life experiences, and the social and structural determinants of health – which affect people's sense of belonging and social connection, and their ability to get the services and supports they need.



Downstream factors, such as the nature of the substance (e.g. the product, how it's used, how toxic/predictable the supply is, how addictive it is), and the social environment (e.g. how accepted its use is, how easy it is to access, how it's priced and promoted).

To reduce substance-use harms, we must invest upstream to help people develop strong relationships and social connections, and to provide more equitable access to the determinants of health that can protect them from harmful substance use (e.g. income, education, employment opportunities, housing, mental health supports). At the same time, we must put in place the downstream policies and "guardrails" that limit risks associated with specific substances.

Addressing Substance Use Harms: A Balancing Act

Ontario's public health sector aims to help all Ontarians lead longer, healthier lives. Part of the public health sector's legislated mandate is to prevent harms associated with substance use.

Public health has a long history of working with communities to implement effective and promising interventions that reduce substance use harms and change social norms related to substance use. As a society, we have also had experience with strategies designed to reduce substance use harms that have had unintended negative consequences (e.g. awareness campaigns that used "scare" targets and were ineffective).

The challenge is to find the balance between:

- respecting people's autonomy – including their desire to use substances – and public health's responsibility to protect citizens, families, and communities from substance-related harms
- the economic and societal benefits of substance use, including the jobs, wealth and enjoyment generated by the regulated alcohol and cannabis industries, and the health and social costs of substance use harms
- providing accurate information about the very real risks of substance use without stigmatizing people who use drugs
- helping people use substances, including unregulated substances like opioids, more safely while not increasing their use
- providing life-saving services to people who use opioids while also ensuring overall community safety.

An All-of-Society Approach to Improve Health and Reduce Substance Use Harms

Substance use harms are an urgent public health issue, and one that public health cannot solve on its own. This report calls for an all-of-society approach to improve health and reduce substance use harms: one that recognizes the complexity of human experience with substances, the factors that drive substance use, and the policy environment where public health policies may conflict with economic policies, and with public attitudes and perspectives.

The report challenges key partners – communities, local, provincial, federal, and Indigenous governments and agencies, social services, other organizations involved in reducing substance use harms, people with lived and living experience, the public health sector, and the health care system – to pursue a range of thoughtful, evidence-based strategies designed to address both the upstream and downstream factors affecting substance use and harms. The goals are to: build healthy families and healthy communities; and ensure Ontarians have the knowledge, skills, supports, services, and relationships to lead healthy lives and avoid substance use harms – as well as the harm reduction and treatment services they need if they use substances or develop a substance use disorder.

Substance-Specific Strategies

The report also describes the current trends and health threats for four substances – tobacco/vaping products, cannabis, alcohol, and opioids – and recommends that Ontario work with its partners to develop multi-pronged substance-specific strategies to reduce those threats.

The aim of **tobacco/vaping products** strategy is to:

- Meet the 2035 national target of fewer than 5% of the population using tobacco (e.g. increase taxes, age of purchase, and availability of smoking cessation treatment)
- Develop and enforce a broad regulatory framework (i.e. beyond tobacco) that covers all vaping and nicotine-containing products
- Review and strengthen policies that reduce smoking and vaping (e.g. tobacco/nicotine pricing and taxation)
- Prevent/reduce vaping among youth, most of whom have never smoked, are too young to legally purchase vaping products, and are highly susceptible to nicotine addiction
- Prevent non-smokers from vaping nicotine products (e.g. make them less appealing, ban flavoured products and disposable vapes)
- Limit online advertising and sales of tobacco/vaping products.

The aim of the **cannabis** strategy is to:

- Reduce high rates of cannabis use by youth and young adults whose brains are highly vulnerable to its ill effects (e.g. increase age of purchase)
- Promote Health Canada's Low Risk Cannabis Guidelines
- Reduce high risk cannabis use behaviours, including during pregnancy, if driving, among people with mental health problems, and polysubstance use (e.g. cannabis and alcohol, cannabis and opioids)
- Work with the federal government to reduce the risks associated with edibles, including the increasing incidence of pediatric poisonings by requiring safeguards (e.g. child-proof packaging, warning labels)
- Limit online advertising and sales of cannabis products
- Train more providers in evidence-based management of cannabis use disorder.

The aim of the **alcohol** strategy is to:

- Shift social norms by making Ontarians more aware of new evidence on alcohol-related harms, particularly its carcinogenic effects, and the risks/harms associated with binge drinking, hazardous drinking, drinking and driving, and drinking during pregnancy (e.g. warning labels)
- Promote Canada's new Guidance on Alcohol and Health
- Bring down rising rates of alcohol use among youth and women
- Monitor the harms of alcohol on youth aged 19 to 21 and explore whether to revisit the current minimum legal drinking age
- Review and strengthen policies that reduce the risk of alcohol-related harms (e.g. alcohol pricing and taxation)
- Monitor the impact of any increases in alcohol retail outlets or hours of sale, and develop a strong regulatory framework to enforce alcohol regulations in all outlets where alcohol is sold
- Limit online marketing and sales of alcohol
- Increase access to effective treatments for people with alcohol use disorder.

While the multi-pronged substance-specific strategies use a similar framework and tools, the priorities and recommendations will be different because the threats are different. For example, Ontario has many decades of experience implementing a tobacco strategy and regulatory system. The province has already had significant success changing social norms and reducing smoking. Its experience with opioids – an unregulated, illegal substance – is much more recent, and the challenges are different.

The aim of the **opioid** strategy is to:

- Raise awareness of the risks associated with the toxic, unregulated drug supply
- Improve access to housing, mental health, and other services that can help people avoid or reduce unregulated opioid use and its harms
- Decriminalize simple possession of unregulated drugs for personal use as recommended by the Chiefs of Police of Ontario and has been done in other jurisdictions, including British Columbia, Oregon, and Portugal
- Develop programs that direct people who use opioids to health services rather than the criminal justice system
- Provide non-judgmental services that reduce the negative impacts of criminalization on people who use opioids (e.g. stigma, discrimination, lack of access)
- Meet the urgent harm reduction needs of people struggling with opioid addiction (e.g. consumption treatment services, naloxone kits, sterile supplies, safer supply programs) while supporting community safety
- Improve access to timely, low-barrier evidence-based treatment programs
- Enhance harm reduction program (e.g. consumption treatment services) that are integrated in the community and offer broad-based services and connections to care
- Ensure harm reduction and treatment services can adapt quickly to changes in substance use patterns (e.g. the shift from injecting to smoking/inhaling opioids)
- Support the families and friends of people who use opioids as well as workers who provide prevention, harm reduction, and treatment services.

When thousands of people are dying from preventable opioid overdoses each year, the system must first take urgent steps to keep people alive, such as creating safe spaces where people can use unregulated drugs and providing regulated pharmaceutical alternatives (e.g. opiate agonist therapy, a safer drug supply). With these harm reduction responses in place, people who are using opioids may be in a position to benefit from offers of education and treatment, and to make choices that enable them to reduce or even stop their opioid use.

The Need to Act Now

When we see preventable threats, like substance use, that harm too many people too young, devastate families, destroy communities, and reduce life expectancy, we must act.

Ontarians will continue to use substances. The challenge is to help people understand the risks, and moderate or stop their use. The recommendations in this report reflect the best available evidence on interventions that can reduce substance use harms. To keep pace with new knowledge, we will revisit these recommendations in two years, and refine our strategies as needed.

While the right toolbox of downstream public health interventions is important, Ontario also needs an all-of-society approach to prevent substance use harms and improve health and well-being. We must continue to advocate for upstream health, social, and economic policies that support strong, healthy, connected families and communities.

Why a Report on Substance Use and its Harms? Why Now?

Ontario's public health sector aims to help all Ontarians lead longer, healthier lives, to improve health for all of society, and leave no one behind.

To fulfill that goal, public health must address the risk factors, diseases, and conditions that threaten health or reduce life expectancy. In recent years, some of the biggest threats to what had been a steady increase in life expectancy in Ontario have been the COVID-19 pandemic and preventable deaths related to substance use. In past years, the Chief Medical Officer of Health's reports highlighted some drivers of substance use and its harms, such as health inequities (*Improving the Odds: Championing Health Equity in Ontario, 2016*).[1] They also identified ways to mitigate those harms, including the role of strong social connections in helping people reduce stress and build resilience (*Connected Communities: Healthier Together, 2017*),[2] and the need for better health, economic and sociodemographic data on communities and populations to guide health programs (*Mapping Wellness: Ontario's Route to Healthier Communities, 2015*).[3]

This year's report focuses specifically on substance use and effective ways to reduce substance use harms in Ontario.

Part of public health's legislated mandate is to prevent harms associated with substance use. My office works closely with our partners to monitor:

- trends in substance use across the province
- the rapidly evolving evidence on how different substances affect health
- policy changes that affect substance use and harms
- evidence-informed interventions that can reduce substance use harms.

Substance Use Harms are an Urgent Public Health Issue

Ontario knows first-hand the harms of substance use. The current opioid toxicity crisis is causing untold pain and suffering: we lost almost 3,000 lives to the toxic drug supply in 2021, and about 2,500 more in 2022.[4] Too many of those deaths were in teens and young adults.

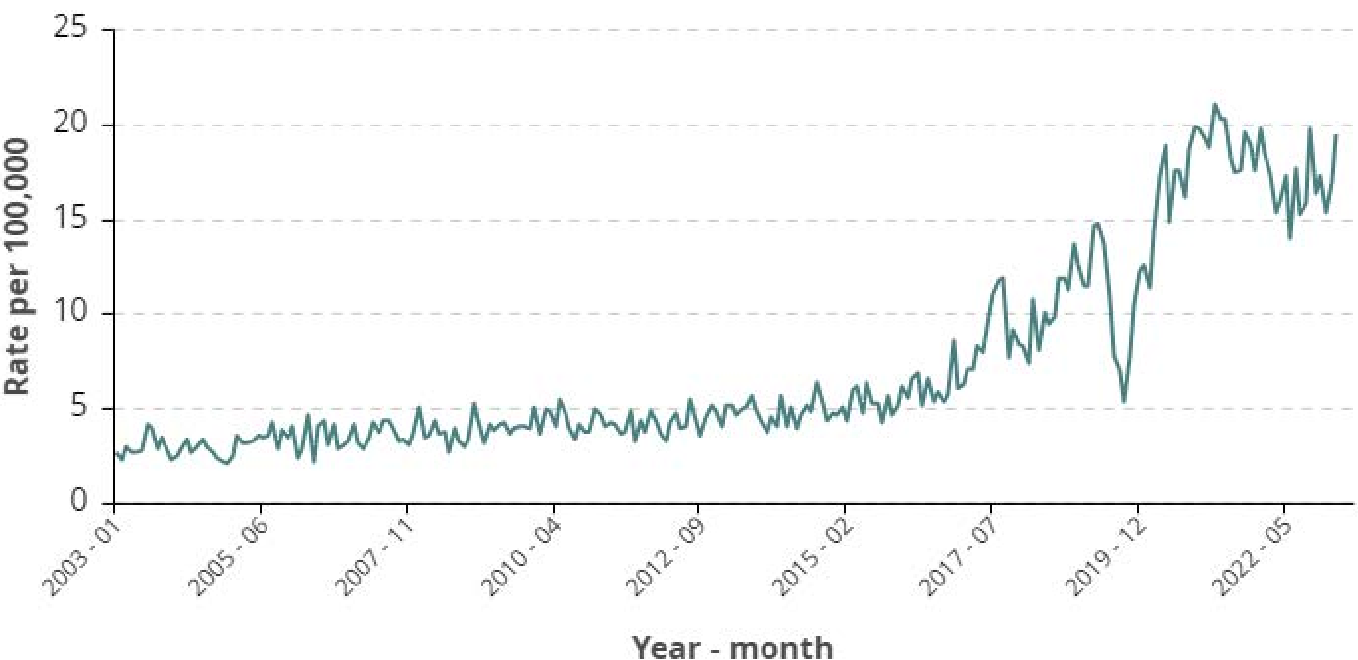
That's one tragic, preventable death from opioids about every three hours – with thousands more Ontarians seeking care in emergency departments and being hospitalized for accidental overdoses each year.

Most opioid-related overdoses and deaths in Ontario are due to fentanyl: a highly potent synthetic opioid that is often found in the unregulated drug supply, making the supply more toxic and unpredictable, and increasing the risk of overdose.

Between 2014 and 2021, the number of opioid-related deaths among teens and young adults in Ontario tripled.

Ontario Drug Policy Research Network, 2023[5]

Figure 1: Opioid toxicity deaths in Ontario, 2003 – 2022



Source: Ontario Agency of Health Protection and Promotion (Public Health Ontario). Interactive opioid tool: cases of opioid-related morbidity and mortality, Ontario, 2003 - 01 – 2023 - 06 [Internet]. Toronto, ON: King's Printer for Ontario; 2024 [modifed 2024 Jan 17; cited 2024 Feb 9]. Available from: https://www.publichealthontario.ca/en/Data-and-Analysis/Substance-Use/Interactive-Opioid-Tool.

Opioid-related harms reach far beyond the individuals using drugs. They have a devastating impact on families and friends, communities of peers (i.e. people with lived or living experience of drug use), and frontline workers who provide health, social, housing, and other services. The stigma associated with opioid use, along with a lack of services and supports, undermines the ability of people affected by opioid overdoses or deaths to prevent and to publicly grieve the heartbreaking losses.

While toxic, unregulated street drugs – like opioids (e.g. heroin, fentanyl), cocaine, and methamphetamine – can cause stark and severe harms, they are not the only substances that threaten health. Other addictive and/or psychoactive substances, including regulated and commonly used products such as **tobacco[i] and vaping products[ii], cannabis, and alcohol**[6], can also be extremely harmful for the individuals using them, their families, their communities, and society at large – although not everyone who uses these substances experiences harms.

Tobacco and alcohol use contribute to thousands of emergency department visits, hospitalizations, and deaths every year in Ontario. Since cannabis use was legalized in 2018, the number of emergency departments visits for cannabis use disorder has increased.

[i] For purposes of this report, "tobacco" refers specifically to commercially manufactured tobacco/nicotine containing products that are used recreationally. It is not intended to encompass tobacco used by First Nations, Inuit and Métis communities for traditional and sacred purposes, which differ in composition, production and use.

[ii] For purposes of this report, tobacco and vaping products have been combined in one category mainly because vaping products were originally developed as a device to deliver the nicotine in tobacco while reducing the harm from other toxic substances released in tobacco smoke. We recognize that vaping products are now also used for cannabis as well as nicotine.

Table 1: Harms and Estimated Costs[iii] Attributable to Substance Use in Ontario, 2020

Substance use attributable harms	Tobacco[iv]	Alcohol	Cannabis	Opioids
Deaths	16,296	6,201	108[v]	2,415
Hospitalizations	54,774	47,526	1,634	3,042
Emergency Department Visits	72,925	258,676	16,584	28,418
Total Costs[vi]	**$4.18 billion**	**$7.11 billion**	**$0.89 billion**	**$2.73 billion**

Source: Canadian Substance Use Costs and Harms Scientific Working Group. (2023). Canadian substance use costs and harms 2007–2020. (Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction.) Ottawa, Ont.: Canadian Centre on Substance Use and Addiction. Available from https://csuch.ca/explore-the-data/

COVID-19 Exacerbated Substance Use and Harms

During the COVID-19 pandemic (2020-2023), we saw concerning trends in the use and harms of tobacco and vaping products, cannabis, alcohol, and opioids:

Smoking rates remain persistently high in Northern Ontario.

- Tobacco sales and the overall prevalence of tobacco smoking in Ontario continued to decline during the pandemic. The proportion of people who reported smoking dropped from 15% in 2018 to 11% in 2022. But more people reported using vaping products (15.5% in 2020, up from 12.3% in 2019) – including people who had not previously smoked tobacco.[7]
- More adults reported using cannabis – 33% in 2020 compared to 25% in 2019 – and more visited emergency departments for cannabis-related mental health problems and behavioural disorders.[8]
- Although the proportion of Ontarians who drink alcohol (80%) did not increase during the pandemic, more adults and youth reported binge drinking (i.e. five or more drinks on a single occasion at least once in the past month) and hazardous alcohol use (i.e. eight to 14 drinks a week in the past month).[10]
- Between 2018 and 2021, Ontario saw a 16% increase in alcohol toxicity deaths (from 256 to 296). Most of these deaths involved other substances as well as alcohol, and alcohol directly contributed to 13% of all substance-related deaths during that time period.[11]
- Youth substance use patterns changed during the pandemic. Young people in grades 7 to 12 reported drinking alcohol more frequently, and were more likely to use cannabis (once the initial pandemic stay-at-home orders were lifted).[12-16]
- There was an increase in polysubstance-related toxicity deaths.[11]
- More people who use opioids died without someone else present to recognize the overdose and intervene.[17]
- In 2023, a majority of Indigenous Friendship Centres in Ontario (72%) reported concerns about widespread substance use among Indigenous people, including the use of opioids (fentanyl), alcohol, and methamphetamines.[18]

[iii] Note: Several different reports that include cost estimates for substances have been cited in this report. Because they use different methodologies, their estimates for morbidity/mortality/costs may differ.

[iv] Refers to tobacco use only; does not include outcomes or costs related to vaping.

[v] Motor vehicle accidents are the main cause of cannabis-related deaths and injuries.[9]

[vi] Total costs include health care costs (hospitalizations, emergency department visits, paramedic services, specialized treatment, physician time, prescription drugs), lost productivity costs, criminal justice costs, and other direct costs (e.g. research and prevention costs, motor vehicle collision damage, workers' compensation).

Over the pandemic period, we also saw changes in the broader environment that may be contributing to substance use harms, including:

- people using substances to help them cope with mental health problems (e.g. stress, anxiety, depression, post-traumatic stress disorder)
- the marketing of vaping products to youth – although federal regulations implemented in 2020 did reduce overall marketing of vaping products compared to pre-pandemic times
- easier access to and availability of a greater variety of cannabis products
- more retail outlets licensed to sell cannabis and alcohol
- more marketing of alcohol to women and young adults
- the increasing toxicity and unpredictability of the unregulated drug supply, particularly opioids
- growing community concerns about some of the harms associated with substance use, such as: injuries caused by people under the influence of alcohol, cannabis or other substances; public intoxication; discarded needles; the exacerbation of existing mental health problems (e.g. psychosis); the increase in homelessness; the potential increase in crime if people steal so they can buy substances; violence related to the use of both unregulated and regulated substances (e.g. alcohol); and the lack of community-based supports and services that could reduce these harms.

Polysubstance Use

"Throughout the COVID-19 pandemic … over 80% of alcohol and stimulant deaths, and 95% of benzodiazepine deaths also involv[ed] opioids. The complex interaction of multiple substances contributes to higher fatality rates compared to exposure to a single substance."

The Ontario Drug Policy Research Network and Public Health Ontario. Characteristics of Substance-Related Toxicity Deaths in Ontario: Stimulant, Opioid, Benzodiazepine and Alcohol-Related Deaths. 2023.[11]

The social costs of harms stemming from substance use – young lives lost, damaged relationships, devastated families, lost productivity, lost opportunities, and anxious and grieving communities – are tragically high. So are the economic costs.

$1.8 Billion

In 2020, the harms associated with substance use cost Ontario about $18 billion[vii] – or $1,234 per person – in health care, social and legal/policing costs.[19]

$1,234 per person

5 X

Those costs are more than five times as much as the Ontario government collected in income[viii] from alcohol sales ($2.55 billion)[20] in 2021-22 and from estimated taxes on tobacco ($840 million)[21] and cannabis sales ($194 million)[21] in 2023.

4.5 X

The costs are also about 4.5 times the amount the province spent on all its population and public health programs in 2021-22 (during the COVID-19 pandemic), and almost 14 times the amount spent on population and public health programs in 2019-20 (pre-COVID)[22].

[vii] Substance use cost is based on overall costs from alcohol, tobacco, cannabis, opioids, other central nervous system depressants, cocaine, other central nervous system stimulants and other substances.

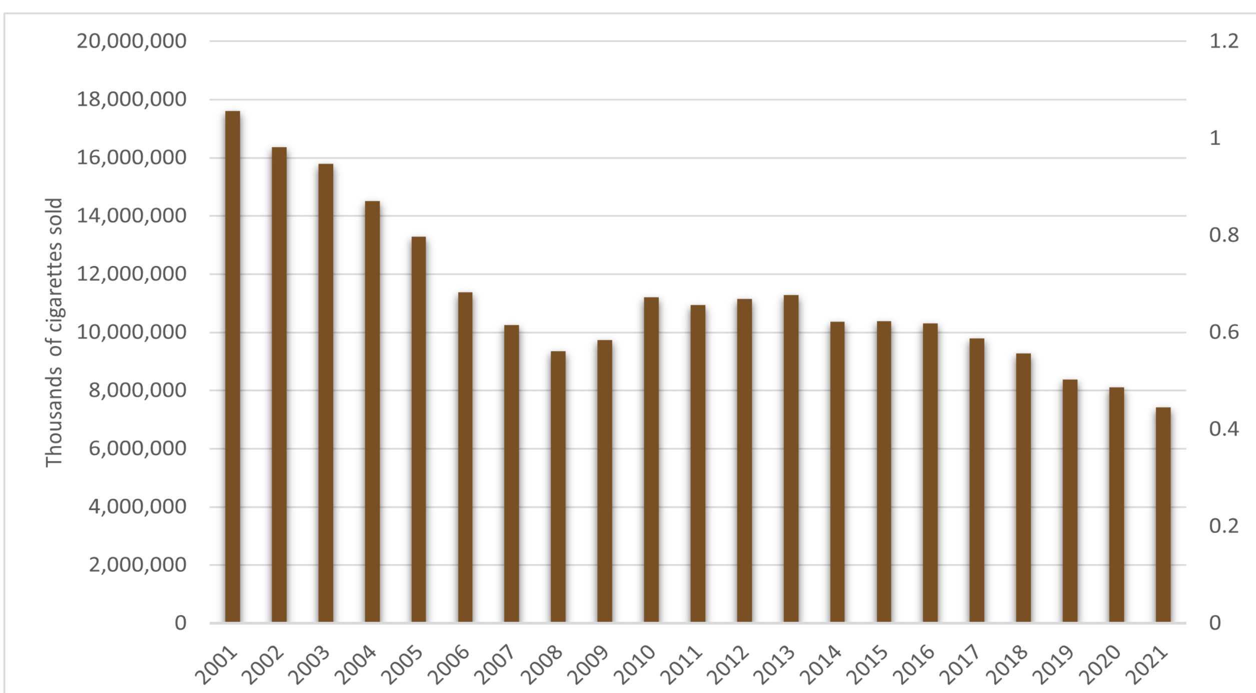
[viii] Income generated by alcohol is based on sales as well as taxes because the provincial government has largely controlled the sale of alcohol through the Liquor Control Board of Ontario (LCBO), while estimated income from tobacco and cannabis is based on taxes on sales only.

Public Health Approaches Can Reduce Substance Use Harms

Ontario's public health sector has a long history of implementing population health interventions designed to build healthier communities, promote safer substance use, and protect people from substance use harms, including substance use disorders or addictions.[ix] Working collaboratively with communities, we have had marked and sustained success in changing social norms related to substance use. For example:

- Ontarians know that smoking tobacco is bad for their health. The number of Ontarians who smoke commercial tobacco products is at its lowest ever.

Figure 2: Cigarettes sold (in thousands) in Ontario, 2001 - 2021[23]



- Public health has been able to work successfully with regulators and store owners to enforce regulations that limit sales of commercial tobacco, alcohol, and cannabis to youth under age 19, who are more susceptible to substance use harms.
- Over time, the legalization of cannabis has shifted a significant proportion of people who use cannabis from the illegal market to safer, regulated products: from 63% in 2021 to 67% in 2022.[24]
- Self-reported rates of driving under the influence of alcohol and cannabis decreased between 2018 and 2022.[16,12] However, the Ontario Provincial Police charged more than 10,000 people with impaired driving related to any substance in 2023: a 16% increase compared to 2022.[25] With the increase in cannabis use among youth, we continue to have serious concerns about the risks associated with people driving under the influence of cannabis.

[ix] In this report we use the terms "addiction" and "substance use disorder" interchangeably.

Well Intentioned Efforts to Address Substance Use Can Cause Harm

We have also learned from past experiences that broader government and social strategies designed to reduce substance use harms can sometimes have unintended negative consequences. For example:

- Awareness campaigns developed in the 1980s and 1990s to prevent substance use, such as "DARE" and "Scared Straight," were ineffective.[26]
- Sudden restrictions on the prescribing of regulated opioids without adequate treatment supports can push people experiencing pain or a substance use disorder to the toxic unregulated opioid market.[27]
- Enforcement activities designed to reduce the supply of street drugs, such as drug seizures, can disrupt individuals' usual supply, forcing them to find other less predictable sources, and increasing the risk of overdose and death.[28]
- Safer supply programs, which improve health by providing people who are addicted to opioids access to safer regulated substances, may result in some of that supply being diverted to others for whom it was not intended, without sufficient controls in place.
- Consumption and treatment services, which provide a space where people can use opioids with supervision, are not currently designed to serve people who smoke or inhale (rather than inject) drugs. Well intentioned efforts to provide harm reduction services that prevent overdoses and deaths may not be keeping pace with changing trends in substance use.
- Enforcement of restrictions on regulated substances (e.g. pricing policies) may result in people selling unregulated products (e.g. tobacco, cannabis) without warning labels or approved packaging, providing products that are less safe or predictable but cost less, and marketing them to minors.[30]
- People arrested for possession of substances can end up with a criminal record, which can limit their ability to find work or housing, and affect their long-term health and well-being.
- People who use substances such as opioids who have been incarcerated are at higher risk of overdose and death due to a loss of drug tolerance and risk of relapse when they are released back into the community– particularly if they are not able to access appropriate treatment and support services.

> Approaches to enforcement that do not take into account the health issues related to substance use have not been as effective in reducing use or in protecting public health and safety, and may deter people who use substances from accessing health services.
>
> Health Canada. Strengthening Canada's Approach to Substance Use Issues, 2018.[29]

My Call for Health-First Substance Use Policy and Action

So, what is the best approach to respond to worrisome trends in substance use in Ontario? How do we find the balance between respecting people's autonomy – including their desire to use substances – and public health's responsibility to protect citizens, families, and communities from substance-related harms, prevent illness, and promote health?

How do we balance the economic and societal benefits of substance use, including the jobs, wealth, and enjoyment generated by the regulated alcohol and cannabis industries, with their health and social costs?

How do we give Ontarians accurate information about the very real risks associated with substance use – particularly the use of unregulated drugs – without stigmatizing people who use drugs? How do we balance policies designed to support people struggling with opioid use disorder and keep them alive (e.g. safer supply programs) with our responsibility to protect communities from exposure to toxic drugs?

How do we balance our efforts to help people use substances more safely (e.g. regulation) without increasing their use? How do we communicate clearly to Ontarians that efforts to make access to and consumption of substances safer do not make the substances "safe" – that there are still real health risks and harms from using them?

Substance use harms are a public health issue, but the public health sector cannot solve the problems associated with substance use on its own. Ontario needs a comprehensive all-of-society approach that engages:

- all levels of government: federal, provincial, territorial, local and Indigenous
- all partners currently involved in substance use issues, including: the regulatory system, the commercial system, finance and taxation systems, the social service system, the child welfare system, the health care system, and the justice system at local, provincial and federal levels
- clinicians and researchers
- communities and populations most affected by substance use harms, including First Nations, Inuit, Métis, and other Indigenous peoples
- citizens – including people with lived or living experience of substance use – who will contribute their expertise and perspectives (i.e. tacit knowledge – see box).

> Including the voices of citizens in policy-making increases public interest in, and understanding of, evidence and political processes, which in turn enhances the legitimacy of policy decisions as well as societal trust.
>
> Tacit knowledge helps contextualize research evidence and find effective ways to address issues where research is either uncertain, value laden or contested. This process of community engagement also helps build consensus and trust.
>
> World Health Organization. (2022). Implementing Citizen Engagement within evidence-informed policy making[31]

I am calling on Ontario to recognize that:

1. **Human experience with substances is complex.** Substance use is widespread in Ontario. Many people use substances, and report personal and social benefits from that use; however, others suffer real harms. The challenge is to help Ontarians understand the benefits and risks, and make safer, more informed decisions about their substance use while, at the same time, implementing the right mix of effective policies and interventions to support the health of people who use substances and reduce substance use harms.
2. **The drivers of substance use are complex.** Substance use is influenced by genetics, early life experiences (e.g. trauma, adverse childhood events, family history of mental health or substance use issues), other mental health conditions, social determinants of health, health inequities, and the social/cultural context, including – for Indigenous peoples – the impacts of colonization. To reduce substance use harms, we must invest upstream to ensure that people have equitable access to income, education, employment opportunities, housing, mental health supports, and other determinants of health as well as strong relationships and social connections that can protect them from harmful substance use. We must also understand culture as a social determinant of health and invest in culturally responsive, community-based programs as a way to improve health outcomes. At the same time, we must put in place the kind of downstream policies and "guardrails" that limit risks associated with specific substances.

Figure 3: Risk and Protective Factors for Substance Use Related Harms

Source: Health Canada. The Canadian drugs + substances strategy: the Government of Canada's approach to substance use related harms and the overdose crisis. Ottawa, ON: His Majesty the King in Right of Canada, as represented by the Minister of Health; 2023. Figure 3. Risk and protective factors for substance use related harms; p.9. Available from: https://www.canada.ca/en/health-canada/services/publications/healthy-living/canadian-drugs-substances-strategy-approach-related-harms-overdose-crisis.html

3. **The policy environment is complex.** Many of the drivers of substance use harms – including the product itself and its potency, predictability, price, promotion, packaging and placement (availability/accessibility) – can be influenced by policy. However, public health policies designed to reduce substance use harms can conflict with other economic and social policies. The public health system must work closely with other government policy makers and industry to find a better balance between the immediate economic benefits of regulated substance use, and the responsibility to minimize short- and long-term substance use harms, including health, societal, and economic costs.

Addiction is not a choice. It is a chronic health condition: one that people can manage with the right supports and treatment.[33] To support Ontarians experiencing substance use harms, we need to build communities that promote safer substance use, and provide compassionate, evidence-based harm reduction and treatment services on demand for people struggling with substance use.

This report:

- Provides a brief overview of substance use in Ontario, including the factors that drive those harms, and the populations most at risk
- Calls on Ontario to build on existing upstream initiatives to create healthier communities that engage citizens, and provide programs that address the underlying social and economic determinants, including systemic harms and discrimination, that drive substance use harms
- Looks at the current trends and impacts of four substances – tobacco/vaping products, cannabis, alcohol, and opioids – and recommends specific strategies to reduce the harms associated with those substances.

Substance use harms are – first and foremost – a health issue that requires a comprehensive all-of-society, health-first strategy. We cannot and should not continue to look to the criminal justice and regulatory systems to solve health problems associated with substance use.

Note: This report does not directly address other unregulated substances that can be harmful, such as cocaine, crystal methamphetamine, benzodiazepines, or ecstasy. However, many of the recommendations can be adapted and used to reduce the harms of those substances.

I. Understanding Substance Use in Ontario

People have been using substances like tobacco, alcohol, cannabis, and opioids for thousands of years. In many ancient cultures, these substances were part of medicinal practices as well as social celebrations and spiritual rituals that brought community together. Some substances were used for enjoyment. Some were used to reduce anxiety, relieve depression, manage pain, and cope with stress and trauma.

People still use these substances for these purposes today, and most do so without experiencing harm to their health or well-being.[34] However, because these substances affect the brain, alter mood and behaviour, and can be addictive, some people will experience harms. Substance use can also have negative effects on people's health, lives, and relationships.

Addiction refers to the problematic use of a substance. Addiction is associated with the presence of the 4 Cs:

- **Craving**
- Loss of **Control** of amount or frequency of use
- **Compulsion** to use
- Use despite **Consequences**

Centre for Addiction and Mental Health (CAMH)[35]

What are the Factors Driving Substance Use and Harms?

Why are some people able to use substances without any apparent harm to their health or well-being, while others will experience serious harms?

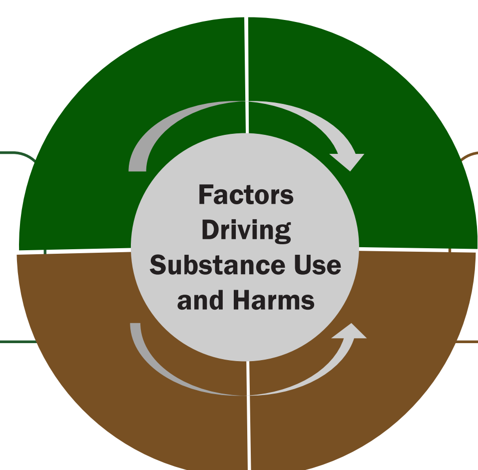
The best antidote to problematic substance use and addiction is connection: connection to family and friends, to community, and to society.

The likelihood that someone will develop a substance use disorder or addiction is strongly influenced by early life experiences and other upstream social and structural determinants of health that affect people's sense of belonging and social connection, and their ability to get the services and supports they need.

It is also influenced by downstream factors, such as the nature of the substance (e.g. how it's used, how toxic/predictable the supply is), and the social environment (e.g. how accepted its use is, how easy it is to access).

Individual and societal harms and benefits of substances are driven by interactions among biopsychosocial and economic conditions, the informational environment, growth/production of substances, other supply and demand variables, availability, accessibility, context, social norms and the laws that govern many of these activities. The interaction of these factors leads to use patterns.

Health Officers of British Columbia, 2011.[36]



Upstream Factors

Early life experiences

Individuals and groups most at risk of harm from substance use are often those who were exposed to certain predisposing factors **early in life** including:

- **biological or genetic factors**
- **adverse childhood experiences (ACEs)**[37] between the ages of 0 and 17 including:
  - o experiencing physical, sexual or emotional violence or abuse
  - o being physically or emotionally neglected (including inadequate supervision)
  - o witnessing violence in their home or community
  - o growing up in a household with substance use or mental health conditions (including being exposed to alcohol or other substances prenatally)
  - o having a family member attempt suicide or die by suicide
  - o living with instability due to parental separation or divorce
  - o having a parent or household member in jail or prison
- **mental health conditions,** including mental health disorders and poor mental health.

The more ACEs a child experiences, the greater the risk of substance use harms, including developing a substance use disorder later in life.

Social and structural determinants of health

Broader social, economic, and structural factors can create health inequities and increase the risk of substance use harms, including:

- inadequate **income** and **housing/living conditions**
- living in neighbourhoods or communities with high rates of **poverty, violence and/or substance use**
- lack of access to **education /health literacy**[38]
- lack of **employment opportunities and unhealthy working conditions**
- **not fitting in socially or experiencing peer pressure** to use substances
- lack of access to timely **health services, including mental health services, harm reduction resources, and addiction treatment services**
- lack of **healthy alternatives to substance use** (e.g. recreational opportunities, physical activities, social connections, hobbies and interests)
- **colonizing and marginalizing social structures, and structural forms of racism, stigma and discrimination**
- **criminalization** of substance use that may drive that use underground, and keep people from using substances more safely or seeking treatment services

Health equity is created when individuals have the fair opportunity to reach their fullest health potential. Achieving health equity requires reducing unnecessary and avoidable differences that are unfair and unjust. Many causes of health inequities relate to social and environmental factors including: income, social status, race, gender, education and physical environment.

Public Health Ontario[39]

These social, economic and structural factors affect risk in complex ways. For example, people may use substances as a way of coping with poverty, violence, unemployment or other health inequities or negative life experiences. The experiences of colonization, racism, marginalization, stigma, and discrimination are drivers of substance use among Indigenous peoples, members of 2SLGBTQ+ communities, and Black and other racialized populations in Ontario. For Indigenous peoples, those traumas have been reinforced by policies that created the residential school system, and continue to contribute to substandard living conditions, racism, and worse access to services in many communities as well as in the broader health care system.

Social and structural inequities increase the risk that a person will start using substances and that their substance use will become harmful.

Downstream Factors

The nature of the substance

The extent to which a substance can cause harm depends on:

- How **addictive** the substance is. Nicotine, opioids, and drugs like methamphetamines are highly and quickly addictive for many, while it typically takes longer for people to become dependent on cannabis or alcohol.
- The **product** itself and its form, which can affect its appeal and impact. For example, edible forms of cannabis may be more appealing and safer than smoking cannabis for many people, but the drug takes effect more slowly when ingested than when cannabis is smoked or vaped. Edibles may reduce risks associated with smoking but they increase the risk that people will consume a higher dose than they expect.
- Its **potency/toxicity.** Some cannabis products available today, including synthetic cannabis, are more potent than they were in the past. Synthetic opioids, like fentanyl and carfentanil, are also more toxic than other opioids (e.g. morphine, heroin).
- How **predictable/safe** the substance is. Does the person using the substance know what's in the substance? Has it been adulterated with other substances that can cause harm? In the unregulated drug market, opioids are often mixed with other substances, such as benzodiazepines and xylazine. The unpredictability of the current unregulated opioid supply contributes to overdoses and deaths.
- The **impact** substance use has **on health** and whether people are aware of those risks. In addition to the risk of addiction associated with nicotine, the smoke from cigarettes, cigars, and pipes contains at least 80 chemicals that can cause cancer. People who smoke cannabis or opioids face similar risks associated with inhaling smoke. There are also serious health risks associated with injecting opioids and other drugs, including abscesses/infections, endocarditis, and bloodborne infections.
- Whether the substance is used alone or **combined with other substances** – either unintentionally or intentionally. For example:
  - People often use drugs from the unregulated supply not knowing exactly what other substances may be present (i.e. unintentional polysubstance use), which increases their risk.
  - Some people choose to use alcohol and cannabis together, or take benzodiazepines or stimulants with opioids (i.e. intentional polysubstance use). Substances used simultaneously may interact in ways that exacerbate the risks: using cannabis and alcohol together leads to more impaired driving, while using benzodiazepines with opioids increases the risk of sedation, respiratory depression, and death.

The Ps that affect substance use and harms:

- Product
- Potency
- Predictability
- Price
- Promotion
- Placement

Social attitudes, promotion and availability

- How **socially acceptable or stigmatized** a particular substance is within families, cultures, and broader society. For example, in most communities in Ontario, alcohol use is more socially acceptable than smoking cigarettes or cannabis. It is also more acceptable than opioid use. Both acceptability and stigmatization can be harmful. High acceptability can increase use and harms, while stigmatization can cause people to use substances in unsafe environments or to not seek care they need.
- How **appealing** the substance or its delivery device is. For example, flavoured cigarettes and vaping products, the design of vaping devices and the way they are **packaged** can make vaping more appealing – particularly to youth – and drive use.
- The **price** of the substance, which determines how accessible it is.
- How effectively substances are **promoted** by the industries that sell them (see box).
- The **placement** of the product and how **easy it is to access** through the regulated market (e.g. outlet density), the unregulated market, and family and friends.
- The level of **popular support for policies** that limit access and promotion, such as pricing policies or restrictions on where substances can be sold and marketed.
- How **willing and able different regulatory systems are to enforce** legal restrictions on substance use, such as age limits, and the distribution and sale of regulated products, like tobacco and cannabis, outside the regulated system.
- The **public health messages** people receive about how safe or risky a substance is, and whether they trust public health and believe those messages.

Public awareness of the health risks associated with substance use is key to reducing substance use harms. For example, it was not until people were aware of the negative impacts of smoking tobacco – both on their own health and on the health of the people around them – that smoking rates began to drop. Even now, most smokers still underestimate the harms that smoking does to their health.

The marketing of legal regulated substances can be a powerful force in affecting choice and driving use, particularly among youth:

- Over the past few years, the alcohol industry has actively targeted women with pink drinks and slogans like "mummy wine time," and women's alcohol use and alcohol-related hospitalizations have increased.[41]
- Tobacco companies that created vaping projects have used sleek, colourful and flavourful products to target youth.[42]
- The dramatic uptick in prescriptions for medicinal opioids, which planted the seeds for the current opioid toxicity crisis, can be traced directly to a pharmaceutical company's aggressive and deceptive marketing to physicians.[43]

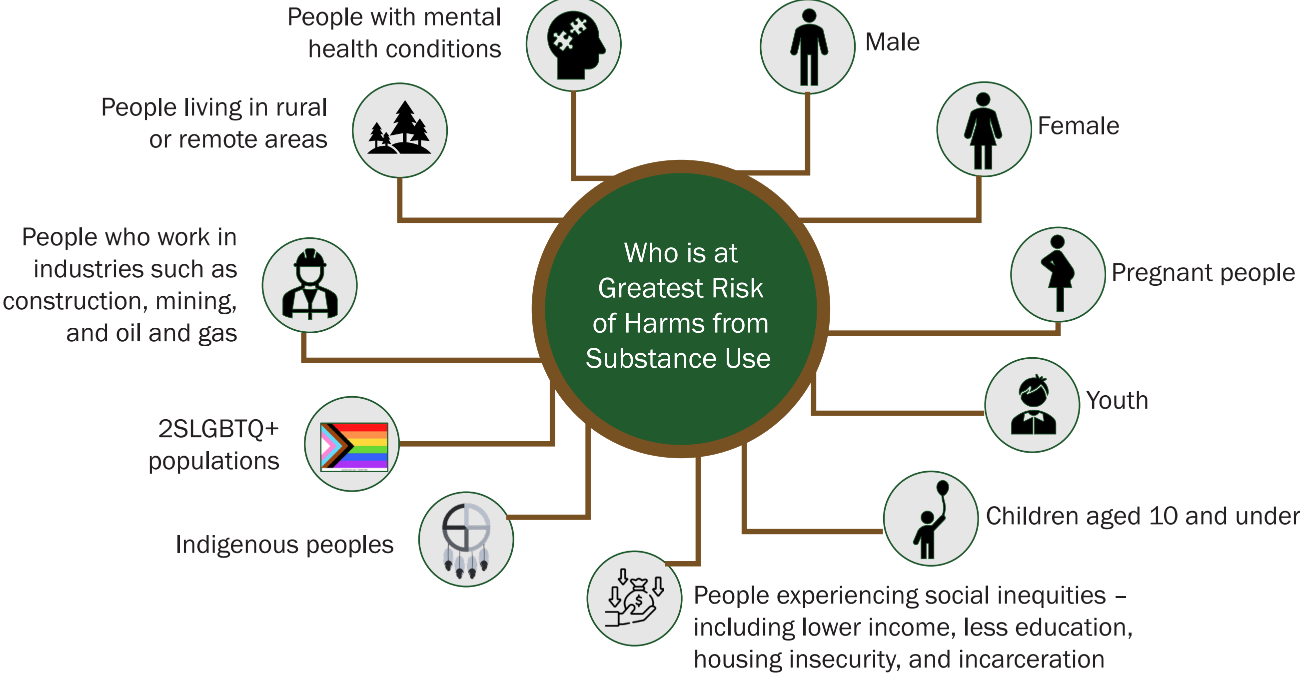
In a soon-to-be published study with people who drink alcohol, 60% were not aware that alcohol causes cancer.

2024 email from E Hobin (Public Health Ontario)

Who is at Greatest Risk of Harms from Substance Use?

While everyone is vulnerable to the harms of substance use, some groups have higher rates of substance use and related harms.[x] As noted above, risks are influenced by factors such as genetics,[44] gender, age, occupation, geographic location, and social determinants of health and health inequities – as well as by the presence of other health conditions.

Note: Ontario does not have detailed information on all populations at risk (e.g. racialized populations), so this list is not comprehensive. Risks can also be cumulative or layered: people may fall into two or more populations at higher risk of substance use harms.



Males. Males are more likely than females to smoke, use cannabis – both long-term and more frequently – and use opioids. They also tend to consume more alcohol, and experience more alcohol-related harms.

Females. Although males drink more alcohol and consume more cannabis than females, the gender gap for the use of both substances is narrowing.[45] Females – particularly professional women – are now drinking more alcohol than they did in the past: between 2013 and 2017, heavy drinking increased by 22% among females while remaining stable in men.[46] Increases in alcohol use and heavy drinking among females are concerning as evidence demonstrates **females are more susceptible to alcohol-related harms: they develop alcohol-related problems (e.g. liver disease) and alcohol use disorders sooner and at lower levels of alcohol use than males.**[47,48]

A recent Canadian study also showed higher substance use among **people who are non-binary** compared to people who identify as male or female.[49]

Males account for 75% of all alcohol-attributable deaths, 85% of hospitalizations, and 71% of emergency department visits in Ontario.[132]

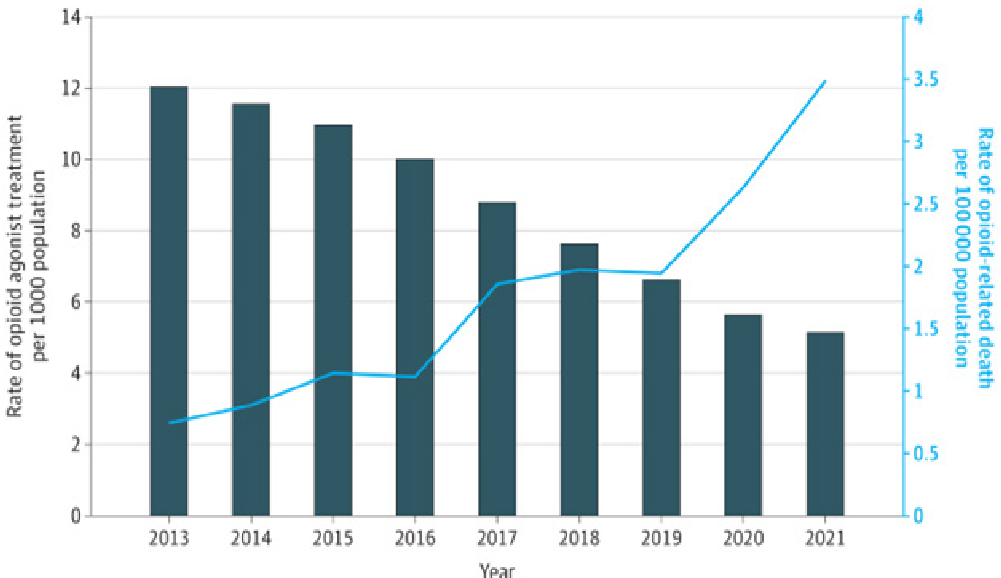
Since the start of the COVID-19 pandemic, 3 in 4 people who died from opioid toxicity in Ontario were male.[11]

Pregnant people. In addition to the risks that these four substances pose to the health of pregnant people themselves, they also threaten the pregnancy, and the health and well-being of the fetus.[50]

[x] Note: This list is not comprehensive, and it relies on available data and may miss key groups.

Youth. Young brains are highly susceptible to the harms associated with substance use,[51] and young people's use of many substances is increasing. Youth use cannabis more heavily and more frequently than people in other age groups.[12-16] Young people reported more hazardous alcohol drinking during the COVID-19 pandemic.[10] Rates of fatal and non-fatal opioid toxicity have increased substantially in the past decade in Ontario for adolescents and young adults age 15 to 24,[5] with the number of deaths increasing from 48 in 2013 to 225 in 2021. Over that same period, the rate of opioid agonist therapy (OAT) decreased by 55.9% in Ontario youth.[52]

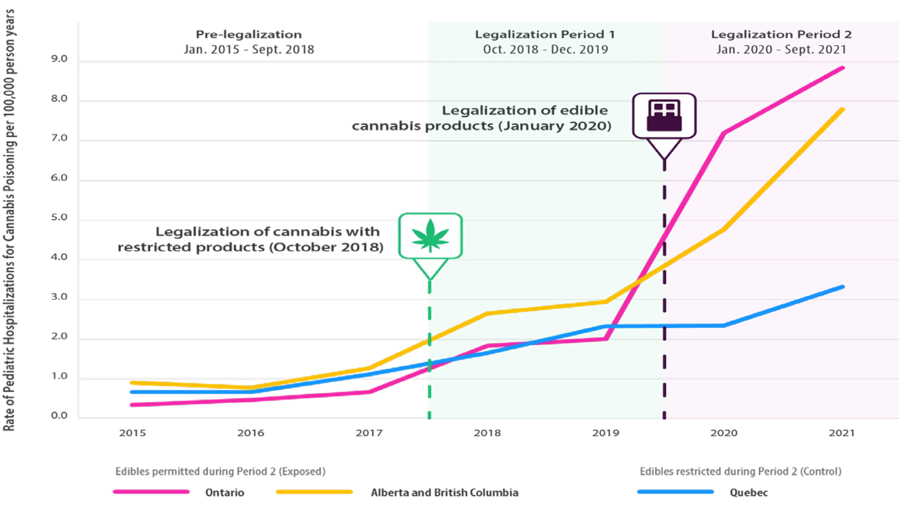
Figure 4: Rates of Opioid Agonist Treatment and Opioid-Related Deaths for Youths in Ontario, Canada, 2013-2021



Source: Rosic T, Kolla G, Leece P, Kitchen S, Gomes T. Trends in Rates of Opioid Agonist Treatment and Opioid-Related Deaths for Youths in Ontario, Canada, 2013-2021. JAMA Netw Open. 2023;6(7):e2321947. doi:10.1001/jamanetworkopen.2023.21947

Children aged 10 and under. With edible forms of cannabis becoming more available and popular, young children are now at higher risk of serious health problems from accidentally eating products that contain cannabis.[53] After the legalization of cannabis edibles in January 2020, Ontario saw a sharp spike in cannabis poisoning in children under age 10. The number of children who visited an emergency department increased from 81 (between January 2016 and September 2018 or pre-legalization) to 317 (between February 2020 and March 2021). Almost 40% of children who were taken to an emergency department for cannabis poisoning had to be hospitalized.[54] Rates of hospitalization were higher in Ontario than other provinces. And particularly higher than in Quebec, where there are additional restrictions on cannabis edibles - they cannot be made of anything that would make them attractive to those under 21 years old, including anything sweet or any added colouring.[55]

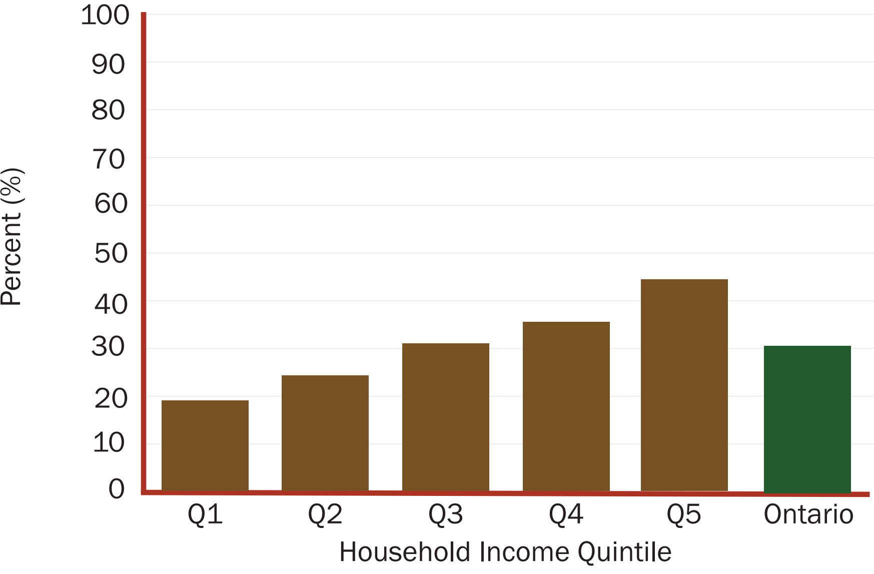
Figure 5: Rate of hospitalizations due to cannabis poisoning in children aged 0-9 years in four Canadian provinces, 2015 to 2021.



Source: Hospital for Sick Children (SickKids). Hospitalizations for unintentional cannabis poisoning among Canadian children surged after legalization [Internet]. Toronto, ON: SickKids; 2022 [cited 2024 Feb 9]. Changes in hospitalizations due to cannabis poisoning in children 0-9 years between 2015 and 2021. Available from: https://www.sickkids.ca/en/news/archive/2022/hospitalizations-for-unintentional-cannabis-poisonings-among-Canadian-children-surged-after-legalization/

People experiencing social inequities –including lower income, less education, housing insecurity, and incarceration. If we look more deeply at other factors that affect substance use harm, both income and education appear to play a more important role than a person's level of substance use. For example, adults in Ontario with higher household incomes are more likely to consume two or more alcoholic drinks in a week or report heavy drinking than those with lower household incomes (see Fig 6) – however, those with lower incomes and less education are at higher risk of alcohol-related harms.[38,56]

Figure 6: Percentage of adults (age 19 and older) reporting drinking more than 2 alcoholic drinks in the past week, by household income quintile, Ontario, 2017 to 2020

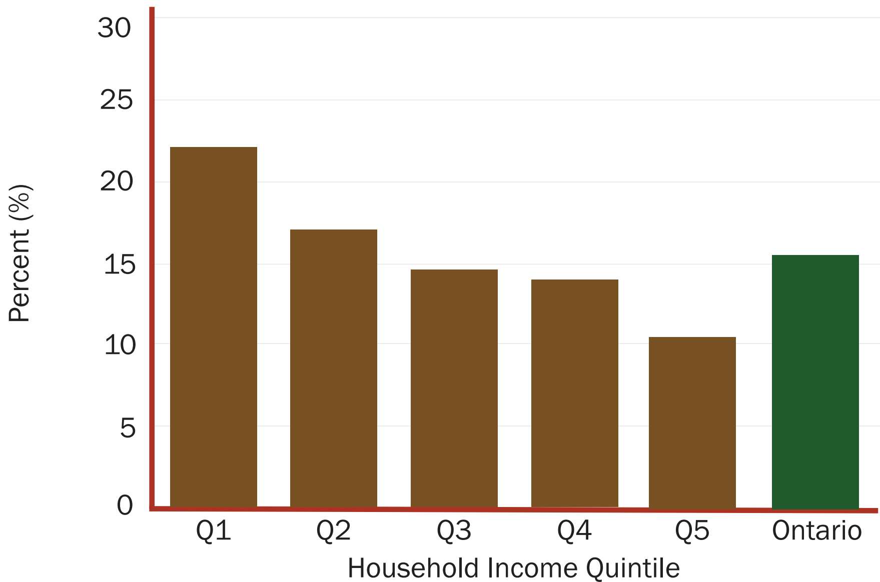


Notes:"Q1" represents the lowest household income quintile and "Q5" represents the highest. Data are presented in Supplementary Table S14. Download supplementary tables at ontariohealth.ca. Estimates are adjusted to the age distribution of the 2011 Canadian polulations.

Source: Ontario Health. Prevention system quality index 2023 [Internet]. Toronto, ON: King's Printer for Ontario; 2023 [cited 2024 Feb 8]. Figure 5, Percentage of adults (age 19 or older) reporting drinking more than 2 alcoholic drinks in the past week, by household income quintile, Ontario, 2017-2022 combined. Available from: https://www.ontariohealth.ca/sites/ontariohealth/files/PSQI_2023_Report_English.pdf

Smoking is more common in adults with lower household incomes.[57]

Figure 7: Percentage of adults (age 20 and older) reporting smoking daily or occasionally, by household income quintile, Ontario, 2017 to 2020



Notes: "Q1" represents the lowest household income quintile and "Q5" represents the highest. Data are presented in Supplementary Table S14. Download supplementary tables at ontariohealth.ca. Estimates are adjusted to the age distribution of the 2011 Canadian polulations.

Source: Ontario Health. Prevention system quality index 2023 [Internet]. Toronto, ON: King's Printer for Ontario; 2023 [cited 2024 Feb 8]. Figure 2, Percentage of adults (age 20 or older) reporting smoking daily or occasionally, by household income quintile, Ontario, 2017-2022 combined. Available from: https://www.ontariohealth.ca/sites/ontariohealth/files/PSQI_2023_Report_English.pdf

Opioid-related emergency department visits and deaths are also more common among adults with low incomes.[11]

During the COVID-19 pandemic, one in six opioid-related deaths occurred among people experiencing **homelessness** – up from one in eight before the pandemic.[58]

More than one in four people who died from opioid toxicity in Ontario between 2015 and 2020 had recently been **incarcerated**.[59]

Indigenous peoples. Indigenous peoples experience a disproportionately large burden of harms related to substance use, including criminalization and violence.[60] The rate of drug toxicity death was almost 6 times higher for First Nations people in BC compared with other BC residents in 2022,[61] and the rate of opioid toxicity death was 7 times higher for First Nations people compared with non-First Nations people in Ontario in 2021.[62]

Most of the available data on substance use among Indigenous peoples come from studies at the national or federal level, which found:

- rates of commercial tobacco smoking two to five times higher among Indigenous peoples compared to non-Indigenous populations.[63]
- higher rates of cannabis use among Métis adults and youth than in others in the general population. Métis youth were also more likely to have used alcohol, smoked tobacco, and taken other drugs than their non-Métis peers. Those who consumed high levels of these substances were more like to report experiencing risk factors including poverty and deprivation, physical and/or sexual abuse, and/or the loss of a family member to suicide.[65]
- lower rates of alcohol use or binge drinking in First Nations adults (42.6%) than other adults in Canada - however, among those who do use alcohol, binge drinking (i.e. five or more drinks on one occasion) is common. Those who drink alcohol and avoid some of the harms (i.e. do not binge drink), tend to be individuals who have greater access to the social determinants of health (e.g. more education, greater career responsibilities).[66]

Substance use among Indigenous peoples is driven by health inequities, including the long-term and ongoing impact of colonization and the residential school system, experiences of stigma and discrimination, intergenerational trauma and substandard living conditions in many Indigenous communities.[64]

The Chiefs of Ontario (COO) and the Ontario Drug Policy Research Network (ODPRN) have been collaborating to study trends in opioid use among First Nations people in Ontario. The most recent update found:[67]

- an increase in opioid-related toxicity events, despite a decrease in opioid prescriptions for the treatment of pain.
- higher opioid use among members of First Nations who live outside their community.
- Almost 3 times the rate of deaths from opioid toxicity among First Nations in Ontario from 2019 to 2021 compared, from 4.1 per 10,000 people to 11.4 per 10,000 people, with 190 deaths in First Nations people in 2021.

The opioid epidemic has been disrupting families and communities across Ontario … The decades long war on drugs has not worked, especially for our people who are already over-represented in the criminal justice system. People need to be supported culturally and spiritually in dealing with mental health and substance use disorders."

Ontario Regional Chief, Glen Hare[62]

The substance use harms experienced by Indigenous peoples, which are impacted by intergenerational trauma from colonial policies and practices such as residential schools, can manifest in ongoing cycles of substance use and addictive behaviours. The risk of harms is also exacerbated by systemic anti-Indigenous racism and discrimination in the health care system, and the lack of culturally appropriate mental health and addictions care.[68]

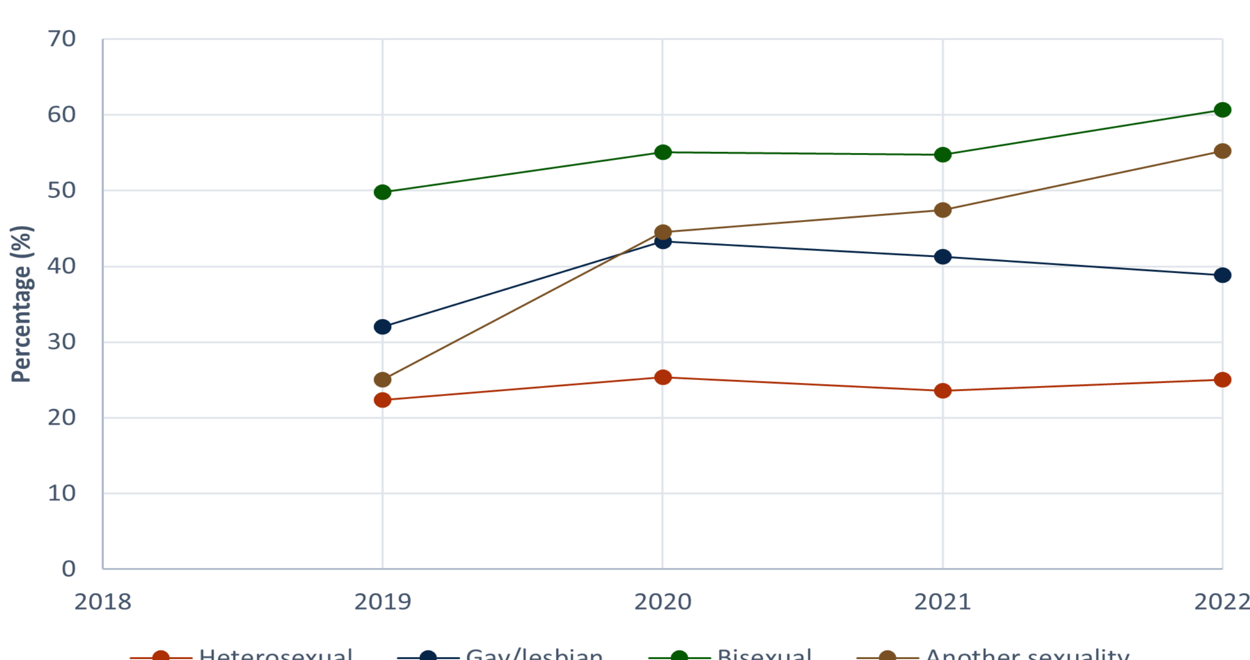
In Ontario, 88% of all Indigenous peoples live off-reserve in cities, towns, and rural communities,[69] and particular attention must be paid to addressing their needs. It is also important to understand that Indigenous people are the fastest growing population and the youngest population in Canada.[70] Indigenous youth make up a significant proportion of the provincial youth population and need access to culturally responsive services.[70]

2SLGBTQ+[xi] populations. 2SLGBTQ+ people experience higher rates of substance use than heterosexual people. Substance use harms in this population are linked to childhood experiences of bullying, homophobia, discrimination, and physical and sexual abuse, as well isolation, alienation, and loss of family or social supports, which result in higher rates of depression, anxiety, obsessive-compulsive and phobic disorders, suicidality and self-harm, as well as double the risk of post-traumatic stress disorder (PTSD).[71] These conditions may cause people to turn to substance use to help them cope. For example: use of alcohol, tobacco, and other substances may be two to four times higher than among heterosexual people.

- Use of alcohol, tobacco, and other substances may be two to four times higher than among heterosexual people.[72]
- Smoking and vaping rates are more than twice as high among members of 2SLGBTQ communities, and estimates suggest use ranges from 24% to 45% across different groups.[63]
- Individuals who identify as gay/lesbian (39%) or bisexual (61%) have higher rates of cannabis use than those who identify as heterosexual (25%).[73]

An Ontario-based study of trans people found that 20% had experienced physical or sexual assault due to their identity, and that 34% were subjected to verbal threats or harassment. Their identity can also affect their access to the social determinants of health: trans people in both Canada and the U.S. report high levels of violence, harassment, and discrimination when seeking stable housing, employment, health or social services.[72]

Figure 8: Past 12-month cannabis use (%) by sexual orientation, Ontario



Source: Canadian Cannabis Study, 2019-2022[13-16]

- Studies done in the U.S. and elsewhere report higher rates of alcohol-related problems among lesbian and bisexual women than heterosexual women.[74]
- 2SLGBTQ+ youth face approximately 14 times the risk of suicide and substance use than their heterosexual peers.[72]

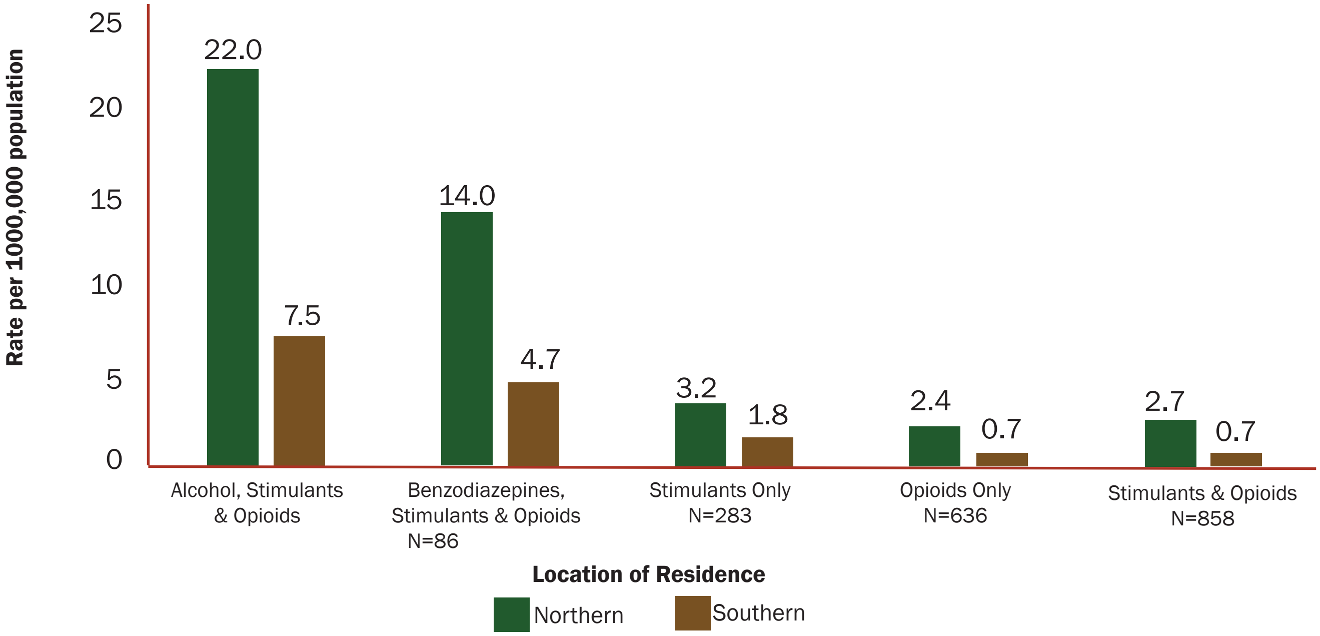
[xi] Two-spirit, lesbian, gay, bisexual, trans, queer plus other gender and sexual identities

People who work in industries such as construction, mining, and oil and gas. People working in the construction industry, who make up 3.6% of the entire Ontario population and 7.2% of all employed people in Ontario in 2021, have been disproportionately affected by the opioid toxicity crisis. A 2021 report showed that one-third of those who were employed when they died from an opioid overdose worked in the construction industry.[58] The nature of these jobs – physically demanding, long hours, stressful – means that workers are prone to injuries and chronic pain, which may contribute to their opioid use.[58] Research currently being conducted by the Institute for Work & Health and the Occupational Cancer Research Centre reinforced these findings: previously injured workers in sectors including construction, mining, and forestry are more likely to end up needing emergency department services or hospitalization due to opioid-related harm than workers in other sectors in Ontario.[75]

People living in rural or remote areas. Compared to those living in urban areas, a greater proportion of Ontarians living in rural areas (37% vs 30.5%) drink more alcohol than recommended by alcohol drinking guidelines.[57] According to the CAMH Monitor (2022), current rates of smoking and the average number of cigarettes smoked daily varies significantly across the province, and both are highest in Northern Ontario.[xii] A recent analysis by the Ontario Drug Policy Review Network and Public Health Ontario also found significantly higher rates of substance-related toxicity deaths in Northern Ontario than Southern Ontario, at 47.9 vs. 16.9 per 100,000.[11]

The highest rates of opioid-related deaths in the province are occurring in the Northern Ontario.

Figure 9: Rates of toxicity deaths from the 5 most common substance combinations, by residence in Northern or Southern Ontario, 2021[11]



Note: Unknown Northern/Southern location ranged from 0.8% to 4.1% across substance combinations.

People with mental health conditions. The use of all four of these substances is often associated with efforts to cope with mental health issues, such as stress, anxiety, and depression. For example, cannabis use is highest among people with poor mental health, and lowest among those who report good mental health. Cannabis-related harms are also higher for people with a family history of mental health conditions, such as psychosis, depression, and anxiety. Some people use cannabis to cope with stress or poor mental health, but its use can make existing mental health conditions worse, and contribute to people developing a mental health disorder.[76]

[xii] Northern Ontario covers the part of Ontario north of Lake Huron (including Georgian Bay), the French River, Lake Nipissing, and the Mattawa River. It includes almost 87% of the province but only six per cent of the province's population lives in the area.

II. Taking an All-of-Society, Health-First Approach to Reduce Substance Use Harms

Public health has been effective in reducing substance use harms because it strives to address both the upstream and downstream factors that drive substance use. Public health goals are to:

- Create healthy communities where everyone has the opportunities, services and supports they need to thrive (i.e. to address the social and structural determinants of health)
- Prevent adverse childhood experiences that make people more vulnerable to mental health conditions and substance use harms
- Protect people from exposure to addictive substances during critical stages of development (e.g. pregnancy, childhood, youth)
- Make the substances people use less harmful whenever possible
- Educate people about the risks associated with different substances
- Influence social attitudes towards substance use
- Encourage low-risk or moderate use of substances (i.e. less is better) by making substances less attractive, harder to access, and more expensive (e.g. pricing, taxation, distribution, marketing policies).

In the all-of-society, health-first approach I am recommending, all partners – including citizens with lived and living experience of substance use – will work collaboratively to:

- Support initiatives that have the potential to change social and structural environments and reduce health inequities, such as Ontario's Poverty Reduction Strategy,[77] affordable housing policies, programs for families that reduce the risk of adverse childhood experiences and domestic violence, initiatives to improve social circumstances, opportunities for Indigenous peoples to decolonize services, and efforts to address stigma and discrimination within the health care system and society
- Provide clear, evidence-based information and education about the risks associated with the use of different substances so people can make informed decisions about their substance use
- Regulate the quality and safety of legal substances
- Continue to find effective ways to limit the supply and use of unregulated substances without having a negative impact on the health of people using those substances
- Implement a range of substance-specific policies that create "guardrails" that help people who use substances do so more safely – similar to the way we use seat belt laws and speed limits to reduce the risk of traffic injuries
- Provide timely access to effective mental health, harm reduction, and addiction treatment services.

> Interventions focused on upstream drivers are more effective at enhancing population health and improving health equity, which will reduce harmful substance use and have benefits across other important aspects of health.

An effective all-of-society approach requires:

Empathy
for the people and families experiencing substance use harms

Engagement
of people with lived and living experience of substance use and their families, as well as all levels of government, organizations, services, and industries

Empowerment
of individuals, families, and communities to protect and enhance health

Environments
that support and promote health and connection

Education
to help individuals make healthy choices

Economic investment
in effective, evidence-based interventions – both upstream and downstream

Engineering
products and processes to reduce harm and risk

Enforcement
of legal measures to reduce harms

Elimination
of harms whenever possible

Ontario has already put in place many policies and initiatives designed to influence the drivers of substance use. However, as we learn more about substances and their impact on health, and as the substances themselves, the market for them, and the populations most at risk evolve, we must continually assess and adapt our policies.

Using a Balanced, Progressive Strategy to Reduce Harms

To develop a thoughtful, comprehensive range of interventions that can help people who use substances reduce their risk and protect their health, the public health sector uses a practical tool: the Nuffield Intervention Ladder (see Figure 10).[78] The laddered approach begins with the least intrusive interventions and progresses to those that are more intrusive only if and when needed. **Less intrusive interventions are preferred as long as they are effective.**

Figure 10: Nuffield Intervention Ladder: Using public health policies to encourage healthier choices[78]

Adapted from: Nuffield Council on Bioethics. Public health: ethical issues [Internet]. London: Nuffield Council on Bioethics; 2007 [cited 2024 Jan 24]. The intervention ladder. Available from: https://www.nuffieldbioethics.org/publications/public-health/guide-to-the-report/policy-process-and-practice

If we apply this ladder to, for example, reducing harms associated with tobacco smoking, we see that, over the past 20+ years, collaboration across all levels of government and health organizations resulted in effective interventions at each step of the ladder – which led to a shift in societal norms and acceptability:

If we were to apply this ladder to unregulated opioids, the strategies would be different because the threats are different. When thousands of people are dying from preventable overdoses each year in Ontario, the system must take urgent steps to keep people alive, such as creating safe spaces where people can use drugs, and providing regulated pharmaceutical alternatives (e.g. a safer supply of drugs). With these harm reduction responses in place, people who use opioids may be in a better position to benefit from offers of education and treatment, and to make choices that enable them to reduce or even stop their opioid use.

While the Nuffield Ladder has mainly been used to address downstream drivers of substance-specific harms, it can be a critical part of a broader effort to address all the factors driving substance use, including ongoing upstream efforts to change social and structural environments, and to ensure individuals and populations at highest risk have access to services that address the social determinants of health. The interventions would focus less on restricting or eliminating choice and more on reducing the health inequities that drive substance use and helping people who are experiencing or at risk of substance use harms to develop stronger social connections and find less harmful ways to cope with stress and pain.

Using the ladder's progressive, tiered approach, I believe it is possible to find the balance between: long-term, upstream efforts to build healthy communities whose citizens have the knowledge, skills and supports to avoid substance use harms; and more immediate, short-term efforts to respond to substance-specific challenges and opportunities, like the opioid toxicity crisis.

A comprehensive whole-of-society population health approach requires interventions across the full spectrum of substance use, from prevention to harm reduction to treatment, and at each step of the ladder.

Effective and Promising Substance Use Interventions

The following are examples of effective and promising interventions that can influence both upstream and downstream drivers of substance use and reduce harms.

Targeting Upstream Drivers

Effective upstream interventions focus on building stronger families and stronger, more connected communities, addressing systemic and structural determinants of health, and improving health equity.

Building stronger families

Healthy Babies, Healthy Children, a program funded by the Ministry of Community and Social Services and administered by public health units, provides services to pregnant people, their partners, and their children from birth up to school age. Public health nurses and family home visitors help families: prepare for the baby's arrival, develop a strong relationship with the baby, learn parenting skills, be knowledgeable about their child's health, behaviour, nutrition, growth and development, and find helpful services in the community.[81]

In 1997, the province committed to providing 100% of the funding for the Healthy Babies, Healthy Children program; however, with the exception of one increase in base funding in 2012 to add public health nursing positions (as part of the 9,000 Nurses Commitment), the program's budget has been flat-lined since 2008. As a result, public health units are not able to fully meet the urgent and growing demand for these services.[82]

The **Nurse-Family Partnership** is an evidence-based home-visiting program developed in the United States that is now being evaluated in Canada. It partners public health nurses with first-time, low-income mothers from early in pregnancy through until the child is two years old. The nurses develop a strong therapeutic relationship with the mother, support the health needs of moms and babies, coordinate care and referrals in the community, and focus on helping them access the social determinants of health. For mothers who have a history of substance use, the goal is to reduce the risk factors that predispose them to substance use harms and replace them with protective factors that support healthy child development and reduce the likelihood of future substance use.[83] The program, which has been in place for more than 20 years in the U.S., has been shown in randomized controlled trials to improve the health, well-being, and self-sufficiency of first-time parents and their children,[84] reduce childhood injuries, improve mothers' parenting and economic self-sufficiency, and improve child mental health and cognitive development. As of the beginning of 2024, 10 health units in Ontario were involved in delivering and evaluating the impact of the program, alongside their Healthy Babies, Healthy Children program.

Improving youth mental health

Ontario has established a network of 22 **Youth Wellness Hubs** across the province that provide integrated services co-designed with youth for youth.[85] The hubs, funded by the Ministries of Health and Education, were established to fill gaps in the youth mental health system. They provide youth ages 12 to 25 with convenient and free mental health, substance use, and primary care services in a safe, welcoming, youth-friendly space. Youth can drop in for counselling or peer support, book an appointment, or access services virtually. Youth who have more specialized and intensive care needs are connected with the right supports and services in the community.

Youth Wellness Hubs Ontario is also leading the provincial implementation of **PreVenture**[86] by: working with School Mental Health Ontario and school boards to deliver the program in grades 7 to 12, and by providing the program in the local hubs. PreVenture is a targeted prevention program that reduces the risk of substance use by giving young people the skills to cope with challenges. Youth learn useful coping skills, set long-term goals, and channel their personality traits to achieve their goals. The program has proven effective in: reducing drug and alcohol use by 50% and tobacco use by 30%; delaying initiation of alcohol use; reducing bullying; and reducing anxiety, depression, and suicidal ideation.

Effective January 2024, all school boards in Ontario are now required to provide **mandatory education about mental health, including substance use, and to have a mental health and addictions strategy**.[87]

All four school boards in Ottawa along with health authorities (Ottawa Public Health, Ontario Health East) and community-based organizations that serve youth have come together to form **project step**:[88] a cross-sector, community-wide, collective impact initiative that works to ensure young people and their families have access to **s**upport, **t**reatment, **e**ducation, and **p**revention of harms related to substance and technology use. The partners have created formal linkages between their systems to: deliver addictions counselling, prevention education, and support in every publicly funded high school and five community-based schools in Ottawa (57 in total), and to provide live-in treatment at two centres – one in each official language – so young people can receive long-term care close to home. The goal of project step is to address substance and technology use challenges early, and stop the cycle of addiction before it begins.

In 2022, 86% of youth who accessed **project step** counselling in community improved their academic or employment success, and 76% had improved mental health outcomes.

Community agencies across the province have also developed programs that help parents develop strong parenting skills, and provide opportunities for young people to be involved in meaningful, well supervised school and community activities. When young people have the opportunity to develop social-emotional learning skills throughout early childhood and the school-age years, they enjoy better overall health and well-being and positive mental health. They also build resilience and thrive.[89]

Preventing initiation and escalation of youth vaping

Youth use of e-cigarettes has grown since these devices entered the market. When the Ontario Tobacco Research Unit conducted a literature review on behalf of the Simcoe Muskoka District Health Unit and the Central East Tobacco Control Area Network, they found little evidence about effective prevention interventions for youth, so they developed an Ontario-based program. ***Not An Experiment*** aims to prevent the initiation and escalation of vaping among youth in grades 7 to 12.[90] The project was informed by:

- best practices from youth smoking prevention
- youth engagement – messaging and health promotion activities were informed by and piloted with youth at multiple stages in the planning process
- input from adult stakeholders (e.g. educators, parents, public health colleagues across Ontario).

Not An Experiment has produced a range of interactive and fun resources and activities to communicate important health messages, which are available on its web site (NotAnExperiment.ca). It appears to be a promising practice that can help prevent youth vaping. In a post-activity survey of the program, youth in grades 7 to 12 reported that: they had a better understanding of the harmful effects of vaping (82%); the game gave them good reasons not to try or continue vaping (84%); and they are now more aware of how the tobacco industry makes youth want to try vaping (90%).

Decolonizing practices and interventions for Indigenous peoples

Indigenous people are cultural experts who hold the knowledge to ensure programs and services are wholistic, trauma-informed, safe, accessible, community-focused, and culturally abundant. Across the country, Indigenous communities are leading unique and innovative programs to address harms associated with substance use. These Indigenous-centred approaches include traditional healing practices, language-based services, culture- and arts-based programs, land-based programs, system navigation, and services embedded in the community. They work by:[91]

- creating space for Indigenous practices, languages and culture
- promoting self-determination in planning and delivery programs
- engaging people with lived experience in program planning and delivery
- destigmatizing programs and communities
- creating programs that are person-centred
- respecting each person's personal journey.

The OFIFC's approach to vaping cessation strategies reflects the community-driven research principles of Utility, Self-Voicing, Accessibility, and Inter-relationality (USAI).

OFIFC. (2012). USAI Framework[92]

Youth-led strategies for vaping cessation

In 2023, the Ontario Federation of Indigenous Friendship Centre-Indigenous **Youth Council (OFIFC IYC) launched the Youth-Led Strategies for Vaping Cessation in Urban Indigenous Communities in Ontario Project.** The project moves beyond "anti-vaping" or "vaping cessation" messages to focus on traditional tobacco use in Indigenous communities. Community-grounded relationships and teachings take priority, and the project seeks to advise, inform, and guide health-related policy and consultation within and outside of urban Indigenous communities.

Project activities centre on youth engagement and community education, and include:

- holding a two-part workshop exploring traditional tobacco use and teachings with a recognized community Elder as well as a two-spirit, trans-youth knowledge carrier from the OFIFC IYC
- creating and sending bundles of essential items used in tobacco ceremonies (e.g. a cedar tree, the four sacred medicines, a copper mug, a shell, feathers) to support ongoing education efforts to promote long-term engagement with the Friendship Centre's health-related activities, and foster learning about the role of traditional tobacco, how to care for it, and its purpose in wholistic community wellbeing
- stressing the importance and impact of youth direction and involvement in research on and solutions to issues that directly affect them.

Supporting Indigenous youth who have to leave their communities for high school

Many students who live in First Nations communities in Northern Ontario must leave their communities to attend high school. In Ontario, Indigenous youth are less likely than their non-Indigenous peers to report being in excellent or good health (57% vs 72%),[93,94] to graduate from high school (40% vs 57.5%),[95] or to find employment (59% vs 70%).[95] To address these disparities as well as the challenges Indigenous youth face making the transition from their homes to unfamiliar communities and schools, the Northwestern Health Unit and the Keewatin-Patricia District School Board collaborated to create the **Community Pathways Partnership** program. Culturally competent student support navigators work with Indigenous and other at-risk students to ensure they can access health and social services, and that their basic needs are met. The navigators differ from community health workers in that they focus on preventing problems and coordinating community supports rather than on treatment. The program actively engages the whole Indigenous student population rather than working only with students who have sought out services on their own. In addition to supporting Indigenous students, the program aims to focus the community health and social service systems on addressing the social determinants of health – the root causes of poor health and academic performance – as well as low graduation rates. The program, now in place in four high schools in the district (Dryden, Beaver Brae, Sioux North, Fort Francis) builds on the existing Four Directions Graduation Coach program, and is based on the Pathways Community HUB model, a recognized best practice approach and effective strategy for achieving improved health, social, and behavioural outcomes.

Building stronger communities

Planet Youth (the Icelandic prevention model) is a promising community-based framework to reduce alcohol and drug consumption among young people. It involves: analysing the predisposing (i.e. risk) and protective factors in each community, building a coalition of stakeholders, and developing interventions that will work in the local context. For example, implementation of this framework in Iceland involved: working with parents to develop their parenting skills and encourage more parental supervision; providing more organized leisure time activities for youth; creating new social norms, such as establishing curfew hours for children under a certain age and encouraging family dinners; and supporting the community with strong alcohol policies.[96]

The Planet Youth model has been adopted in Lanark County, Ontario. See: https://planetyouthlanark.ca/

Housing First programs provide affordable supportive housing for Ontarians living with mental health and addiction issues. These programs enhance physical and mental health, decrease stress, improve sleep and diet, and make people feel safer. People who are stably housed are more likely to participate in treatment programs and manage their addiction.[97]

Creating healthier workplaces

The **Opioids and Work Data Tool**, an interactive data visualization tool, uses data from about 1.7 million Ontario workers to understand how many were diagnosed with opioid-related harm and who was most likely to have an opioid-related injury (e.g. age, sex, occupation, industry, and health region).[98] Workplaces can use this information to develop targeted prevention programs. The National Institute of Environmental Health Sciences in the U.S. has developed a series of training tools on the prevention of occupational exposure to opioids, and on the impact of the opioid toxicity crisis on workers, the workplace, and the community.[99] A group representing Ontario construction companies is launching a campaign to raise awareness of the risk of opioid use by workers, and urging companies to take action to create safer, more supportive workplaces.[100] In terms of harm reduction, the Ontario government now requires high-risk workplaces to have naloxone on site.[101]

Diverting people from the justice system to the health system

Decriminalization of simple possession of unregulated substances for personal use reduces or eliminates the risk that people will be arrested simply because they use drugs. Decriminalization of simple possession also allows the justice and enforcement systems to focus their resources on stopping the organizations and individuals profiting from unregulated drug sales rather than on people who use substances whose needs would be better met in the health system.

As the 2020 statement from the Ontario Association of Police Chiefs supporting decriminalization of simple possession notes: "Ontario police services recognize the benefits of addressing the simple possession of drugs through health channels rather than a criminal justice response. Decriminalization of simple possession of drugs must be accompanied by a framework of diversion program options to provide frontline police with established pathways to health, rehabilitation, and recovery support. The policing lens will maintain its focus on public safety and wellbeing by combatting organized crime and targeting the illegal production, sale, and import/export of drugs and the various substances used in their production."[102]

Because opioid use is highly stigmatized, some of these policies and interventions are controversial. However, the public health sector has a responsibility to try a range of evidence-based strategies to slow and stop opioid-related illnesses and deaths, while also supporting the health of people who use unregulated opioids.

Mental health conditions and substance use disorders account for between 11% and 15% of the burden of disease in Ontario. However, only 7% of health care dollars are invested in services to treat these conditions, and wait times for these services are often long. Many services are only available through private insurance or private pay.

Institute for Health Metrics and Evaluation (2018). Global Burden of Disease Study – GBD compare data visualizations.[104]

Other ways to divert people from the criminal justice to the health system include **multidisciplinary crisis response programs** and **drug treatment courts**.[103] Culturally responsive and trauma-informed crisis response programs, where social or mental health workers accompany police on mental health crisis calls and wellness checks, help ensure that people struggling with mental health conditions are connected with health services rather than being arrested. In communities with drug treatment courts, people arrested for possession are referred to treatment and supportive services instead of being sent to jail. Depending on how they are implemented, drug treatment courts have the potential to reduce the harms associated with incarceration, as well as the risk of overdoses and deaths when people are discharged from prison, while also improving access to treatment.

Targeting Downstream Drivers

Educating people about the risks

Both Health Canada and the Ontario Ministry of Health provide information/education about the risks associated with different substances – tailored to populations most at risk of harms. They also actively promote low-risk alcohol and cannabis use guidelines. For example, with the legalization of cannabis, Ontario and Canada:

- provided information/education on the effects of cannabis on the brain and mental health, particularly for youth and young adults
- reinforced the risks and consequences of cannabis-impaired driving
- provided information on how to avoid pediatric cannabis poisonings, including storing edibles safely
- promoted Cannabis Low Risk Use guidelines and the importance of choosing legal products to reduce risk.

Most recently, a number of public health initiatives are trying to raise public awareness of the carcinogenic (i.e. cancer-causing) effects of alcohol.

Figure 11: Ontario Central East's Regional Cancer Program social media campaign – June 2023

Source: Central East Regional Cancer Program. Community resources [Internet]. Scarborough, ON: Central East Regional Cancer Program; [cited 2024 Jan 24]. Printable handouts. Available from: https://cercp.ca/community-resources/

Education programs also make people aware of the predisposing factors, such as a mental health condition, that can affect a person's response to a substance, and encourage pregnant people to protect their children from being exposed to substances prenatally.

Regulatory Measures

Regulatory systems establish the **minimum legal age** to buy substances, which helps protect youth from substance use harms.

Because of the negative impact of substance use on young brains, Ontario restricts the sale of tobacco, vaping products, alcohol, and cannabis to people aged 19 or older, which is consistent with most other provinces and territories. However, some jurisdictions have established a higher minimum age to legally purchase some substances, such as Prince Edward Island for tobacco (21), Quebec for cannabis (21), and the U.S. for alcohol and nicotine products (21).[105]

Table 2: Minimum legal age to purchase tobacco, alcohol, and cannabis by province/territory

Province/Territory	Minimum Legal Age for Tobacco and Nicotine Vaping Products	Minimum Legal Age for Cannabis	Minimum Legal Age for Alcohol
Alberta	18	18	18
British Columbia	19	19	19
Manitoba	18	19	18
New Brunswick	19	19	19
Newfoundland and Labrador	19	19	19
Northwest Territories	19	19	19
Nova Scotia	19	19	19
Nunavut	19	19	19
Ontario	19	19	19
Prince Edward Island	21	19	19
Quebec	18	21*	18
Saskatchewan	19	19	19
Yukon	19	19	19

*increased from 18 on January 1, 2020

There is a growing sense that the minimum legal age may be an underused and – in the case of alcohol – an underrated intervention that could prevent serious harms among young people.[106-7] A recent review of alcohol control policies classified laws that increase the minimum legal drinking age as best practice,[108] and research from the US and Canada has identified that increasing the legal drinking age is associated with decreases in alcohol-related deaths and crime among those below the minimum legal drinking age.[108] However, the evidence regarding the health impacts of changing the minimum legal drinking age is inconsistent, and there are challenges to quantifying these impacts.[107,109] More research would help to understand the potential impacts of increasing the minimum legal drinking age to 21 for Ontarians, in particular on impacts on alcohol-attributable mortality and morbidity in young people.

The minimum legal age to purchase alcohol in Ontario (19) is consistent with most other provinces but lower than the U.S. (21).

Regulatory systems also:

- **control the types of products** that can be sold, **product quality and toxicity** (level of psychoactive ingredients)
- set requirements for **product packaging** (to make products less appealing) and **warning labels** (to make consumers aware of the risks)
- control **availability** (where regulated substances can be sold and consumed), **product price**, and **product marketing**.
- work with other partners to inspect retail outlets, and **enforce** relevant laws and regulations.

For example, in 2020, Ontario used the Smoke-Free Ontario Act to ban the sale of vaping products in flavours other than mint, menthol, and tobacco in non-specialty (e.g. convenience, grocery) stores – although these products, which are banned outright in other provinces/territories, can still be sold in specialty vape stores in Ontario.[110]

In terms of **availability/accessibility**, there is good evidence that the more **places** people can buy substances (i.e. retail density) and the way those products are displayed (**placement**), the more people buy and use.[111] Ontario currently limits the sale of tobacco, vaping products, alcohol, and cannabis to certain retail outlets – although it is not as strict as some other jurisdictions, and the number of outlets licensed to sell alcohol or cannabis has increased in recent years. Restricting the number of retail outlets also makes it easier for regulators/inspectors to ensure that retailers are trained to verify age, and are enforcing age restrictions.

Since vaping products became legal in Canada (2018), the number of retail outlets in Ontario selling vaping products has proliferated. (Seale et al 2022).[112]

All 13 provinces and territories tax tobacco, 10 of 13 tax alcohol, and the federal government taxes cannabis and shares the revenue with the provinces and territories. There is general public support for tax and **pricing policies** to reduce harmful substance use, and consistently strong evidence they are effective in reducing consumption of both tobacco and alcohol.[113-4] Minimum unit pricing – that is, setting a minimum price below which a standard drink (or unit) of alcohol cannot be sold – can significantly reduce deaths and hospitalizations attributable to alcohol and address inequities in health harms,[115-6] while increasing tax revenues. To be an effective disincentive, legislated tax rates and minimum unit prices should be automatically adjusted each year for inflation to avoid products becoming less expensive relative to other consumer goods over time.[57]

Promotion (advertising) is a driver of substance use, and policies that limit advertising are effective.[117] Both federal and provincial laws restrict the advertising and display of tobacco products – although Ontario does allow marketing of tobacco through signs in bars, price signs in convenience, grocery and some other stores, and displays of tobacco products in specialty tobacconist stores. The federal Cannabis Act prohibits advertising of cannabis products but Ontario allows specialty retail outlets to display their cannabis and vaping products under certain conditions. Ontario's restrictions on alcohol advertising are not as comprehensive as those in some other jurisdictions. The province does prohibit advertising of alcohol to minors on traditional media outlets (e.g. television, radio, print) but neither the federal nor the provincial government limits advertising on social media platforms, which is where youth get most of their information.

Enforcement of restrictions on selling to minors is a key part of the Smoke-Free Ontario Strategy. Public Health Enforcement Officers hold retailers accountable for complying with age restrictions. They visit retail outlets, monitor their practices, and use methods such as "test-shoppers" to ensure retailers are verifying ages.[118] This approach could be expanded and adapted to help enforce cannabis and alcohol regulations.

A number of jurisdictions have had success **taking legal action against companies** that promoted products that they knew were harmful, such as tobacco and prescription opioids. When these settlements occur, a portion of the awards should be protected to support public health efforts to reduce the use and harms of these substances.

Reducing the harms of regulated substances

Health promotion efforts support lower risk ways to use regulated substances (when available), such as using edibles or oils rather than smoking cannabis to reduce the risks associated with inhalation.[119] The market also makes low and no-risk alternatives available. For example, the Liquor Control Board of Ontario (LCBO) began stocking non-alcoholic drinks in 2018, and it reports that sales of these products grew 20% in 2022 compared to the previous year.[120]

Between 2019 and 2021, sales of edible products increased rapidly. Edible forms of cannabis reduce the risks associated with smoking, but they increase the potential risk that children will accidentally be exposed to cannabis in the home or that adults consume too much because it takes longer to feel their effects.

Reducing the harms of unregulated substances

A number of harm reduction policies and services have been developed to address the harms associated with the use of unregulated street drugs, including opioids:

- **Harm reduction supplies distribution programs** distribute sterile needles and other supplies to prevent the spread of infectious diseases when people use substances like opioids and stimulants, and collect and safely dispose of used supplies.
- **Naloxone kits**, which can be used to reverse an overdose from opioids, are now widely available through public health units, community-based organizations, pharmacies and hospital emergency departments free of charge.
- **Consumption and treatment services (CTS)** are integrated service hubs that offer seamless wraparound care for people who use drugs, including supervised consumption and overdose prevention services, mental health services, access to primary care, public health and housing services, and connection to other community-based services, including addictions treatment.
- **Drug checking services** will analyze a person's street drugs for toxic substances currently in the supply. Although these programs cannot ensure the drugs are safe, they help provide information to people who use drugs to allow them to adjust their substance use patterns in response to what is in their supply.
- **For safer supply programs**, physicians prescribe regulated or prescription opioids for people at high risk (e.g. numerous overdoses; imminent threat to their lives; unable to use opioid agonist therapies, such as suboxone and methadone) to reduce their reliance on the unpredictable unregulated toxic drug supply.
- **Monitoring** substance use trends helps the system respond quickly to changes in use patterns (e.g. inhalation versus injection).

Service providers, including peers, working with people who use opioids actively encourage them to use with other people or in a supervised setting (such as a CTS) so someone can intervene in the case of an overdose. Researchers are also working with people who use opioids to pilot the use of "spotting" services where someone who is about to consume a drug in their home calls a family member or friend who stays on the line with the person for five to 15 minutes after they take the drug to make sure they are safe.[121]

The ***Good Samaritan Drug Overdose Act***[122] protects bystanders who help someone who has overdosed (e.g. administers naloxone, calls 911) from a lawsuit if the person dies or suffers other harms. However, the ongoing criminalization of unregulated opioid use may discourage people from using with other people, providing assistance, or calling first responders in time of crisis for fear of legal repercussions.

Providing fast, easy access to evidence-based treatments

In March 2020, the Ontario government released Roadmap to Wellness, the province's mental health and addiction strategy.[123] Roadmap sets out a plan to build a mental health and addictions system that provides people across Ontario with consistent, high-quality services where and when they need them. Through the Roadmap to Wellness, Ontario has made significant investments across the mental health and addictions care continuum, including establishing developmentally appropriate substance use services for youth through the Youth Wellness Hubs Ontario program, and funding the Rapid Access Addiction Medicine (RAAM) clinics, which offer low-barrier access to addiction medicine and wrap-around supports.

Opioid agonist therapy (OAT) is the gold standard treatment for opioid use disorder: it reduces mortality, and has other positive health outcomes.[124] OAT involves treatment with methadone, buprenorphine or slow-release oral morphine (SROM), which prevent withdrawal, reduce cravings, and maintain tolerance, thereby reducing the risk of overdose as well as other substance-related harms. There are also highly effective pharmacological treatments for smoking cessation as well as alcohol use disorder. Notably, fewer than 2% of eligible people with a diagnosed alcohol use disorder in Canada are currently prescribed anti-craving medication.[125]

Pharmacological treatments for substance use disorders are most effective when combined with mental health/ behavioural interventions, such as cognitive behavioural therapy.[126]

The Next Steps in an All-of-Society, Health-First Approach to Substance Use and Harms

Substance use is common in Ontario. Most Ontarians use substances in low-risk ways that do not threaten their health. However, some individuals, and their families and friends struggle with the heartbreaking impact of substance use disorders and addictions.

When developing policies and programs that encourage safer substance use, we must try to find the balance between supporting Ontarians to make informed choices about their substance use and protecting the most vulnerable. The role of public health is to minimize substance use harms, and help society ensure that the personal, social, health, and economic costs of a substance's use do not outweigh its benefits.

Ontario should continue to pursue a range of thoughtful, evidence-based strategies designed to build healthy communities and ensure Ontarians have the knowledge, skills, supports, services, and relationships to lead healthy lives and avoid harms from substances.

Recommendations

I recommend that our province adopt a comprehensive, whole-of-society approach to reduce the harms associated with substance use. To that end, I challenge:

Communities, including **leaders, organizations, networks, service providers, people with lived and living experience of substance use, and their families and neighbours**, to come together to build community coalitions and create supportive local environments.

Local, provincial, federal and Indigenous governments and agencies to:

- Invest in programs and services that address the upstream social factors, such as equitable access to income, education, housing, and child care, that contribute directly and indirectly to people initiating or continuing substance use
- Increase the investment in public health programs, such as Healthy Babies, Healthy Children, that support healthy child development and strong families and communities
- Enforce legislation on the sale of illegal tobacco, alcohol, and cannabis products
- Earmark a portion of any settlement from litigation against a company for knowingly marketing a substance that causes harm to fund public health measures to reduce those harms.

Public health and social services to work together and with community partners to:

- Engage with community coalitions, including non-governmental organizations, to develop community substance use committees as well as policies and resources to support local action
- increase local substance use prevention interventions, such as positive parenting, social-emotional learning, and youth hub services

Organizations at all levels (local, provincial, national, Indigenous) responsible for developing and delivering policies, programs and services to reduce substance use harms to:

- Partner and engage people with lived and living experience with substance use in the design of those interventions, recognizing their knowledge, expertise and relationships, and providing employment opportunities
- Work collaboratively with populations at greatest risk of substance use harms to enhance health equity
- Increase access to culturally competent and culturally safe, trauma-informed care and services for people who use substances – including those with addictions and those experiencing other substance use harms – and their families
- Address the systemic and structural stigma, racism and discrimination that people who use substances experience when they access health, social, housing, and legal services.

The **public health sector** to:

- Enhance the province's capacity to conduct surveillance and assess population health related to substance use, harms, risk and protective factors, equity considerations, and specific substances that are causing harms, including the toxic drug supply
- Evaluate policies and programs that may have an impact on substance use and harms and/or on health equity, to build evidence and advance healthy public policy
- Determine whether the public health standard related to substance use should be updated to meet emerging needs
- Continue to educate the public and increase awareness of substance use harms
- Continue to work with regulators to enforce age restrictions on the sale of all regulated substances.

The **health care system** to:

- Build on the Roadmap to Wellness to develop a comprehensive, connected mental health and addiction system that improves quality and access, expands existing services, and implements innovative solutions
- Provide effective and acceptable treatment for conditions that make people vulnerable to substance use and its harms, including stress, anxiety, depression and other mental health conditions, and chronic pain
- Establish recommended minimum wait times for Ontarians to access addiction and mental health treatment services
- Enhance the capacity of primary care to assess, monitor, and treat substance use disorders
- Enhance and ensure equitable access to evidence-based screening, diagnosis, crisis response, withdrawal management, and treatment for substance use disorders in primary care and acute care settings such as emergency departments and hospitals
- Enhance access to evidence-based treatment programs within correctional facilities as well as continuity of care and supports post-release
- Enhance and ensure equitable access to evidence-based treatments, including pharmacotherapy as well as longer-term and residential treatment programs

III. Adapting Our Substance-Specific Responses

Tobacco/vaping products, cannabis, alcohol, and opioids are different substances with different harms and challenges. As the number of different products grows and the market for them evolves, we must continually review and refine our efforts to reduce their harms. In addition to the all-of-society, health-first approach to substance use discussed above, I recommend that the province take specific steps to reduce the harms caused by each of these substances.

In this section of my report, we describe the current trends in each substance's use, its impacts on health, and the current policy environment, and recommend substance-specific strategies that address each substance's unique challenges.

1. Tobacco/Vaping Products

Trends and Health Impact

- Over the past 20 years, Ontario has seen a steady decline in the number of people who smoke tobacco. In 2022, only about 11% of the population reported smoking at all (including having an occasional cigarette) – down from 14% in 2019 – and only 8% reported smoking daily[127-8] – although smoking rates remain high in Northern Ontario.
- Ontario had the lowest reported smoking rate among 15-19 year olds in 2022 (2.9%) in the country.[127-8]
- Cancer continues to be the #1 cause of death in Ontario. Despite the significant decrease in the number of Ontario adults who smoke, **tobacco continues to be the leading preventable cause of cancers and premature death** in Canada.[129]
- There is no safe level of smoking. People who smoke have two to three times higher risk of premature death than those who do not. On average each year, smoking tobacco is responsible for about 17% of deaths (16,673), 8.7% of hospitalizations (68,046), and 3.4% of emergency department visits (125,384) in Ontarians aged 35 and older.[132]
- Too many Ontarians are still being exposed to second-hand smoke. People who do not smoke and who live with someone who smokes have a 30% greater risk of lung cancer, heart disease, and stroke than those who live with non-smokers.[133]
- In 2020, people in Canada reported a higher level of second-hand smoke exposure than those from the United Kingdom and the U.S.[57]
- Tobacco use costs Ontario about $4.2 billion a year in health care, disability, premature mortality, criminal justice, and other direct costs.[134]
- While fewer people are smoking tobacco, more are vaping. In the first few years after vaping products were legalized, their use increased rapidly in individuals ages 15 and older. In 2020 – the first year of the COVID-19 pandemic – 15.2% of Ontario adults reported using e-cigarettes or vaping – up from 12.8% in 2019.[10]

Tobacco is a carcinogen[130] and can cause cancer almost anywhere in the body, including the mouth and throat, esophagus, stomach, colon, rectum, liver, pancreas, voicebox (larynx), lung, trachea, bronchus, kidney and renal pelvis, urinary bladder, and cervix. It also causes atherosclerosis, coronary heart disease, and peripheral arterial disease, increases the risk of strokes and ischemic heart disease, a risk factor for type 2 diabetes and the leading cause of chronic obstructive pulmonary disease (COPD) and death due to COPD.

(https://www.cdc.gov/cancer/tobacco/index.htm)[131]

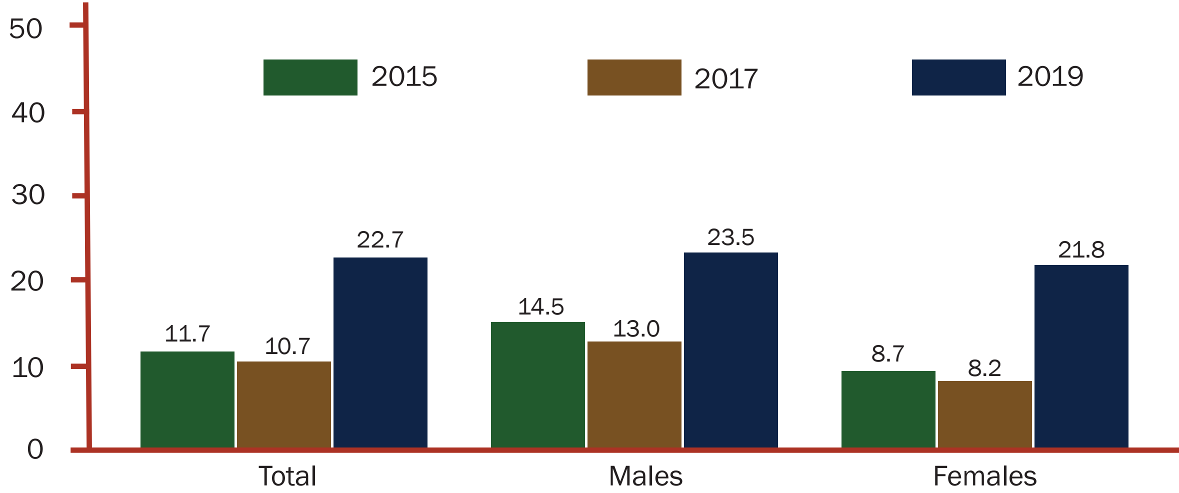
Vaping has increased among students across all groups by gender, ethnicity, and smoking status. The largest increases in use between 2017-18 and 2018-19 were among females.

PHO, Youth Trends in ON[135]

Correspondence A

- Vaping products that contain nicotine – and most vaping products sold in Canada do[136] – are addictive and can affect brain development, particularly in youth and young adults, who can become dependent on nicotine at lower levels than adults.[137-8]
- Youth vaping rates in Canada and the U.S. went down early in the COVID-19 pandemic –when students were at home and had less access to vaping products – but they went back up again in each country post-pandemic.[139]
- One of the most concerning recent trends is the rising rates of vaping among youth in grades 9 to 12, most of whom are too young to legally purchase vaping products.[135]
- Youth who vape also tend to use other substances, particularly alcohol and cannabis. This polysubstance use is often related to mental health challenges: most youth who vape and use other substances report symptoms of anxiety, depression, or both.[140]

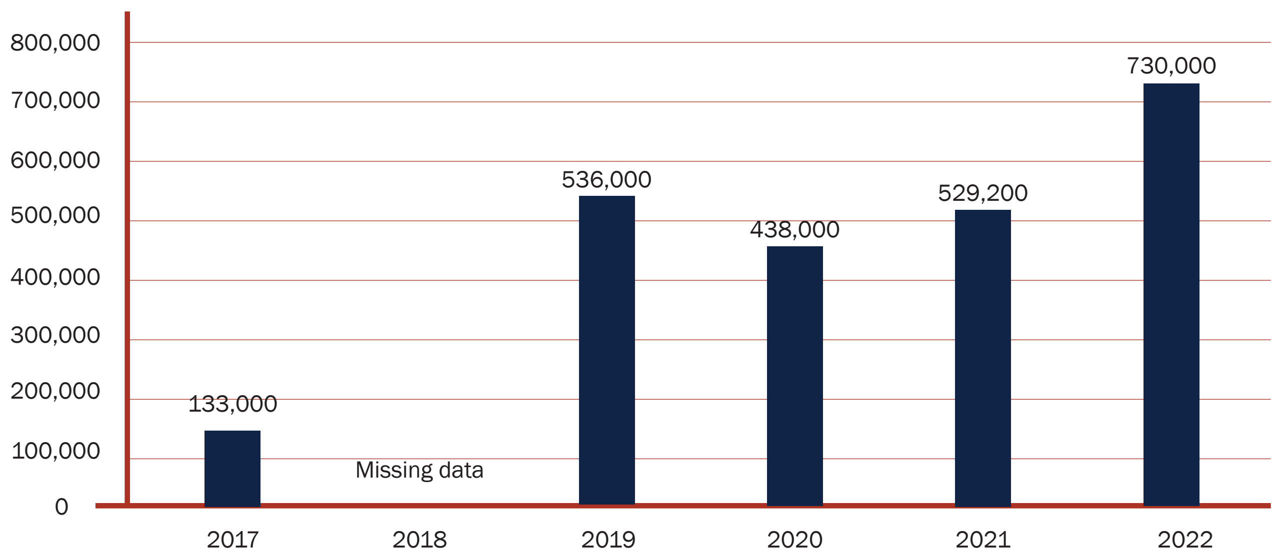
Figure 12: Percentage of high school students (grades 7-12) in Ontario using E-cigarettes (vaping) by sex, 2015, 2017, 2019



Note: significant increase between 2015 and 2019 for the total sample, and for males and females (p<01)
Source: Boak A, Elton-Marshall T, Mann RE, Hamilton HA. (2020). Drug use among Ontario students, 1977-2019: detailed findings from the Ontario Student Drug Use and Health Survey (OSDUHS). Toronto, ON: Centre for Addiction and Mental Health; 2020. Figure 3.3.11, Past year e-cigarette use (vaping) by sex, 2015–2019 OSDUHS (Grades 7–12); p.62. Available from: https://www.camh.ca/-/media/files/pdf---osduhs/drugusereport_2019osduhs-pdf.pdf

- Another concerning trend is the growing number of individuals who have never smoked who are vaping. People exposed to nicotine through vaping are more likely to develop a nicotine addiction and to start using tobacco later in life.

Figure 13: Number of Canadians who vape but who have never smoked, 2017 and 2019-2022



Sources: Canadian Tobacco, Alcohol and Drugs Survey (CTADS),45 2017 and Canadian Tobacco and Nicotine Survey (2019-2022).128,[142-4]

- A third disquieting trend is the development of non-tobacco nicotine products, such as nicotine pouches, that can lead to nicotine addiction and future tobacco use. These products do not fall under tobacco control legislation and are not adequately regulated. To address this emerging threat to health, Ontario needs a broad, overarching framework for nicotine regulation and control that goes beyond tobacco-based products.[146]

The health effects of exposure to second-hand aerosol from vaping devices are currently unknown.[145]

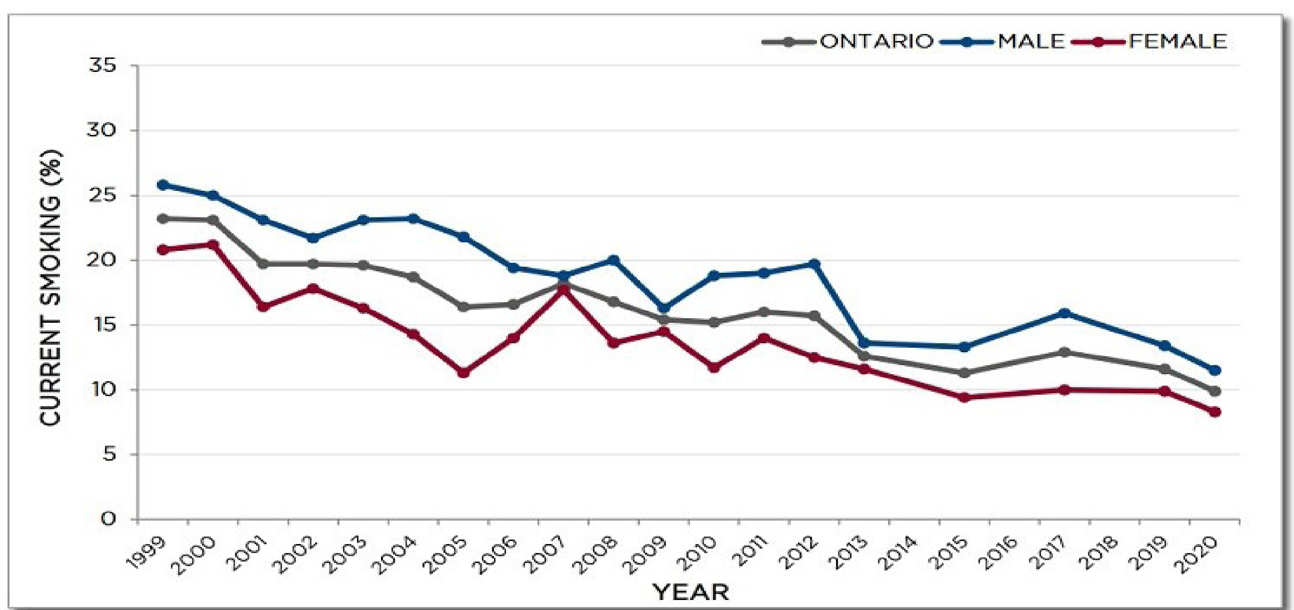
- In addition to containing highly addictive nicotine, most vaping products contain and emit many toxic substances that can affect the respiratory, immune, and cardiovascular systems, cause coughing and wheezing, and exacerbate asthma.[147]

The Policy Environment/Challenges

Tobacco

The serious harms associated with smoking tobacco were identified almost 60 years ago,[148] and Ontario – like many jurisdictions – has introduced a range of initiatives, such as the Smoke-Free Ontario Strategy, designed to help people who smoke stop smoking, and to keep those who don't smoke from starting. As a result, the trend in tobacco use in Ontario is different from the other substances in this report. Between 1999 and 2020, the province saw a significant and steady decline in the number of people who smoke tobacco,[xiii] and in smoking rates across all age groups.

Figure 14: Current smoking prevalence* for people in Ontario, by sex and overall, 1999 to 2020



Source: Reid JL, Hammond D, Burkhalter R, Rynard VL. Tobacco use in Canada: patterns and trends: 2022 edition [Internet]. Waterloo, ON: University of Waterloo; 2022 [cited 2024 Feb 8]. Figure 2.15: Current smoking prevalence* among males and females, Ontario, 1999-2020; p.29. Available from: https://uwaterloo.ca/tobacco-use-canada/sites/default/files/uploads/files/tobacco_use_in_canada_2022_4.pdf

Despite that progress, Ontario has fallen behind other provinces in its use of taxation policy to reduce smoking. As Figure 15 indicates, the provincial/territorial tobacco tax rate on cigarettes is lower in Ontario than any other province or territory except Quebec, and it has not increased since 2018.[149] It also falls short of covering the health care and other costs associated with tobacco use. To be an effective deterrent, the tax on cigarettes should be increased each year to keep pace with inflation otherwise it will effectively become cheaper over time compared to products that rise with inflation.

[xiii] Includes both daily and occasional smokers

Figure 15: Provincial/territorial tobacco taxes per carton of 200 cigarettes, December 2023

Source: Physicians for a Smoke-Free Canada. Taxes on cigarettes in Canadian jurisdictions [Internet]. Ottawa, ON: Physicians for a Smoke-Free Canada; 2024 [cited 2024 Feb 8]. Price of a hypothetical 'average' pack of cigarettes in Canadian provinces and components of this cost, January 1, 2024; p.2. Available from: https://www.smoke-free.ca/pdf_1/taxrates.pdf

Both Prince Edward Island and the United States have 21 years as their legal age of tobacco purchase. Ontario lags behind other provinces and jurisdictions in terms of restricting where smoking is allowed, and how it is marketed (e.g. number of signs allowed in retail locations), and in managing tobacco retail density. Ontario currently does not require tobacco retailers to pay an annual licensing fee as it does for alcohol retailers. Despite the health risks associated with water pipe smoking,[150] Ontario does not prohibit smoking of water pipe products in places where smoking is banned.

The same policies used to reduce use of tobacco products should also be applied to new non-tobacco nicotine products, and the sale of nicotine pouches which, because they don't contain tobacco, are not covered by current regulations. These products do contain nicotine and are being actively marketed to youth and people who do not smoke.

Vaping Products

Efforts to reduce tobacco use and harms have been complicated by the relatively recent introduction of electronic cigarettes (e-cigarettes) and other vaping devices and products. E-cigarettes – first introduced into the U.S. market in 2006 – were originally promoted by companies as an alternative to traditional tobacco products: a way for people to use nicotine in places where smoking is not permitted – although all provinces and territories, and many municipalities have now passed by-laws that restrict vaping in public spaces (e.g. workplaces, public spaces, parks, beaches, transit facilities).

Vaping devices were also seen as a potential harm reduction and smoking cessation tool: a way for people to obtain the nicotine in tobacco without breathing in the other toxins in tobacco smoke and, perhaps, a way for people to stop smoking. Recent findings from a Cochrane Review[151] found strong evidence that nicotine e-cigarettes are more effective than traditional nicotine-replacement therapy (NRT) in helping people quit smoking for at least six months. However, this review has been criticized on the basis of its methodology.[152] Studies comparing nicotine e-cigarettes to usual care/no treatment suggest only a small benefit, and the long-term (i.e. longer than two years) benefits and harms of e-cigarette use are largely unknown due to short follow-up of current studies. The World Health Organization (WHO) recommends that "any government pursuing a smoking cessation strategy utilizing e-cigarettes should control the conditions under which the products are accessed to ensure appropriate clinical conditions and regulate the products as medicines."[153]

Although originally developed as an alternative for people who smoke, vaping products are increasingly and alarmingly being used by people who have never smoked, including significant numbers of youth and young adults. While using vaping products may be less risky than smoking tobacco, these products can still cause harm. They contain different concentrations of nicotine, which can lead to dependence or addiction and interfere with brain development in youth. Vaping products sold in Ontario are required by law to list their ingredients, including concentrations of nicotine. However, in a number of instances, products that contain nicotine have been mislabelled as "nicotine- free," which means consumers can unknowingly be exposed to nicotine and its associated health risks. Vaping products also contain a variety of substances, including propylene glycol and/or glycerol (vegetable glycerin) as well as chemicals used for flavouring which, when they are vaped, are harmful to health.[145]

To increase the appeal and use of vaping products, manufacturers are actively marketing them to people who do not smoke. They have also created flavoured products that appeal to youth. While Ontario limits where flavoured vaping products can be sold, it has not gone as far as some other provinces and territories, which have banned all flavours except tobacco in all retail locations.

Vaping products are also now sold in single-use disposable units that create plastic waste as well as toxic hazardous waste from the nicotine, lead, and other chemicals they contain. The full environmental impact of these new disposable products is not yet known.[155]

In December 2023, the World Health Organization issued a call for urgent action to protect children and prevent the uptake of e-cigarettes.[153] To reduce demand for vaping products, particularly among youth, Ontario announced that it will join the federal vaping tax, imposing an additional tax on vaping products that will double the current federal duties.[156] The policy will not only increase the price to help deter consumption, it will generate approximately $49.4 million in annual revenues, which can be reinvested in health care and disease prevention.[154] However, Ontario still falls short of many of the World Health Organization recommendations to protect children, including banning flavours as well as any features that could appeal to youth.[153]

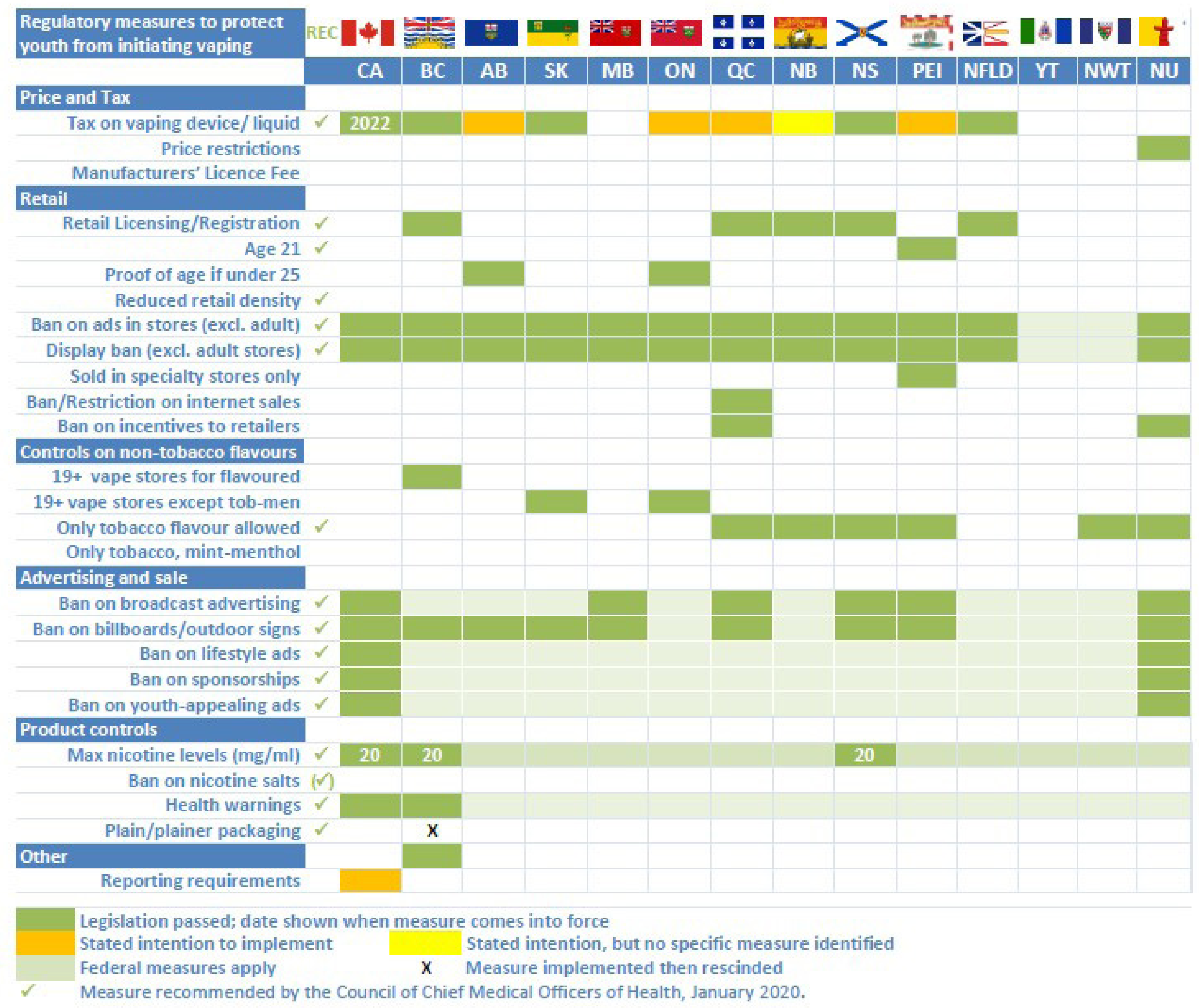
Figure 16 illustrates how Ontario compares to other provinces and territories in terms of regulating the sale of and access to vaping products.

To keep pace with rapid changes in the vaping product industry, Canada legalized the use of vaping devises and products in 2018, and began to establish a regulatory framework to mitigate their harms. More work must be done to understand and minimize the potential harms associated with vaping.

Taxation is one of the more effective policy measures to reduce consumption and it is particularly impactful among price-sensitive youth. [...] We've seen through tobacco control efforts that an increase in price prevents initiation and increases quit rates. Preliminary results from other regions show a similar outcome, with vape rates among youth declining after a vape tax is implemented."[154]

Dr. Lesley James, Director, Health Policy & Systems, Ontario at Heart & Stroke

Figure 16: Overview of federal, provincial, and territorial regulatory measures to prevent youth from initiating vaping, November 2023



Regulatory measures to protect youth from initiating vaping	REC	CA	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NFLD	YT	NWT	NU
Price and Tax															
Tax on vaping device/ liquid	✓	2022													
Price restrictions															
Manufacturers' Licence Fee															
Retail															
Retail Licensing/Registration	✓														
Age 21	✓														
Proof of age if under 25															
Reduced retail density	✓														
Ban on ads in stores (excl. adult)	✓														
Display ban (excl. adult stores)	✓														
Sold in specialty stores only															
Ban/Restriction on internet sales															
Ban on incentives to retailers															
Controls on non-tobacco flavours															
19+ vape stores for flavoured															
19+ vape stores except tob-men															
Only tobacco flavour allowed	✓														
Only tobacco, mint-menthol															
Advertising and sale															
Ban on broadcast advertising	✓														
Ban on billboards/outdoor signs	✓														
Ban on lifestyle ads	✓														
Ban on sponsorships	✓														
Ban on youth-appealing ads	✓														
Product controls															
Max nicotine levels (mg/ml)	✓	20	20							20					
Ban on nicotine salts	(✓)														
Health warnings	✓														
Plain/plainer packaging	✓		X												
Other															
Reporting requirements															

Legislation passed; date shown when measure comes into force
Stated intention to implement
Stated intention, but no specific measure identified
Federal measures apply
X Measure implemented then rescinded
✓ Measure recommended by the Council of Chief Medical Officers of Health, January 2020.

Source: Physicians for a Smoke-Free Canada. At-a-glance: provincial restrictions on vaping products: November 2023 [Internet]. Ottawa, ON: Physicians for a Smoke-Free Canada; 2023 [cited 2024 Feb 8]. Overview of federal and provincial regulations on marketing of electronic cigarettes; p.1. Available from: https://www.smoke-free.ca/SUAP/2020/Provincial%20regulations%20on%20vaping%20promotions.pdf

Figure 17: Overview of provincial and territorial minimum age for legal sale of vaping products, November 2023

	BC	AB	SK	MB	ON	QU	NB	NS	PEI	NL	YK	NWT	NU
Minimum legal age for sale	19	18	19	19	19	18	19	19	21	19	19	19	19
Ban on youth possession													

Source: Physicians for a Smoke-Free Canada. At-a-glance: provincial restrictions on vaping products: November 2023 [Internet]. Ottawa, ON: Physicians for a Smoke-Free Canada; 2023 [cited 2024 Feb 8]. Overview of federal and provincial regulations on marketing of electronic cigarettes; p.1. Available from: https://www.smoke-free.ca/SUAP/2020/Provincial%20regulations%20on%20vaping%20promotions.pdf

Figure 18: Overview of places where vaping products may not be sold*, November 2023

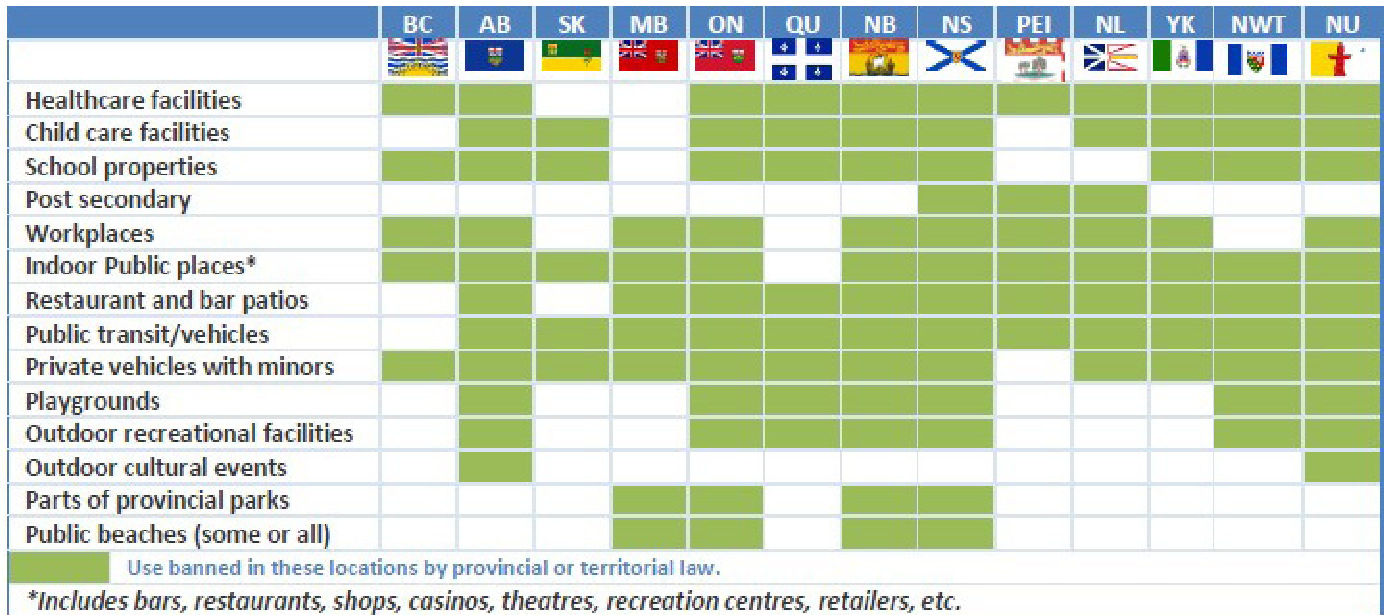
	BC	AB	SK	MB	ON	QU	NB	NS	PEI	NL	YK	NWT	NU
Non-specialty vape stores	◆				◆				✓				
Hospitals	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓
Long term care			✓		✓	✓		✓	✓	✓			✓
Some other health facilities	✓	✓	✓	✓	✓	✓		✓	✓	✓			✓
Pharmacy		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Post Secondary Campus	✓	✓			✓	✓		✓	✓	✓			✓
Schools			✓		✓	✓		✓	✓	✓		✓	✓
Child care settings					✓	✓				✓			✓
Vending machines		✓		✓	✓	✓		✓	✓	✓			✓
Government buildings	✓		✓					✓	✓	✓			
Amusement Park/arcades			✓			✓		✓	✓	✓			✓
Theatres			✓			✓		✓	✓	✓			✓
Recreation Centres	✓					✓		✓	✓	✓		✓	✓
Library & Cultural Centres						✓		✓		✓			✓
Casinos								✓					
Bars and Restaurants						✓		✓					✓
Temporary facilities		✓				✓		✓		✓			✓
Internet Sales						✓							✓

✓ (green) Sales banned in these locations
◆ (blue) Sales of some flavours banned in these locations (Ontario, British Columbia)
(yellow) Measures proposed

**Generally the same as for tobacco sales, other than BC and Ontario which restrict some types of e-cigarettes to specialty stores.*

Source: Physicians for a Smoke-Free Canada. At-a-glance: provincial restrictions on vaping products: November 2023 [Internet]. Ottawa, ON: Physicians for a Smoke-Free Canada; 2023 [cited 2024 Feb 8]. Overview of federal and provincial regulations on marketing of electronic cigarettes; p.1. Available from: https://www.smoke-free.ca/SUAP/2020/Provincial%20regulations%20on%20vaping%20promotions.pdf

Figure 19: Overview of places where vaping products may not be used, November 2023



	BC	AB	SK	MB	ON	QU	NB	NS	PEI	NL	YK	NWT	NU
Healthcare facilities	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓
Child care facilities		✓	✓		✓	✓	✓	✓		✓	✓	✓	✓
School properties	✓	✓	✓		✓	✓	✓	✓			✓	✓	✓
Post secondary								✓	✓	✓			
Workplaces	✓	✓		✓	✓		✓	✓	✓	✓	✓		✓
Indoor Public places*	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Restaurant and bar patios		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Public transit/vehicles		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Private vehicles with minors	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Playgrounds		✓			✓	✓	✓	✓				✓	✓
Outdoor recreational facilities		✓			✓	✓	✓	✓				✓	✓
Outdoor cultural events		✓											✓
Parts of provincial parks				✓	✓		✓	✓					
Public beaches (some or all)				✓	✓		✓	✓					

✓ (green) Use banned in these locations by provincial or territorial law.

**Includes bars, restaurants, shops, casinos, theatres, recreation centres, retailers, etc.*

Source: Physicians for a Smoke-Free Canada. At-a-glance: provincial restrictions on vaping products: November 2023 [Internet]. Ottawa, ON: Physicians for a Smoke-Free Canada; 2023 [cited 2024 Feb 8]. Overview of federal and provincial regulations on marketing of electronic cigarettes; p.1. Available from: https://www.smoke-free.ca/SUAP/2020/Provincial%20regulations%20on%20vaping%20promotions.pdf

While existing laws prohibit retail stores from selling vaping products to youth, these rules are not always enforced. In 2022, at least 23% of specialty vape stores and 9% of non-specialty stores in Ontario[xiv] were non-compliant with laws that ban the sale of vaping products to youth. More work must be done to enforce the restrictions designed to protect young people and delay initiation of vaping. Some public health units have been using Section 13 orders under the Health Protection and Promotion Act – which can be used to eliminate health hazards – with vaping product retailers who are persistently non-compliant.

Enforcement within physical retail settings is only one part of the problem. Many youth (and adults) are ordering vaping products online. E-commerce now accounts for ~34% of vaping product sales in Ontario, which is the highest of any province or territory in Canada.[157] Enforcement of age-verification of online purchases is both time and labour-intensive, and it typically requires an in-person interaction with the purchaser at the point of delivery.

Ontario will need to work with its partners, including Health Canada, the Canada Border Services Agency, and Canada Post, to develop new strategies to reduce the potential harm of online sales – domestic and international – as well as new policies to address the growing use of new generations of personal vaping devices to deliver other regulated substances, such as cannabis, as well as unregulated substances, like fentanyl, and crystal methamphetamine.[158]

Recommendations

Reinvigorate the Smoke-Free Ontario Strategy, focusing on populations and regions with high rates of tobacco use. Expand the strategy to create a comprehensive, coherent public health-oriented framework for regulating vaping and all nicotine-containing products.

Targets

- Adopt Health Canada's target of less than 5% tobacco use by 2035
- Develop aggressive targets to prevent the use of vaping products by youth and people who do not smoke

Health Promotion

- Continue to raise awareness among Ontarians, particularly youth, of the risks associated with tobacco and vaping products

Regulatory Measures

Minimum legal age of purchase

- Increase the minimum legal age to purchase tobacco and vaping products from 19 to 21 years old
- Consider progressively increasing the minimum legal age to purchase these products over time as a way to ban the purchase of these products by future generations

Product Controls

- Ban flavours for all tobacco and vaping products
- Expand restrictions on where people can smoke or vape (i.e. not in social housing, near building entrances, exits and air intakes, in all outdoor spectator stands, beaches, and specified parts of provincial parks)
- Require apartment landlords and condominium boards to have a smoking/vaping policy
- Ban the use of water pipes in all places where smoking is banned
- Expand the current regulatory framework to include specified non-tobacco nicotine products, such as nicotine pouches, and prevent their sale and promotion to youth and people who do not smoke
- Ban the sale of disposable vaping products
- Establish product controls to prevent the evolving risk of vaping devices being used to deliver other drugs, such as cannabis, fentanyl, and crystal methamphetamine

[xiv] Note: the level of non-compliance was even higher based on Health Canada compliance checks.

Availability

- Restrict physical store locations where tobacco and vaping products can be sold, including prohibiting any new stores within 200 metres of an elementary or secondary school or an existing tobacco/vaping retail outlet, and capping the total number of retail locations in a municipality/region (i.e. retail density)
- Impose a licensing fee for retailers of tobacco and vaping products
- Explore measures to reduce illegal, untaxed tobacco sales outside of First Nations communities
- Work with the federal government to ban online retail sales of tobacco and vaping products without in-person age verification at delivery

Pricing and Taxation

- Increase the provincial sales tax on tobacco products and increase the tax each year to keep pace with inflation
- Maintain provincial sales tax on vaping, and increase annually to keep pace with inflation

Promotion

- Work with the federal government to restrict:
  - online and social media advertising of tobacco and vaping products
  - the design, appearance, and branding of e-cigarettes to reduce their appeal to youth
- Reduce or eliminate the number of price signs allowed in tobacco and vaping retail settings visible to youth
- Prohibit manufacturers from offering incentives to retailers (e.g. bonuses for reaching sales volume targets, chances to win vacations or entertainment tickets, lower prices based on volumes purchased), and prohibit retailers from passing incentives on to consumers

Enforcement

- Issue time-limited suspensions for retail outlets that repeatedly sell vaping products to minors, as is done for tobacco
- Enforce the current limitations on nicotine concentration in vaping products (20 mg/ml), determine whether companies are using product strategies to undermine the 20 mg/ml standard, and restrict the capacity of tanks, pods and refill containers

Treatment

- Increase access, including free products, to evidence-based smoking cessation therapies and supports, such as the Ottawa Model for Smoking Cessation[159]
- Increase research and training on vaping cessation therapies and supports for youth and adults

Monitoring and Reporting

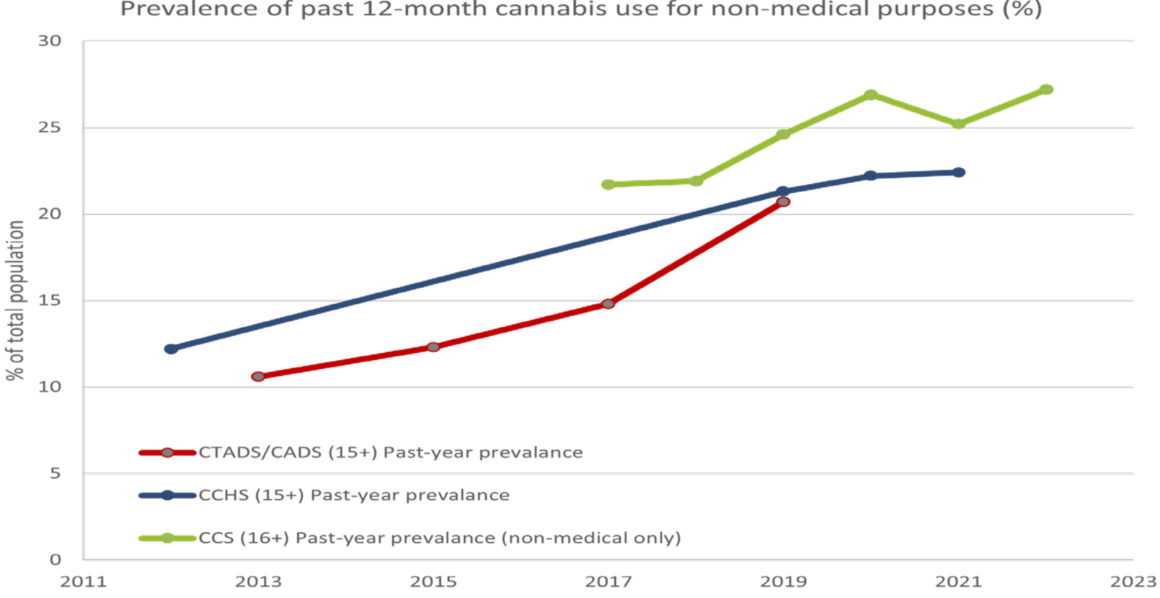
- Establish key performance indicators for public health inspectors and others involved in enforcing tobacco and vaping policies designed to protect minors and non-smokers
- Work with Public Health Ontario and with federal, provincial, territorial and Indigenous partners to continue to:
  - Monitor the impact of tobacco and vaping on health
  - Review new evidence on vaping and other non-tobacco nicotine use
  - Assess the impact/effectiveness of tobacco and vaping policies
  - Issue regular public reports on Ontario's progress (key performance indicators) in reducing harms associated with tobacco and vaping use

2. Cannabis

Trends and Health Impact

- Cannabis use began increasing before legalization (2018) and has grown steadily since. It is now the second most commonly used psychoactive substance in Canada after alcohol.[16,160]

Figure 20: Prevalence of past 12-month cannabis use for non-medical purposes (%)[16,160]



- In 2022, more than half of Ontario adults (54%) reported having used cannabis at least once in their lifetime, and a third (33%) reported using cannabis in the past 12 months. More concerning: 19%reported problematic cannabis use.[161] Cannabis use and frequent cannabis use (i.e. five or more days a week) is highest among those between the ages of 20 and 34.[162]
- Ontario limits the sale of cannabis to people age 19 and older, which is younger than the 21 age-limit in Quebec. Despite the age restrictions on cannabis sales, a significant proportion of youth in grades 7 to 12 reported using cannabis in 2021: almost 1 in 4 (22%) had tried cannabis, 14% said they used it at least once to cope with a mental health problem, and 12% reported using alcohol and cannabis together.[10]
- Canadian youth and young adults have some of the highest rates of cannabis use among developed countries.[162-3]
- The rates of cannabis use are highest among youth ages 15 to 18, and young adults ages 18 to 24. The highest rates of increase are among youth 18 to 24.[164-5]
- While most people who use cannabis smoke it (70%),[73] there has been an increase in Ontarians using cannabis in the form of edibles and vaping products.[166]
- Polysubstance use – cannabis and alcohol, cannabis and opioids – is common, and has a significant impact on judgement.
- The long-term impacts of cannabis use are not fully understood but evidence suggests the health risks include: becoming dependent on cannabis, developing a mental health condition (e.g. cannabis use disorder, psychosis, schizophrenia),[167] problems concentrating and making decisions, slower reaction times (e.g. when driving), and developing bronchitis from smoking cannabis.[168] A growing number of people who use cannabis long-term are experiencing cannabis hyperemesis syndrome (CHS): recurring episodes of nausea, vomiting, dehydration, and abdominal pain that result in frequent visits to emergency and possible health complications.[169] Between January 2014 and June 2021, the monthly rate of emergency department visits for CHS in Ontario increased 13-fold.[170]

- Since 2015, Ontario has seen a marked increase in the number of adults – most between the ages of 19 and 24 – hospitalized for mental health and behavioural problems related to cannabis use. Cannabis-induced psychosis doubled between 2015 and 2019.[171]
- While cannabis edibles reduce the harms associated with smoking cannabis (which are similar to those associated with smoking tobacco), they create the risk of other harms. As noted earlier, Ontario has seen a sharp spike in emergency department visits and hospitalizations for cannabis poisoning in children under the age of 10 since the legalization of cannabis edibles in January of 2020. These trends are related to commercialization and availability of cannabis, and highlight the challenges associated with regulating substances that can cause harm.[172] However, restrictions on edible product formulations, as required in Quebec, are associated with a much smaller increase in pediatric poisoning hospitalizations post-legalization.[55]

> A recent study found that 76% of children presenting to the Emergency Department with unintentional cannabis ingestion had been exposed to edible products.[173]
>
> Coret & Rowan-Legg, 2022

- A recent study found that among children younger than 18 presenting to the Emergency Department of the Children's Hospital of Eastern Ontario for unintentional cannabis ingestion, 76% had been exposed to edible products.[173] The majority of these injuries have occurred post legalization. Of 581 pediatric hospitalizations for cannabis poisoning for children younger than 10 years old between January 2015 and September 2021, 79% occurred after cannabis use was legalized in October 2018.[174]
- Cannabis use during pregnancy, which became more common after cannabis was legalized,[175] increases the likelihood of preterm birth, low birth weight, small-for-gestational age, major congenital anomalies, learning problems, and depression.[176-7]
- Rates of cannabis-related emergency department visits for traffic injuries in Ontario increased significantly after cannabis use was legalized. Those most likely to be in cannabis-related motor vehicle collisions were younger age males, and individuals with low household incomes.[178]
- In 2020, Ontario's total cannabis-use attributable costs was $890 million.[179] However, Ontario had one of the lowest per capita cannabis-use costs at $60.45 compared to other provinces. The total costs in 2020 were over 8 times what Ontario collected in taxes on cannabis products in 2020 ($106 million).[180]

> Health care accounted for about $122 million or 13% of cannabis costs in 2020; the majority of the costs were criminal justice related.

The Policy Environment/Challenges

Canada legalized the sale of cannabis in 2018. Over the past five years, the market for legal cannabis in Ontario has grown steadily, particularly among young males.

Health Canada is currently in the process of its five-year review of the national cannabis legislation,[181] which has identified successes as well as opportunities to strengthen the legislation and reduce harms. The review's recommendations are expected in 2024. In the meantime, Ontario has identified pressing challenges with trends in cannabis use in the province.

In July 2023, the Council of Chief Medical Officers of Health and Public Health Physicians of Canada submitted a joint statement, that I signed on to, outlining the public health challenges and recommendations for the future of national cannabis policy.[182]

> Legalization of cannabis drew people away from the unregulated market, and reduces the risk that they will purchase and use substances that are more potent or toxic than they expect.

In addition to the high rates of cannabis use among youth and the increase in emergency department visits and hospitalizations in the province noted above, Ontario has identified a number of issues that must be addressed. Although the legislation has been effective in shifting people to the regulated market, the unregulated market still exists and continues to make unregulated products widely available at lower prices and higher concentrations of tetrahydrocannabinol (THC), the principal psychoactive constituent of cannabis, than legal, regulated cannabis products.

While cannabis legislation sets limits on the concentrations of THC in products that can be sold in the legal market, information about the content of different products (e.g. leaf, edibles, oils/extracts) is not clearly or consistently communicated to purchasers, so they are less able to make informed choices about their use.[183,119] This is a gap that should be addressed.

The Public Health Agency of Canada published Low Risk Cannabis Use Guidelines (LRCUG) in 2019.[184] and a follow-up Lower-Risk Cannabis Use Guidelines for Psychosis (LRCUG-PSYCH) was published in 2023.[185] Both are evidence-based recommendations to reduce the harms of cannabis use. Complete with posters, brochures, and other tools that make the information more accessible, the guidelines are designed for individuals who are either using or thinking about using cannabis, and for clinicians to encourage non-judgmental conversations with their clients about the risks of cannabis use and safer cannabis practices.

Canada's Lower-Risk Cannabis Use Guidelines for Psychosis (LRCUG-PSYCH)

Evidence-based recommendations for reducing psychosis-related risks when using cannabis

There is also a youth version of the LRCUG, developed for youth by youth.[186] However, research has shown that – despite the availability of these guidelines – Ontario service providers treating problematic substances use in youth are not aware of low-risk use guidelines or had not mentioned them to the youth they treated.[187]

The researchers also found that legalization of cannabis has made its use more acceptable and normalized, affecting youth's perception of the risks. As one provider said, "Cannabis is widely considered normal and a rite of passage for youth. It is also legal (for adults) and even considered a medical treatment, natural, 'good for you' by many people in Canada. As such, youth tend to think it's not a big deal to use it often and/or to self-medicate."[187] This message is reinforced by the number of cannabis retail outlets, and by the way cannabis is promoted on retailers' web sites.[187]

Families also struggle to find providers who have been trained in evidence-based management of cannabis use disorder. The research highlighted the urgent need to educate and train providers, reduce access to and availability of cannabis, increase public education, and improve availability of health and addiction services, particularly for youth.[188]

Recommendations

Develop a comprehensive cannabis strategy designed to reduce cannabis-related harms, focusing on youth and young adults who have the highest rates of cannabis use.

Health Promotion

- Actively promote Canada's Low Risk Cannabis Use Guidelines
- Continue to educate Ontarians about the risks associated with:
    - the impacts of different forms and concentrations of cannabis, very high THC content products, and oral versus inhaled cannabis use
    - driving under the influence of cannabis
    - cannabis use exacerbating mental health problems, including risks of developing cannabis use dependency, disorder and psychosis
    - cannabis use during pregnancy
    - accessibility of cannabis products in the home by young children

Regulatory Measures

Minimum legal age of purchase

- Increase the minimum age to purchase cannabis to 21 years old as Quebec has done

Product Controls

- Work with the federal government to:
  - Limit the potency of cannabis products
  - Set maximum concentrations of THC for all cannabis products
  - Maintain the limit of 10 mg THC per package of edible cannabis to reduce the likelihood and severity of unintentional pediatric poisonings
  - Require plain packaging and health warning labels (e.g. don't use and drive) for all cannabis products
  - Develop and promote safeguards to reduce harms from edible products (e.g. lockboxes, child-proof packaging, limiting appeal of edible products)

Availability

- Restrict physical store locations where cannabis products can be sold, including prohibiting any new stores within 200 metres of an elementary or secondary school or an existing cannabis retail outlet, and capping the total number of retail locations in a municipality/region
- Work with the federal government to ban online retail sales of cannabis products without in-person age verification at delivery

Pricing and Taxation

- Consider tiered taxation based on the THC content of the cannabis product

Promotion

- Work with the federal government to restrict online and social media advertising of cannabis products

Enforcement

- Enforce legislation related to the legal sale of cannabis products, age verification to purchase cannabis, packaging, and promotion

Treatment

- Increase access to mental health and addiction services for youth and young adults
- Improve access to treatment for cannabis use disorder:
  - Educate health care and social service providers on the treatment of cannabis use disorder
  - Increase access to primary care, emergency, and other health professionals trained to identify and treat cannabis use disorder
  - Increase emergency room capacity to respond to cannabis-related conditions

Monitoring and Reporting

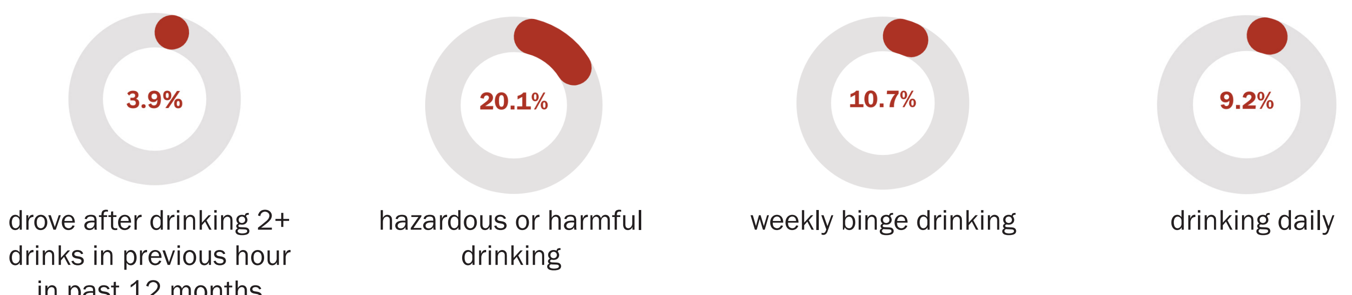
- Establish a “standard unit” of cannabis to improve surveillance and research on cannabis use and its associated harms
- Establish key performance indicators for those involved in enforcing cannabis regulations and policies
- Work with Public Health Ontario and with federal, provincial, territorial, and Indigenous partners to continue to:
  - Monitor the impact of cannabis on health, including the impact of the illegal cannabis market
  - Review new evidence on cannabis use
  - Assess the impact/effectiveness of cannabis policies
  - Issue regular reports on Ontario's progress (key performance indicators) in reducing harms associated with cannabis use

3. Alcohol

Trends and Health Impact

- Alcohol is the most widely used substance in Ontario. About 8 in 10 Ontarians ages 15 and older (80%) report using alcohol.[10] During the COVID-19 pandemic, Ontarians who use alcohol reported drinking more, and alcohol consumption was higher in Ontario than in other provinces. More adults reported consuming 5 or more drinks – the equivalent of a bottle of wine – on the days they used alcohol during the pandemic, and more reported hazardous use.[189] Reasons for the increase in drinking included: lack of a regular schedule, boredom, and stress.[57,190]

Figure 21: Percentage of adults in Ontario reporting higher risk alcohol use,* 2022[10]



* Hazardous/harmful drinking is defined as a score of 8+ on AUDIT. Binge drinking is 5 or more drinks on a single occasion at least once weekly in the past month.

- Although men drink more than women on average, women's alcohol consumption and the associated harms have been increasing at a faster rate, and the gender gap is narrowing. Between 2008 and 2018/19, emergency visits and hospitalizations in Ontario related to alcohol use increased by 37% and 300% for females compared to 2% and 20% for males.[191]
- In 2021, 60% of students in grades 7 to 12 reported trying alcohol, 24% using alcohol in the past month, 8% binge drinking (i.e. five or more drinks on one occasion at least once in the past month), and 5% hazardous drinking (i.e. 8 to 14 drinks per week in the past month).[192]
- Alcohol is a leading cause of preventable death in Ontario and a significant cause of serious health harms. In an average year in Ontario, about 4,330 (4.3%) deaths, 22,009 (2.1%) hospitalizations, and 195,693 (3.7%) of emergency department visits among people aged 15 and older can be attributed to alcohol use.[132] Most alcohol-attributable deaths in Ontario are from cancers (e.g. breast, colon, throat, mouth, larynx, esophagus, and liver) while most hospitalizations are for neuro-psychiatric conditions, such as alcohol withdrawal, amnesic syndrome and other mental and behavioural disorders, and most emergency department visits are for unintentional injuries such as falls or alcohol poisoning.[132]
- Even a small amount of alcohol per week (i.e., more than 2 standard drinks) can be damaging to health.[193] And the risk of alcohol-related harm increases with how frequently people drink and the amount they drink at one time.[66]
- Although lower levels of alcohol consumption may have a protective effect for some diseases, such as ischemic heart disease, people cannot selectively experience the potential benefits of low alcohol consumption while avoiding its carcinogenic effects. "Less is better" is the best message when talking to patients about alcohol.[194]

> Alcohol is a carcinogen, and even low levels of exposure to a carcinogen are likely to have adverse health effects, especially if the person has other risk factors for cancers caused by alcohol.[66]
>
> Paradis C, Butt P, Shield K, Poole N, Wells S; Low-Risk Alcohol Drinking Guidelines Scientific Expert Panels. 2023.

- Alcohol use is particularly harmful during pregnancy as it interferes with fetal growth and development. Exposure to alcohol in utero can lead to fetal alcohol spectrum disorder (FASD), a lifelong disability that affects the brain and body, and results in physical, mental, behavioural, and/or learning problems. There is no safe amount or type of alcoholic beverage, and no safe time to drink alcohol during pregnancy.[195]
- Alcohol is frequently associated with violent and aggressive behaviour, including intimate partner violence, male-to-female sexual violence, and other forms of aggression and violence between adults. Alcohol can also increase the severity of violent incidents. No exact dose–response relationship can be established, but consuming alcohol increases the risk of alcohol-related violence.[66]
- Alcohol plays a significant role in injuries and accidental deaths, including those that occur when people are driving under the influence.[66]
- Economically, alcohol and its related harms cost Ontario $7.1 billion in 2020 – significantly more than other substance use including tobacco ($4.1 billion) and opioids ($2.7 billion).[134]

> Compared to other substances, alcohol has the highest cost to the criminal justice system: higher than the use of opioids.
>
> Canadian Centre on Substance Use and Addiction (CCSA)[203]

The Policy Environment and Challenges

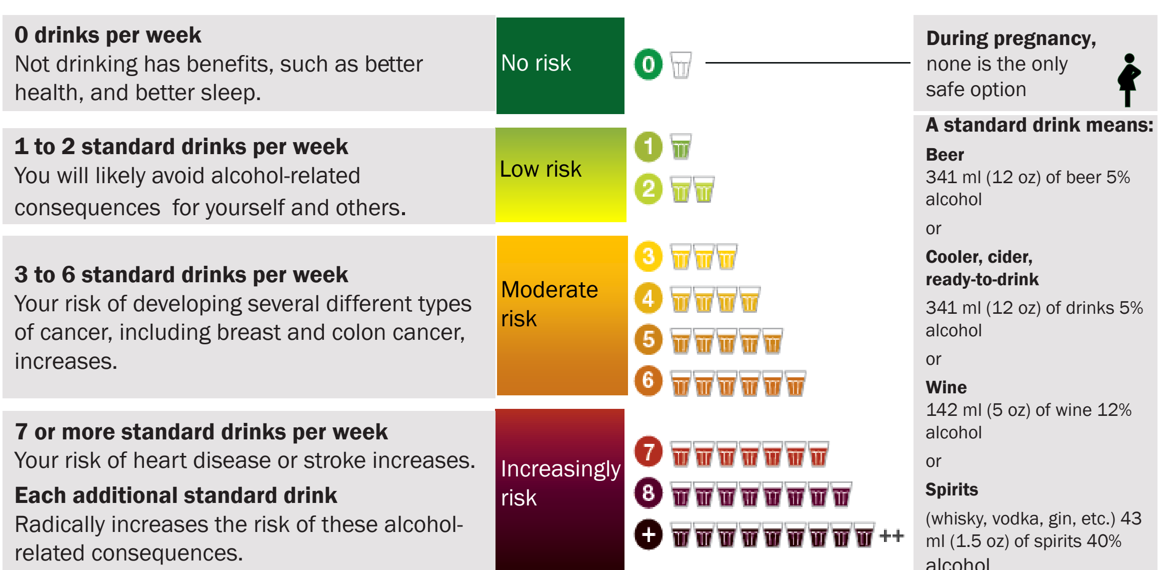
Alcohol is the most commonly used substance in Ontario. Binge drinking and hazardous drinking both increased during the COVID-19 pandemic.

Health Canada funded an initiative to update Canada's Low-Risk Drinking Guidelines to reflect the most recent evidence on alcohol and health (see box).[193] Developed by the Canadian Centre on Substance Use and Addiction (CCSA) and released in January 2023, the new guidelines represent a marked change in public health messaging about alcohol consumption. They note that "no amount of alcohol is good for your health. It doesn't matter what type of alcohol it is – wine, beer, cider or spirits. Drinking alcohol, even a small amount, is damaging to everyone, regardless of age, sex, gender, ethnicity, tolerance or lifestyle. That's why, if you drink, you should drink less."

Canada's Guidance on Alcohol and Health recommends that if you drink more than 2 drinks a week, you should not exceed 2 drinks on any day to reduce the risk of injuries or violence.

The key message is "less is better." The guidelines acknowledge that the health risks of alcohol are greater for females than males, but they no longer suggest different alcohol consumption thresholds by sex. They encourage Ontarians to balance any benefits they derive from alcohol use against its negative health effects.[194]

Figure 22: Spectrum of Risk from Alcohol Use



Source: Reproduced with permission from the Canadian Centre on Substance Use and Addiction (CCSA). Drinking less is better [Internet]. Ottawa, ON: Canadian Centre on Substance Use and Addiction; 2023 [cited 2024 Jan 30]. Alcohol consumption per week. Available from: https://www.ccsa.ca/sites/default/files/2023-05/CGAH-Drinking-Less-is-Better-en.pdf

Despite research on the health impacts of alcohol and the new guidelines, public awareness is low regarding the links between alcohol and risks such as cancer.[196] Alcohol warning labels – similar to those used on tobacco products – are one possible tool to raise awareness of the risks. According to a recent (2022) systematic review, 43 countries currently require alcohol warning labels, including 14 countries in the Americas. In the United States, alcohol warning labels have been shown to be effective in raising awareness, particularly among higher risk drinkers, and stimulating discussions about alcohol consumption. They appear to have the potential to change the conversation about alcohol, and may play a role in shifting social norms to reduce risks.[197]

Evidence-informed efforts to reduce alcohol harms by, for example, limiting its availability (i.e., where and when alcohol can be sold) are often in conflict with economic policies designed to support the alcohol and restaurant industries as well as reflect societal preferences. For example:

- In 2015, the province expanded alcohol sales to certain grocery stores. Ontario now has 2.1 alcohol retail outlets per 10,000 population, which is slightly higher than the 2.0 per 10,000 maximum retail density recommended by the Canadian Alcohol Policy Evaluation (CAPE),[199] an ongoing research project that provides rigorous assessments of the progress that provinces, territories and the federal government are making in implementing policies proven to reduce alcohol-related harms.
- During the COVID-19 pandemic, Ontario introduced policies that permitted:
  - alcohol take-out and delivery from licensed establishments
  - alcohol sales and service on docked boats
  - lower minimum alcohol delivery fees
  - extended hours for alcohol sales in authorized grocery and alcohol stores.
- In 2019, Ontario passed legislation that gave municipalities the authority to permit alcohol consumption in public parks. In August 2023, Toronto began a two-month pilot project allowing people aged 19 and older to drink alcohol in 27 select parks in the city. That pilot was extended to March 31, 2024.
- The province may allow convenience stores, gas stations, and remaining grocery stores in Ontario to sell beer – in which case, Ontario will exceed the CAPE recommendations for alcohol retail density.

> If the number of retail outlets for alcohol increases, the province will need to invest in services to monitor whether these new sites are complying with laws related to minimum age of purchase, products, and promotion. It will need to consider other measures to reduce potential harms, such as fines and license fees, progressive enforcement up to and including loss of license, and enforcing restrictions related to the distance/proximity of these outlets to places like schools and daycares.

Public health-driven alcohol pricing strategies can also run up against policies enacted for other social and economic reasons. For example:

- Pricing has long been used as a way to reduce how much people drink. In 2021, Ontario reduced wholesale alcohol prices to help businesses, including bars and restaurants, affected by the COVID-19 pandemic. Businesses saved 20% compared to retail prices, which reduced the cost of alcohol sold at licensed establishments, making it easier for people to buy more.
- In 2022, Ontario delayed the basic beer tax increase to 2023 to support beer brewers.

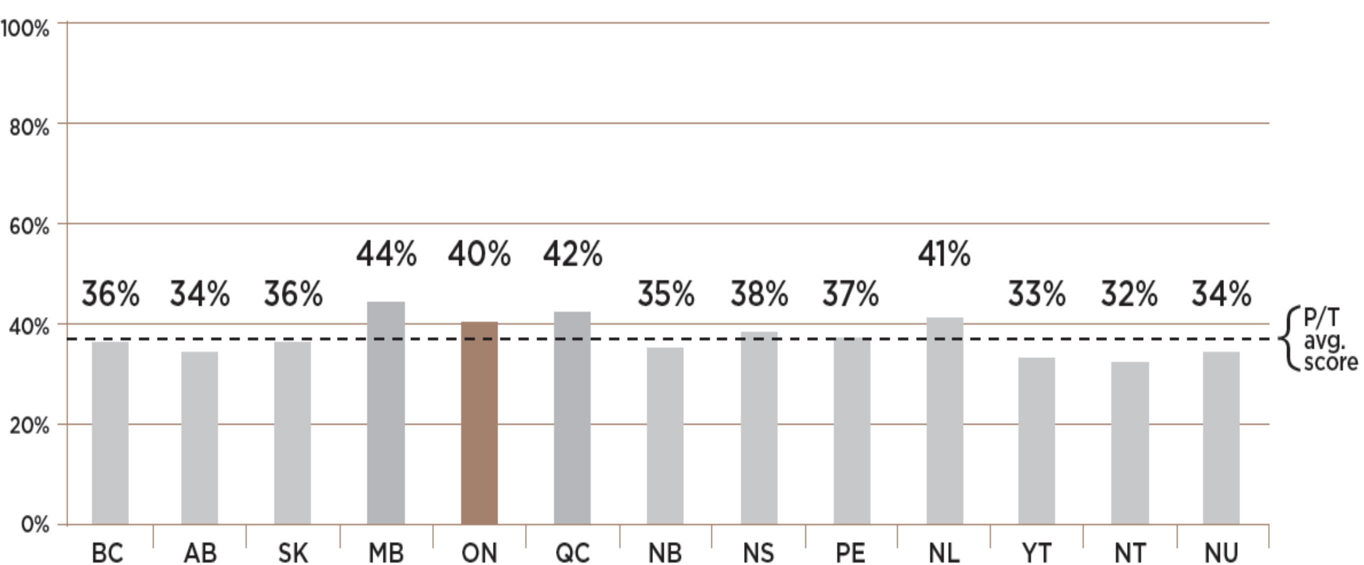
> No type of alcohol product (beer, wine, spirits) meets the World Health Organization's recommended minimum unit price of $1.97 per standard drink in 2022 dollars. The gap between the recommended minimum price and the actual retail price in Ontario has been increasing since 2013.[57]

While these types of policy changes can benefit the industry, they can also cause health harms. For example, the expansion of alcohol sales in Ontario in 2015 was associated with a 17.8% increase in emergency department visits attributable to alcohol, which was more than twice the rate of increase for all emergency department visits over this period.[198] Ontario must continually monitor the impact of recent pricing and other policy changes on rates of alcohol consumption and alcohol-related harms.

Ontario restricts alcohol advertising in traditional media, but those restrictions do not extend to online media where many people- including most youth- get their information. Youth and young adults are particularly vulnerable to sophisticated social media alcohol marketing campaigns. In recent years, there has been a marked increase in alcohol advertising targeting both youth and women, which is likely a factor in the increase in women's rates of alcohol use and harms.

Ontario does have a graduated licensing program as well as a requirement that all young drivers 21 and under, regardless of license class, have a blood alcohol level of zero. These types of restrictions on young drivers, including zero-tolerance for drinking and driving, help mitigate some of the harms associated with a minimum legal drinking age of 19. The province also has a relicensing program for people who lose their license for driving impaired. However, that program falls short of the CAPE recommendations. As Figure 23 shows, Ontario has yet to implement the full range of effective, evidence-based alcohol policies/interventions (e.g. pricing, taxation, number and location of outlets, marketing controls, enforcement) recommended by CAPE.[199] If it were to do so, it could make significant progress in preventing or reducing alcohol harms.

Figure 23: Score for Ontario and other provinces and territories on assessment of implementation of best practice policies for alcohol



Source: Canadian Institute for Substance Use Research; Naimi T, Stockwell T, Giesbrecht N, Wettlaufer A, Vallance K, Farrell- Low A, et al. Canadian Alcohol Policy Evaluation 3.0: Results from Ontario. 2023. Available at: https://www.uvic.ca/research/centres/cisur/assets/docs/cape/cape3/on-results-en.pdf.

In December 2023, in light of the new guidance on alcohol and health, and growing evidence on the effectiveness of different alcohol policies and interventions, the Association of Local Public Health Agencies (alPHa) recommended that Ontario create a provincial alcohol strategy. I endorse that recommendation as well as the CAPE policies and interventions that have the potential to reduce harms associated with alcohol use.

When it comes to treatment for alcohol use disorder, the health care system has been slow to adopt highly effective pharmaceutical treatments. As noted earlier in this report, fewer than 2% of eligible people with a diagnosed alcohol use disorder in Canada are currently prescribed anti-craving medication,125 and fewer still have access to the mental health/behavioural interventions such as cognitive behavioural therapy, dialectical behavioural therapy, and trauma therapy that are critically important in helping people recover from alcohol addiction and improve their health and wellbeing.

Recommendations

Develop and implement, in collaboration with stakeholders, including local public health units and the alcohol regulatory system, and in consultation with the alcohol industry, a comprehensive alcohol strategy designed to reduce alcohol-related harms.

Health Promotion

- Launch a wide-reaching evidence-informed education/multimedia campaign designed to improve public awareness and understanding of the health risks and harms of alcohol over consumption – particularly its carcinogenic effects as well the risks of driving under the influence, alcohol-related violence, alcohol use during pregnancy, and addiction.
- Encourage clinicians to communicate to patients that alcohol consumption, even at low levels, has adverse effects on health.

Regulatory Measures

Minimum legal age of purchase

- Continue to monitor:
    - The impact of the minimum legal drinking age on the health of Ontarians
    - Evidence supporting a higher minimum legal drinking age
    - Public support for increasing the minimum legal drinking age
- Explore the value of increasing the legal minimum drinking age from 19 to 21 in terms of youth morbidity and mortality as well as longer-term health outcomes
- Require proof of age verification for anyone purchasing alcohol online or by phone

Product controls

- Continue to limit/control the potency/toxicity of alcohol products sold in Ontario
- Work with the federal government to require that all alcohol products have warning labels and signage that describe the risks/harms of alcohol use (e.g. cancer risk, standard drink size, national alcohol guidance, calories)

Availability

- Continue to implement strategies to control alcohol availability:
    - Establish and maintain a moratorium on alcohol privatization (i.e. no further privatization of the alcohol distribution system, and no expansion of existing private retail channels)
    - Implement an evidence-informed, quantity-based system to manage outlet density
    - Maintain or reduce current per-capita levels of retail outlet density
    - Limit or prevent further extension of hours of sale in both on- and off-premise outlets

Pricing and Taxation

- Continue to use Ontario's alcohol pricing system to help reduce alcohol related harms:
    - Increase the legislated tax rates and minimum pricing per standard drink for all beverage types sold both on- and off-premises
    - Automatically adjust the taxes and minimum prices annually to keep pace with inflation so alcohol does not become less expensive relative to other goods over time

Promotion

- Work with the federal government to restrict alcohol advertising – particularly online and social media marketing that targets youth and/or women

Enforcement

- Ensure a strong regulatory and funding framework to support enforcement of alcohol regulations, including licensure, age verification, hours of operation, advertising, and signage, with all alcohol retailers.
  - Explore the potential for the Alcohol and Gaming Commission of Ontario to invest in additional enforcement to enhance inspections and prevent youth access to alcohol in convenience stores.
  - Explore the potential for the Ministries of Health and the Attorney General, the Alcohol and Gaming Commission of Ontario, and public health units to collaborate to implement a referral system – similar to the existing system for the Tobacco Tax Act – to ensure all convenience stores licensed to sell alcohol comply with liquor laws, including age limits and verification, hours of operation, promotion, and signage (e.g. public health unit inspectors who observe non-compliance with liquor laws during their regular tobacco and vaping product inspections would refer those incidents to the Alcohol and Gaming Commission of Ontario)
  - Explore the potential to support the Alcohol and Gaming Commission of Ontario in implementing a youth test-shopping program to ensure compliance with age limits and verification requirements to purchase alcohol, like the ones in place for tobacco and vaping products
- Adopt the CAPE 2023 recommendations to keep pace with best practices and reduce harms related to impaired driving:
  - Strengthen the graduated licensing program by making stage 1 a minimum of 12 months and stage 2 a minimum of 24 months, and implement a stage 2 night-time driving ban
  - Extend the zero-tolerance for alcohol to all new drivers with less than five years' driving experience, and set penalties for all graduated licensing program and new driver violations
  - Impose stricter penalties for people driving under the influence of alcohol and another substance (e.g. cannabis)
  - Impose comprehensive mandatory administrative license suspensions and automatic vehicle identifications that increase based on blood alcohol level and repeat occurrences
  - As a condition of relicensing, continue to require all first and repeat federal convictions for driving under the influence to successfully complete the ignition interlock program (i.e. driver must blow into a breathalyzer on the device before being able to start or operate the vehicle), and offer incentives for people to enroll in the program to discourage unlicensed/uninsured driving

Treatment

- For people who are experiencing harms related to alcohol use, enhance access to screening, brief interventions, harm reduction services (e.g., managed alcohol programs), withdrawal management, and treatment for alcohol use disorder:
  - Make training in the health impact of alcohol use and treatment of alcohol use disorder mandatory in medical and nursing schools
  - Continue to train and update health professionals in primary care, emergency departments, and hospitals
  - Promote the use of best practice guidelines for the treatment of alcohol use disorder
  - Facilitate mobile/online and in-person care
  - Increase access to evidence-based treatments, including residential treatment and pharmacotherapy

Monitoring and Reporting

- Work with Public Health Ontario and with federal, provincial, territorial, and Indigenous partners to:
  - monitor alcohol-related indicators in Ontario
  - review new evidence on the effects of alcohol use
  - assess the impact of alcohol policies implemented across Canada and internationally
  - identify opportunities to strengthen provincial policies
  - issue biennial public reports on progress (key performance indicators) to guide Ontario's alcohol strategy

4. Opioids

Trends and Health Impact

Over the past decade, both Canada and Ontario have seen a dramatic and tragic increase in harms associated with opioid use, including deaths and illness (e.g. fatal and non-fatal overdoses) related to the toxic unregulated drug supply.

- The rate of opioid-related deaths is Canada is 2.5 times higher than the average of other Organization for Economic Co-operation and Development (OECD) countries.[200]
- The number of people who died from opioid toxicity – which was already high in 2019 (1,559 deaths) – almost doubled in 2021 (2,857 deaths).[4]
- Fentanyl contributed to most (84%) opioid-related toxicity deaths in Canada in the first half of 2023.[201] Fentanyl and fentanyl analogues are highly potent, synthetic opioids that are now widely present in the unregulated opioid supply, making the unregulated supply more toxic and more likely to result in death.

The toxicity of the unregulated drug supply has caused thousands of accidental deaths in Ontario.[202]

- Every year between 2013 and 2022, Ontario saw an increasing number of opioid-related visits to emergency departments and deaths. In 2020, opioid-related emergency department visits were up over 50% (28,419 visits) compared to 2013 (15,275 visits).[203]
- Non-fatal overdoses can cause serious and lasting harms. Approximately 1 out of 25 people hospitalized for opioid toxicity is diagnosed with an anoxic brain injury.[204]
- As high as the number of opioid-related deaths and emergency visits are,[205] they do not show the actual extent of opioid use. We do not have good population-level data on the extent of opioid use, but we do know that, in 2022, 4 of every 1,000 people in Ontario received opioid agonist therapy to treat opioid use disorder.[205] We also know that people who have **not** been diagnosed with an opioid use disorder are at risk of harm from the toxic unregulated drug supply: approximately one-third of Ontarians who die from opioid toxicity have no indication of having been diagnosed with an opioid use disorder in the last five years.[206]
- There is a substantial treatment gap in Ontario. People who could benefit from opioid agonist therapy are either not receiving it or not retained in treatment. From 2005 to 2019, the proportion of people retained in opioid agonist therapy for six months decreased, and those living in rural areas and/or with a history of a mental health diagnosis were less likely to be on OAT and to stay on OAT for 6 months or longer.[124]
- Access to OAT is remarkably low even for people with opioid use disorder who access hospital-based care for opioid toxicity in Ontario. During the first quarter of 2020, only 5.6% of people accessed OAT within 7 days after an emergency department visit for opioid toxicity or after being discharged from hospital for opioid toxicity.[207]
- The opioid toxicity crisis has placed extreme pressure on ambulance and paramedic services, as well as on community outreach and harm reduction workers, many of whom are peers. The stress of responding daily to so many overdoses and deaths can cause trauma and burnout,[208] and reduce the level of these services available to respond to other emergencies.
- To meet the needs of the broad range of people in our communities at risk of opioid harms, we need comprehensive services and supports.

The Policy Environment/Challenges

Of the four types of substances in this report, opioids are the only substance that is not fully regulated in Ontario. There is a legal, regulated supply of prescription opioids and an unregulated supply of opioids, which is often unpredictable and contaminated with other substances. It is also the only one of the four substances discussed in this report for which simple possession for personal use is a criminal offence.

Ontario has responded to the opioid toxicity crisis by funding a range of responsive, evidence-based harm reduction services that help prevent overdoses and deaths, including naloxone programs, and consumption and treatment services (CTSs), where people who inject drugs can use substances safely, with someone nearby to intervene in the case of an overdose and provide access to other health services. Ontario is also actively supporting efforts to reduce opioid-related harms among Ontario workers.[209]

The challenge for Ontario is to stop the overdoses and deaths – that is, reduce the harms – while, at the same time, addressing the drivers of opioid use.

However, the existing CTS programs are not widely available across the province, and they do not allow people to smoke or inhale opioids, which has become an increasingly common form of use: people who only smoke rather than inject opioids now account for about one-third of opioid toxicity deaths.[58] Because the substances that people use and how they take them are continually changing, harm reduction policies must be more nimble. To be effective, harm reduction services must be able to adapt quickly to changes in patterns of substance use.

While there is public support for compassionate, supportive services for people dealing with opioid use disorder, there are also public concerns about the impact of the opioid toxicity crisis on neighbourhood safety, including discarded needles, public substance use, and people who sell drugs being attracted to CTS sites. Many of these problems can be addressed through the way services are planned and delivered. Providing a wider array of harm reduction and treatment services (e.g. more supportive housing, less stigma) and changing existing services (e.g. more CTS sites and allowing inhalation so that people can use substances within CTS rather than outdoors) would help to meet the urgent harm reduction needs of people who use opioids while promoting community safety.

Criminalization of simple possession for personal use increases the risk of people using drugs alone, and overdosing and dying. It also makes people less willing to call 911 in the event of emergency, or to help someone who is overdosing for fear they, too, could be charged for possession. People who use opioids who experience incarceration are often at greater risk of overdose when they are released from custody because of inadequate access to treatment while in prison, lost tolerance for the drug while incarcerated, and poor continuity with community-based health care and other services after release.

Diverse organizations, including the Ontario Association of Police Chiefs,[210] the Registered Nurses Association of Ontario (RNAO),[211] the Centre for Addiction and Mental Health (CAMH),[212] the Association of Local Public Health Agencies (alPHa) in Ontario,[213] and organizations of people who use drugs[214-5] have all called for decriminalization of the simple possession of opioids for personal use, along with the services required to support people who are using unregulated drugs.

Arresting, charging, and incarcerating people who use drugs has failed as a strategy to reduce harmful opioid use.

Some jurisdictions (e.g. Portugal, Oregon, BC) have decriminalized simple possession of small amounts of opioids. Ontarians are carefully watching the experience in these jurisdictions to determine the best way to move forward with a public health-based and evidence-based approach to opioid use. In March 2023, the City of Toronto put forward its proposed approach to decriminalizing drugs for personal use: instead of charging and arresting people who had drugs for personal use, police would give them a referral card that contains information about a range of health and social supports, legal rights, and youth programming. The goal is to “reduce the mental, physical, and social harms associated with criminalizing people for possessing drugs for their personal use,” with “the potential to meaningfully improve the health and wellbeing of all Torontonians.”[216]

The model would apply to all areas of the city except around child care facilities and K-12 schools – where provincial laws prohibit alcohol, cannabis, and unregulated drug use – and airports, which fall under federal jurisdiction.

Even without the legal changes required to decriminalize possession for personal use, Ontario has seen a marked decrease in possession charges. In response to a 2020 directive asking federal crown attorneys to avoid prosecuting people for possession, about 85% of drug possession charges were dropped in 2021 (compared to 44% in 2019).[217] The directive was an effort to establish a community standard and reduce backlogs in the system. It also reflects the growing recognition that charging people for possession is not the most effective way to address a health issue like opioid use.

In coming to grips with the negative impacts of criminalization, Ontario has had some success diverting people arrested for possession of opioids away from jails into drug treatment courts where they receive access to harm reduction services, treatment, and comprehensive health care and supports. However, access to these services is extremely limited and inequitable. The programs tend to be concentrated in larger urban centres rather than in parts of the province, like Northern Ontario, where there are relatively high rates of opioid use, overdoses, and deaths. Depending on how they are implemented, drug treatment courts have the potential to reduce the harms associated with incarceration as well as the risk of overdoses and deaths when people are discharged from prison, while also improving access to treatment.

It is also extremely difficult for people experiencing opioid use disorder and their families to access effective, evidence-based treatment and support services. There are long waits for addiction treatment services in most communities, including for youth.

Recommendations

Develop and implement, in collaboration with stakeholders– including people with lived or living experience with substance use – a comprehensive strategy designed to reduce opioid-related harms.

Health Promotion

- Increase access to evidence-based education, mental health, and supportive housing programs and services that have the potential to prevent people from developing an opioid use disorder
- Continue to raise awareness of the risks associated with the toxic, unregulated drug supply
- Raise awareness of the Good Samaritan Drug Overdose Act to encourage people to respond effectively (e.g. administering naloxone, calling 911) when they see someone experiencing an overdose

Regulatory Measures

Decriminalization

- Decriminalize the simple possession of unregulated drugs for personal use as recommended by the Ontario Association of Chiefs of Police
- Develop a framework of diversion program options to provide front-line police with established pathways to refer people to health services, and rehabilitation and recovery supports
    - Develop policies and programs to increase access to evidence-based programs that divert people from the criminal justice system (e.g. drug treatment courts)
    - Involve nurses and mental health workers on emergency teams responding to people experiencing problems related to their substance use
- Engage people who use drugs in the process of implementing decriminalization of simple possession and creating service pathways

Toxic Drug Supply Controls/Availability

- Work with the federal government to protect the community from exposure to toxic drugs
- Work with the federal government,[218] local law enforcement. and other partners to develop effective, timely strategies to:
  - monitor and understand the local impact of the toxic drug supply (e.g. overdose monitoring platform)
  - help communities detect and respond to a sudden increase or spike in overdoses
- Avoid the unintended negative consequences of disruptions and unpredictable toxicity in the illegal drug supply:
  - Increase access to evidence-based safer supply programs[219-20]
  - Continue to evaluate safer supply programs for any risk of diversion, and address broader public concerns about diversion

Enforcement

- Work with the federal government, the Canada Border Services Agency, and the U.S. and other international governments to control the illegal drug supply and address the role of organized crime in the production, distribution (i.e. trafficking), and diversion of toxic drugs:
  - Disrupt shipments of illegal drugs and precursor chemicals
  - Dismantle illegal drug labs
  - Share intelligence among different enforcement and regulatory agencies responsible for reducing harms related to the toxic drug supply
  - Use forensic accounting services to help find and break up organized crime groups
- Provide new training and tools for enforcement officers to reduce drug stigma

Harm Reduction

- Increase access to integrated harm reduction services for people who use opioids, including:
  - Supervised consumption services (including for smoking/inhalation)
  - Naloxone kits, including for people who use drugs other than opioids and any others who may be at risk of experiencing opioid toxicity or witnessing opioid toxicity[221]
  - Distribution of sterile supplies
  - Peer-led outreach supports
  - Links to public health and health services, including RAAM (rapid access addiction medicine) clinics and wrap-around services
- Increase investment in drug checking services, and continue to evaluate their ability to reduce harms
- Continue to evaluate and learn from experiences in Ontario and other jurisdictions (e.g. Portugal, Oregon, B.C.) about effective ways to locate, structure, implement, and manage harm reduction programs
- Ensure equitable access to harm reduction services that are tailored to the specific needs of rural, remote, and northern communities
- Work with Indigenous communities to increase access to Indigenous-led culturally appropriate, responsive harm reduction programs and interventions
- Integrate access to harm reduction services in housing/shelter supports for people who use substances
- Work with people who use substances, harm reduction programs, communities, and police to ensure community safety

Treatment

- **Increase access to timely, low-barrier evidence-based treatment for people with opioid use disorder:**
  - o Develop integrated, culturally appropriate care/service hub models for people who use opioids that:
    - Build on existing services, including RAAM (rapid access addiction medicine) clinics and other health system partners
    - Provide a full spectrum of evidence-based services based on each person's goals (e.g. harm reduction, medications for opioid use disorder, support for abstinence)
    - Include psychosocial supports, peer support, counselling, and/or psychotherapy
    - Include residential treatment models, including longer-term assisted living and supportive housing that may be required for individuals living with acquired brain injuries or other sequelae or co-occurring conditions
  - o To reduce the risk of overdose and death for people released from prison, ensure continuity of opioid agonist therapy and access to coordinated community-based treatment and harm reduction services
  - o Ensure opioid use disorder treatment services in Ontario meet the forthcoming national standards for mental health and substance use services
  - o Expand the Ontario Drug Benefit (ODB) formulary to include injectable forms of opioid agonist treatment
  - o Provide multiple types of low-barrier treatment and withdrawal management services in primary care, emergency departments, and specialized clinical settings, such as the RAAM (rapid access addiction medicine) clinics, including:
    - Same-day access to care and agonist therapies
    - Inpatient and outpatient, virtual and mobile models of care
    - Injectable opioid agonist treatment
    - Expansion of addiction medicine consulting services.
  - o Work with correctional services to address the health needs of people with opioid use disorder who are incarcerated, including ensuring access to first-line treatment options (i.e. opioid agonist therapy) and harm reduction services

Services for Families, Friends and Workers

- Address the impacts of grief and loss caused by the opioid toxicity crisis:
  - o Provide compassionate mental health and counselling services, and other forms of grief and loss programs and supports for family members, peers, and friends
  - o Provide support for memorializing activities and cultural ceremonies

Monitoring and Reporting

- Work with Public Health Ontario, the Chief Coroner, police, local public health units, and with federal, provincial, territorial, and Indigenous partners to enhance surveillance:
  - o Monitor the impact of the toxic drug supply on the health of Ontarians
  - o Assess the effects of provincial opioid-related policies and programs
  - o Develop more integrated data reporting tools, such as a comprehensive dashboard, that could be used to identify opportunities to strengthen Ontario's response to the opioid toxicity crisis
  - o Identify best-practice interventions to reduce harms associated with opioid use
  - o Issue regular reports on Ontario's progress (key performance indicators) in addressing the opioid toxicity crisis

Conclusion

Public health aims to help all Ontarians lead longer, healthier lives. We focus on entire populations across the life course from birth to death. When we see preventable threats, such as substance use, that harm too many people too young, devastate families, destroy communities, and reduce life expectancy, we have no choice but to act.

But the public health sector cannot solve the problem of substance use harms on its own. We need an all-of-society approach that engages communities, governments, public health and social services, and individuals – including people with lived and living experience of substance use.

Our approach must recognize the complexity of human experience with substances – many people use substances without experiencing harms while some struggle and suffer – as well as the complex factors that drive substance use, and the complex policy environment in which health policies sometimes conflict with economic policies and with public attitudes and preferences.

Ontarians will continue to use substances. How can we help them understand the risks, moderate their use (less is better), and use in ways that are less risky?

If we do not invest upstream, more Ontarians will die preventable deaths, families will continue to suffer, and the province will continue to spend billions each year to cover the health care, social and legal/policing costs of substance use harms.

We must be focused. We must strive to find a way to balance the benefits and risks of substance use, leveraging the full toolbox of effective and promising public health interventions to reduce harms and improve health.

We must be responsive. The health care system must be able to provide quick easy access to effective, on-demand harm reduction, and mental health and addiction treatment services for Ontarians at risk of or experiencing substance use harms and their families.

We must be nimble. We need to actively monitor how specific substances are affecting health, and how those threats are changing (e.g. new products in new forms, delivered in different ways, targeting different people, promoted through new channels). We must be able to quickly adapt our **downstream** programs, services, policies, and regulations – the guardrails we have put in place to protect the most vulnerable – to counter evolving threats.

We must be strategic. At the same time that we are constantly refining our downstream interventions, we must continue to invest **upstream** to create the social conditions that can prevent harmful substance use and help people find other, healthier ways to cope with stress, anxiety, depression, pain, and trauma. The best antidote for addiction and other substance use harms is connection and a sense of belonging: strong, healthy, connected families and communities

We must take action. There are concrete steps and actions we can take now to reduce harms from tobacco/vaping, cannabis, alcohol and opioids.

We must be determined. Working together in an all-of-society approach, we must continue to advocate for health, social, and economic policies – at all levels – that will build stronger communities, and help all of us enjoy longer lives in good health.

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Appendix

Ontario Public Health Units with Vacant Medical Officer of Health (MOH) Positions*
Filled by Acting MOHs as of December 31, 2023

Public Health Unit
Chatham-Kent Health Unit
Halton Region Health Department
Peel Public Health
Timiskaming Health Unit
Total = 4 Public Health Units with MOH Vacancies

*Under 62. (1)(a) of the *Health Protection and Promotion Act,* every board of health shall appoint a full-time medical officer of health.

Ontario Public Health Units with Vacant Associate Medical Officer of Health (AMOH) Positions*
as of December 31, 2023

Public Health Unit
Durham Regional Health Unit
Grey Bruce Health Unit
Halton Region Health Department
Niagara Region Public Health Department**
North Bay Parry Sound District Health Unit
Northwestern Health Unit
Peel Public Health
Sudbury and District Health Unit
Thunder Bay District Health Unit
Windsor-Essex County Health Unit
Total = 10 Health Units with AMOH Vacancies

*Under 62 (1)(b) of the *Health Protection and Promotion Act*, every board of health may appoint one or more associate medical officers of health.

**Vacancies may include less than or more than one FTE position per health unit and include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.

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alPHa Summary
2024 Ontario Budget:
Building a Better Ontario

The 2024 Ontario Budget was tabled on March 26th, 2024. It is focused on the themes of rebuilding the provincial economy, continuing to build infrastructure; a range of measures related to improving outcomes for workers, including employment opportunities, buffers against cost-of-living increases, and increasing housing stock and affordability; and improving services, which includes the measures related to education and health.

As always, there is a section devoted to health care expenditures, which is where measures related to public health are typically found. This year's budget includes only one mention of public health, and it is specific to Indigenous supports. There is no mention of the ongoing Strengthening Public Health initiative or any of its elements (mergers, OPHS Review, PH Funding Review).

Nevertheless, there are a few points of interest to our members, based on existing positions on a range of public health issues. alPHa has taken note of these and may refer to them in future advocacy (links to related alPHa positions are provided):

- The planned 4.6% increase to levies on alcoholic beverages will not proceed for at least two years (pp. 73-74). (alPHa Positions: Substance Use)
- Investing in Indigenous and Northern Community Supports includes a reference to public health (the only such reference in the entire budget document), with specific commitments to mental health and addictions, vaccination, and prevention-focused activities related to diabetes, chronic diseases, and smoking (p. 89). (alPHa Positions: Determinants of Health).
- Supporting Women's and Children's Health includes a reference to increasing access to the Indigenous Healthy Babies Healthy Children program (p. 89). (alPHa Positions: Early Years).
- Enhancing School Safety includes a reference to providing funding for the installation of "vape detectors" in schools (p. 95). (alPHa Positions: Tobacco, Vape, Cannabis).

Please note that the practice of inviting interested parties to a full budget lockup, which provided access to the complete budget documents at least four hours in advance of the Minister rising to present it in the house, was suspended at the outset of the COVID-19 pandemic. These have not been reinstated, having since been replaced with 30-45-minute, high-level technical briefings. The consequence of this is that we must wait until the documents are public to begin our analysis.

Links to the 2024 Budget documents

- Landing page for the 2024 Ontario Budget is here.
- The full Budget can be read online and downloaded here.
- Budget highlights are here.
- The News Release is here.

Selected Media Coverage: CBC News; Globe and Mail; Toronto Star.

We hope you find this information useful.

Middlesex-London Board of Health
External Landscape Review – April 2024

The purpose of this briefing note is to inform MLHU Board of Health members about what is happening in the world of public health and impacts to the work of the MLHU and Board. This includes governance and legislative changes, news from other local public units, external reports on important public health matters, learning opportunities and MLHU events. **Please note that items listed on this correspondence are to inform Board members and are not necessarily an endorsement.**

Local Public Health News

Another step toward 'good place' in Hamilton public health reform

Hamilton's Board of Health will be moving to a semi-autonomous governing model by the end of 2024. In a council meeting on Tuesday, April 2, a sub-committee was struck to implement forming a Board of Health to include community members and members with a medical background.

Haldimand-Norfolk and Hamilton are Ontario's only public health units using a single-tier governance model, where the board of health is made up of all members of municipal council, with no community or provincially appointed members.

To learn more, please see the article from the Hamilton Spectator.

Impact to MLHU Board of Health
MLHU's Board of Health is a fully autonomous Board of Health with a diverse group of individuals from different backgrounds and appointment methods. The Board supports the work of fellow Boards of Health and it will be important to understand the composition of Hamilton's newly designed Board of Health.

National, Provincial and Local Public Health Advocacy

Federal government commits to creation of national school food program

On April 1, the federal government will launch a national school food program with a target of providing meals to 400,000 children every year, beyond those served by existing school food programs. The Program will be a safety net for the kids who need this support the most. The lack of access to food disproportionately impacts children from lower-income families and from racialized and Indigenous communities. At this time, $1 billion in funding will be allotted to the provinces and territories, along with First Nations, Inuit, and Métis communities as well as Self-Governing and Modern Treaty partners to support children experiencing food insecurity.

More details will be announced after the 2024 Budget is released on April 16. It is noted that the Board has also received correspondence (E) from Haliburton, Kawartha, Pine Ridge District Public Health Unit with their support of this program.

To learn more, please see the article from CBC and the media release from the Office of the Prime Minister of Canada.

Impact to MLHU Board of Health
The Board of Health has heard the impacts of food insecurity in the community and has supported advocacy efforts for a school food program in Report 69-23. In May 2023, the estimated local monthly cost to feed a family of four was $1,124, an increase from $1,084 in May 2022; this highlights that incomes and social assistance rates have not kept pace with the increased cost of living.

Correspondence C

The Honourable
Peter Bethlenfalvy
MINISTER OF FINANCE

2024 Ontario Budget: Building a Better Ontario

On March 26, the Provincial Government released the 2024 Ontario Budget: Building a Better Ontario. The highlights included:

- $1 billion in the new Municipal Housing Infrastructure Program and quadrupling the Housing-Enabling Water Systems Fund to a total of $825 million to help municipalities repair and expand the critical infrastructure needed to reach their housing targets.
- Connecting approximately 600,000 people to primary health care with a total additional investment of $546 million over three years.
- $200 million in a Community Sport and Recreation Infrastructure Fund to invest in new and upgraded sport, recreation and community facilities.
- Investing $46 million over three years, including for the purchase of four police helicopters to improve community safety in the Greater Toronto area.
- Extend the temporary cuts to the gasoline tax rate by 5.7 cents per litre and the fuel (diesel) tax rate by 5.3 cents per litre until December 31, 2024.
- An additional $100 million investment in 2024–25 through the Skills Development Fund Training Stream.
- Investing an additional $152 million over three years towards various supportive housing initiatives designed to support vulnerable people.

To view the full 2024 Ontario Budget, please visit the Ontario Budget website.

Impact to MLHU Board of Health
The Board of Health (along with Boards of Health for other public health units) are actively advocating for increased financial support to provide crucial public health programming for the communities they serve. Without adequate funding received, work outlined in the Ontario Public Health Standards will not be reached to its full potential. It is noted that the Board of Health has received the Association of Local Public Health Agencies' review on public health matters within the 2024 budget as a part of their agenda package.

MLHU News

Canadian Public Health Week at MLHU

On April 8, 2024, MLHU celebrated Canadian Public Health Week! For the third year in a row, the Canadian Public Health Association (CPHA) is highlighting the many contributions of public health professionals and agencies in Canada, highlighting the many ways public health plays a key role in promoting and protecting the health of Canadians coast-to-coast. Canadian Public Health Week ran from April 8-12, 2024.

For more information about Canadian Public Health Week, please visit the Canadian Public Health Week website.

Impact to MLHU Board of Health
Canadian Public Health Week highlights the work of public health units across Canada and celebrates the work that MLHU staff do to support the Middlesex-London community. The Board of Health recognizes, acknowledges and supports MLHU staff in their work!

Association of Local PUBLIC HEALTH Agencies

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

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E-mail: info@alphaweb.org

April 5, 2024

Hon. Sylvia Jones
Minister of Health
College Park 5th Flr, 777 Bay St
Toronto, ON M7A 2J3

Dear Minister Jones,

Re: 2023 Chief Medical Officer of Health (CMOH) Annual Report: An All-of-Society Approach to Substance Use and Harms

On behalf of the Association of Local Public Health Agencies (alPHa) and its Boards of Health Section, Council of Ontario Medical Officers of Health Section, and Affiliate Associations, we are writing in response to the Chief Medical Officer of Health's 2023 Annual Report, which addresses substance use and harms and recommends strategies to reduce them.

Public Health has an important mandate in several areas of the Ontario Public Health Standards to reduce harms related to substance use, including activities in chronic disease prevention, injury prevention, social determinants of health and substance abuse prevention and harm reduction. Comprehensive strategies to address the potential harms of substance use can only succeed through a multisectoral combination of interventions: education, early prevention, harm reduction, treatment, and regulation. The CMOH's report strongly supports this approach and suggests specific and evidence-informed policy measures in each of these areas to reduce the rising public health toll of substance use in Ontario.

We are very pleased that Dr. Moore has chosen this as the theme of this year's report, as our members have a long history of highlighting the significant impact of substance use on Ontarians and its burden on public services such as health care and law enforcement. With alPHa as their collective voice, they have endorsed a number of resolutions that are directly connected to the themes of this report. A selection of these is attached, and their connections to the CMOH's observations and recommendations are outlined below.

Resolution A23-02: Toward a Renewed Smoking, Vaping, and Nicotine Strategy in Ontario

This resolution touches upon the ongoing burden of tobacco, with references to the rising prevalence of vaping and cannabis use. It urges the Minister of Health to develop a renewed and comprehensive smoking, vaping, and nicotine strategy, with the support of a multidisciplinary panel of experts, local public health, and people with lived experience. The CMOH outlines the elements of a recommended strategy beginning on page 48.

Resolution A11-1: Conduct a Formal Review and Impact Analysis of the Health and Economic Effects of Alcohol in Ontario and Thereafter Develop a Provincial Alcohol Strategy

This resolution outlines the significant direct and indirect health and economic impacts of alcohol use and asks the Ontario government to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and develop a provincial Alcohol Strategy. The CMOH outlines the elements of a recommended strategy beginning on page 58.

Resolution A22-4: Priorities for Provincial Action on the Drug/Opioid Poisoning Crisis in Ontario.

This resolution outlines the alarming morbidity, mortality, and societal impacts of the ever-worsening drug toxicity crisis in this province. It calls for a collaborative, well-resourced and comprehensive multi-sectoral approach based on nine priorities identified in the appendix. The CMOH outlines elements of a recommended strategy on page 62.

Resolution A19-3: Public Health Approach to Drug Policy

This resolution, which is cited in the CMOH's report among similar positions that support his own recommendation, calls for the decriminalization of the possession of all drugs for personal use, and scaling up prevention, harm reduction and treatment services. These positions support the CMOH's observation that "arresting, charging, and incarcerating people who use drugs have failed as a strategy to reduce harmful opioid use" (p. 61).

Resolution A19-8, Promoting Resilience through Early Childhood Development Programming

This resolution is aligned with the CMOH's observations about the upstream interventions that need to be considered to reduce the risk factors that lead to substance abuse and addictions later in life. These interventions "focus on building stronger families and stronger, more connected communities, addressing systemic and structural determinants of health, and improving health equity". Our resolution calls on the province to support investments in early childhood development to enable health and resiliency throughout life, promote mental health and reduce mental illness and addictions. It also repeats our ongoing call to adequately fund the Healthy Babies Healthy Children program, which is cited in the CMOH report as an existing public health program that would effectively address some of the early drivers of substance use and addictions with proper investment (p. 31).

Resolution A22-5: Indigenous Harm Reduction: A Wellness Journey

This resolution outlines the burden of harm associated with substance use among Indigenous peoples, and calls for the adoption of policies, practices and programs for harm reduction that are culturally safe and rooted in community-knowledge and needs, as well as additional funding to support Indigenous harm reduction interventions. The CMOH similarly outlines the disproportionate impacts of substances and addictions on Indigenous peoples (p. 25) and recommends decolonizing practices and interventions in favour of Indigenous-centred approaches (p. 33).

We recognize that addressing substance use and its harms is multifaceted and complex and appreciate the CMOH's acknowledgement that it is indeed a "balancing act", where there may be tension among a range of valid interests as interventions are considered. This report recognizes the challenges and is deliberate about including the many societal factors and multiplicity of influential policy drivers that should be considered as part of constructive discussion of a strategic approach.

alPHa would like to thank the Chief Medical Officer of Health Dr. Kieran Moore and his staff for their leadership on key evidence-based strategies to prevent and reduce the harms related to tobacco, alcohol, cannabis, and opioids. As he has clearly stated, this is an all-of-society, health-first issue, and the public health sector plays an important role, but we are just one player. We look forward to playing our part in a comprehensive approach to advancing the aims of this important report through our already mandated efforts and related advocacy.

We look forward to working with you and welcome any questions you may have. Please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

Dr. Charles Gardner,
President

Copy: Hon. Doug Ford, Premier of Ontario
Deborah Richardson, Deputy Minister of Health
Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health

Encl.

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to Ontario's boards of health. alPHa represents all of Ontario's 34 boards of health, medical officers and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology, and business administration. As public health leaders, alPHa advises and lends expertise to members on the governance, administration, and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective, and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

Correspondence D

RESOLUTION A23-02

TITLE: **Toward a Renewed Smoking, Vaping, and Nicotine Strategy in Ontario**

SPONSOR: **Simcoe Muskoka District Health Unit (SMDHU)**

WHEREAS commercial tobacco use remains the leading preventable cause of death and disease in Ontario and Canada; and

WHEREAS the direct and indirect financial costs of tobacco smoking are substantial and were estimated at $7 billion in Cancer Care Ontario and Public Health Ontario's 2019 report The Burden of Chronic Diseases in Ontario; and

WHEREAS the prevalence of cigarette smoking among Ontarians aged 15 years and older in 2020 was 9.9%, amounting to 1,222,000 people; and

WHEREAS the commercial tobacco control landscape has become more complex with the rapid rise of vaping among youth, as well as the concerning prevalence of waterpipe and cannabis smoking; and

WHEREAS the membership previously carried resolution A21-1 proposing policy measures to address youth vaping for implementation at the provincial and federal levels, several of which have yet to be implemented; and

WHEREAS the membership previously carried resolution A17-5 recommending that the provincial tobacco control strategy be aligned with the tobacco endgame in Canada; and

WHEREAS Ontario and Canada have made great strides in commercial tobacco control in Ontario, which are now endangered by the lack of a provincial strategy and infrastructure to support its continuation; and

WHEREAS disproportionate commercial tobacco and nicotine use and associated health burdens exist among certain priority populations;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies write to the Ontario Minister of Health recommending that a renewed and comprehensive smoking, vaping, and nicotine strategy be developed with the support of a multidisciplinary panel of experts, local public health, and people with lived experience;

AND FURTHER that the Association of Local Public Health Agencies recommend that, in the development of a target for such a provincial strategy, the expert panel examine the sufficiency and inclusiveness of Canada's Tobacco Strategy target of less than 5% commercial tobacco use by 2035 with respect to all nicotine delivery products;

AND FURTHER that the Association of Local Public Health Agencies recommend that the pursuit of health equity be foundational to such a provincial strategy;

AND FURTHER that a copy be sent to the Chief Medical Officer of Health of Ontario.

BACKGROUND:

TOWARD A RENEWED COMMERCIAL TOBACCO AND NICOTINE STRATEGY IN ONTARIO

1. Commercial Tobacco

Canada has made great strides in commercial tobacco[1] control, and Ontario has until recent years been a leader among our provinces and territories, having made tremendous progress in decreasing smoking rates and in turn the negative health outcomes of smoking. Smoking prevalence among Canadians and Ontarians 15 years and older have dropped from 25% and 23%, respectively, in 1999 down to around 10% in 2020.[1] This decrease is representative of a remarkable downward trend nationally and provincially that appear to be on track to reach the endgame goal of less than 5% tobacco use by 2035, a target adopted by the federal government in Canada's Tobacco Strategy[2] and previously recommended for adoption in Ontario[3]. The recent Report of the First Legislative Review of the *Tobacco and Vaping Products Act* elaborates on this trend, noting that "declines in the number of young persons who smoke played an important role in declining prevalence rates overall; smoking rates among Canadians aged 15-19 are currently at an all-time low."[4]

However, it is crucial to note that this progress was achieved over decades, with explicit commercial tobacco control strategies in place to guide tobacco control research, policy development, and policy implementation; all this work was also undergirded by a robust infrastructure. Recent examples of progress in the federal policy arena include the implementation of policies around plain and standardized packaging for commercial tobacco products and enhanced package health warnings, as well as a ban on flavours in cigarettes and most cigars. Provincially, Ontario has strengthened its commercial tobacco contraband measures.

While Canada retains a strategy, Ontario is now operating without one—and there is still much work to be done: Tobacco use remains the leading preventable cause of death and disability in Canada,[5,6] killing approximately 48,000 Canadians each year,[2] of which nearly 17,000 are Ontarians.[7] The Ontario Public Health Standards' *Tobacco, Vapour and Smoke Guideline, 2021* states that "[e]very day tobacco kills more Ontarians than alcohol, illegal drugs, accidents, suicides and homicides combined. People who use tobacco are more likely to go to the hospital and stay longer. They are also likely to die younger."[8] The economic burden is similarly immense: While updated data on the economic burden of tobacco use is needed, 2017 data indicated health care costs of $6.1 billion and overall costs of $12.3 billion nationally.[9] In Ontario, a separate report determined the overall annual economic burden of tobacco smoking to be around $7 billion, exceeding that of alcohol consumption, physical inactivity, or unhealthy eating, taken separately.[10]

2. Vaping

The landscape of commercial tobacco and nicotine products has become more complex with the advent of vaping products containing nicotine, which includes electronic cigarettes (e-cigarettes), the primary users of which are youth. Vaping is the "act of inhaling and exhaling an aerosol produced by a vaping product, such as an electronic cigarette."[11] Most vaping devices use electrical power from a battery to heat a liquid solution to produce an aerosol that is breathed in by the user through the mouthpiece. Most vaping liquids contain nicotine, the levels of which range from very low to more than what is found in a typical tobacco cigarette, together with flavouring compounds that are dissolved in a liquid mixture

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[1] Commercial tobacco is distinct from traditional or ceremonial use of tobacco by Indigenous peoples. In the implementation and enforcement of the *Smoke-Free Ontario Act, 2017*, the Ministry of Health protects the use of tobacco by Indigenous peoples and communities when used for traditional or ceremonial purposes.

composed typically of propylene glycol and/or glycerol (i.e., vegetable glycerin).[11] Some vaping liquids also contain cannabis.[12]

National data from 2021 indicates that 13% of adolescents aged 15 to 19 years and 17% of young adults aged 20 to 24 years in Canada reported having vaped at least once during the 30-day period before the survey, compared with 4% of adults aged 25 or older.[13] Provincially, there has been a meteoric rise in youth vaping rates in recent years: According to the Ontario Student Drug and Health Survey, grade 7–12 students who reported used vaping products in the past year doubled from 11% in 2017 to 23% in 2019, with 13%—representing approximately 105,600 students—vaping weekly or daily.[14] These rates are particularly alarming among students in higher grades: The 2019 survey indicated that 35% of students in grade 12 vaped in the past year, of which 21% were vaping weekly or daily.[14] Moreover, among students who vaped in the past year, those who reported using a nicotine-containing product doubled from 28% in 2017 to 56% in 2019.[14] The more recent 2021 survey noted a decrease of past-year vaping among students to 15%. However, those who reported using a nicotine-containing product increased further to 84%, implying that the overall percentage of students vaping nicotine-containing products remained approximately the same as in 2019. There are several challenges to interpretation of the 2021 survey results. For example, the change to an online mode of questionnaire delivery for 2021 led to dramatically decreased response rates that may impact the provincial representativeness of the results.[15] The report also indicates that "because of the significant changes to the methodology in 2021, caution is warranted when comparing these estimates with those from previous OSDUHS cycles."[15] More broadly, both the COVID-19 pandemic as well as changes to the federal and provincial regulatory and policy environments since 2019 have likely impacted the prevalence of youth vaping; however, longitudinal assessments have been disrupted by the pandemic and therefore the extent of impacts is unknown. Further monitoring, data collection and evaluation is needed to understand the impact of these changes and events on adolescent vaping initiation, escalation, and overall prevalence.

Regardless of the method of delivery, the highly addictive effects of nicotine are fundamentally the same, and may have particularly insidious effects on the developing brains of youth.[16,17] Although vaping products have been advertised in part as a harm reduction and smoking cessation product that may reduce health risks and possibly save lives for people who smoke, with some evidence to support this claim,[18,19] there has been no discernible population-level change in smoking cessation rates since vaping products entered the market.[20] Therefore, any individual-level efficacy of vaping products as a smoking cessation tool does not appear to translate to population-level impact. Furthermore, the vast majority of uptake has been among youth without a smoking history. In fact, among those who reported having vaped in the past 30 days, a majority (61%) of youth aged 15 to 19 and more than one-quarter (27%) of young adults aged 20 to 24 had never tried a tobacco cigarette in their life, which suggests that the majority of youth are not using vaping devices to reduce or quit smoking.[13] Therefore, the current evidence around the benefits of vaping products for the purpose of smoking cessation, while still evolving, is not of relevance to youth. In contrast, the evidence to date around the harms of vaping is becoming increasingly clear; in particular, people who vape but do not smoke are on average around three times more likely than those who do not vape to initiate cigarette smoking,[21,22] lending credence to the concern of a gateway effect. Additional evidence of harms from vaping includes the following:

- A variety of substances known to be toxic, carcinogenic, or cause disease have been identified in vaping products.[23]
- Intentional or accidental exposure to nicotine e-liquids can lead to poisoning, which can be lethal, with a significant number of accidental poisonings occurring in children under the age of six.[21]
- Vaping can cause burns and injuries, which can be lethal.[21]
- Vaping can cause respiratory disease in the form of E-cigarette or Vaping Use-Associated Lung Injury (EVALI).[21]
- Vaping can lead to seizures.[21]

- Vaping products contribute to environmental waste.[21]

Moreover, there are differences between vaping and smoking dependence that may impact attempts to quit, including the greater variability in vaping products compared to cigarettes, the discreteness and convenience of vaping, and the greater social acceptability of vaping among youth.[24] To address the rise of vaping, Ontario has required retail registration with local public health units for sale of flavoured vaping products (except mint-menthol or tobacco flavours), restricted sale of flavoured products (except mint-menthol and tobacco flavours) to specialty vape stores, banned sale of vaping products in several public premises, and banned their use in most public premises, though with notable exceptions such as post-secondary institutions. There are also several promising local and regional campaigns such as "Not an Experiment"[25] aiming to raise awareness among youth, parents, and educators about the risks of vaping. However, more control measures and interventions, as well as evaluation of their effectiveness, are needed to protect youth from the harms of both vaping as well as all future commercial nicotine delivery products.

3. Waterpipe smoking

Also referred to as "shisha" or "hookah", waterpipe smoking involves smoking a heated tobacco or non-tobacco "herbal" product.[26] Its increase in prevalence globally may be explained in part by misconceptions of lesser harm relative to other forms of tobacco smoking, its social nature, and the availability of various flavours and nicotine-free products.[26] However, waterpipe smoking of both tobacco and non-tobacco products results in inhalation of various carcinogens and toxins, and results in similar negative health effects to cigarette smoking.[26] Moreover, while the *Smoke-Free Ontario Act, 2017* prohibits the use of tobacco in waterpipes in restaurants and bar patios, the use of non-tobacco products in waterpipes is still permitted, impacting not only waterpipe smokers but also the public through secondhand and thirdhand smoke.[26]

4. Cannabis smoking

Cannabis, which can be consumed by various means including smoking, vaping, and ingestion, refers to all products derived from the *Cannabis sativa* plant, and can consist of up to approximately 540 different chemical substances, among which the main psychoactive constituent is tetrahydrocannabinol (THC).[27] The federal *Cannabis Act* came into force in October 2018, resulting in legalization and regulation of production, distribution, sale, import, export, and possession of cannabis for adults of legal age.[28] The 2021 Canadian Cannabis Survey indicates that approximately 25% of Canadians have reported using cannabis in the past 12 months, of whom 74% reported smoking as one method of cannabis consumption.[12] In addition to an array of health effects associated with cannabis consumption, smoked cannabis in particular can increase risk of bronchitis, lung infections, and chronic cough.[29] The *Smoke-Free Ontario Act, 2017* prohibits the smoking of cannabis in enclosed workplaces, enclosed public places, and other designated places.

5. Ontario's commercial tobacco and nicotine control landscape

Despite concerted efforts through research and reports providing evidence-informed recommendations towards a "tobacco endgame" culminating in the *Smoke-Free Ontario Modernization* report in 2017,[3] there has been limited incorporation of these recommendations into the province's approach to commercial tobacco and nicotine control.[30] For example, actions to increase the cost of commercial tobacco products through tax and other pricing policies have been limited; Ontario continues to have the second lowest retail price and total tobacco tax for tobacco products in Canada.[31,32] Moreover, among the many programs and services that have been lost during the COVID-19 pandemic, commercial tobacco and nicotine prevention, protection, and cessation programs have been significantly impacted. Indeed, the

broader commercial tobacco control infrastructure in Ontario has declined substantially both before and during the pandemic, a decline that is closely tied to the loss of a provincial strategy. With the loss of the Smoke-Free Ontario Strategy, the following crucial infrastructure has been lost: the Smoking and Health Action Foundation, the Leave the Pack Behind program, the Youth Advocacy Training Institute as well as the associated youth advocacy programming, the Program Training and Consultation Centre, funding to public health units for youth and young adults as staff, Smokers' Helpline telephone counselling, Registered Nurses Association of Ontario special projects for tobacco control, Heart & Stroke Foundation of Ontario mass media campaigns, and provincial mass media campaigns. In addition, provincial funding has been reduced for monitoring, research, and evaluation, which has impacted the activities of organizations such as the Ontario Tobacco Research Unit. Funding from other sources such as NGOs has also been lost for organizations such as the Ontario Campaign for Action on Tobacco. Furthermore, many stakeholder engagement opportunities at the provincial level, such as through the Tobacco Control System Committee, the Youth Prevention Task Force, the Communications and Marketing Advisory Committee, the Protection and Enforcement Task Force, the Research and Evaluation Task Force, the Capacity Building and Training Task Force, and monthly calls between Tobacco Control Area Networks and Ministry staff, have been discontinued. Finally, organizations such as Public Health Ontario have had a reduced focus on commercial tobacco and nicotine as an inevitable consequence of the significant resources that have been committed to combatting the COVID-19 pandemic, although their recent re-engagement in this area is inspiring.

These setbacks are compounded by ongoing inequities in the health impacts of tobacco and nicotine use among certain populations. Smoking is a socioeconomically stratified behaviour, as evidenced by decreasing prevalence rates with increasing education.[33] Disproportionate commercial tobacco and nicotine use and associated health burdens exist among Indigenous populations, members of the LGBTQ2S+ community, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals.[2,9,31,34] Moreover, while reaching less than 5% tobacco use by 2035 may be possible with current strategies, such a target on its own does not sufficiently address this disproportionate burden among these populations. When addressing such health inequities among Indigenous peoples, it is also important to take a culturally safe approach that distinguishes between commercial tobacco use and traditional or ceremonial use of tobacco.

6. Examining the policy options

In late 2022, the Simcoe Muskoka District Health Unit (SMDHU) performed a brief jurisdictional scan focusing on recently implemented commercial tobacco and nicotine control policies (see Appendix A) and explored the grey literature to both identify existing policies at the federal and provincial levels, as well as determine some of the priority areas for action for a renewed smoking and nicotine strategy. SMDHU also conducted a conversation with key informants, the key points of which were summarized through the lens of an adapted version of the World Health Organization's MPOWER framework[2] (see Appendix B).[36]

Given the relative recency of vaping as a phenomenon, evidence is emerging related to the effectiveness of interventions to reduce vaping[23,37–41] as well the cost-effectiveness of doing so.[42] Lessons learned from interventions used to combat commercial tobacco use may also be applied to address vaping.[40] However, evaluation will be needed to confirm effectiveness. There have already been a variety of effective

[2] The World Health Organization Framework Convention on Tobacco Control (FCTC) is a legally binding international health treaty on tobacco control, which 182 countries including Canada have ratified.[35] To help countries reduce demand for tobacco, the WHO developed the MPOWER measures: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco.[36]

commercial tobacco and nicotine control interventions implemented in Ontario and other Canadian jurisdictions over the years, but a coordinated, comprehensive, multi-level, evidence-informed, and enduring strategy is needed to achieve the target of less than 5% tobacco use by 2035. Such a strategy would continue to be informed by evidence and focus on the traditional pillars of prevention, cessation, and protection, as well as industry denormalization and engagement of disproportionately impacted groups such as First Nations, Inuit and Métis (FNIM) organizations and communities.[3,9,34,43,44] However, for such a strategy to work, there must be provincial and federal commitments to strong regulations around all alternative methods of nicotine delivery. In particular, the Council of the Chief Medical Officers of Health has recommended a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult who smoke to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

7. Conclusion

Despite significant progress in commercial tobacco control, the health and economic burdens of tobacco-related disease in Canada remain unconscionably high. Moreover, vaping, waterpipe smoking, and cannabis smoking have added further complexity to the smoking and nicotine control landscape that risks undoing the tremendous progress that has been made. A coordinated, comprehensive, and enduring provincial smoking and nicotine control strategy is needed to save lives, protect young minds, reduce health inequities, and save money.

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Appendix A: Jurisdictional Scan of Tobacco and Nicotine Control Policies in Canada

Summary: A jurisdictional scan of Canadian federal, provincial, and territorial tobacco and nicotine control strategies was performed. An array of pre-existing documents[32,46–48] (environmental scans, briefing notes, etc.) produced by Physicians for a Smoke-Free Canada (PSC) cover similar objectives, and therefore constitute a major contribution to this scan. Overall, strategies have continued to focus on efforts surrounding the four pillars of prevention, cessation, protection and denormalization, with varying degrees of emphasis on each. However, the last few years have seen a deceleration in commercial tobacco control efforts, while vaping products have taken the spotlight, particularly following the amendment of the *Tobacco Act* in 2018 to become the *Tobacco and Vaping Products Act* (TVPA).

With respect to commercial tobacco control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- plain and standardized packaging
- enhanced package health warnings
- ban on flavours in cigarettes and most cigars including menthol and cloves
- additional contraband measures in some jurisdictions

With respect to vaping control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- taxes on vaping products
- retail licensing/registration
- minimum age restrictions
- requiring proof of age in stores
- display bans in stores
- restriction to sale in specialty vape stores
- bans on internet sales
- bans on incentives to retailers
- bans on non-tobacco flavours
- bans on various forms of advertisement
- restrictions on nicotine content
- health warnings

There are also plans at the federal level for implementing "reporting requirements that would require vaping product manufacturers to submit information to Health Canada about sales and ingredients used in vaping products."[4]

Limitations: While such a scan would be most useful if it summarized the implementation of the jurisdictional strategies that were identified (in addition to effects of implementation, technical feasibility, political viability, alignment with the Canadian regulatory landscape, etc.), the scan was largely limited to information that could be gleaned from web-based searches of the grey literature. Furthermore, jurisdictions outside of Canada such as New Zealand,[49] Australia,[50,51] Finland[52] and California[53] may provide further insights into tobacco and nicotine control, but were not covered in this scan.

Table A1: Jurisdictional Scan Results

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
Fed	Canada's Tobacco Strategy[2] (2018)	• Supports endgame goal of less than 5% by 2035. • Note: In 2020/2021, Health Canada changed its progress indicator from "percentage of Canadians (aged 15+) who have used any tobacco product in the last 30 days" to "Percentage of Canadians (aged 15+) who are current cigarette smokers."[54]	• Vaping products: ban on ads in stores (except age-restricted stores), display ban, ban on broadcast ads, ban on billboards/outdoor signs, ban on lifestyle ads, ban on sponsorships, ban on youth-appealing ads, health warnings / labelling requirements, restriction on nicotine content (max 20 mg/mL), excise tax, plan to ban all flavours except tobacco and mint-menthol, plan to impose vaping product reporting requirements, compliance and enforcement activities • Tobacco products: Plain and standardized packaging, enhanced package health warnings, ban on flavours in cigarettes and most cigars including menthol and cloves
BC	BC's Tobacco Control Strategy: targeting our efforts[55]	• No endorsement of endgame goal • BC's 2013 Guiding Framework for Public Health[56] targets a reduction of smoking to 10% by 2023. • In the 2018 report First to 5% by 2035[57], the Clean Air Coalition of BC recommended that BC be the first jurisdiction to achieve 5% by 2035, but there is no evidence of endorsement by government.	• Vaping products: tax, retail notification and reporting requirement, sale of flavoured products restricted to specialty vape stores, ban on sale and use in some public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents, second highest level of overall taxation on cigarettes ($15.30 for a 20-pack), highly regarded stop-smoking service model, some exemplary practices in Indigenous stewardship
AB	Creating Tobacco-free Futures: Alberta's Strategy to Prevent and Reduce Tobacco Use 2012-2022[58]	• No endorsement of endgame goal • 10-year targets set for 2022: - Albertans ages 15 and over: 12 % - Albertans ages 12 to 19: 6% - Albertans ages 20 to 24: 20% - Pregnant women in Alberta: 11%	• Vaping products: ban on possession below minimum legal age, ban on sale in some public premises, ban on use in most public premises including outdoor cultural events

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
		- Reduce estimated per capita tobacco sales by 50 per cent to 745 units in 2022.	
SK	No strategic document identified. Public-facing Information available on their Tobacco and Vapour Products webpage.	• No endorsement of endgame goal • The Saskatchewan Coalition for Tobacco Reduction produced a report entitled Protecting our Future: Recommendations to reduce tobacco use in Saskatchewan, but this document does not appear to have been endorsement by government.	• Vaping products: tax, ban on sale and use in some public premises
MB	No strategic document identified. Public-facing information available on their Smoking, Vaping Control & Cessation webpage.	• No endorsement of endgame goal	• Vaping products: ban on sale and use in some public premises
ON	Smoke-Free Ontario: The Next Chapter - 2018[30] Note: This strategy was neither adopted nor implemented by the present government.	• No endorsement of endgame goal • Reduce smoking to 10% by 2023 • Reduce the number of smoking-related deaths by 5,000 each year. • Reduce exposure to the harmful effects of tobacco and the potentially harmful effects of other inhaled substances and emerging products (including medical cannabis).	• Vaping products: retail registration with local public health unit required for sale of flavoured products (not tobacco or mint-menthol), sale of flavoured products (except tobacco and menthol) restricted to specialty vape stores, ban on sale in several public premises, ban on use in most public premises (post-secondary institutions excluded) • Tobacco products: additional contraband measures
QC	Stratégie pour un Québec sans tabac 2020-2025[59] (see Appendix A for summary English translation)	• No endorsement of endgame goal • Reduce smoking to 10% by 2025.	• Vaping products: retail notification requirement, ban on internet sale and on incentives to vaping product retailers, ban on sale in most public premises, ban on use in many public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents
NB	New Brunswick's Tobacco-Free	• **Supports endgame goal of less than 5% by 2035.**	• Vaping products: retail licensing/registration, ban on all

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	Living Strategy: A Tobacco and Smoke-Free Province for All[60] (2019-2023) was produced by the NB Anti-Tobacco Coalition, funded by the Government of NB.		flavours except tobacco, ban on use in most public premises
NS	Moving toward a Tobacco-Free Nova Scotia: Comprehensive Tobacco Control Strategy for Nova Scotia[61] (2011) Public-facing information available on their Tobacco Free Nova Scotia webpage.	• No endorsement of endgame goal • Decrease tobacco use rates individuals aged 15-19 years to 10%, 20-24 years to 20%, and 25 years and older to 15%.	• Vaping products: retail licensing/registration, tax, ban on all flavours except tobacco, ban on sale and use in most public premises (post-secondary institutions included)
PEI	No strategic document specific to tobacco control identified. Tobacco control is addressed in PEI's Wellness Strategy[62] (2015-2018)	• No endorsement of endgame goal	• Vaping products: Sale restricted to age 21 years and above and only in specialty stores, ban on all flavours except tobacco, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included)
NL	Tobacco and Vaping Reduction Strategy[63] (2021) produced by the Newfoundland and Labrador Alliance for the Control of Tobacco, which is an alliance of government and non-government partners.	• No endorsement of endgame goal Action areas: • Community capacity building • Education and awareness • Healthy public policy • Cessation and treatment services • Research, monitoring and evaluation	• Vaping products: retail licensing/registration, tax, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included) • Highest level of overall taxation on cigarettes ($15.71 for a 20-pack)
YT	No strategic document identified. Public-facing information available on	• No endorsement of endgame goal	• Vaping products: ban on use in many public premises

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	government webpage.		
NWT	No strategic document identified. Public-facing information available on Tobacco Control webpage.	• No endorsement of endgame goal	• Vaping products: ban on all flavours except tobacco, ban on possession below minimum legal age, ban on sale in some public premises, ban on use in many public premises
NU	Nunavut Tobacco Reduction Framework for Action[64] (2011-2016)	• No endorsement of endgame goal • Guiding principles draw from Inuit culture and practices. • Supports a coordinated communications plan using a range of media tools and using both universal and targeted approaches (including youth, pregnant women and their partners, and parents and Elders). • Younger age group is targeted through school and community youth programs because youth initiate tobacco use largely between 8 and 16 years of age.	• Vaping products (per Tobacco and Smoking Act[65], which received Assent on June 8, 2021, but is not anticipated to come into force until 2023): plan to consider vaping product price restrictions, plan to ban incentives to vaping product retailers, plan to ban sale and use in most public premises, plan to ban all flavours except tobacco and any product designed for use as flavouring for any smoking product, plan to make all publicly funding housing smoke-free, plan for biennial reporting requirements for vape retailers

Appendix B: Priorities for a Provincial Smoking and Nicotine Strategy — Key Informant Conversation Summary

To inform the call for a renewed and comprehensive provincial commercial tobacco and nicotine strategy, the Simcoe Muskoka District Health Unit (SMDHU) conducted a conversation on November 17, 2022, with a panel of key informants with extensive experience in commercial tobacco control in Ontario and Canada, in addition to following up individually upon request from some key informants for further discussion. The meeting was framed as an informal discussion around commercial tobacco and nicotine control, using past strategies and reports as a springboard to identify provincial priorities for a renewed commercial tobacco and nicotine strategy, as well as federal priorities to address relevant policy gaps.

Participants included:

- John Atkinson, Executive Director, Ontario Public Health Association
- Cindy Baker-Barill, Smoke-Free Program Manager, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU
- Hillary Buchan-Terrell, Advocacy Manager (Ontario), Canadian Cancer Society
- Cynthia Callard, Executive Director, Physicians for a Smoke-Free Canada
- Vito Chiefari, Manager, Health Protection, Community & Health Services Dept, York Region
- Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society
- Dr. Charles Gardner, Medical Officer of Health and Chief Executive Officer, SMDHU
- Dr. Lesley James, Director, Health Policy & Systems, Heart & Stroke Foundation
- David Neeson, Supervisor, Tobacco and Electronic Cigarette Control Team, Health Protection Division, Community and Health Services, York Region
- Michael Perley, former Director, Ontario Campaign for Action on Tobacco
- Dr. Emil Prikryl, Public Health and Preventive Medicine Resident, NOSM University
- Dr. Steven Rebellato, Vice President, Environmental Health Department, SMDHU
- Dr. Robert Schwartz, Executive Director, Ontario Tobacco Research Unit and Professor, Dalla Lana School of Public Health
- Linda Stobo, Program Manager, Substance Use Program, Healthy Living Division, Middlesex-London Health Unit
- Melissa van Zandvoort, Health Promotion Specialist, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU

While it is our recommendation that the development of a renewed strategy be supported by a multidisciplinary panel of experts, Table B1 frames the priorities identified during the key informant conversation through the lens of an expanded version of the World Health Organization's MPOWER framework (i.e., MPOWER+):

Table B1: Priorities within the MPOWER+ Framework

MPOWER+ Measure	Priorities
Monitor tobacco and vaping use and prevention, cessation and protection/enforcement programs and policies.	• Re-invest in research/monitoring and evaluation to ensure practice and policy decisions are based on evidence. • Continue to explore age restrictions for smoking and vaping.
Protect people from tobacco smoke and e-cigarette aerosol.	• Further expand smoke- and vape-free public places. • Continue to increase access to smoke- and vape-free housing. • Direct focus towards consumer rights to be protected from marketing of nicotine products.
Offer help to quit smoking and vaping.	• Increase subsidization of smoking cessation pharmacotherapy for all residents.
Warn about the dangers of commercial tobacco and vaping products.	• Implement mass media and social marketing campaigns of greater intensity and duration targeted at youth and young adults addressing the real and potential harms of vaping such as its impacts on mental health, addiction, and environmental waste. • Implement mass media and social marketing campaigns of greater intensity and duration targeted at high-risk populations addressing the harms of smoking and the benefits of quitting.
Enforce bans on commercial tobacco and vaping product advertising, promotion and sponsorship.	• Return the focus of nicotine control efforts to the industry through activities such as leveraging litigation opportunities to further denormalize the industry and hold industry accountable for past and future harms to society. • Ban all flavours except tobacco flavour (if not achieved federally). • Restrict availability in brick-and-mortar settings and online access. • Strengthen retail registration and licensing requirements. • Further regulate vaping product design (e.g., plain and standardized packaging for vaping, health warnings). • Intensify tobacco and vaping product advertising promotion and sponsorship bans.

MPOWER+ Measure	Priorities
	• Ensure continued funding for enforcement through the *Smoke-Free Ontario Act, 2017*.
Raise taxes on commercial tobacco and vaping products.	• Implement a tax on vaping products, as well as regulatory fees as a means of cost recovery. • Further increase taxes on combustible tobacco products.
+ **Add** a strong health equity lens by linking commercial tobacco and nicotine control approaches to broader objectives addressing health inequities.	• Address the disproportionate use of commercial tobacco and nicotine use and associated health burdens among Indigenous populations, members of the LGBTQ2S+ community, youth, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals.
Add bold interventions as indicated by evidence to further reduce the supply, demand, and access of all current and future industry nicotine delivery systems.	• Implement recommendations from the Council of Chief Medical Officers of Health to develop a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult smokers to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

alPHa RESOLUTION A11-1

TITLE: **Conduct a Formal Review and Impact Analysis of the Health and Economic Effects of Alcohol in Ontario and Thereafter Develop a Provincial Alcohol Strategy**

SPONSOR: **Middlesex-London Board of Health**

WHEREAS There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol; and (Barbor et al., 2010)

WHEREAS Ontario has a significant portion of the population drinking alcohol (81.5%), exceeding the low risk drinking guidelines (23.4%), consuming 5 or more drinks on a single occasion weekly (11.2%), and reporting hazardous or harmful drinking (15.6%); and (CAMH Monitor)

WHEREAS Ontario youth (grades 9-12) have concerning levels of alcohol consumption with 69.4% having drank in the past year, 32.9% binge drinking (5 or more drinks), and 27.5% of students reporting drinking at a hazardous level; and (OSDUHS Report)

WHEREAS Each year alcohol puts this province in a $456 million deficit due to direct costs related to healthcare and enforcement; and (G. Thomas, CCSA)

WHEREAS Billions of dollars are spent each year in Canada on indirect costs associated with alcohol use (illness, disability, and death) including lost productivity in the workplace and home; and (The Costs of Sub Abuse in CAN, 2002)

WHEREAS Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (drowning, burns, poisoning and falls) and intentional injuries (deliberate acts of violence against oneself or others); and (WHO – Alcohol and Injury in EDs, 2007)

WHEREAS Regulating the physical availability of alcohol is one of the top alcohol policy practices in reducing harm; and (Barbor et al., 2010)

WHEREAS The World Health Organization (WHO, 2011) has indicated that alcohol is the world's third largest risk factor for disease burden and that the harmful use of alcohol results in approximately 2.5 million deaths each year. Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and develop a provincial Alcohol Strategy.

ACTION FROM CONFERENCE: **Resolution CARRIED**

alPHa RESOLUTION A22-4

TITLE: **Priorities for Provincial Action on the Drug/Opioid Poisoning Crisis in Ontario**

SPONSOR: **Council of Ontario Medical Officers of Health (COMOH)**

WHEREAS the ongoing drug/opioid poisoning crisis has affected every part of Ontario, with the COVID-19 pandemic further exacerbating the issue, leading to a 73% increase in deaths from opioid-related toxicity from 2,870 deaths experienced in the 22 months prior to the pandemic (May 2018 to February 2020) to 4,951 deaths in the 22 months of available data since then (March 2020 to December 2021); and

WHEREAS the burden of disease is particularly substantial given the majority of deaths that occurred prior to the pandemic and the increase during the pandemic have been in young adults, in particular those aged 25-44, and the extent of the resulting trauma for families, front line responders, and communities as a whole cannot be overstated; and

WHEREAS the membership previously carried resolution A19-3, asking the federal government to decriminalize the possession of all drugs for personal use based on broad and inclusive consultation, as well as supporting robust prevention, harm reduction and treatment services; and

WHEREAS the membership previously carried resolution A21-2, calling on all organizations and governmental actors to respond to the opioid crisis with the same intensity as they did for the COVID-19 pandemic; and

WHEREAS the Association of Local Public Health Agencies (alPHa) has identified that responding to the opioid crisis is a priority area for local public health recovery in their *Public Health Resilience in Ontario* publication (Executive Summary and Report); and

WHEREAS recognizing that any responses to this crisis must meaningfully involve and be centred-around people who use drugs (PWUDs), inclusive of all backgrounds, and must be founded not only on evidence- and trauma-informed practices but also equity, cultural safety, anti-racism as well as anti-oppression; and

WHEREAS COMOH's Drug / Opioid Poisoning Crisis Working Group has recently identified nine provincial priorities for a robust, multi-sector response that is necessary in response to this crisis (see Appendix A); and

WHEREAS local public health agencies are well positioned, with additional resourcing, to play an enhanced role in local planning, implementation and coordination of the following priority areas: harm reduction, substance use prevention and mental health promotion, analysis, monitoring and reporting of epidemiological data on opioid and other substance-

related harms, health equity and anti-stigma initiatives, efforts towards healthy public policy related to substance use including but not limited to decriminalization, and providing and mobilizing community leadership; and

WHEREAS this work of local public health agencies aligns with the Substance Use and Harm Reduction Guideline (2018) and the Health Equity Guideline (2018) under the Ontario Public Health Standards;

THEREFORE BE IT RESOLVED that alPHa endorse the nine priorities for a provincial multi-sector response;

AND FURTHER that the noted provincial priorities and areas of contribution by local public health agencies be communicated to the Premier, Minister of Health, Associate Minister of Mental Health & Addictions, Attorney General, Minister of Municipal Affairs & Housing, Minister of Children, Community & Social Services, Chief Medical Officer of Health, Chief Executive Officer (CEO) of Ontario Health and CEO of Public Health Ontario;

AND FURTHER that alPHa urge the above mentioned parties to collaborate on an effective, well-resourced and comprehensive multi-sectoral approach, which meaningfully involves and is centred-around PWUDs from of all backgrounds, and is based on the nine identified provincial priorities.

AND FURTHER that alPHa recommend the provincial government consider the potential role and appropriate timing of declaring the drug poisoning crisis in Ontario as an emergency under the Emergency Management and Civil Protection act (R.S.O. 1990).

CARRIED AS AMENDED

Appendix A – Priorities for a Provincial Multi-Sector Response

The following was developed by the Drug / Opioid Poisoning Crisis Working Group of COMOH, and shared with the COMOH membership for review at its general meeting on April 27th, 2022:

1. Create a **multi-sectoral task force**, including people with lived experience of drug use, to guide the development of a robust, integrated provincial drug poisoning crisis response plan. The plan should ensure necessary resourcing, health and social system coordination, policy change, and public reporting on drug-related harms and the progress of the response. An **integrated approach** is essential, to address the overlap between the use of various substances, to integrate aspects of the response such as treatment and harm reduction, and to ensure a common vision for addressing health inequities and preventive opportunities.

2. Expand access to **harm reduction** programs and practices (e.g. Consumption and Treatment Service (CTS) sites, Urgent Public Health Needs Sites (UPHNS), drug checking, addressing inhalation methods as a key route of use and poisonings, and exploring the scale up of safer opioid supply access).

3. Enhance and ensure sustainability of support for substance use **prevention** and mental health promotion initiatives, with a focus from early childhood through to adolescence.

4. Expand the collection, analysis and reporting of timely integrated **epidemiological data** initiatives, to guide resource allocation, frontline programs and services, and inform healthy public policy.

5. Expand access to **treatment** for opioid use disorder, including opioid agonist therapy in a range of settings (e.g., mobile outreach, primary care, emergency departments) and a variety of medication options (including injectable). To support the overall health of PWUDs, also connect with and expand access to care for other substances, for mental illness and trauma as key risk factors for drug use, and for comprehensive medical care for PWUDs.

6. Address the structural **stigma**, discrimination and related harms that create systemic barriers for PWUDs, through re-orienting systems for public health, first responders, health care, and social services, to address service provider and policy-level stigma, normalize services for drug use, and better meet the needs of PWUDs. Also, support community and community leadership conversations to address drug use stigma and its societal consequences.

7. Advocate to and support the Federal government to **decriminalize** personal use and possession of substances, paired with increased investments in health and social services and a focus on health equity at all levels. These efforts aim to address the significant health and social harms of approaches that criminalize PWUDs, including Black, Indigenous and other racialized communities.
8. Acknowledge and address **socioeconomic determinants of health**, **systemic racism**, and their intersections that are risk factors for substance use and substance use disorders, and pose barriers to accessing supports. This includes a need for more affordable and supportive **housing** for PWUDs, and efforts to further address **poverty** and **unemployment/precarious employment**.

9. Provide funding and other supports to enable consistent **community leadership** by PWUDs and by community organizations, including engagement with local drug strategies. People who bring their lived experience should be paid for their knowledge contribution and participation at community tables.

alPHa RESOLUTION A19-3

TITLE: **Public Health Approach to Drug Policy**

SPONSOR: **Toronto Public Health**

WHEREAS governments around the world are considering different approaches to drugs, including the decriminalization of drug use and possession and legal regulation, including here in Canada for non-medical cannabis; and

WHEREAS a growing number of health officials and boards of health are calling for changes to our approach to drugs, especially in the midst of the opioid poisoning crisis in which the contaminated, unregulated supply of illegal drugs is the main contributor to the crisis; and

WHEREAS laws that criminalize people simply for using and possessing drugs have resulted in serious health and social harms, including forcing people into unsafe spaces and high-risk behaviours leading to HIV and HCV infection, resulting in criminal records that make it difficult to obtain employment and housing, and reinforcing negative stereotypes and judgements about people who use drugs; and

WHEREAS some groups are more impacted by our drug laws than others, including people who are homeless and/or living in poverty, people with mental health and substance use issues, people from racialized groups, Indigenous people, women and youth; and

WHEREAS a public health approach to drugs would be based on principles and strategies that have been shown to support healthy individuals, families and communities; and

WHEREAS countries that have decriminalized personal drug use and possession and invested in public health interventions have seen results, including decreases in HIV and overdose, decreases in costs to the criminal justice system, and improved police/community relationships; and

WHEREAS the evidence on the health and social harms of our current criminalization approach to illegal drugs as well as that of alternative approaches such as decriminalization and legal regulation strongly support the need to shift to a public health approach to drugs in Canada;

NOW THEREFORE BE IT RESOLVED that the federal government be urged to decriminalize the possession of all drugs for personal use, and scale up prevention, harm reduction and treatment services;

AND FURTHER that the federal government convene a task force, comprised of people who use drugs, family members, and policy, research and program experts in the areas of public health, human rights, substance use, mental health, and criminal justice, to explore options for the legal regulation of all drugs in Canada, based on a public health approach.

ACTION FROM CONFERENCE: Carried as amended

alPHa RESOLUTION A19-8

TITLE: **Promoting Resilience through Early Childhood Development Programming**

SPONSORS: **Northwestern Health Unit**
Thunder Bay District Health Unit
Middlesex-London Health Unit

WHEREAS one in five Canadians are affected by mental illness or an addiction issue every year, and the burden of illness is more than 1.5 times the burden of all cancers and 7 times the burden of all infectious diseases; and

WHEREAS suicide is the second leading cause of mortality among young Canadians aged 10-24 and suicide accounted for 24% of all deaths among youth 15 to 24 years old from 2009-2013; and

WHEREAS there were more than 9,000 deaths in Canada from 2016 to 2018 and more than 1,250 deaths in Ontario in 2017 related to opioids; and

WHEREAS the annual economic burden of mental illness is approximately 51 billion in Canada with a substantial impact on emergency room departments and hospitals; and

WHEREAS 70% of mental health and substance use problems begin in childhood; and adverse childhood experiences, such as poor attachment to parents, child abuse, family conflict and neglect, have been clearly linked to risk for mental illness and addiction later in life; and

WHEREAS programming that enhances the early childhood experience has proven benefits in IQ levels, educational achievements, income levels, interactions with the criminal justice system and utilization of social services; and

WHEREAS every $1 invested in early childhood development can save $9 in future spending on health, social and justice services; and

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to the child's transition to school) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the HBHC program provides home visiting services and home visiting programs have demonstrated effectiveness in enhancing parenting skills and promoting healthy child development in ways that prevent child maltreatment; and

WHEREAS the HBHC program supports the early childhood experience and development of resiliency by enhancing the parent-child attachment, parenting style, family relationships, and financial instability and addressing parental mental illness and

substance misuse, child abuse or neglect thereby reducing the risk of subsequent mental illness and addictions; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008 with the exception of increased base funding in 2012 for an increase in public health nursing positions for Healthy Babies Healthy Children program as part of the 9,000 Nurses Commitment; and

WHEREAS fixed costs such as salaries and benefits, travel, supplies, equipment and other operational costs have increased the costs of operating the HBHC program, and

WHEREAS operating the HBHC program with the existing funding has become increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) actively engage with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to support investments in early childhood development as a strategy to enable health and resiliency throughout life, promote mental health and reduce mental illness and addictions;

AND FURTHER that alPHa engage with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to urgently support adequate funding (including staffing and operational costs) of the Healthy Babies Healthy Children program as a strategic immediate action to enhance the early childhood experience and address mental illness and addictions in Ontario;

AND FURTHER that the Chief Medical Officer of Health of Ontario, Ontario Public Health Association, Centre for Addictions and Mental Health and other relevant partner agencies be so advised.

ACTION FROM CONFERENCE: Carried as amended

alPHa RESOLUTION A22-5

TITLE: **Indigenous Harm Reduction: A Wellness Journey**

SPONSOR: **Haliburton Kawartha Pine Ridge District Health Unit**

WHEREAS The burden of harm associated with substance use among Indigenous peoples is far reaching. From 2009 to 2019 there has been a 480% increase in hospital visits related to opioid poisoning for First Nation peoples compared to 164% for non- First Nation peoples. The rate of hospital visits for opioid-related poisoning among First Nation peoples totaled 45.1 per 10,000. First Nation peoples living outside of First Nations communities experienced the highest rate of hospital visits for opioid-related poisoning at 57.5 per 10,000 people. The rate of hospital visits for opioid-related poisoning among First Nation peoples living within First Nations communities was 19.6 per 10,000 people, and the rate among non-First Nation peoples was 6.0 hospital visits per 10,000 people. There is a gap in readily available Ontario surveillance data specific to alcohol, prescription drug, and other substance misuse in addition to data specific to registered and non-registered status First Nation peoples, Inuit and Metis.

WHEREAS The increased burden of harm associated with substance use among Indigenous peoples can be directly attributed to historical and ongoing colonial violence perpetrated against Indigenous peoples. It is deeply rooted in colonization, disenfranchisement, the Indian residential school system, the 60's scoop, intergenerational trauma, forced removal from land, and oppression. The health system has been a key tool utilized in the violence against Indigenous peoples, resulting in mistrust in the health system by Indigenous populations. As a result, public health units must adapt and decolonize their approaches when working with Indigenous populations and work alongside communities to develop culturally-based and trauma-informed Indigenous harm reduction strategies.

WHEREAS In 2017 alPHa passed a resolution on the Truth and Reconciliation: Calls to Action. The resolution requested alPHa to modify and reorient public health intervention to be culturally safe for Indigenous peoples, and to advocate to ensure that Ontario's Indigenous peoples have more equitable access to the social determinants of health as well as access to culturally safe health care and Aboriginal healing practices. Harm Reduction is a public health priority written in the Ontario Public Health Standards and Guidelines.

WHEREAS Inequities of culturally based Indigenous harm reduction, prevention, and treatment exist for Indigenous peoples in Ontario. There is a lack of integrated land-based harm reduction service provision, lack of Indigenous specific safe consumption services, and lack of public awareness and education on Indigenous harm reduction. There are barriers and limited access to local Treatment and Healing Centres across Ontario.

WHEREAS Indigenous Harm reduction policies, programs, and practices must be grounded in local Indigenous knowledges, traditions, teachings, ceremonies, land, and languages which are unique to each community. Evidence suggests that culturally based harm reduction interventions for Indigenous peoples, including access to local Treatment and Healing Centres, are beneficial to help improve functioning in all areas of wellness.

THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies recognize the critical importance of working with Indigenous communities to better understand Indigenous harm reduction and adopt policies, practices and programs for harm reduction that are culturally safe and rooted in community-knowledge and needs.

AND FURTHER that the Association of Local Public Health Agencies advocate with Indigenous partners to the Minister of Health and other appropriate government bodies for additional funding to support Indigenous harm reduction including additional Indigenous Treatment and Healing Centres.

CARRIED AS AMENDED

alPHa Resolution A22-5 - Backgrounder
Submitted by: Haliburton, Kawartha, Pine Ridge District Health Unit

Backgrounder – Indigenous Harm Reduction: A Wellness Journey

Substance use within Indigenous populations is rooted in colonization, disenfranchisement, the Indian residential school system, the 60's scoop, intergenerational trauma, forced removal from land, and oppression. In 2016, the government of Ontario adopted the Truth and Reconciliation: Calls to action[1]. Call to Action # 19 and #20 speak to the recognition of the right to optimum health regardless of residence, and #21 calls to provide funding for sustainable Healing Centres. In 2017, the Association of Local Public Health Agencies (alPHa) adopted the Truth and Reconciliation recommendations and committed to assisting member boards of health to modify and reorient public health interventions to be culturally safe for Indigenous peoples, and to advocate to ensure that Ontario's Indigenous peoples have more equitable access to the social determinants of health as well as access to culturally safe health care and Aboriginal healing practices[2].

The burden of harm associated with substance use among Indigenous peoples is far reaching. From 2009 to 2019 there has been a 480% increase in hospital visits related to opioid poisoning for First Nation peoples compared to 164% for non- First Nation peoples[3]. In 2019, the rate of hospital visits for opioid-related poisoning among First Nation peoples totaled 45.1 per 10,000. First Nation peoples living outside of First Nations communities experienced the highest rate of hospital visits for opioid-related poisoning at 57.5 per 10,000 people. The rate of hospital visits for opioid-related poisoning among First Nation peoples living within First Nations communities was 19.6 per 10,000 people, and the rate among non-First Nation peoples was 6.0 hospital visits per 10,000 people[3]. While opioid poisoning data is readily available, there is a need to establish epidemiological surveillance to address other substances such as cannabis, prescription drugs, and alcohol use also impacting the health of Indigenous peoples. Additional data is needed to understand substance use trends among registered and non-registered status First Nation peoples, Inuit, and Metis.

Harm Reduction is a public health priority within the Ontario Public Health Standards and Guidelines[4]. A public health response to the current epidemic of opioid poisonings has been highlighted as a priority as communities work to recover from the COVID-19 pandemic. alPHa Resolution A21-2[5] called on public health to lead and coordinate the response to address the opioid crisis, capitalizing on the momentum of managing the COVID-19 emergency.

In Public Health, harm reduction refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing substance consumption. Harm reduction interventions respect the rights of individuals to use such substances, increase awareness regarding lower risk use, and address risk and protective factors related to harms[6].

Emerging substance use trends articulate the need to adopt policy solutions based on evidence-informed harm reduction and treatment practices, eliminating structural stigma, investing in prevention, and declaring the opioid poisoning crisis an emergency[7]. The policy approach is grounded in public health principles.

Indigenous harm reduction policies, programs, and practices must be grounded in local Indigenous knowledges, traditions, teachings, ceremonies, land, and languages which are unique to each community[8]. To this end, it is important that public health units not re-inscribe colonial systems but work with Indigenous communities to understand what harm reduction means for them and establish approaches that are specific to community needs. Indigenous harm reduction is reducing the harms of colonization and colonialism[8]. Evidence supports utilizing land-based service delivery models[9], Wellness Circles[10], and Feather Carriers Wise Practices[11] that involve a wellness journey connected to ceremony, land, water, spirit, community, and family. Healing spaces that offer a wholistic approach with a Traditional Indigenous Healer/Elder/Knowledge Keeper who conducts lands-based teachings, sweat lodge ceremony, traditional healing ceremony, and other culturally appropriate ceremonies and teachings are

key to some Indigenous harm reduction programs[12,13]. In addition, for some communities the use of safe consumption sites supports prevention of overdose and death.

In 2022, Ontario announced the Addictions Recovery fund focused on building quality client centred mental health and addiction system services[14]. Funding was allocated to Northern Rural communities and Indigenous Treatment and Healing Centres were established[15]. Despite increased investment, there are still gaps in access to Treatment and Healing Centres (e.g. Southeastern Ontario) as well as to the broader array of culturally safe harm reduction policies, practices and programs. Barriers such as long waitlists, unclear approval criteria, costs of transportation, and application barriers remain to access current Treatment and Healing Centres.

In addition, there is a lack of awareness and understanding of Indigenous approaches to harm reduction throughout public health in Ontario. By further establishing robust surveillance of substance use harms, adopting Indigenous harm reduction strategies for health promotion, utilizing culturally based education and awareness resources, and working to advocate for equitable access to 'safe consumption sites' and Treatment and Healing Centres, alPHa will support boards of health in working towards the Truth and Reconciliation Calls to Action.

Trust • Engagement • Accountability • Leadership

March 21, 2024

Philip Lawrence, MP Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
House of Commons Ottawa, ON K1A 0A6

Sent via email to: Philip.Lawrence@parl.gc.ca & Jamie.Schmale@parl.gc.ca

Dear MP Lawrence and MP Schmale

Re: Private Member's Bill C-322 – *National Framework for a School Food Program Act*

The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDHU), is writing to you today in strong support of MP Serge Cormier's Private Member's Bill C-322, *National Framework for a School Food Program Act*. Specifically, we are requesting that you work with your caucus colleagues to seek unanimous consent of this Bill in support of children and youth across Canada. As the preamble to the Bill states, "almost one in five children reported to school or to bed hungry sometimes, often or always because there was not enough food at home." In a country as developed and wealthy as ours, this is simply unacceptable. In fact, Canada is currently the only country in the G7 that does not have a national school food program or national standards.

The Board of Health for the HKPRDHU fully supports the concept of a universal, non-stigmatizing national school food policy and program for all public schools. A growing body of research demonstrates that school food programs can benefit students' physical and mental health, improve food choices, and lead to student success (e.g. academic performance, student behaviour, and school attendance).[1] In Ontario, these programs help reduce the $5.6 billion/year in costs due to nutrition-related chronic disease injuries. Well-designed and non-stigmatizing School Nutrition Programs (SNPs) also have broad, positive impacts on families, communities, and the economy by reducing household food costs, creating jobs, and strengthening the Agrifood sector.[2]

Given the widespread need across Ontario and Canada, and the inequities faced by schools in marginalized neighborhoods, there is a strong need for the federal government, in partnership with provincial ministries and school boards/districts, to commit to a National School Food Policy.

…/2

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A national policy would set a standard both for securing food for schools and ensuring it is delivered consistently, sustainably, and within a context of transformative action to improve students' health and achievement outcomes and build cultural and economic success.

The policy should be followed up by the rollout of a National School Nutritious Meal Program, and with it the $200 million per year that the Government of Canada committed to in 2021. An investment in Budget 2024 in a national school food program will support both families and school food providers, who have been struggling due to the affordability crisis.

The Board of Health for the HKPRDHU looks forward to continued engagement on this critical issue for children and youth and encourage you to vote to pass Bill C-322 as soon as possible. For more information, please review the Employment and Social Development Canada National School Food Policy Engagements – What We Heard Report.

Please do not hesitate to contact me should you wish to discuss the importance of this legislation.

Yours truly

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

Original signed by Mr. Marshall

David Marshall
Board of Health Chair
Haliburton, Kawartha, Pine Ridge District Health Unit

DM:kl

cc: Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
David Piccini, MPP, Northumberland-Peterborough South
Association of Local Public Health Agencies
Ontario Boards of Health

[1] The case for a Canadian national school food program. Hernandez et al., 2018; Nourishing Young Minds. Toronto Public Health, 2012; The impact of Canadian School Food Programs on Children's Nutrition and Health. Colley et al., 2018; Coalition for Healthy School Food
[2] The Burden of Chronic Disease in Ontario. CCO & PHO 2019