Board of Health Meeting # 03-24

Public Health Sudbury & Districts

Thursday, April 18, 2024

1:30 p.m.

Boardroom

1300 Paris Street

Reminder: Board of Health Luncheon, April 18, 2024, 12 noon, PHSD Boardroom

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – THIRD MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
THURSDAY, APRIL 18, 2024 – 1:30 P.M.

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) 2023 Year-In Review

- Stacey Gilbeau, Director, Health Promotion and Vaccine Preventable Diseases Division and Chief Nursing Officer
- Stacey Laforest, Director, Health Protection Division
- Renée St Onge, Director, Knowledge and Strategic Services Division
- Kathy Dokis, Director, Indigenous Public Health

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Special Board of Health Meeting – February 15, 2024

b. Second Board of Health Meeting – February 20, 2024

ii) Business Arising From Minutes

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

a. MOH/CEO Report, April 2024

v) Correspondence

a. Bill C-322, National Framework for a School Food Program Act

- Letter from Haliburton, Kawartha, Pine Ridge District Health Unit Board of Health Chair to the Members of Parliament for Northumberland-Peterborough South and Haliburton-Kawartha Lakes-Brock, dated March 21, 2024

b. Regulatory modernization of foods for special dietary use and infant foods

- Letter from the Association of Local Public Health Agencies (alPHa) to Bureau of Nutritional Sciences, Food Directorate, Health Products and Food Branch, Health Canada, dated February 23, 2024

c. Congratulations Re Dr. Sutcliffe's Retirement

- Letter to Dr. Penny Sutcliffe from Public Health Ontario President and CEO, dated March 11, 2024
- Letter to Dr. Penny Sutcliffe from Dr. Kieran Moore, Chief Medical Officer of Health and Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health, dated January 25, 2024

d. 2023 Annual Chief Medical Officer of Health Report *Balancing Act – An All-of-Society Approach to Substance Use and Harms*

- Letter to the Chief Medical Officer of Health from René Lapierre, Board of Health Chair and Dr. M. Mustafa Hirji, Acting Medical Officer of Health and Chief Executive Officer dated April 11, 2024
- Letter from the Association of Local Public Health Agencies (alPHa) to the Ministry of Health, dated April 5, 2024

e. Support for Improved Indoor Air Quality in Public Settings

- Letter from Peterborough Public Health Board of Health Chair to provincial Minister of Health, Minister of Municipal Affairs and Housing and federal Minster of Health and Minister of Housing, Infrastructure and Communities, dated January 31, 2024

vi) Items of Information

a. Statement from the Chief Public Health Officer of Canada Update on Measles and Risk to Canadians dated March 27, 2024

b. 2024 alPHa Annual General Meeting and Conference

APPROVAL OF CONSENT AGENDA

MOTION:

THAT the Board of Health approve the consent agenda as distributed.

6. NEW BUSINESS

i) Ministry of Health Public Health Strengthening – Voluntary Merger Exploration with Algoma Public Health

- The Sault Star, *We were going to lose Power: Algoma Board of Health echoes merger opposition to ministry*, March 28, 2024
- Letter from the Corporation of the Town of Bruce Mines dated March 11, 2024
- Letter from Public Health Sudbury & Districts to Partners dated March 1, 2024

ii) Government Regulation of Nicotine Pouches

- Briefing Note from Dr. M. Mustafa Hirji, Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair, Public Health Sudbury & Districts, April 11, 2024
- Letter from Middlesex London Health Unit Board of Health to the Minister of Health dated March 22, 2024
- Windsor-Essex County Health Unit Board of Health Motion, January 2024

RECOMMENDATIONS FOR GOVERNMENT REGULATION OF NICOTINE POUCHES

MOTION:

WHEREAS Health Canada approved nicotine pouches for sale under the Natural Health Product regulations providing no restrictions on advertising or sale to children and youth; and

WHEREAS the unrestricted sale, display, and promotion of nicotine pouches contribute to their accessibility, the normalization of nicotine use, and potential health hazards; and

WHEREAS nicotine is highly addictive and its use, in any form, is unsafe for children and youth; and

WHEREAS exposure to nicotine can have adverse effects on the developing brains of adolescents and young adults and increases the likelihood of initiation and long-term use of tobacco products; and

WHEREAS the emergence of nicotine pouch products occurred rapidly without requiring adherence to the restrictions of the federal *Tobacco and Vaping Products Act, 1997*, and the *Smoke-Free Ontario Act, 2017*; *and*

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts strongly encourage Health Canada to take immediate action to close the regulatory gap that permits the sale of nicotine pouches to youth under 18 years of age; and

FURTHER THAT the Board of Health urge Health Canada to strengthen regulations to restrict the sale of new and emerging tobacco and nicotine products, ensuring that nicotine availability to children and youth never occur again; and

FURTHER THAT the Board of Health for Public Health Sudbury & Districts strongly encourage the Government of Ontario to exclusively sell nicotine pouches from behind pharmacy counters, limit their display in retail settings, and restrict their promotion, especially to youth; and

FURTHER THAT the Government of Ontario expand the Smoke-Free Ontario Strategy to create a comprehensive, coherent public health-oriented framework for the regulation of vaping and all nicotine-containing products.

iii) Public Health Sudbury & Districts Accountability Monitoring Plan, 2024–2028

- Briefing Note from Dr. M. Mustafa Hirji, Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair, Public Health Sudbury & Districts, April 11, 2024
- Public Health Sudbury & Districts Accountability Monitoring Plan 2024–2028, April 2024

ACCOUNTABILITY MONITORING PLAN, 2024-2028

MOTION:

WHEREAS the Board of Health motion #65-23 endorsed the 2024–2028 Strategic Plan and directed the Medical Officer of Health to operationalize the Strategic Plan, ensuring regular monitoring reports to the Board of Health; and

WHEREAS the 2024-2028 Accountability Monitoring Plan is an essential monitoring framework for comprehensive performance measurement related to the provincial mandate, the Board of Health's 2024–2028 Strategic Plan, and local programs and services;

THEREFORE BE IT RESOLVED that the Board of Health approve the 2024–2028 Accountability Monitoring Plan for Public Health Sudbury & Districts and direct the Medical Officer of Health to operationalize the Plan, ensuring an annual report to the Board of Health; and

FURTHER THAT the Board of Health endorse the establishment of a joint Board of Health/Staff Accountability Working Group for 2024–2028 for the purpose of guiding the reporting of the Accountability Monitoring Plan to the full Board of Health.

7. ADDENDUM

ADDENDUM

MOTION:

THAT this Board of Health deals with the items on the Addendum.

8. IN CAMERA

IN CAMERA

MOTION:

THAT this Board of Health goes in camera to deal with labour relations or employee negotiations, advice that is subject to solicitor-client privilege, including communications necessary for that purpose, and 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 Board. Time: _____

9. RISE AND REPORT

RISE AND REPORT

MOTION:

THAT this Board of Health rises and reports. Time: _____

10. ANNOUNCEMENTS

11. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

MINUTES
SPECIAL BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
THURSDAY, FEBRUARY 15, 2024 – 1:30 P.M.

BOARD MEMBERS PRESENT

Ryan Anderson	René Lapierre	Mark Signoretti
Robert Barclay	Bill Leduc	Al Sizer
Renée Carrier	Abdullah Masood	Natalie Tessier
Guy Despatie	Ken Noland	

BOARD MEMBERS REGRET

Mike Parent

STAFF MEMBERS PRESENT

Rachel Quesnel	Renée St Onge	Dr. Penny Sutcliffe

R. LAPIERRE PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:30 p.m.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

There will be an in-camera session for today's meeting.

4. NEW BUSINESS

i) Public Health Strengthening – Voluntary Merger, Algoma Public Health and Public Health Sudbury & Districts

a. Motion from The Corporation of the Municipality of Wawa dated February 6, 2024

b. Letter from Monarch Recovery Services CEO to Public Heath Sudbury & District Board of Health Chair, dated January 30, 2024

c. Sudbury Star article dated January 30, 2024

Correspondence was received in response to a joint letter to local community partners from the Algoma Public Health and Public Health Sudbury & Districts Board Chairs dated January 18, 2024, inviting comments regarding the exploratory merger discussions. An additional letter received today will be included in the February 20, 2024, Board agenda package.

5. IN CAMERA

13-24 IN CAMERA

MOVED BY ANDERSON – TESSIER: THAT this Board of Health goes in camera to deal with personal matters involving one or more identifiable individuals, including employees or prospective employees and to deal with labour relations or employee negotiations. Time: 1:37 p.m.

CARRIED

6. RISE AND REPORT

14-24 RISE AND REPORT

MOVED BY BARCLAY – NOLAND: THAT this Board of Health rises and reports. Time: 4:30 p.m.

CARRIED

7. ADJOURNMENT

Board members were reminded that there is no regular Board of Health meeting in March. The next regular Board meeting will be held on April 18, 2024, at 1:30 p.m.

Dr. Mustafa Hirji will begin as Medical Officer of Health and Chief Executive Officer at Public Health Sudbury & Districts effective March 18, 2024, and will be Acting until such time as the Minister approves his appointment.

15-24 ADJOURNMENT

MOVED BY NOLAND – SIGNORETTI: THAT we do now adjourn. Time: 4:31 p.m.

_____ _____

(Chair) (Secretary)

MINUTES – SECOND MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
TUESDAY, FEBRUARY 20, 2024 – 1 P.M.

BOARD MEMBERS PRESENT

Ryan Anderson	René Lapierre	Mark Signoretti
Robert Barclay	Abdullah Masood	Al Sizer
Renée Carrier	Ken Noland	Natalie Tessier
Guy Despatie	Michel Parent	

BOARD MEMBERS REGRET

Bill Leduc

STAFF MEMBERS PRESENT

Kathy Dokis	Stacey Laforest	Renée St Onge
Stacey Gilbeau	Rachel Quesnel	Dr. Penny Sutcliffe

R. LAPIERRE PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:05 p.m.

The Board Chair shared that one recommendation through the merger Governance Working Group was to have Indigenous representation on the future Board of Health to ensure a voice at the decision-making table. This would also be an opportunity to learn from each other and continue with our reconciliation work.

The Board of Health Chair began with a brief heartfelt, bittersweet acknowledgement noting today marks Dr. Penny Sutcliffe's final Board of Health meeting before she embarks on her planned one-year sabbatical and then heads into her well-deserved retirement. For over two decades, she has been a driving force in addressing the social determinants of health, advocating tirelessly for Sudbury and districts and seeking to create opportunities for health for all. Her commitment and contributions in the areas of health promotion and

health protection, Indigenous engagement and reconciliation, health equity and racial equity, and public mental health have significantly enhanced the health of our communities. Her steadfast leadership skillfully guided Public Health Sudbury & Districts through a global pandemic, local disease outbreaks, and public health emergencies, safeguarding the health and wellbeing of countless individuals. R. Lapierre extended his deepest gratitude to Dr. Sutcliffe on behalf of the Board of Health indicating her service, vision, compassion, and expertise have been instrumental in championing public health and bringing about positive change. Dr. Sutcliffe was wished the best and thanked for her years of service.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

There will be an in-camera session for today's meeting.

4. DELEGATION/PRESENTATION

None.

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Board of Health Meeting – January 18, 2024

ii) Business Arising from Minutes

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

Deferred.

v) Correspondence

Deferred.

vi) Items of Information

Deferred.

16-24 APPROVAL OF CONSENT AGENDA

MOVED BY MASOOD – TESSIER: THAT the Board of Health approve the consent agenda as distributed.

CARRIED

6. NEW BUSINESS

i) Public Health Strengthening – Voluntary Merger

a. Letter from CHADWIC Home Board of Directors Chair to Board of Health Chairs, Algoma Public Health & Public Health Sudbury & Districts dated February 14, 2024

Another letter from community partners has been received further to the joint update that was sent by both Boards of Health.

IN CAMERA

17-24 IN CAMERA

MOVED BY ANDERSON – NOLAND: THAT this Board of Health goes in camera to deal with labour relations or employee negotiations, advice that is subject to solicitor-client privilege, including communications necessary for that purpose, and 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 Board. Time: 1:11 p.m.

CARRIED

RISE AND REPORT

18-24 RISE AND REPORT

MOVED BY BARCLAY – PARENT: THAT this Board of Health rises and reports. Time: 1:58 p.m.

CARRIED

The Board Vice-Chair reported that one item was dealt with relating to labour relations or employee negotiations, advice that is subject to solicitor-client privilege, including communications necessary for that purpose, and 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 Board. The following motions emanated:

19-24 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY SIZER – SIGNORETTI: THAT this Board of Health approve the meeting notes of the November 16, 2023, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the **Municipal Freedom of Information and Protection of Privacy Act.**

CARRIED

20-24 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY PARENT – NOLAND: THAT this Board of Health approve the meeting notes of the November 21, 2023, special Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the* Municipal Freedom of Information and Protection of Privacy Act*.

CARRIED

21-24 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY CARRIER – DESPATIE: THAT this Board of Health approve the meeting notes of the December 13, 2023, special Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the* Municipal Freedom of Information and Protection of Privacy Act*.

CARRIED

22-24 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY NOLAND – BARCLAY: THAT this Board of Health approve the meeting notes of the January 18, 2024, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the* Municipal Freedom of Information and Protection of Privacy Act*.

CARRIED

23-24 INTENT TO MERGE – ALGOMA PUBLIC HEALTH AND PUBLIC HEALTH SUDBURY & DISTRICTS

MOVED BY SIZER – TESSIER: WHEREAS the Boards of Health for the District of Algoma Health Unit (APH) and the Sudbury and District Health Unit, operating as Public Health Sudbury & Districts, (PHSD) each passed resolutions in November 2023 to direct their Medical Officers of Health/Chief Executive Officers (MOH/CEOs) to seek provincial funding to study the potential benefits and drawbacks of a voluntary merger of APH and PHSD and report back to their respective Boards for discussion and direction;

WHEREAS the MOH/CEOs for APH and PHSD have since undertaken a process of negotiation and joint engagement to pursue this study, resulting in the confidential Impact Assessment document dated February 9, 2024 (IAD), delivered to the APH and PHSD Boards of Health;

WHEREAS the APH and PHSD Boards of Health have identified important principles to inform the negotiation, planning and implementation of any merger of APH and PHSD, including commitments:

- ***to the continued presence of public health personnel across the geography of the new entity with services being maintained or improved***
- ***to work with rural and remote communities to ensure they benefit equitably from public health programs and services***
- ***to prioritize a Health Equity lens to its work, including rural/remote, equity-seeking/vulnerable/marginalized and Francophone populations***
- ***to have, as one of the new entity's guiding principles, a commitment to Truth and Reconciliation***
- ***to make investments such that the quality of programming across the new geography is brought to the higher of the levels that currently exist in the two predecessor entities***

WHEREAS the actual merger of APH with PHSD (if any) will only be effected in accordance with the terms and conditions of a definitive merger agreement to be negotiated following government approval (if any), further to an additional process that will:

- ***include due diligence, partner and stakeholder engagement and consultation, and development of a detailed multi-year implementation plan and supporting budget; and***
- ***address important issues including composition of the membership for the new board of health, resolution of the current discrepancy in municipal funding levels as between APH and PHSD, treatment of APH's outstanding debt, and confirming the consent of any external parties from whom this is required;***

WHEREAS the PHSD Board of Health understands and anticipates that any Voluntary Merger Business Case for APH and PHSD as submitted by APH and PHSD will be further informed and shaped by the negotiation, due diligence, consultation, and implementation plan and budget development activities expected to follow any Government approval and that the definitive merger agreement to be negotiated, if any, will reflect these activities;

The Board of Health for Public Health Sudbury & Districts therefore resolves:

1. ***THAT it intends to merge PHSD with APH, subject to the following conditions:***
    a. ***the Government approves the intended merger and this Board in its sole discretion is satisfied that this approval will enable APH and PHSD to successfully complete the intended merger;***

b. the Government commits to provide funding to APH and PHSD to support the intended merger, including transition costs and business continuity/stabilization funding in amounts sufficient to ensure program and service delivery stability while change is underway, and this Board in its sole discretion is satisfied that this funding commitment will enable APH and PHSD to successfully complete the intended merger;

c. the negotiation, due diligence, consultations and implementation plan and budget development activities following Government approval do not identify any material issue that this Board in its sole discretion determines will undermine its assessment of the benefits and drawbacks of the intended merger with APH such that the Board no longer supports the intent to merge;

d. this Board shall have reviewed and approved PHSD to enter into a definitive merger agreement that sets out the detailed steps of the merger in a manner that this Board in its sole discretion is satisfied will enable APH and PHSD to successfully complete the intended merger;

e. the actual merger of PHSD with APH, if any, will only be effected in accordance with the terms and conditions of the definitive merger agreement, subject to any changes that have been specifically approved by the APH and PHSD Boards; and

f. the APH Board of Health expresses its intent to merge with PHSD by resolution that this Board in its sole discretion is satisfied is substantially in accordance with the terms and conditions of this PHSD resolution.

2. THAT the PHSD MOH/CEO be directed to:

a. to further negotiate with APH to complete a Voluntary Merger Business Case for submission to the Ministry no later than April 2, 2024, substantially in accordance with the IAD and fully signed by the MOH/CEOs and Board Chairs for APH and PHSD; and

b. communicate this resolution to key stakeholders including the Ministry and the APH Board Chair.

3. THAT the PHSD Board Chair ensure timely reporting back to the Board on this matter at future meetings to enable subsequent Board engagement and direction, as the Board may deem appropriate in the expected negotiation, due diligence, consultations and implementation plan and budget development activities, including negotiation of the definitive merger agreement, as the Board may deem appropriate. Following completion of these matters, the Board will meet for full report, deliberation and decision-making regarding whether to proceed with the intended merger.

	YEA	NAY
Anderson, Ryan	**X**	
Barclay, Robert	**X**	
Carrier, Renée	**X**	
Despatie, Guy	**X**	
Leduc, Bill	**X**	
Masood Abdullah	**X**	
Noland, Ken	**X**	
Parent, Michel	**X**	
Signoretti, Mark	**X**	
Sizer, Al	**X**	
Tessier, Natalie	**X**	
Lapierre, René	**X**	
TOTAL	**12**	

CARRIED UNANIMOUSLY

7. ADDENDUM

None

8. ANNOUNCEMENTS

There is no regular Board of Health meeting in March. The next regular Board meeting is April 18, 2024.

9. ADJOURNMENT

24-24 ADJOURNMENT

MOVED BY MASOOD – BARCLAY: THAT we do now adjourn. Time: 2:11 p.m.

CARRIED

_____ _____

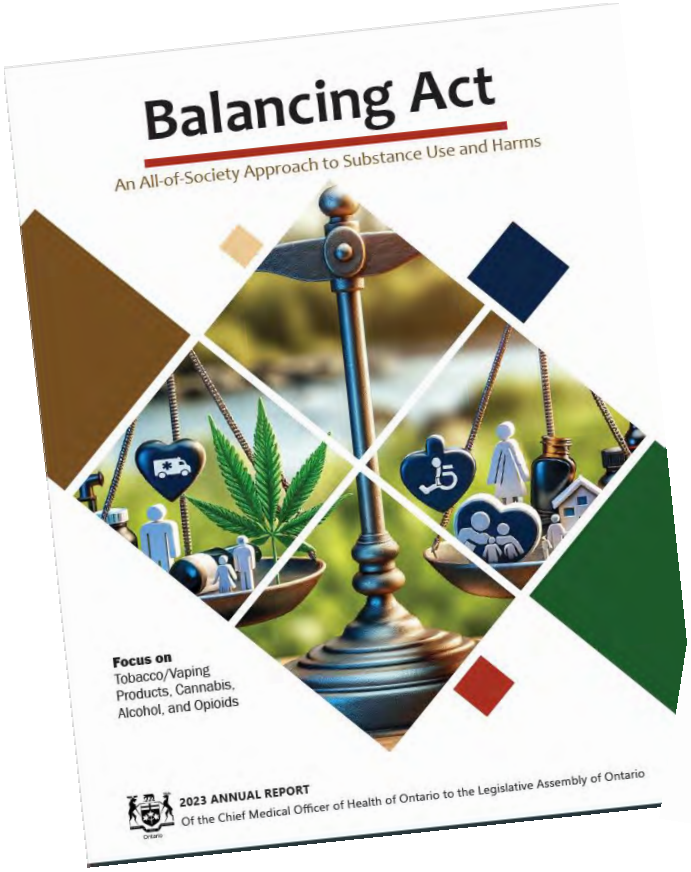
(Chair) (Secretary)

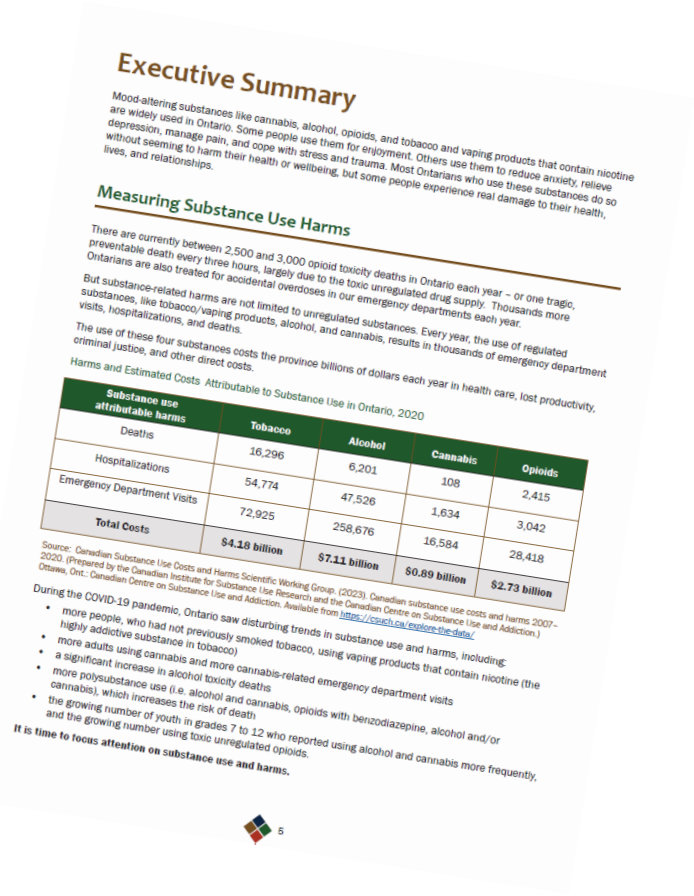
Medical Officer of Health/Chief Executive Officer
Board of Health Report, April 2024

Words for thought

Balancing Act – An all-of-Society Approach to Substance Use and Harms

2023 Annual Report of the Chief Medical Officer of Health of Ontario





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.

5

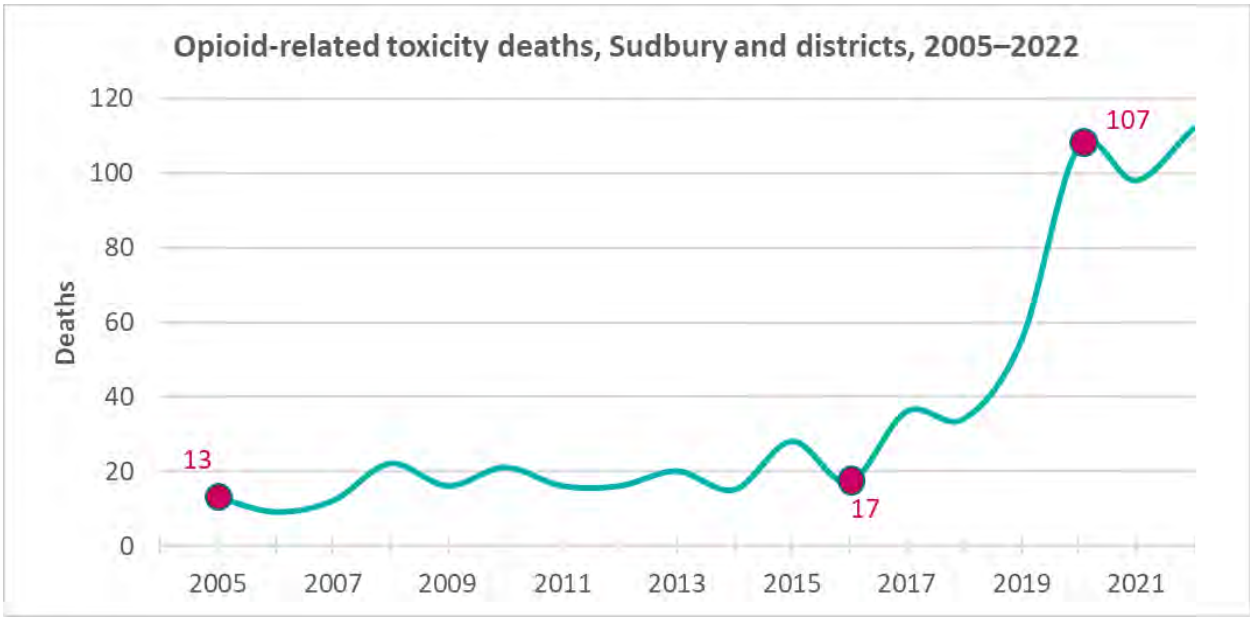
Source: https://www.ontario.ca/page/chief-medical-officer-health-2022-annual-report

Chair and Members of the Board,

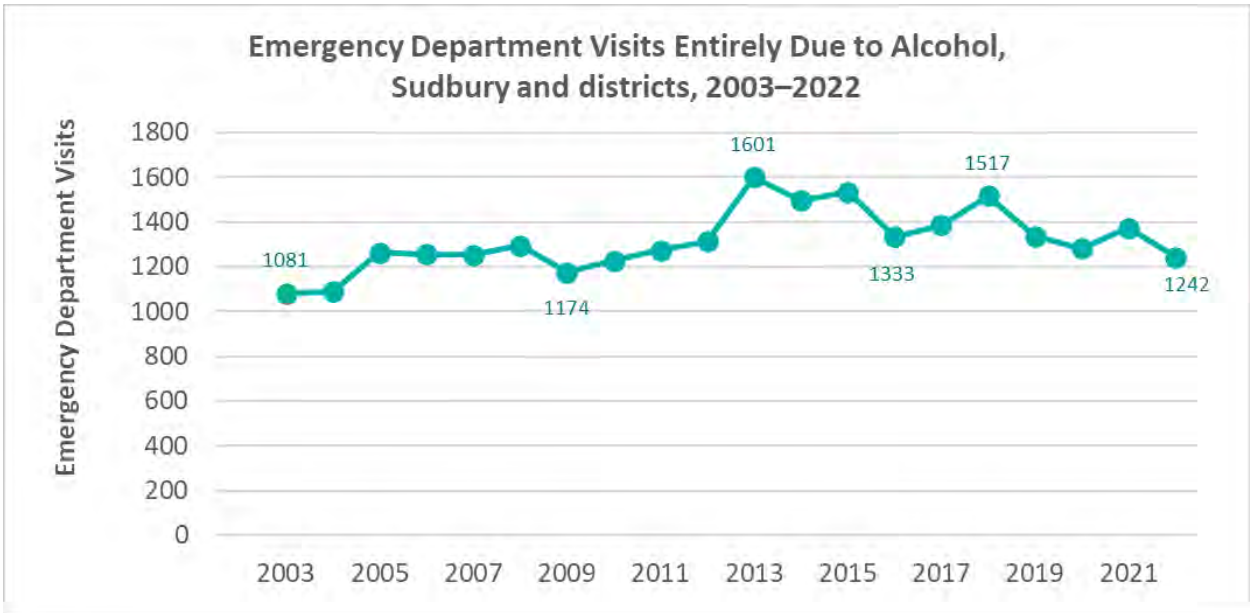
Welcome to spring!

The 2023 Annual Report of the Chief Medical Officer of Health of Ontario, quoted above and included in today's agenda package, highlights the very sizeable harms that are experienced from substance use.

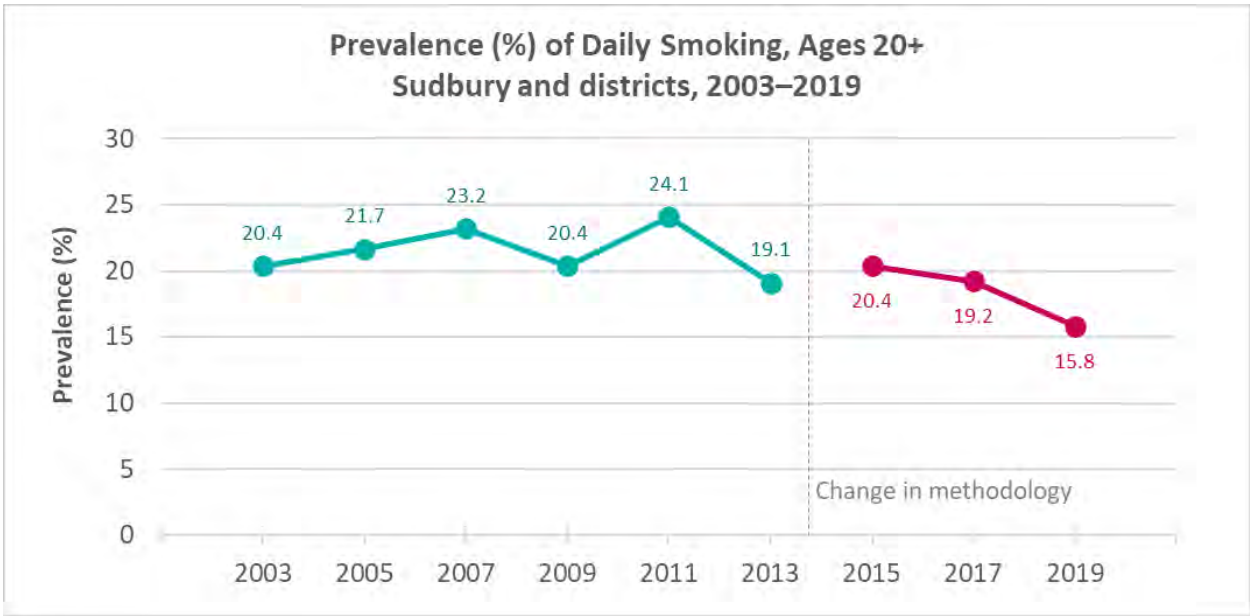
In recent years, our community has rightly been troubled by the increase in opioid toxicity: a 500% increase in deaths from 2016 to 2020, and further increases during the pandemic thereafter. Given the complexity of the problem, the challenge of tackling the opioid crisis can feel overwhelming.



I think the stories of alcohol and tobacco are instructive. In 2022, residents visited the emergency department 1,242 times due to health conditions entirely attributable to alcohol. This is trending downwards since its peak of 1,601 visits in 2013.



The story of tobacco is even more positive: from 2003 to 2019, smoking prevalence has decreased from 20.4% to 15.8% (a minor caveat is that the way this is measured changed between 2003 and 2020).



Alcohol and tobacco show us that use of substances that were ubiquitous in our society can be brought under control.

The stories of alcohol and tobacco are ones of collective action: policy changes at the local, provincial, and federal level; business selling responsibly; a culture change in the public's view of these; and intense efforts to support those experiencing inequities.

Addressing opioids, as well as building to further reduction of harms from alcohol and tobacco will require new and different measures, but the principle that all of society must be involved is key.

Recommendations in the Chief Medical Officer of Health's report focus on investing in collective action interventions that we know work. These interventions include health promotion efforts, strategies to prevent harms from drug use, access to evidence-based treatment, and regulatory measures and enforcement.

Since substance use is often rooted in early life experiences and intergenerational trauma, we need comprehensive interventions—both upstream investments to address structural factors and downstream strategies to mitigate acute risks.

"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." pg. 65

2023 Year in Review

This month's report outlines the Public Health Sudbury & Districts previous year's work "by the numbers" and provides a snapshot of our work in addition to key governance updates.

General Report

1. Board of Health

alPHa Workplace Health & Wellness Month

Association of Local Public Health Agencies (alPHa) members are encouraged to engage in activities that improve their physical and mental health for 30 minutes per day during May.

Board of Health members are invited to join Public Health Sudbury & Districts staff in participating in this year's annual alPHa workplace health and wellness month by getting moving. Participation includes any physical or mental health-related activities that are at least 30 minutes long during the month of May. Examples include running, walking, or cycling, doing yoga, or sharing healthy recipes. You can also send your pictures with alPHa on X (formerly known as Twitter) by tagging @PHAgencies and using the hashtag #alPHa2024. The pictures will also be featured at this year's alPHa Conference in June.

Annual Board of Health declaration forms

All Board of Health members are required to complete the Board of Health Code of Conduct and Conflict of Interest declaration forms. Reminders will be sent to Board of Health members who have not had a chance to complete the forms.

Continuing education opportunity for Board of Health members

alPHa Annual General Meeting and Conference

alPHa will be holding its in-person 2024 Annual General Meeting (AGM), Conference and Section Meetings from June 5 to June 7, 2024, in Toronto. A motion will be included on the May Board of Health agenda relating Board member attendance and voting delegation for the AGM. Any Board of Health member interested in attending is asked to communicate with the Board of Health Secretary who will look after registration and book accommodation. Registration, accommodation, travel, and meal expenses will be covered by Public Health Sudbury & Districts.

2. Public Health Sudbury & Districts MOH/CEO Engagement

Since beginning as the Acting Medical Officer of Health and CEO on March 18, I participated in many engagement opportunities with staff and external partners. I introduced myself through an e-mail and at a hybrid staff meet and greet session where staff had the opportunity to ask questions. I met with Management Forum at the end of March and plan to attend division management meetings, and team meetings throughout April and May. I also met with Board of Health members in person on March 28 and at a virtual drop-in session on April 4. In addition to these meetings, I received a tour of the main office, as well as of the Elm Place space and programming areas. I will be visiting the Mindemoya and Espanola district offices on April 16,

Sudbury East district office on April 17 and the Chapleau district office on May 27-28. These opportunities provide me with the occasion to build informal connections with staff, begin to learn the corporate culture, and see the community I serve.

In addition to these initiatives, I sent an email to external partners to introduce myself and express interest in working together soon. I attended a luncheon hosted by the Greater Sudbury Chamber of Commerce where I met key community partners, including members of Health Sciences North's leadership team. Additional opportunities for in-person partner meetings are being scheduled. Overall, these engagement activities will help me learn about programming and gain an understanding of our local communities' strengths and assets. Further engagement activities will continue to take place over the next few months.

3. Financial Report

The Infection Prevention and Control (IPAC) Unit in the Office of the Chief Medical Officer of Health, Public Health (OCMOH, PH) has indicated they will continue funding the IPAC Hubs in the 2024-25 fiscal year and the years following. Details relating to funding levels have not yet been communicated. The OCMOH, PH expects to engage with IPAC Hubs and partner ministries to have further discussions.

4. Annual Service Plan and Budget Submission

The Ministry of Health's Annual Service Plan and Budget Submission was completed. The report includes a summary of population health needs identified from available data and detailed descriptions of programs and services prioritized for delivery in 2024. Program plans from each division were used to populate this document. This is in addition to detailed budget information which presents the 2024 Board approved budget aligned to the Ontario Public Health Standards.

5. Quarterly Compliance Report

The agency is compliant with the terms and conditions of our provincial *Public Health Funding and Accountability Agreement*. Procedures are in place to uphold the *Ontario Public Health Accountability Framework and Organizational Requirements*, to provide for the effective management of our funding and to enable the timely identification and management of risks.

Public Health Sudbury & Districts has disbursed all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to March 15, 2024, on March 18, 2024. The Employer Health Tax has been paid, as required by law, to February 29, 2024, on March 14, 2024. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to February 29, 2024, on March 27, 2024. There are no outstanding issues regarding compliance with the *Occupational Health & Safety Act*, *Ontario Human Rights Code*, or *Employment Standards Act*.

6. Regulatory Health Protection Reporting

Control of Infectious Diseases (CID): In January, February, and March, staff followed up with 254 new local cases of COVID-19, and investigated 368 sporadic reports of other communicable

diseases. Further, 39 respiratory outbreaks were declared. The causative organisms identified in these outbreaks included COVID-19 (22 outbreaks), influenza A (9 outbreaks), parainfluenza virus (3 outbreaks), RSV (2 outbreaks), and metapneumovirus (1 outbreak). One outbreak identified three causative agents: influenza A, metapneumovirus, and parainfluenza virus. The causative organism for four respiratory outbreaks could not be identified. Further, twelve enteric outbreaks were declared in institutions. The causative organism for two of these outbreaks was confirmed. One was confirmed to be Norovirus and the other was confirmed to be *Clostridium difficile*. The causative organism for the remaining ten enteric outbreaks could not be identified. Staff continue to monitor all reports of enteric and respiratory illness in institutions, as well as sporadic communicable diseases.

During the months of January, February, and March, four infection control complaints were received and investigated.

Food Safety: Public health inspectors issued five charges to two food premises for infractions identified under the *Food Premises Regulation*.

Health Hazard: In January, February, and March, 92 health hazard complaints were received and investigated.

Rabies Prevention and Control: In January, February, and March, seventy-four rabies-related investigations were carried out.

Safe Water: One drinking water order was issued. Furthermore one boil water order, and one drinking water order were rescinded. One boil water order was revoked.

Smoke-Free Ontario Act, 2017 Enforcement: In January, February, and March, one individual was charged for smoking on school property, one individual was charged for smoking in a prohibited place (workplace), and three charges were issued to a single employer.

Health Promotion and Vaccine Preventable Diseases Division

Chronic Disease Prevention and Well-Being

- **72** community partners actively collaborated with Public Health staff on chronic disease prevention and well-being topics such as physical activity, healthy eating, healthy aging, and the built environment
- **1 531** community members learned and engaged with Public Health staff on chronic disease prevention and well-being topics such as physical activity, healthy eating, healthy aging, and the built environment

- **9** healthy public policies related to chronic disease prevention were initiated or advanced because of engagement with Public Health staff. These include motions to the Board and letters of support
- **1** evaluation related to chronic disease prevention was completed

Mental Health Promotion

- **1** mental health literacy survey sent to **all** Public Health staff
- **1** mental health literacy (*Promoting Mental Health for All*) training delivered to **all** Public Health staff
- **1** social prescribing webinar presented: **350** registrants consisting of mental health practitioners and public health professionals across Ontario
- **1** endorsement of the open letter from the City of Sudbury to declare intimate partner and gender-based violence an epidemic
- **6** Centre for Addiction and Mental Health's Mental Health Promotion in Public Health Community of Practice Champion meetings chaired
- **4** meetings with public health agencies for knowledge sharing about the *Public Mental Health Action Framework*
- **1** mental health stigma presentation for **150** Public Health staff
- **2** mental health promotion presentations to **40** community members
- **4** meetings with the Child and Youth Mental Health Week Planning Committee
- **11** meetings co-leading the foundation on of the Youth Wellness Hub

Life Promotion, Suicide Risk and Prevention

- **200** community partners attended 2 suicide prevention and life promotion events hosted with the Suicide Safer Network for World Suicide Prevention Day in Sudbury and on Manitoulin Island
- **4** meetings with Suicide Safer Network to collaborate on community level life promotion and suicide prevention programming

Healthy Growth and Development

Breastfeeding

- **1 332** breastfeeding clinic appointments were provided at the main, Val Caron, Manitoulin, and Espanola offices

Preparation for Parenting

- The new *Preparation for Parenting* class launched in November 2023. Topics covered included preparing for a smooth transition to parenthood, attachment and bonding, communication, roles and responsibilities, demands of caring for a newborn, post partum mood disorder, infant mental health, and taking care of a newborn

Healthy Pregnancies

- **439** people registered for Public Health's online prenatal class

Healthy Babies

- **688** reminder post cards were sent to parents to book their 18-month well-baby visit
- **20** presentations were provided to community partners and their client families regarding food literacy, injury prevention, infant feeding, and mental health promotion

Positive Parenting

- **3** Parenting Service Advisory Committee meetings were co-chaired. This committee works to coordinate and monitor parenting programming across the service area with over 20 key partners.
- **1** 10-part series of *Bounce Back and Thrive* program was provided to parents in Espanola
- **10** parents were provided the *Triple P* online parenting program (8 primary and 2 teen)
- **700** rack cards provided to school boards for *Welcome to Kindergarten* directing parents to the parenting4me.com website

Health Information Line

- Total number of calls: **1 159**
  - Of those calls:
    - **50** calls were related to health during pregnancy
    - **228** calls were related to breastfeeding
    - **67** calls were related to formula feeding
    - **48** calls were related to healthy eating
    - **25** calls were related to infant care
    - **59** calls were related to a general health inquiry of children less than 12 years old
    - **15** calls related to car seat safety.
    - **135** calls related to a lack of a primary care physician
    - **13** walk-ins occurred requesting information or assistance
    - **36** calls were related to contagious or infectious diseases
    - **19** calls were related to perinatal mood disorder or mental health
    - **22** calls were related to vaccine and immunization

Injury Prevention

- **40** community partners actively collaborated with Public Health staff on injury prevention topics such as falls prevention, concussions, and on- and off-road safety
- **429** community members learned and engaged with Public Health staff on injury prevention topics such as falls prevention, concussions, and on and off-road safety
- **2** healthy public policies related to injury prevention were initiated or advanced because of engagement with Public Health staff. These include motions to the board and letters of support.
- **3** evaluations related to Injury Prevention were completed

School Health

- **67** consultations or planning meetings with partners, school staff, decision makers
- **2** policy and advocacy motions or products were supported
- **2 141** visits to Public Health's web pages related to schools and daycares, and curriculum
- **1 155** adult influencers trained or reached with professional development workshops and activities

Mental Health

- **793** students received mental health programming, including flourishing life and mindfulness programming

Substance Use

- **749** students received substance use programming

Sexual Health

- **294** students received healthy sexuality and puberty programming

Physical Activity

- **14** schools received school health physical activity programming

Healthy Eating

- **98** schools received school health healthy eating programming, including the *Northern Fruit and Vegetable Program*

Oral Health

- **907** callers or walk-ins were assisted with accessing financial assistance for dental treatment, completing paperwork, or other oral health inquiries
- **9 680** dental screenings were completed in elementary schools
- **696** referrals were made for children in need of urgent dental treatment
- **933** preventive appointments were provided to children at Public Health clinics
- **327** children were enrolled in *Healthy Smiles Ontario* for emergency dental treatment
- **834** dental screenings were provided to children at schools in First Nations' communities

Vision

- **80** schools participated in the senior kindergarten vision screening program
- **1 619** children in senior kindergarten received vision screening at school
- **495** children screened were referred to an optometrist for follow up

Substance Use

Alcohol

- **1** motion submitted and passed by the Board of Health to support alcohol warning labels
- **1** letter of support submitted on alcohol warning labels and *Bill S-254*
- **2** media interviews surrounding alcohol-related health risks and public health-based prevention strategies
- 6 meetings held with Northeastern public health units to discuss regional alcohol and cannabis programming

- **3** social media posts made collaboratively with **4** other Northeastern public health units promoting Canada's new *Guidance on Alcohol and Health* and alcohol-free alternatives that reached **3366** individuals
- **240** posters to promote Canada's new *Guidance on Alcohol and Health* distributed to inform community members of the harms and risks of alcohol
- **400** *Plan Ahead* information packages (bilingual) distributed to community members in collaboration with Greater Sudbury Police Service for impaired driving prevention as part of the Festive RIDE program
- **150** *Connex Ontario* cards were distributed to direct community members to available treatment options

Cannabis

- **1** consultation submitted on cannabis regulations and legislation to Health Canada
- **1** *Lock It Up: Kids Can't Tell the Difference* campaign—**2** bus shelter ads, **110** inside bus ads, and **14** digital displays
- **158** lockboxes distributed to community partner agencies with educational resources included for safe storage of cannabis products
- **250** *Lower-Risk Cannabis Use Guidelines* pamphlets distributed to inform community members of the harms and risks of cannabis and safe use of cannabis products

Comprehensive Tobacco Control

- **163** inquiries were responded to by the Tobacco Information Line
- **1** advocacy letter submitted for *Bill-103, Smoke-Free Ontario Amendment Act (Vaping is Not for Kids), 2023*
- **1** consultation submitted on the second legislative review of the *Tobacco and Vaping Products Act 2023* to Health Canada
- **1** media interview with CBC radio in Sudbury related to new health warnings on individual cigarettes
- **6** radio ad campaigns (including 1 podcast and 1 digital ad) promoting *Stop on the Net* that delivered **41 149** impressions
- **16** social media posts promoting smoking cessation and prevention that reached **6203** individuals
- **2** campaigns for *World No Tobacco Day* and *Stop on the Net* highlighting the benefits of quitting smoking. This campaign had **87 926** impressions and **218** interactions

Harm Reduction – Naloxone

- **29 526** doses of naloxone were distributed in the Sudbury and Manitoulin districts (up to November 2023)
- **3335** individuals trained to administer nasal spray naloxone
- **3** new agencies onboarded to the Ontario Naloxone Program

Opioids and Other Drugs

- **1** *Summit on Toxic Drugs* that hosted **17** panelists, **15** speakers, and **180** participants
- **2** *Drug Alerts* released to prevent overdoses in the community
- **5** drug warnings released in the community
- **2** Community Drug Strategy Executive Committee meetings
- **7** Community Drug Strategy Steering Committee meetings

Vaccine Preventable Diseases

Supported various program areas in 2023

Routine Immunization

- **95 086** doses of vaccine distributed to community partners (publicly funded and cost products)
- **21 785** doses of vaccine administered by public health nurses through Public Health's offices (publicly funded and cost products)

Grade 7 Immunization

- **134** clinics led by Public Health
- Vaccines for protection against meningitis, hepatitis B, and HPV offered to **61** schools across the service area
- **9 815** doses of vaccine administered at Public Health's offices and school clinics

Annual Review of Records

- Staff worked directly and indirectly with all affected students, families, and school communities to support compliance with the *Immunization of School Pupils Act (ISPA)* legislation
- Records were assessed for students at all **79** elementary schools and all **23** secondary schools in the service area
- **8 593** notification letters were sent to parents, guardians, and students whose immunization records on file with Public Health were out of date
- **2068** students were suspended

COVID-19 Immunization

- **348** Public Health and **33** partner-led clinics
- **19 276** doses administered at Public Health offices and in community clinics
- **2 571** doses administered through partners.

Influenza Immunization

- **31 709** doses distributed to community partners.
- **1 548** doses administered at Public Health's offices.

Vaccine Preventable Diseases Information Line

- **8 406** incoming calls for vaccine related inquiries

Healthy Babies Healthy Children (HBHC) Program

- There were **1571** births in the Sudbury and Manitoulin districts in 2023. Of those:
  - **1 357** mothers screened to identify those who would benefit from further services
  - **1 540** 48-hour infant feeding calls made

- Over **400** families supported with ongoing home-visiting from HBHC
- **10 242** interactions with clients, including assessments, in-home visits, virtual visits, phone calls, etc., from public health nurses and family home visitors
- **2** consultation requests completed to support the efforts of Indigenous agencies to strengthen programming on-reserve
- Increased collaboration with the new Indigenous patient navigator at Health Sciences North to support local families

Seniors Dental Health

- **1 337** callers were assisted with booking appointments, completing paperwork, and other oral health inquiries
- **294** new client charts were created
- **596** clients received at least one appointment for a dental service at our clinic or through contracted providers

Smoke-Free Ontario (TCAN)

- **9** media campaigns: **1 million** web-based impressions and **3100** interactions, **30 weeks** of TV ads with a weekly viewership of over **400 000** and **38 000** resources and promotional items distributed across the Northeast
- **3** multi-regional social media campaigns targeting the young adult "outdoors" peer crowd:
  - **7.1 million** impressions
  - **32 600** interactions
  - **86** new brand ambassadors recruited
- **New** provincial TCAN structure formed including **3** advisory committees, **7** working groups, and **1** leadership team formed. **33** public health units engaged with **2** regional committees and **2** provincial advisory groups chaired by NE TCAN. **2** consultation and endorsement letters submitted on proposed tobacco and vapour product regulations, and **1** in-person planning meeting hosted with **25** attendees from across the Northeast

Health Protection Division

Chronic Disease Prevention

- **4** *Healthy Menu Choices Act* inspections
- **1** *Healthy Menu Choices Act* investigation
- **2** *Skin Cancer Prevention Act* inspections
- **1** *Skin Cancer Prevention Act* investigation

Control of Infectious Diseases

Infectious Diseases

- **3 898** investigations of Diseases of Public Health Significance
- **214** consultations and inquiries

Enteric Outbreaks

- **15** enteric outbreaks declared in institutions
- **367** people ill

Respiratory Outbreaks

- **135** respiratory outbreaks declared in institutions
  - **58** in long-term care home
  - **46** in hospital
  - **10** in retirement home
  - **21** in congregate living setting
- **2 182** people ill
- **45** institutions placed on enhanced respiratory surveillance

Rabies

- **408** animal exposure incidents investigated
- **12** animal specimens submitted; **0** positive cases of rabies
- **29** individuals received post-exposure prophylaxis
- **29** consultations and inquiries

Infection Control

- **3** institutional infection control meetings
- **25** inspections in institutional settings
- **125** inspections in licensed child care centres
- **370** inspections in settings where there is a risk of blood exposure (personal services settings)
- **2** infection prevention and control lapse investigations
- **24** consultations and inquiries
- **22** complaint investigations
- **48** requests for service
- **1** closure order issued

Infection Prevention and Control (IPAC) Hub

- **81** proactive IPAC assessments in institutions
- **75** IPAC assessments in response to respiratory or enteric outbreak
- **388** outbreak management team meetings in response to respiratory or enteric outbreak
- **31** education sessions
- **18** institutional policy and procedure packages reviewed
- **68** consultations and inquiries

Vector-borne Diseases

- **198** mosquito traps set
- **11 843** mosquitoes trapped
- **6 903** mosquitoes speciated

- **259** mosquito pools tested
  - **4** for eastern equine encephalitis
  - **255** for West Nile virus (WNv)
- **1** positive mosquito pool for WNv
- **1** human case of WNv
- **37** ticks submitted
- **6** human cases of Lyme disease reported
- **41** complaints
- **29** consultations and inquiries

Tuberculosis Control Program

- **274** tuberculin skin tests performed
- **146** reports of latent tuberculosis infection received and investigated
- **10** suspect tuberculosis (TB) cases investigated; **3** TB cases confirmed
- **39** medical surveillance reports received for TB screening

Emergency Preparedness and Response

- Participated in **6** municipal emergency exercises
- **1 029** calls to the after-hours line (24/7)

Environmental Health Policy

Extreme Weather Alerts

- **9** heat warnings issued

Built Environment

- **3** plans and proposals reviewed

Food Safety

- **2 542** inspections of food premises
- **245** complaint investigations
- **6** charges; **2** closure orders issued
- **46** food handler training courses offered
- **679** food handlers certified
- **3** food recalls resulting in **727** proactive outreach activities
- **498** special events food service and farmers' market permits
- **150** consultations and inquiries
- **101** requests for service

Growing Family Health Clinic

- **1 066** client appointments
- **94** total (**72** prenatal and **22** postnatal appointments)
- **511** appointments for children aged 0–6 years (**489** well-baby and **22** postnatal appointments)

Harm Reduction Supplies and Services

- **31 762** client visits and contacts
- **633 904** needles given out
- **549 087** needles taken in
- **87%** needle return rate
- **1 310 017** inhalation kits distributed
- **35 760** condoms distributed

Health Hazard

- **367** complaints received (related to one or more issues)
- **460** issues investigated
  - **88** mould
  - **96** insects, cockroaches
  - **54** bed bugs
  - **60** rodents, vermin
  - **8** birds, other animals
  - **12** marginalized population or housing
  - **20** house disrepair or sanitation
  - **16** odours or animal excrement

  - **11** indoor air quality
  - **26** sewage backup, spills
  - **16** heating
  - **7** garbage and waste
  - **7** flooding
  - **39** miscellaneous complaints
- **109** consultations and inquiries
- **3** orders issued
- **27** arena air quality inspections

Part 8 Ontario Building Code

- **301** sewage system permits issued
- **50** consent applications processed
- **194** renovation applications processed
- **50** mandatory maintenance inspections completed
- **3** private sewage complaints investigated
- **1** order issued
- **1** charge issued
- **302** consultations and inquiries
- **9** file search requests
- **66** copy of record requests
- **302** requests for service

Safe Water

Drinking Water

- **20** boil water orders
- **12** drinking water orders
- **4** blue-green algae advisories
- **1** health information notice (sodium exceedance)
- **717** adverse drinking water reports investigated
- **219** bacteriological samples taken
- **94** consultations and inquiries
- **4** complaint investigations and **10** blue-green algae investigations
- **99** Small Drinking Water System (SDWS) risk assessments completed
- **99** SDWS directives completed
- **107** SDWS inspections conducted

Recreational Water

- **8** beaches inspected weekly; **26** beaches inspected monthly
- **169** beach inspections (total)
- **905** bacteriological samples taken (public beach samples)
- **3** beaches temporarily posted
- **1** blue-green algae beach advisory
- **129** pool inspections (Class A and B pools)
- **27** spa inspections
- **31** splash and spray pad and wading pool inspections (Class C Recreational Water facilities)
- **97** bacteriological samples taken
- 4 pool and spa closure orders issued

Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections (including HIV)

- **3 553** client visits
- **4 025** sexual health consultations and inquiries
- **866** nominal HIV tests completed
- **50** anonymous HIV tests completed
- **91** point-of-care HIV tests completed (may have been nominal or anonymous)
- **43** client visits in secondary school settings (Espanola/Lacloche and Manitoulin Island)
- **99** client visits at community partner agencies

Sexual Health Promotion

- **1 588** pamphlets distributed
- **1 049** promotional items distributed
- **18** presentations and **12** interactive displays to **1 983** participants
- **7** media campaigns

Substance Use and Injury Prevention – Comprehensive Tobacco Control

Smoke-Free Ontario Act

- **421** youth access inspections
- **272** display and promotion inspections
- **24** school compliance inspections and checks
- **19** sales or supply charges issued
- **19** warnings issued to retailers and vendors
- **17** charges: smoking or vaping on school property
- **27** charges: smoking or vaping on hospital property
- **2** charges: smoking or vaping in the workplace
- **8** charges: workplace
- **1** charge: smoking or vaping in a public place
- **2** charges: City of Greater Sudbury smoking or vaping by-law
- **210** complaints investigated
- **21** requests for service

Knowledge and Strategic Services

Population Health Assessment and Surveillance

- **1 912** data requests (totaling **1 802** hours of staff time), consisting of **1 342** internal and **570** external requests on such topics as infection and communicable diseases, demographics, healthy aging, food insecurity, priority populations, and health behaviours
- **1 200** residents (**685** landlines and **515** cellphones) from the Public Health's service area were surveyed by the Rapid Risk Factor Surveillance System (RRFSS) to collect information to support program and service planning decisions
- **884** hours of reporting systems maintenance (updates), data modelling, and dashboard development related to:
    - Opioid Surveillance Dashboard (public facing)
    - Respiratory Illness Surveillance Dashboard (public facing)
    - School Resources Atlas (internal)
    - COVID-19 Vaccine Coverage Dashboard (internal)
    - Reportable Diseases Dashboard (internal)
    - Census Dashboard (internal)
    - Student Immunization Dashboard (internal)

- **712** hours of systematic reporting on topics such as opioid overdose-related EMS calls, suspected opioid-related deaths, Seasonal Acute Care Enhanced Surveillance (ACES) reports, COVID-19 cases, and school absenteeism
- **5** Socio-demographic and population health status reports providing information on youth (12 to 25 years), older adults (55+ years), francophone population, and drug & toxicity crisis
- **1** presentation at the Greater Sudbury Summit on Toxic Drugs

Research, Evaluation, and Needs Assessments

- **13** research and evaluation projects were led and completed by Public Health staff
- **11*** new proposals reviewed by the Research Ethics Review Committee *Note: Since June 2023, RERC reviews were conducted for all evidence generating projects
- **16** consultations conducted by the Research Ethics Review Committee to provide guidance on projects or ethics submissions
- **18** literature reviews, environmental scans, needs assessments, or rapid reviews conducted to inform programs and services
- **48** electronic surveys developed and administered on a variety of topics
- In addition to the stats above, the team provided ongoing support and consultation for evidence-informed practice throughout 2023

Knowledge Exchange

- **6** Knowledge exchange activities conducted, including **1** all-staff Knowledge Exchange Symposium
- **27** presentations and workshops delivered to colleagues, partners, or post-secondary students, on evidence-informed practice
- **10** knowledge products produced and disseminated (including reports, primers, and factsheets)
- **2** conference abstracts submitted and one accepted
- Additional support was provided to lead key organization wide projects including**,** Program Planning Business Cases, Readiness Checklist, Community Engagement Primer, Drug Toxicity Environmental Scan, Measles Outbreak Response Plan, and COVID-19 vaccine clinic planning

Professional Practice and Development

Academic Affiliations

3 faculty appointments with NOSM University

Student Placements

- **33** students from **7** post-secondary institutions representing **8** disciplines
- **7 364** hours of student placement experience
- **0** undergraduate medical students from NOSM University
- **3** NOSM University Northern Ontario Dietetic Internship Program (NODIP) students

- **2** postgraduate medical residents from NOSM University's Public Health and Preventive Medicine program
- **4** Master of Public Health students
- **33** staff in preceptor roles

Staff Development

82 staff completed staff orientation

4 in-house management development sessions

7 externally hosted management and leadership webinars or workshops

90 non-mandatory staff development opportunities

12 mandatory staff development opportunities

Strategic Planning

In 2023 Public Health Sudbury & Districts developed a new five-year strategic plan. The Public Health Sudbury & Districts 2024-2028 Strategic Plan was approved in November and was shaped by the comprehensive consultation process. This process included:

- **1** Board of Health engagement session
- **14** staff engagement sessions
- **5** community partner engagement sessions
- **540** individual online survey submissions

A communications plan was developed to support the implementation and dissemination of the new Strategic Plan. The plan included:

- **1** all staff email
- **1** email communication to **62** municipal contacts (Mayors, Clerks, Chief Administrative Officers) and Ministry contacts
- **1** email to nearly **250** community partners
- **1** all staff meeting presentation
- Posting to Public Health's website, which was visited **580** times
- **1** media release
- Social media announcements that reached **1 650** people via Facebook and X (formerly known as Twitter)

Accountability Monitoring

To demonstrate Public Health's accountability, a number of reports were produced and included:

- Public Health Sudbury & Districts *2022 COVID-19 Response by the Numbers and Recovery Progress Report*. The Report is a numerical overview of the agency's 2022 response to the COVID-19 pandemic, and a summary of progress in addressing Public Health's recovery priorities
- Public Health Sudbury & Districts and the COVID-19 pandemic: From risk to recovery and resilience. It outlined initial priorities for Public Health action.
- The COVID-19 Pandemic Response: Partner Debrief Summary Report

Committee Work and Partnerships

Participation on:

- **1** national committees
- **16** provincial committees
- **8** local or regional committees

Health Equity

Requests to the Health Equity team

External requests

141 instances of external support including:

- **4** presentations or workshops
- **62** meetings
- **20** external supports and collaborative work requests
- **2** media interviews
- **1** media request for a roundtable discussion
- **14** resources provided
- **26** consultations
- **10** referrals
- **2** letters of support

Internal requests

109 instances of staff support including:

- **68** internal supports or collaborations
- **21** consultations
- **9** presentations or workshops
- **2** instances of training
- **2** letters of support
- **4** internal reports
- **3** instances of research

Public Health Equitable Systems Change Webinar Series – Core Foundational Health Equity Training

- All staff completed the mandatory **6** sessions as part of the webinar series
- **60** staff attended three subsequent Reflective Circles sessions
    - **"**Allows me to understand where there may be gaps in knowledge," Reflective Circle participant

Health Equity & Mental Health Promotion Module

- Development of the Health Equity and Mental Health Promotion Module and incorporated into the onboarding package for new staff
- **5** staff completed the Health Equity and Mental Health Promotion Module

Health Equity Checklist

- Launch of a Health Equity Checklist: tool developed to support Public Health staff in applying a health equity lens to public health work and offer inclusive and equitable programs, services and processes
- **2** team presentations to orient staff to the Health Equity Checklist

2SLGBTQIA+

Staff development opportunities with Rainbow Health Ontario:

- The *2SLGBTQ Foundations* course was included in the onboarding package for new staff
- **75** staff completed the *2SLGBTQ Foundations* course in 2023
- **216** staff participated in **4** sessions of the *Removing the Barriers: How to Make Your Organization 2SLGBTQ Friendly* course offered to staff
- **49** staff attended the **2** Reflective Circles sessions pertaining to *2SLGBTQ Foundations* and *Removing the Barriers* courses
    - **"**Helped reflect on how day-to-day practices can be simply modified to be more inclusive for everyone," Reflective Circle participant

Positive Space

- Launch of the *Positive Space* initiative to demonstrate Public Health's commitment to equity, diversity, and inclusion for all who come into contact with Public Health, with intentional support toward members of the 2SLGBTQIA+ community
    - The development of a Positive Space statement to signal to the staff and community what they can expect at Public Health
    - The development of an anti-discrimination statement to make it explicit to everyone what will not be tolerated at Public Health
    - Washroom signage was installed confirming the agency's commitment to respect that each individual can make the choice to use the washroom that is most comfortable and appropriate for them
- **32** intake and client forms were reviewed and implemented across key clinical service areas
- The client satisfaction survey was updated to invite feedback from clients specific to the *Positive Space* initiative, and the staff feedback form survey was developed to provide an opportunity for staff to share input related to the *Positive Space* commitment

Equity, Diversity, and Inclusion

- **154** staff completed Public Health's Workforce Diversity Data Collection survey

Racial Equity

- **12** front-line staff from the Sexual Health, Vaccine Preventable Diseases and COVID-19 Vaccination Division, Health Promotion Division, Knowledge and Strategic Services, and Health Protection Division participated in the consultation on engaging the Black community

- Helped complete the development of the 3-hour in person, French Allyship training, in partnership with Centre de santé Communautaire du Grand Sudbury and Contact interculturel francophone de Sudbury
- **4** referrals to external Allyship training and resources in English
- Staff participated in **2** events that aim to foster Newcomers' inclusion in Greater Sudbury (Local Immigration Partnership Summit Roundtable, Welcome Event - Exhibitor Information)
- **3** front-line service staff participated in a roundtable interview with Radio-Canada about Francophone public health services for newcomers during la *Semaine de l'immigration francophone*
- **1** Racial equity staff survey and internal report that identified essential areas to advance racial equity efforts across the agency, including staff development, agency policies, structures, and community engagement

Health Equity-related Social Media

- **7** social media messages in French and English for Facebook and X related to Indigenous engagement
- **9** social media messages in French and English for Facebook and X related to racial equity
- **17** social media messages in French and English for Facebook and X related to health equity

Indigenous Engagement

Continued advancement of agency strategy, "Finding our Path Together – Maamowi Mkamang Gdoo-miikaansminaa – Kahkinaw e mikskamahk ki meskanaw".

Key focus on Strategic Direction III, "*Strengthen our capacity for a culturally competent workforce",* including:

- **1** Board of Health Training May 17 and 18, 2023
- **1** development and approval of an agency-wide Indigenous Engagement policy, procedure, and information sheet (*Smudging indoors at main office on Paris St*.)
- **4** updates to previously approved Indigenous Engagement policies, procedures, and information sheets (*Territorial Acknowledgment, Indigenous Engagement Policy C-I-190, Guide for offering semaa (tobacco) to Elders, and Guide for working respectfully with Elders)*
- **2** agency specific in-service presentations on implementing the *Smudging indoors at main office on Paris St*. policy, procedure, and information sheet (December 13 and December 21), with a total of **10** staff attending

- **3** agency-wide capacity building activities
    - **92** staff participated in the Second Annual Greater Sudbury Police Services Relay for National Day for Truth and Reconciliation, July to September, 2023
    - **85** staff attended the Presentation and Reflection Walk with Joelle Lachance-Artindale, September 19th, 2023
    - **294** staff attended the mandatory Indigenous Worldview Experiential Cultural Safety Training *Journeying from the Head to the Heart, to Affinity & Beyond* with Stephanie Stephens, Fall 2023
- **64** staff completed the survey to assess the impact of recent Indigenous cultural competency activities on workforce capacity
    - "I participated in two activities, and I think that my main takeaways from both were that we need to form meaningful relationships with our community members and should consult with them more often. Work should be done with and in collaboration instead of us doing what we think is best," survey respondent
- **1** installation of a wall mural on the 3rd floor of the main building at 1300 Paris St. to create a warm and welcoming space with an Indigenous focus aligning with the Strategic Directions
- **2** letters of support (Brunswick House First Nation and Sagamok First Nation)

Communications

- **447** resource review and approval requests
- **83** media releases issued
- **171** media requests processed
- **128 400** Facebook users reached (Eng./Fr. combined)
- **300 015** X (Twitter) impressions (Eng./Fr. combined)
- **780** requests for information received through phsd.ca

Respectfully submitted,

Original signed by

M. Mustafa Hirji, MD MPH FRCPC
Acting Medical Officer of Health and Chief Executive Officer

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

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

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E-mail: info@alphaweb.org

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

Bureau of Nutritional Sciences, Food Directorate
Health Products and Food Branch, Health Canada
251 Sir Frederick Banting Driveway
Mail stop 2203E
Ottawa, ON K1A 0K9
Email: bns-bsn@hc-sc.gc.ca

February 23, 2024

Re: Regulatory modernization of foods for special dietary use and infant foods

On behalf of the Association of Local Public Health Agencies (alPHa) and its Council of Ontario Medical Officers of Health, Boards of Health Section and Affiliate Associations, we are writing to provide our input to the consultation named above, specifically where infant formula is addressed.

Section 4.1 of the proposal to modernize the regulations for foods for special dietary use and infant foods addresses several requirements for infant formula, including measures to ensure that such products adhere to the WHO International Code of Marketing of Breastmilk Substitutes.

We are pleased to have this opportunity to remind you that alPHa Resolution A14-7, Enactment of Legislation to Enforce the International Code of Marketing of Breast-Milk Substitutes (attached), clearly states our support for these measures and urges the establishment of a sustainable enforcement program to allow for monitoring and addressing non-compliance with eventual legislation.

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: Dr. Kieran Moore, Chief Medical Officer of Health, Ontario

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.

alPHa RESOLUTION A14-7

TITLE: **Enactment of Legislation to Enforce the International Code of Marketing of Breast-Milk Substitutes (the Code)**

SPONSOR: **Haliburton, Kawartha, Pine Ridge District Health Unit**

WHEREAS breastfeeding is known to provide the ideal food for infants and is recommended by Health Canada for all healthy full-term infants; and

WHEREAS breastfeeding promotes both maternal and child health and contributes to the reduction of chronic health conditions, obesity and health inequalities; and

WHEREAS interventions to improve breastfeeding are cost-effective with high cost-benefit ratios compared to curative interventions; and

WHEREAS the Government of Canada endorsed the International Code of Marketing of Breast-Milk Substitutes which outlines the minimum requirements necessary to promote and protect breastfeeding by restricting the marketing of breast-milk substitutes; and

WHEREAS the government of Canada has not enacted legislation making all aspects of the Code enforceable by law; and

WHEREAS numerous violations of the Code have been and continue to be reported on an ongoing basis since 1981 when the Code was adopted voluntarily by the Canadian Government; and

WHEREAS the suppliers of breast-milk substitutes, a $25 billion dollar industry world-wide, have unparalleled marketing abilities; and

WHEREAS compliance with the Code leads to improved breastfeeding initiation, duration and exclusivity rates; and

WHEREAS the Ontario Public Health Association (OPHA) outlined in their 2010 position paper their support and ongoing efforts to advocate at the federal level for legislation to support the Code including the ability to enforce this legislation; and

WHEREAS the Peterborough County-City Health Unit has taken action at the federal level, asking the Canadian government to honour its commitment to maternal and child health by advocating for legislation of the Code in Canada; and

WHEREAS the Health and Social Services Committee of Durham Regional Council, the Board of Health for the Grey Bruce Health Unit, the Board of Health for the North Parry Sound Health Unit and the Board of Health for the Haliburton Kawartha Pine Ridge District Health Unit have all endorsed Peterborough County-City Health Unit's position to urge the Federal government to enact legislation;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies strongly recommends and urgently requests the Prime Minister of Canada, the federal Minister of Agriculture and Agri-Food, Ontario Minister of Children and Youth Services, Ontario Minister of Education, the federal Minister of Health, and Ontario Minister of Health and Long-Term Care to enact legislation implementing all provisions of the International Code of Marketing of Breast-Milk Substitutes and its subsequent relevant World Health Assembly Resolutions;

AND FURTHER the Association of Local Public Health Agencies strongly recommends and urgently requests the Prime Minister of Canada, the federal Minister of Agriculture and Agri-Food, Ontario Minister of Children and Youth Services, Ontario Minister of Education, the federal Minister of Health, and Ontario Minister of Health and Long-Term Care to establish a sustainable enforcement program to allow for monitoring and addressing non-compliance with the legislation.

ACTION FROM CONFERENCE: **Resolution CARRIED AS AMENDED**

Public Health Ontario | Santé publique Ontario

March 11, 2024

Dr. Penny Sutcliffe
Medical Officer of Health and Chief Executive Officer
Public Health Sudbury & Districts
1300 Paris Street
Sudbury, ON P3E 3A3

Dear Dr. Sutcliffe:

On behalf of Public Health Ontario (PHO), I am pleased to offer thanks, congratulations and best wishes on the occasion of your retirement. Your efforts throughout your career, particularly your work to champion health equity, speak volumes about how you have supported our mutual goal to protect and promote the health of Ontarians. Public Health Sudbury & Districts (PHSD) has benefited greatly from your leadership over the last 23 years.

PHO has appreciated collaborating with you, especially during our early years of operation when you supported PHO's vision and advocated for our organization's success. PHO has also been delighted to have PHSD as a frequent participant and contributor to the Ontario Public Health Convention (TOPHC) over the years. We also appreciated the opportunity to provide epidemiologic support to PHSD in 2021 to help deal with a surge in COVID-19 cases in the region.

My colleagues and I look forward to continuing our relationships with PHSD, working with your successor, Dr. Mustafa Hirji. Our very best to you as you begin your retirement.

Best wishes,

Michael Sherar

Michael Sherar, PhD
President and CEO
Public Health Ontario

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Ontario

Ministry of Health

Office of Chief Medical Officer of Health, Public Health
Box 12
Toronto, ON M7A 1N3

Fax: 416 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en chef, santé publique
Boîte à lettres 12
Toronto, ON M7A 1N3

Téléc. :416 325-8412

January 25, 2024.

Dr. Penny Sutcliffe
Medical Officer of Health
Sudbury & District Health Unit
1300 Paris Street
Sudbury, ON P3E 3A3

Dear Penny:

I would like to take this opportunity to congratulate you on your retirement and to thank you for your strong and steady leadership as the Medical Officer of Health for the Sudbury & District Health Unit for over 23 years.

I appreciate your ability to bring the Board of Health, Public Health Unit staff, and community together through the years. I want to mention three outstanding areas of contribution: your leadership during the COVID-19 pandemic, including at the provincial level through the Public Health Measures Table, your sustained and impactful work as a champion of health equity, including your work with Indigenous partners, and your exceptional service as Chair of the Council of Medical Officers of Health.

I would also like to thank you for your time and advice over the past number of years to strengthen and improve Ontario's public health system.

Again, I want to extend my sincere appreciation for your commitment and contributions to public health in Ontario, and I wish you all the best in your retirement.

Yours truly,

Dr. Kieran Michael Moore
MD, CCFP(EM), FCFP, MPH,
DTM&H, FRCPC, FCAHS
Chief Medical Officer of Health and
Assistant Deputy Minister, Public Health

Elizabeth Walker
Executive Lead
Office of Chief Medial Officer
of Health, Public Health

14-075

Balancing Act

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

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

Ontario

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.

Catalogue No. 301527 ISBN 9978-1-4868-7880-2 (PDF) March 2024

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

Contents

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.

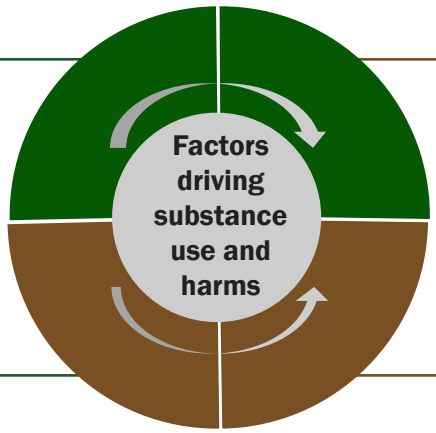
It is time to focus attention on substance use and harms.

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.

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.

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.

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.

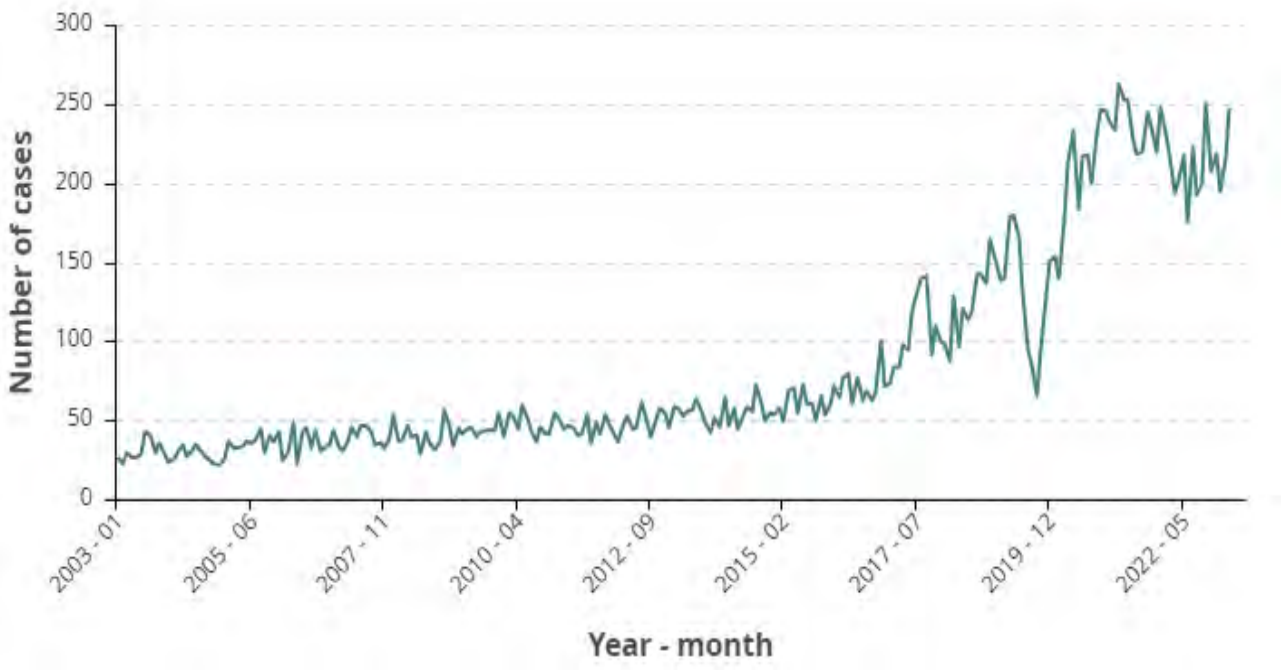
That's one tragic, preventable death from opioids about every three hours – with thousands more Ontarians seeking care in emergency departments and being hospitalized for accidental overdoses each year.

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.

$18 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.

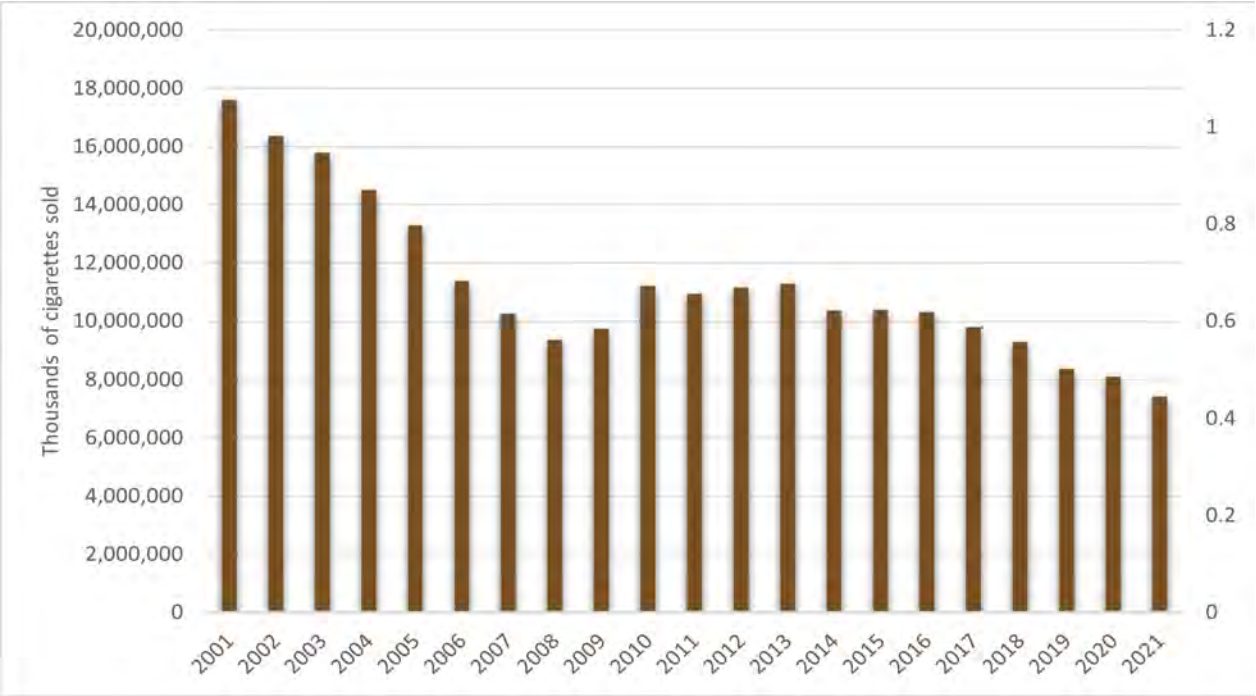
[viii] Income generated by alcohol is based on sales as well as taxes because the provincial government has largely controlled the sale of alcohol through the Liquor Control Board of Ontario (LCBO), while estimated income from tobacco and cannabis is based on taxes on sales only.

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:

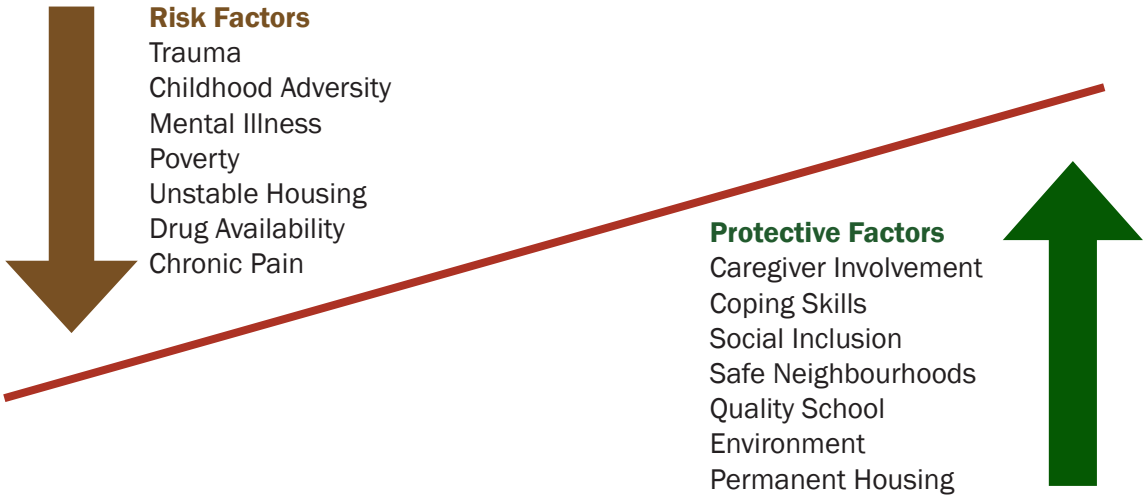
- all levels of government: federal, provincial, territorial, local and Indigenous
- all partners currently involved in substance use issues, including: the regulatory system, the commercial system, finance and taxation systems, the social service system, the child welfare system, the health care system, 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?

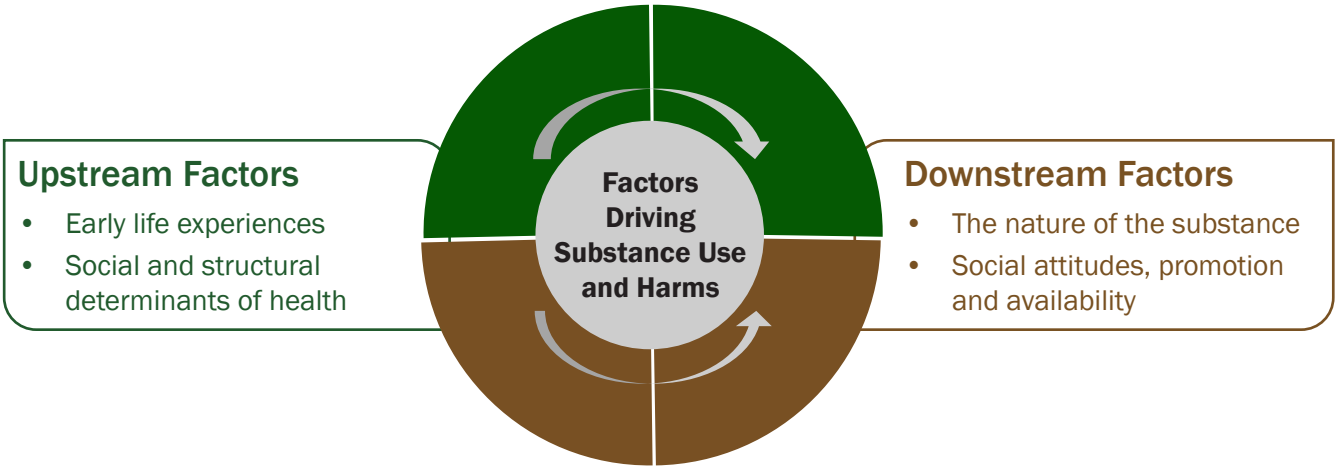
The best antidote to problematic substance use and addiction is connection: connection to family and friends, to community, and to society.

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:
  - experiencing physical, sexual or emotional violence or abuse
  - being physically or emotionally neglected (including inadequate supervision)
  - witnessing violence in their home or community
  - growing up in a household with substance use or mental health conditions (including being exposed to alcohol or other substances prenatally)
  - having a family member attempt suicide or die by suicide
  - living with instability due to parental separation or divorce
  - 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]

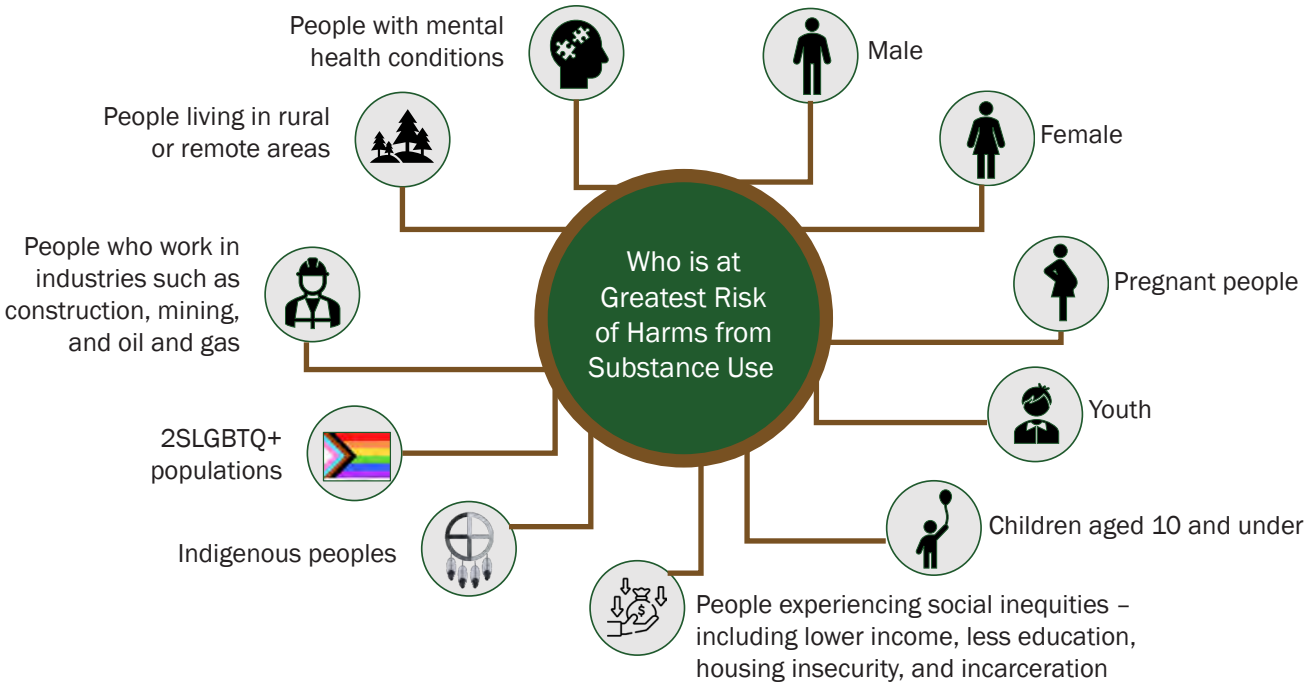
In a soon-to-be published study with people who drink alcohol, 60% were not aware that alcohol causes cancer.

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]

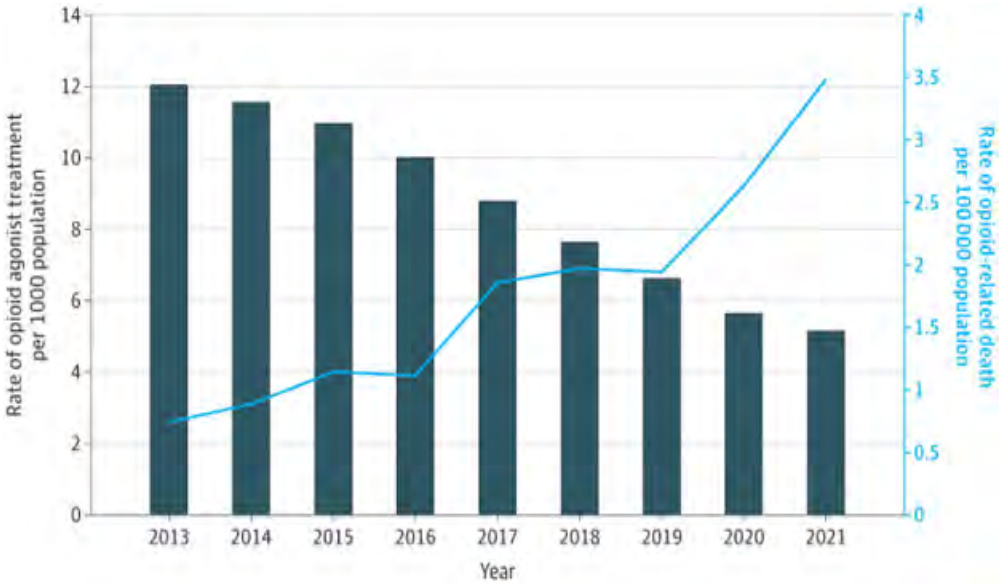
Since the start of the COVID-19 pandemic, 3 in 4 people who died from opioid toxicity in Ontario were male.[11]

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]

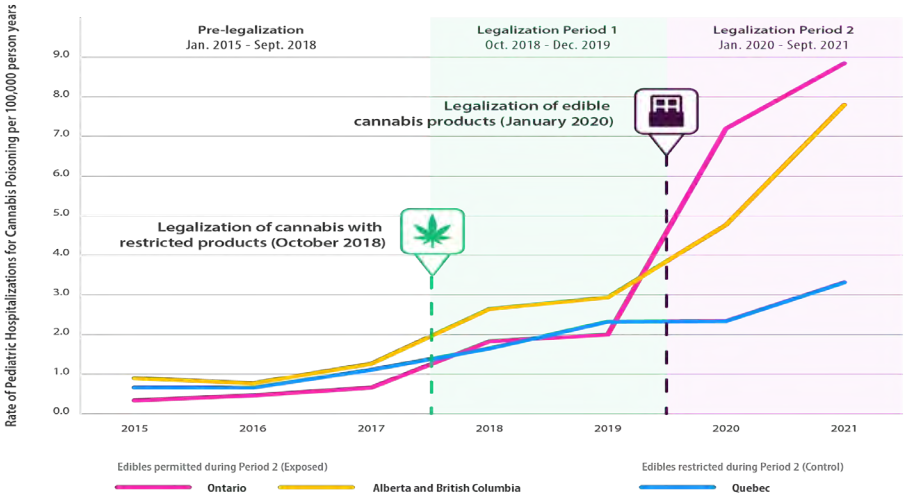
Figure 4: Rates of Opioid Agonist Treatment and Opioid-Related Deaths for Youths in Ontario, Canada, 2013-2021



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]

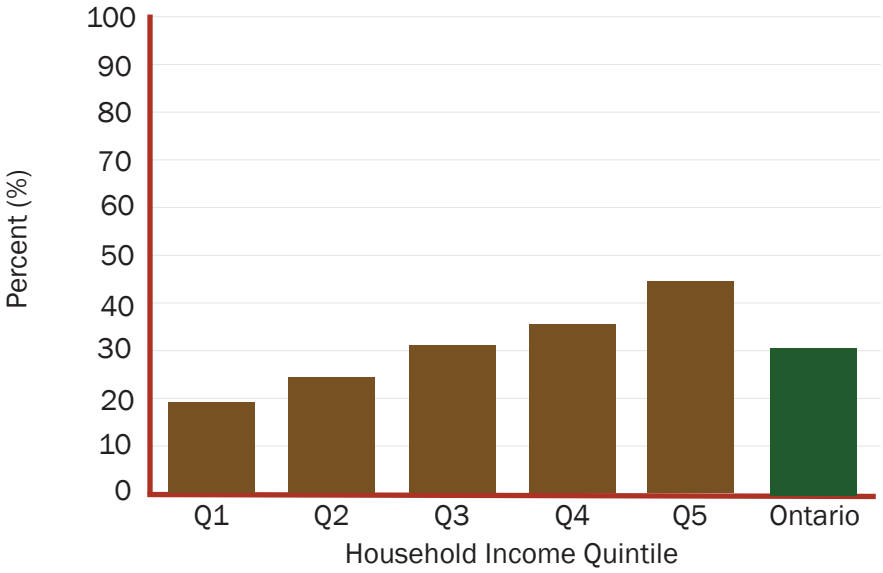
Figure 5: Rate of hospitalizations due to cannabis poisoning in children aged 0-9 years in four Canadian provinces, 2015 to 2021.



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

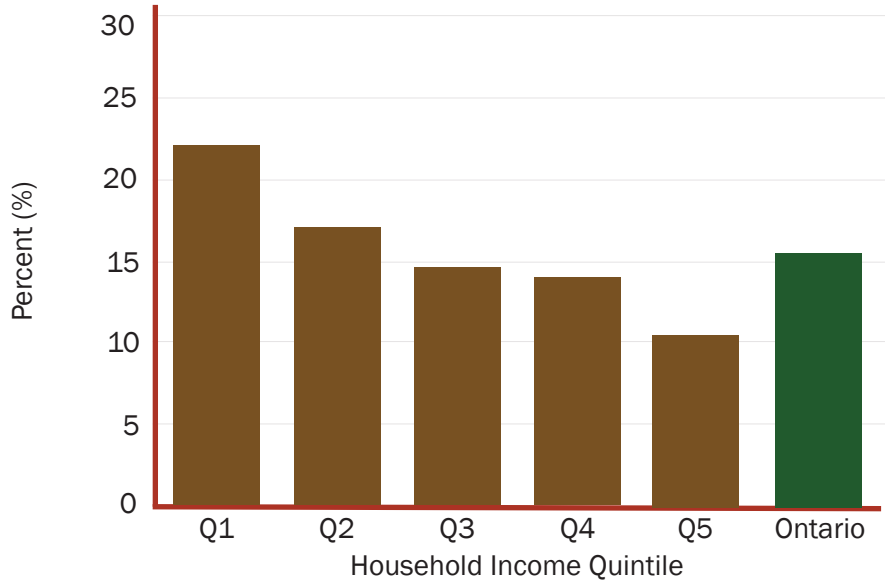


Notes:"Q1" represents the lowest household income quintile and "Q5" represents the highest. Data are presented in Supplementary Table S14. Download supplementary tables at ontariohealth.ca. Estimates are adjusted to the age distribution of the 2011 Canadian polulations.

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]

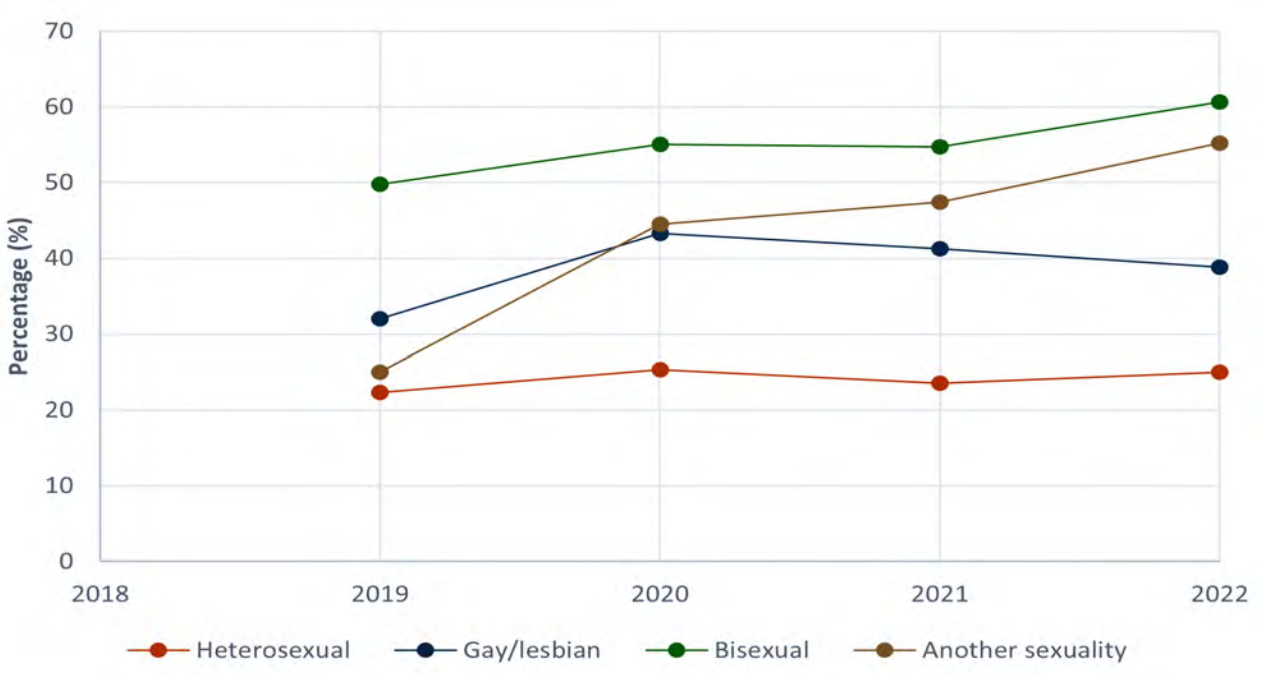
In Ontario, 88% of all Indigenous peoples live off-reserve in cities, towns, and rural communities,[69] and particular attention must be paid to addressing their needs. It is also important to understand that Indigenous people are the fastest growing population and the youngest population in Canada.[70] 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]

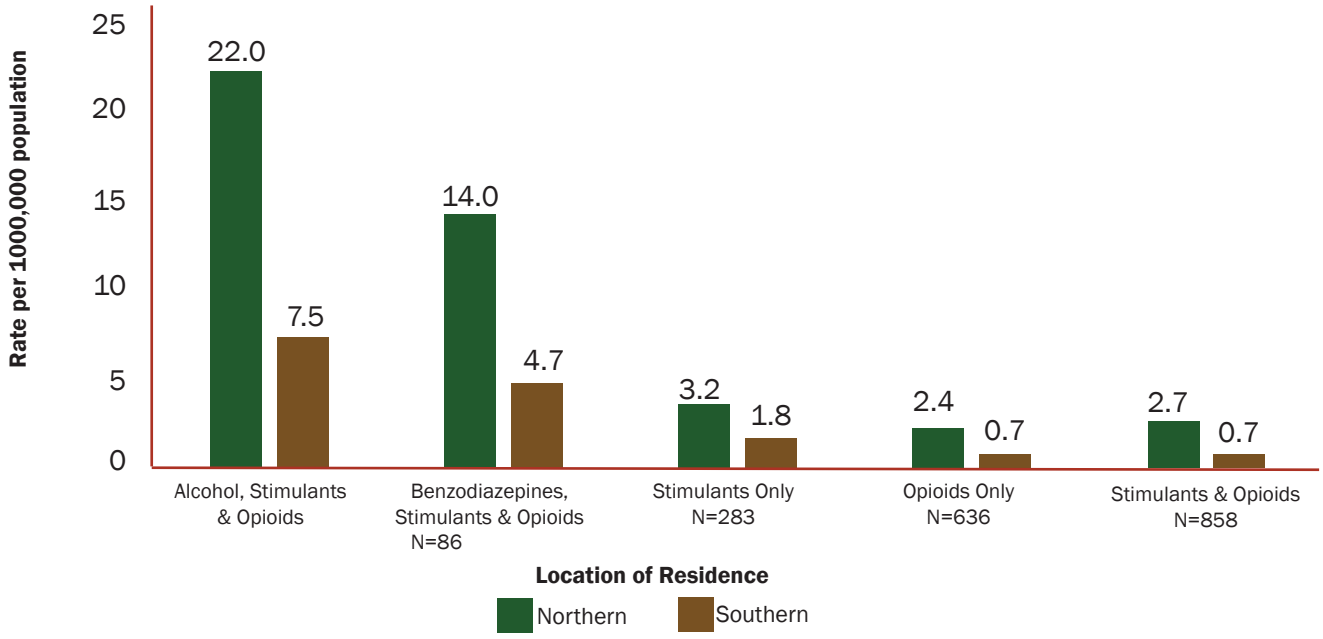
[xi] Two-spirit, lesbian, gay, bisexual, trans, queer plus other gender and sexual identities

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

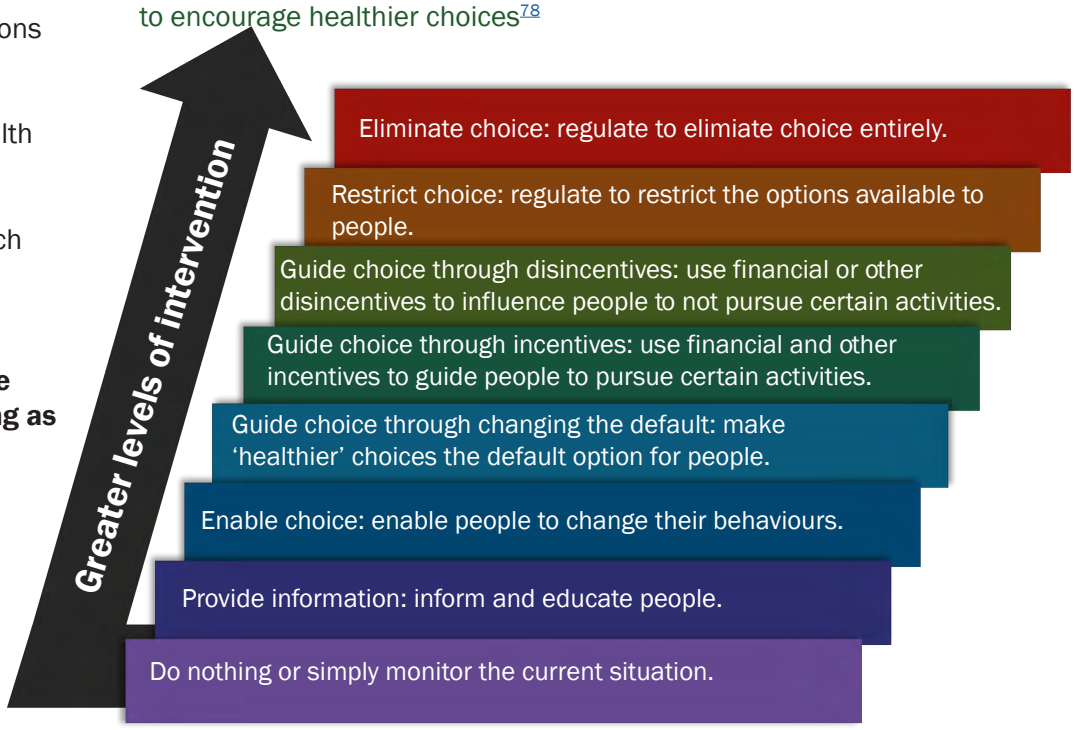
Ontario has already put in place many policies and initiatives designed to influence the drivers of substance use. However, as we learn more about substances and their impact on health, and as the substances themselves, the market for them, and the populations most at risk evolve, we must continually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

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

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



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.

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.

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]

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.

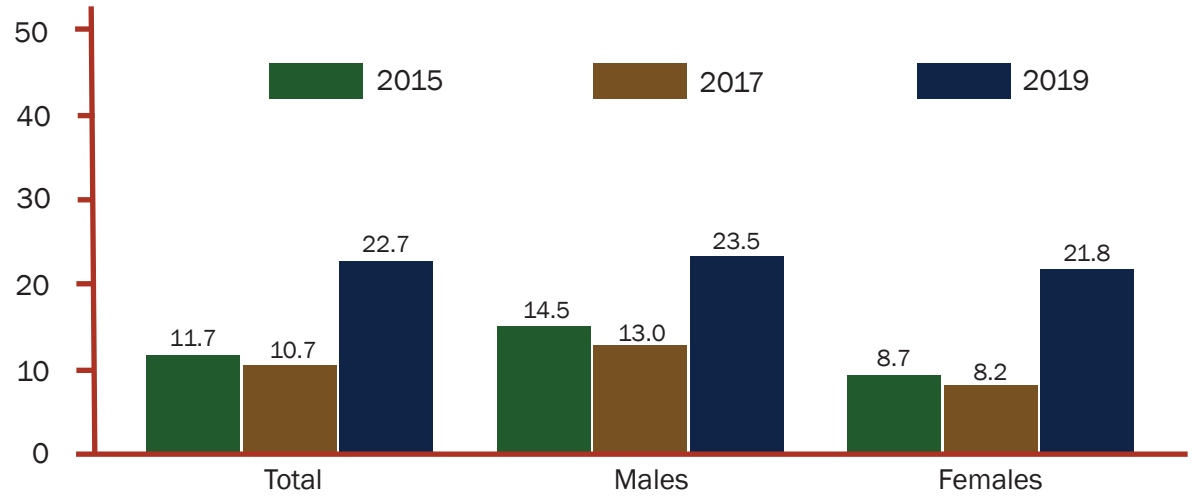
(https://www.cdc.gov/cancer/tobacco/index.htm)[131]

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]

- 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]

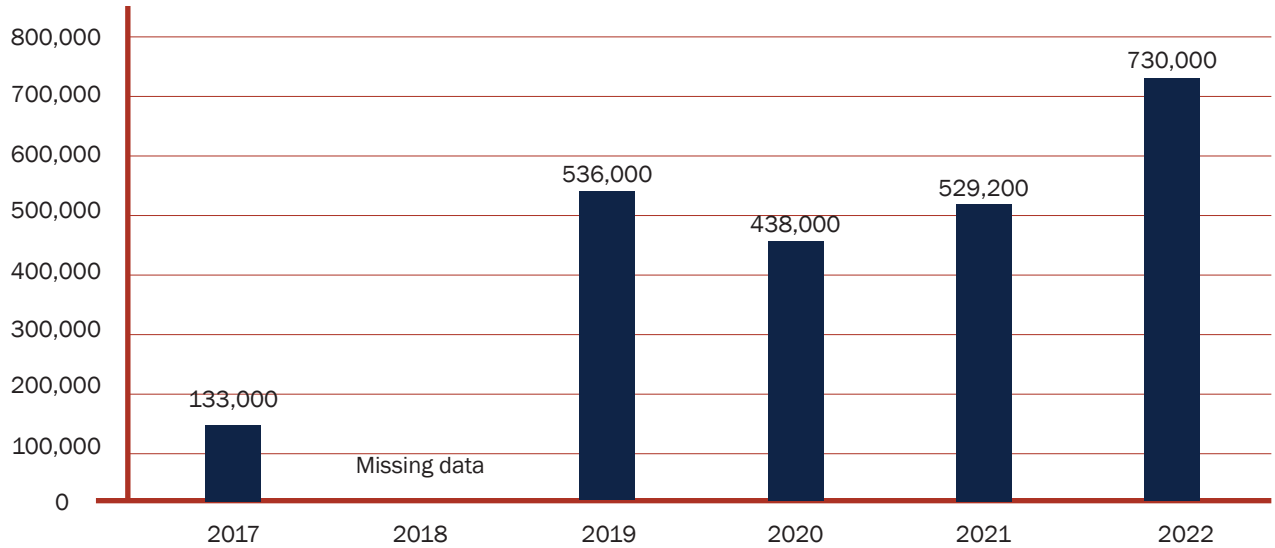
Figure 12: Percentage of high school students (grades 7-12) in Ontario using E-cigarettes (vaping) by sex, 2015, 2017, 2019



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]
- 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]

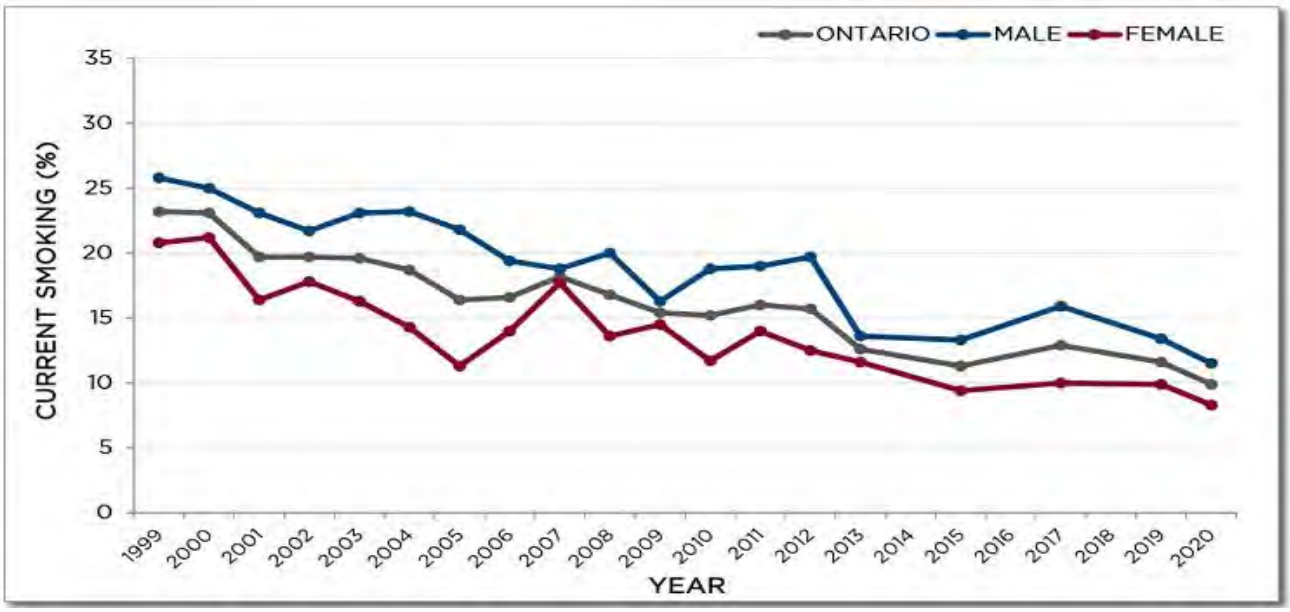
The health effects of exposure to second-hand aerosol from vaping devices are currently unknown.[145]

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

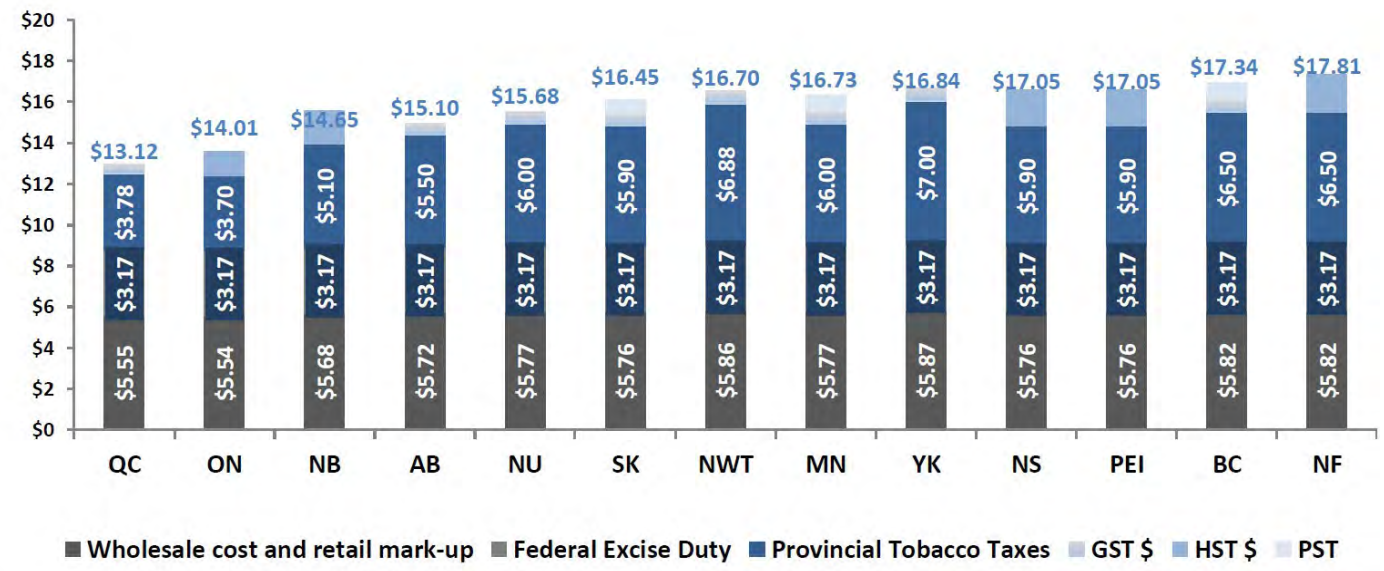


Source: Reid JL, Hammond D, Burkhalter R, Rynard VL. Tobacco use in Canada: patterns and trends: 2022 edition [Internet]. Waterloo, ON: University of Waterloo; 2022 [cited 2024 Feb 8]. Figure 2.15: Current smoking prevalence* among males and females, Ontario, 1999-2020; p.29. Available from: https://uwaterloo.ca/tobacco-use-canada/sites/default/files/uploads/fil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

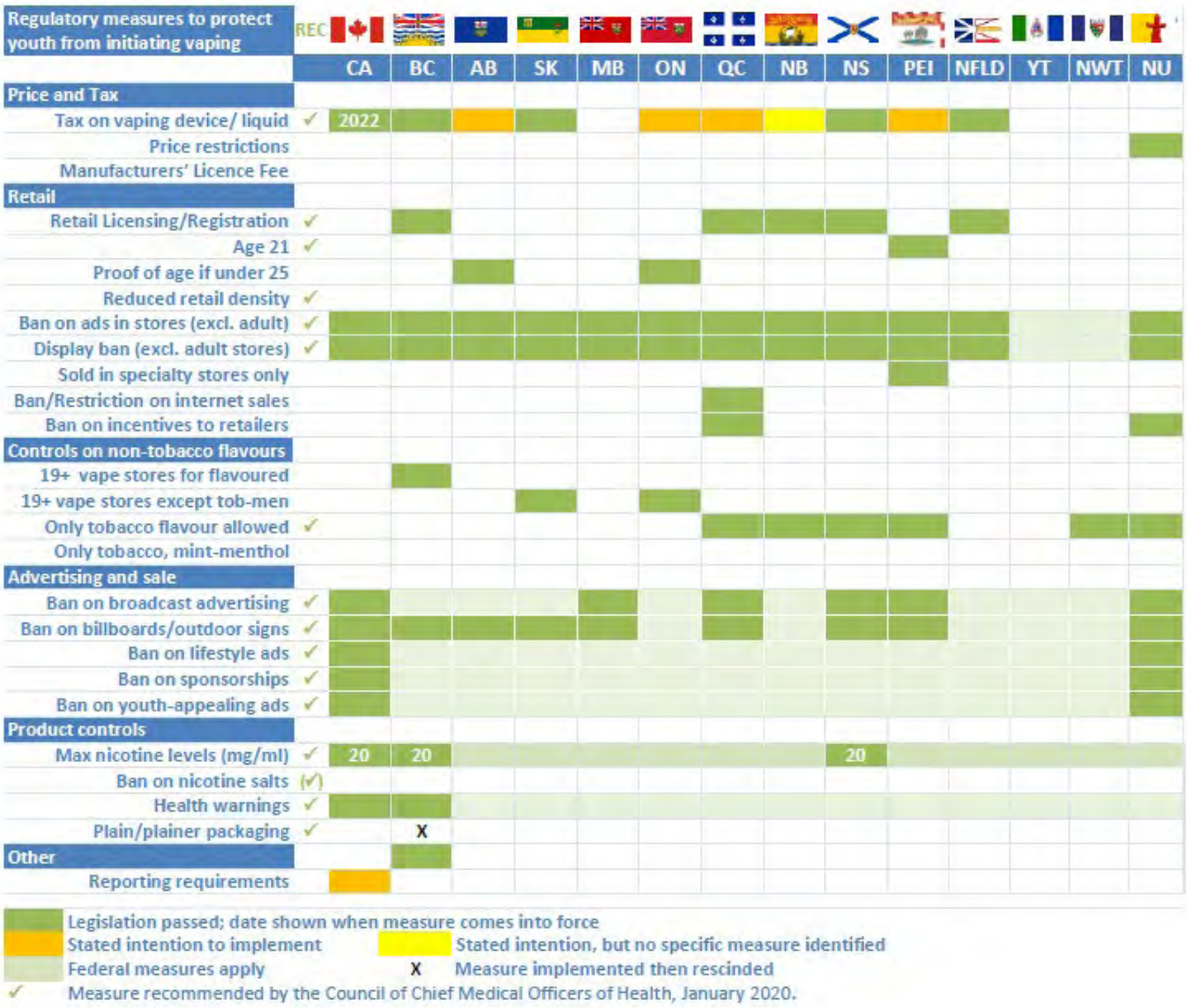
Figure 16 illustrates how Ontario compares to other provinces and territories in terms of regulating the sale of and access to vaping products.

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



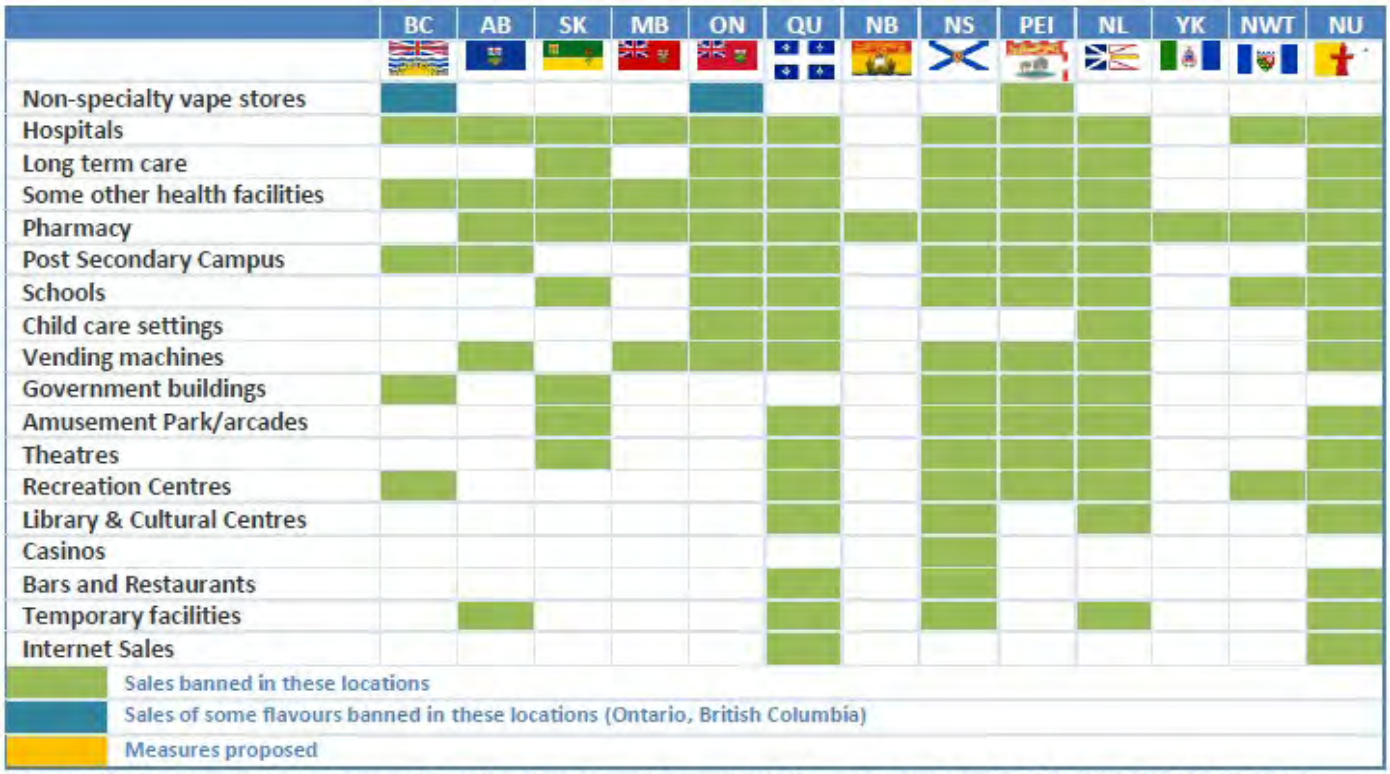
Source: Physicians for a Smoke-Free Canada. At-a-glance: provincial restrictions on vaping products: November 2023 [Internet]. Ottawa, ON: Physicians for a Smoke-Free Canada; 2023 [cited 2024 Feb 8]. Overview of federal and provincial regulations on marketing of electronic cigarettes; p.1. Available 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



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

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

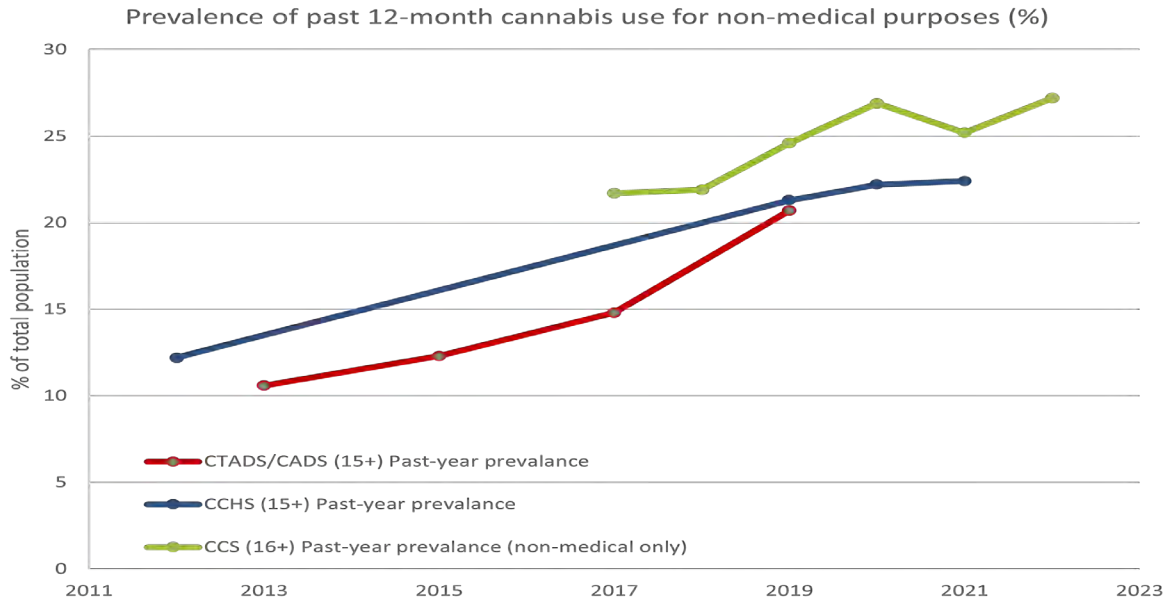
- Establish key performance indicators for public health inspectors and others involved in enforcing tobacco and vaping policies designed to protect minors and non-smokers
- Work with Public Health Ontario and with federal, provincial, territorial and Indigenous partners to continue to:
  - Monitor the 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.

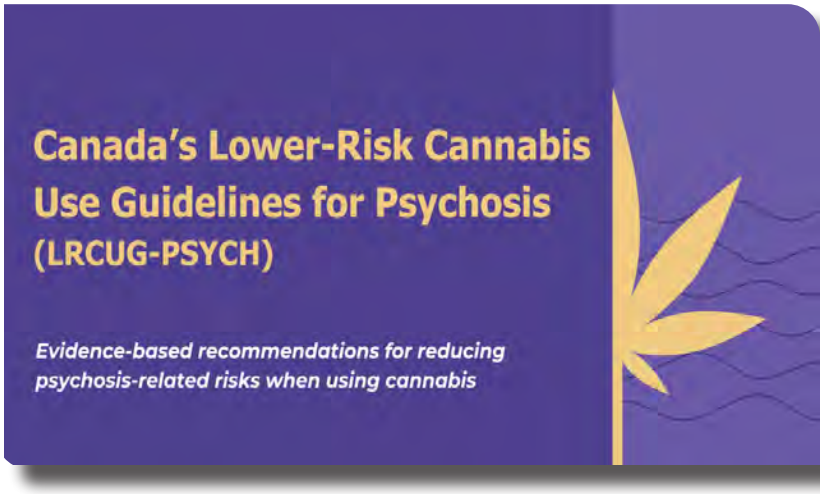
In July 2023, the Council of Chief Medical Officers of Health and Public Health Physicians of Canada submitted a joint statement, that I signed on to, outlining the public health challenges and recommendations for the future of national cannabis policy.[182]

> 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.



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]

drove after drinking 2+ drinks in previous hour in past 12 months

hazardous or harmful drinking

weekly binge drinking

drinking daily

* 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

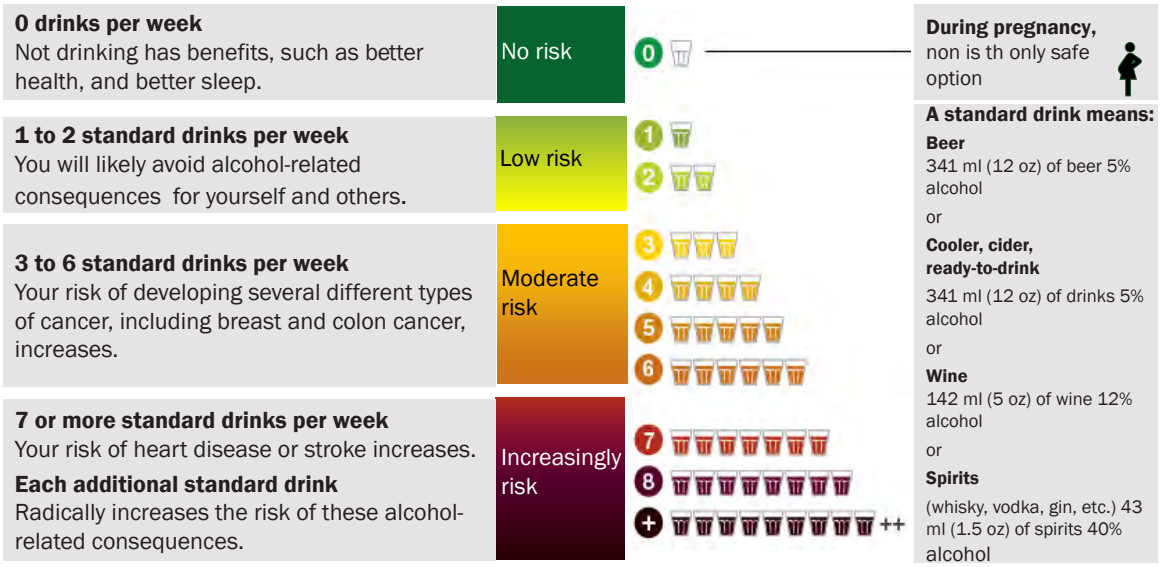
Alcohol is the most commonly used substance in Ontario. Binge drinking and hazardous drinking both increased during the COVID-19 pandemic.

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.

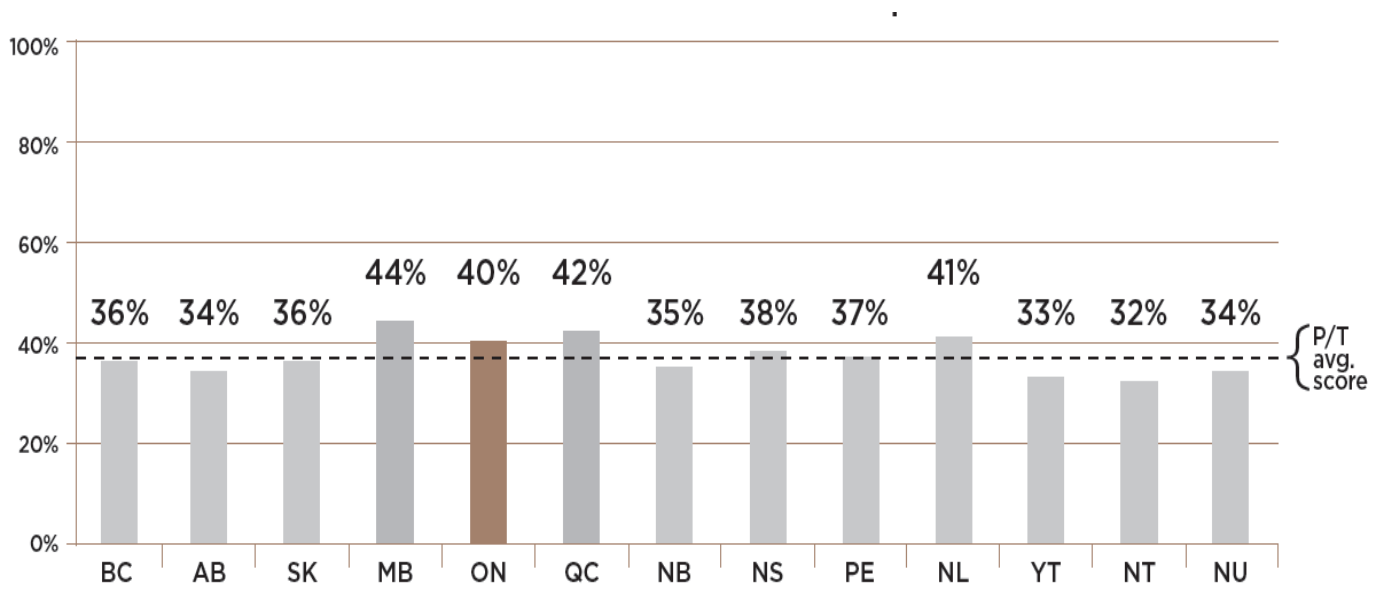
No type of alcohol product (beer, wine, spirits) meets the World Health Organization's recommended minimum unit price of $1.97 per standard drink in 2022 dollars. The gap between the recommended minimum price and the actual retail price in Ontario has been increasing since 2013.[57]

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:**
  - 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
  - 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
  - Ensure opioid use disorder treatment services in Ontario meet the forthcoming national standards for mental health and substance use services
  - Expand the Ontario Drug Benefit (ODB) formulary to include injectable forms of opioid agonist treatment
  - 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.
  - 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:
  - Provide compassionate mental health and counselling services, and other forms of grief and loss programs and supports for family members, peers, and friends
  - 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:
  - Monitor the impact of the toxic drug supply on the health of Ontarians
  - Assess the effects of provincial opioid-related policies and programs
  - 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
  - Identify best-practice interventions to reduce harms associated with opioid use
  - 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.

Acknowledgements

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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

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

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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Public Health
Santé publique
SUDBURY & DISTRICTS

April 11, 2024

VIA ELECTRONIC MAIL

Dr. Kieran Moore
Chief Medical Officer of Health
Ministry of Health
Office of Chief Medical Officer of Health, Public Health
Box 12
Toronto, ON M7A 1N3

Dear Dr. Moore:

Re: Letter of Support – *Balancing Act: An All-of-Society Approach to Substance Use and Harms* Report

We are writing on behalf of Public Health Sudbury & Districts to express our strong support for the findings and recommendations outlined in your report, *Balancing Act: An All-of-Society Approach to Substance Use and Harms*. This report is a valuable guide forward in addressing the complex challenges of substance use and its associated harms within our communities. This timely report will help support us in our efforts to address substance use in Sudbury and districts.

We are particularly encouraged by the report's broad look at all substances, its emphasis on the social determinants of health, and its bold articulation of policy change opportunities. The recommendations presented in the report provide a solid foundation for developing policies and programs that are compassionate, effective, and inclusive. We believe your office has succeeded in producing a report that will guide the sector for many years to come.

In Sudbury and districts, there has been a 500% increase in deaths from 2016 to 2020 due to opioid toxicity. In 2019-2020, we had the highest heavy drinking rate in the province at 27.9%, compared to provincial rate of 15.6%. Further, in 2022, Sudbury and districts experienced the highest rate in Ontario for hospitalizations for cannabis related harms.

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Notably, in Sudbury and districts, 20.1% of people 12 years and older are current smokers, compared to 12.7% of the Ontario population. Smoking rates are higher in populations that are more rural, blue collar, Francophone, and Indigenous, and with lower education, which are all attributes of our population. We are also concerned about youth vaping and youth having access to non-tobacco products like nicotine pouches. In 2018-2019, 30.6% of grade 7-12 students in Northern Ontario reported having used electronic cigarettes at least once in the last year, compared with 22.7% for Ontario.

Your report's call for a coordinated all-of-society approach while acknowledging the multifaceted nature of substance use is one we wholeheartedly agree is essential for creating sustainable change and improving the health and well-being of individuals and communities across Ontario.

We are eager to support the implementation of the report's recommendations and to collaborate with you, stakeholders, and community members.

We extend our personal gratitude and all of Public Health Sudbury & Districts to you and your team for the diligent work on this report.

Sincerely,

M. Mustafa Hirji, MD, MPH, FRCPC
Acting Medical Officer of Health and
Chief Executive Officer

René Lapierre
Chair, Board of Health

alPHa
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

Hon. Sylvia Jones
Minister of Health
College Park 5th Flr, 777 Bay St
Toronto, ON M7A 2J3

April 5, 2024

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.

Peterborough Public Health

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January 31, 2024

Hon. Sylvia Jones
Deputy Premier and Minister of Health
sylvia.jones@ontario.ca

Hon. Paul Calandra
Minister of Municipal Affairs and Housing
minister.mah@ontario.ca

Hon. Mark Holland
Minister of Health (Canada)
hcminister.ministresc@hc-sc.gc.ca

Hon. Sean Fraser
Minister of Housing, Infrastructure and Communities (Canada)
minister-ministre@infc.gc.ca

Dear Honourable Ministers,

Re: Legislated improvements to indoor air quality (IAQ) in indoor public settings are required to reduce the transmission of COVID-19 and other airborne pathogens

Through the COVID-19 pandemic, we have learned that the SARS-CoV-2 virus transmits via an airborne mechanism. Additionally, despite the end to the global declaration of emergency, COVID-19 continues to cause illness and death due to severe disease and through Post COVID Condition (Long COVID). In the region served by Peterborough Public Health, there were 109 PCR-confirmed COVID-19 deaths in 2022 and 35 in 2023.[1] Recently released data from Statistics Canada shows that nationally, in 2022, COVID-19 climbed to the third leading cause of death in Canada; in 2020 and 2021, COVID-19 was the fourth leading cause of death.[2] Last month, the seven-day average wastewater signal for December 11, 2023 was at 42 normalized viral copies per mL, the highest since monitoring began in January 2021.[3] Suffice it to say that COVID-19 is still present and harming our community's health and the economy's stability.

With this recognition, the Board of Health of Peterborough Public Health continues to advocate for improvements in preventive activities and at its January 10th Board of Health meeting resolved to continue this advocacy with this letter to you for your consideration.

Among the most important interventions to prevent COVID-19 is improving the indoor air quality (IAQ) of the air that we breathe. In January 2023, we last wrote to you to advocate for consideration of IAQ improvements. In May of 2023, the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) released a new standard that now operationalizes the improvements. Canada uses ASHRAE to inform its current building code development, and so this new standard should be integrated as soon as possible in Canada to improve health and save lives.

ASHRAE Standard 241: Control of Infectious Aerosols, specifically addresses improving IAQ to reduce infection from airborne pathogens. The Ontario Society of Professional Engineers notes that "incorporating ASHRAE Standard 241 into the Canadian National Building Code will significantly improve indoor air quality and ensure that building designs and systems are optimized to minimize airborne disease transmission."[4]

Advancing cleaner air policies and implementing ASHRAE Standard 241 comes with a significant boost to both public health and economic outcomes. "The total monetized COVID-reduction benefit of 16 weeks of Infection Risk Management Mode per year [during the peak 'season' of transmission] is about $40 billion, about 10 times the total cost. Monetized values of other benefits, such as increased productivity and reduction in other virus infections, would likely be another $20 billion to $40 billion."[5] The return on investment is *at least* 6:1, potentially as much as 8:1.

The bottom line is that scientists, academics, engineers, doctors, and public health practitioners agree that cleaner air in indoor public spaces is needed to truly get ahead of this pandemic and mitigate the onset of future public health emergencies related to airborne pathogens.[6,7,8]

ASHRAE Standard 241 specifically addresses improved IAQ as it relates to respiratory viruses, a component currently missing from provincial and federal building codes and regulations. The Standard lays out practical solutions that owners, operators, and managers of shared spaces can take to protect those occupying their spaces from airborne pathogens.

ASHRAE Standard 241 and improved indoor air quality should be adopted into federal and provincial building codes and highly considered for inclusion in local property standards by-laws to ensure improvements in the air we breathe and our health.

Respectfully,

Original signed by

Councillor Joy Lachica
Chair, Board of Health

/ag

cc: Local MPPs
Local MPs
Local Councils
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)

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[8] Ibid.

Statement from the Chief Public Health Officer of Canada Update on Measles and Risk to Canadians Français

NEWS PROVIDED BY
Public Health Agency of Canada →
Mar 27, 2024, 13:30 ET

OTTAWA, ON, March 27, 2024 /CNW/ - Canada is currently experiencing an increase in measles activity, with cases reported in four provinces in 2024. As of today, the Public Health Agency of Canada (PHAC) is aware of 40 measles cases in Canada this year, which is already more than three times the number of cases reported in 2023. PHAC has received reports that seven of these people with measles required hospital care. The majority of measles cases in Canada are in people who are unvaccinated, most of whom are children. Some people with recent measles infections were exposed to measles while travelling internationally, while others were exposed in Canada.

I remain concerned that measles **vaccination coverage** among school-age children (for whom two doses of measles-containing vaccines are recommended) is not high enough in some parts of the country to protect against further spread of measles. Measles is highly contagious; 90% of people who are unvaccinated or not previously infected can become infected if they come into close contact with someone with measles. It is also important to understand that **measles** is more than a rash. Infection can lead to rare, but severe complications, including deafness and brain injury caused by inflammation of the brain, and can even be fatal.

Measles can be prevented through vaccination. **I strongly advise parents and caregivers to ensure that children in their care have received all measles vaccines according to their provincial or territorial vaccination schedule.** There is currently adequate supply of measles

containing vaccines in Canada for those who need a vaccine. If a child in your care has not received all recommended measles-containing vaccines for their age it is important to get them back on schedule. Talk to the child's health care provider or your local public health department about catching up on your child's missing vaccines.

PHAC recently undertook an **assessment** with provinces and territories and other partners to understand the potential risks and impact of measles in Canada. Risk assessments such as this one, support public health planning, responses and decision making to improve health outcomes for people living in Canada. The assessment concluded that there is a high likelihood of travellers infected with measles continuing to enter Canada. It is possible that infections spreading from these travellers could result in transmission in the community and outbreaks in educational settings, including child-care and pre-school, health care facilities, and un- or under-vaccinated communities. Measles infection is mainly a concern for un- or under-vaccinated persons who have not had previous infection. The risk of serious illness among those who become infected is highest in infants, children under the age of five, and persons who are immunocompromised, or pregnant.

People in Canada are at very low risk of catching measles if they have received two doses of a measles-containing vaccine, or if they have been infected with the measles virus in the past. Two doses of a measles-containing vaccine is almost 100% effective at preventing measles infection and is recommended in all provinces and territories for children, adolescents and some adults.

If you plan to **travel outside of Canada**, talk to a health care provider or local public health department preferably 6 weeks before travel to see if you need additional doses of a measles-containing vaccine.

If you believe you or your family may have been exposed to measles and have not been adequately vaccinated (or have not had a measles infection in the past), isolate and contact your health care provider or local public health department immediately for guidance. You should avoid travel and gatherings if you have symptoms of measles.

Initial symptoms of measles include fever, red watery eyes, runny nose, and cough followed by a red rash that starts on the face and then moves to the rest of the body. If you develop symptoms of measles, call a health care provider immediately. If you need to be seen in person, the health care provider can arrange to see you while preventing the spread to others.

No one should have to experience serious illness from a vaccine-preventable disease like measles. Help stop the spread of measles in Canada by ensuring you and your family receive recommended measles vaccines.

SOURCE Public Health Agency of Canada

For further information: Media Relations: Public Health Agency of Canada, 613-957-2983, media@hc-sc.gc.ca

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Providing leadership in public health management

NOTICE

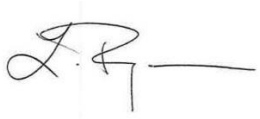
2024 ANNUAL GENERAL MEETING

NOTICE is hereby given that the 2024 Annual General Meeting of the **ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES (alPHa)** will be held in Toronto on **Thursday, June 6th, at 10:15 a.m. Eastern Daylight Time** at the *2024 Annual Conference*, for the following purposes:

1. To consider and approve the minutes of the 2023 Annual General Meeting;
2. To receive and adopt the annual reports from the President, Executive Director, Section Chairs, and others, as appropriate;
3. To consider and approve the Audited Financial Statements for 2023-2024;
4. To appoint an auditor for 2024-2025; and
5. To transact such other business as may properly be brought before the meeting.

DATED at Toronto, Ontario. Wednesday, March 6, 2024

BY ORDER OF THE BOARD OF DIRECTORS.



Loretta Ryan
Executive Director

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APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approve the consent agenda as distributed.

News / Local News

‘We were going to lose power’: Algoma Board of Health echoes merger opposition to ministry

Province says focus is now on those boards looking to join

Jeffrey Ougler

Published Mar 28, 2024 • Last updated 6 days ago • 6 minute read

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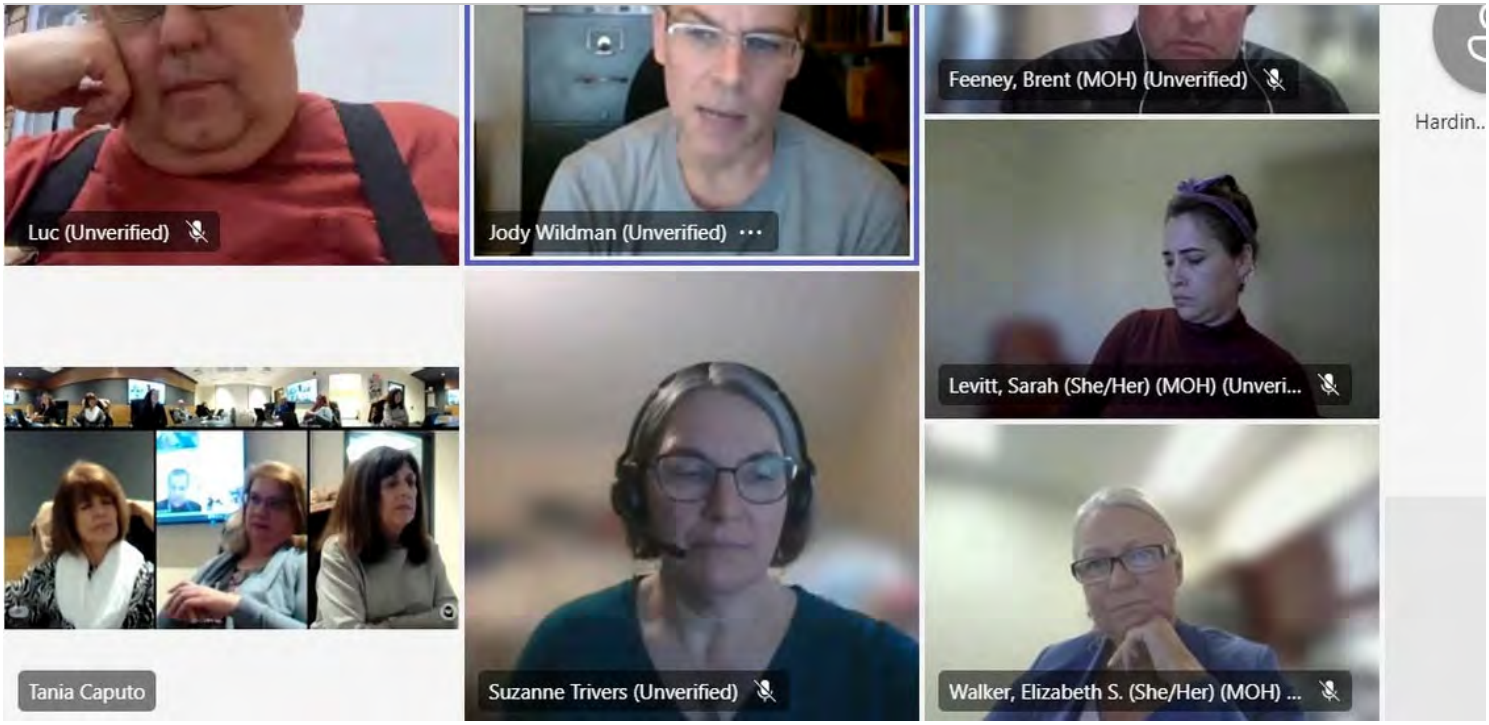

Financial fine points of a proposed merger between Algoma Public Health and Public Health Sudbury and Districts 'raised a lot of red flags,' Algoma Board of Health member Jody Wildman tells a virtual meeting between the board and Ministry of Health officials this week. SCREENSHOT

Algoma Board of Health remains unbending.

STORY CONTINUES BELOW

Members of Algoma Public Health's governing body echoed their earlier opposition to any merger between APH and Public Health Sudbury and Districts during a virtual discussion Wednesday with Ministry of Health officials, citing everything from fiscal to governance concerns.

Essentially, members contend Algoma would have received short shrift had they given the green light.

"Although the word equity kept being used in our conversations, the approach that was being presented, that was being proposed, was actually an inequality approach," Suzanne Trivers told ministry officials, who joined into the open portion of the board's regular March meeting.

Ample community representation is vital – and would not have happened in the case of a merger, said Trivers, who worked in health care for 35 years, often in rural communities.

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Algoma communities' "health status" was not taken into consideration, she said.

"We were going to lose power," Trivers added.

Jody Wildman said he understands public health services are centred in larger areas, but solid rural representation is a must.

"The governance thing became very difficult," said Wildman, also mayor of the Township of St. Joseph, a small community on St. Joseph Island, east of Sault Ste. Marie.

As it is, rural board members, such as himself, must often go to bat for small communities.

"If we're already doing that now, it's just going to become more difficult with a larger area and less representation for rural areas on the board that is dominated by much larger centres," Wildman said.

APH's governing body agreed unanimously in late February that it did not "intend" to merge with Public Health Sudbury and Districts, nor would it further negotiate with PHSD to complete a voluntary merger business case for submission to the Ministry of Health.

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Talks of a merger date back to 2019. At that time, the Ontario government attempted to force the merger of all Northeastern Ontario health units into a single entity. It was part of a larger plan to merge 35 public health units into 10 regional structures, which was abandoned with the onset of the COVID-19 pandemic.

Public health units have since been asked to voluntarily examine mergers. APH and PHSD began "undertaking a process to explore a potential merger" by seeking feedback from stakeholders. PHSD's board, however, voted unanimously to proceed with a merger but said, given Algoma's verdict, the matter has ended.

The Ontario government has said that mergers of smaller health units are a key strategy to strengthen public health units as well as slice duplicate services and focus resources on improving access to programs and services closer to home.

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Such reasoning didn't wash in Algoma. Dr. Jennifer Loo, APH CEO and medical officer of health, said at the time that "right from the outset, it was clear" such a merger was not a "cost-saving exercise" that would allow any savings to go toward beefing up health-care services here.

While the February meeting during which Algoma's decision was made heard that many of the merger's financial details were "confidential," Loo did cite "significant" transition costs.

Financial factors “raised a lot of red flags,” Wildman said.

provided to APH at the same amount as in 2020 and, going forward, the health unit could expect a one-per-cent increase per year to that base funding from 2024 to 2026. Six APH positions were axed earlier this year, including three nurses.

STORY CONTINUES BELOW

Board first vice-chair Luc Morrissette suggested merger dollars would have been better spent funding the unit and, thus, avoiding job cuts.

“We have to look after people in our district and I didn’t feel that it was an equal board and I felt that this was not going to happen to our satisfaction,” said Morrissette, contending the board was “rushed” into making a decision that would have likely angered many small Algoma communities, especially at tax time.

“An increase in levies would have been hard to sell to some of our municipalities,” he said.

The board heard earlier that had Algoma and Sudbury “simply” merged, there would have been 22 members in total, which board member Don McConnel branded “unworkable.”

The APH board includes one representative from Elliot Lake, one from Blind River, Spanish or Township of the North Shore, one from Wawa, White River or Dubreuilville, one from Thessalon or the Municipality of Huron Shores, and one from Bruce Mines, Village of Hilton Beach, Townships of Hilton,

Jocelyn, Johnson, Laird, Mac-Donald, Meredith and Aberdeen, Plummer Additional, Prince, St. Joseph or Tarbutt.

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Asking the province to change legislation allowing for the board to expand was suggested – and frowned upon.

Board chair Sally Hagman said that “right from the get-go” she was concerned the ministry was pitching the merger without providing a uniform integrated financial and administration system.

“I think it’s so important that health speaks from the same common language,” she said. “We know that 34 public health units all have unique circumstances, but there are certain templates that could be organized right from the top down and that would certainly help everyone to ensure that we’re not re-inventing the wheel.”

Hagman also cited current leadership concerns; Loo is going on maternity leave, Dr. John Tuinema, APH’s associate medical officer of health, is on parental leave and Penny Sutcliffe, PHSD medical officer of health, has retired.

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“I truly believe that a merger would have seen staff jumping ship.”

Board member Deborah Graystone said health conditions in Algoma District are “very poor,” and many residents do not have ample access to tertiary care centres, specialty services and primary care.

“Our health is failing and to compromise or stretch the limits of health promotion and illness prevention in our community at this time, I just saw very big risks and I did not see any benefits that could mitigate that risk,” she said.

STORY CONTINUES BELOW

Board member Loretta O’Neill also cited geography “constraints.”

“It became very difficult from a governance perspective to make sure we were representing the public health needs of our whole geography,” she said.

The Ministry of Health told The Sault Star shortly after the APH decision the province had no plans to stick its oar in, saying all public health unit mergers are “voluntary” and “driven” by the local communities.

“The only intervention from the province would be to provide onetime funding to support any voluntary merger,” ministry spokesperson Hannah Jensen told The Sault Star.

Elizabeth Walker, ministry executive lead in public health, echoed the province's earlier stance Wednesday.

Walker said the priority now is on those boards that have shown interest in joining and others still deciding. Business cases are expected in early April.

"What may happen after that, I don't know," Walker said. "I honestly, transparently, don't know. We have not had that conversation with government."

jougler@postmedia.com

On X: @JeffreyOugler

COMMENTS

365 Bloor Street East, Toronto, Ontario, M4W 3L4

The Corporation of the Town of Bruce Mines

PO Box 220
9126 Hwy. 17 East
Bruce Mines ON P0R 1C0

MAYOR: LORY PATTERI
MUNICIPAL ADMINISTRATOR: JUDY DAVIS

Phone: (705)785-3493
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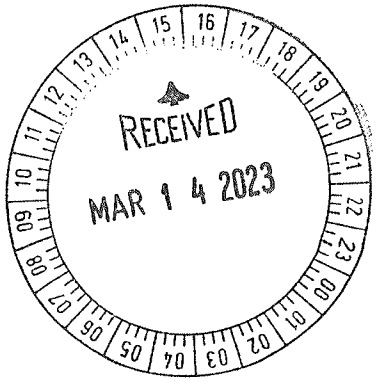

March 11, 2024

Municipality of Wawa
40 Broadway Avenue
Wawa ON P0S 1K0

Mayor & Council:

RE: Merger of APH & PHSD

Please be advised that the following resolution was passed at our regular council meeting of March 4, 2024:

RESOLUTION NUMBER: 2024-61
MOVED BY: SHANE ROCK
SECONDED BY: JAMIE STOPES
WHEREAS THE TOWN OF BRUCE MINES HAS REVIEWED THE CORRESPONDENCE FROM THE MUNICIPALITY OF WAWA REGARDING OPPOSITION TO THE MERGER OF ALGOMA PUBLIC HEALTH (APH) WITH PUBLIC HEALTH SUDBURY AND DISTRICT(PHSD); AND
WHEREAS THE TOWN OF BRUCE MINES HAS REVIEWED THE NEWS RELEASE DATED FEBRUARY 20, 2024 FROM ALGOMA PUBLIC HEALTH WHEREIN APH HAS VOTED NOT TO MERGE WITH PHSD; AND
WHEREAS THE TOWN OF BRUCE MINES AGREES WITH THE FINDINGS OF APH CONCERNING SUCH A MERGER;
NOW THEREFORE *BE IT RESOLVED THAT THE COUNCIL OF THE CORPORATION OF THE TOWN OF BRUCE MINES* SUPPORTS THE CORRESPONDENCE DATED FEBRUARY 6, 2024 FROM THE MUNICIPALITY OF WAWA AND DIRECTS THE MUNICIPAL ADMINISTRATOR TO SEND A LETTER OF SUPPORT TO THE MUNICIPALITY, MICHAEL MANTHA MPP, CAROL HUGHES MP, THE ASSOCIATION OF MUNICIPALITIES OF ONTARIO (AMO), BOARD CHAIRS OF BOTH APH AND PHSD AND THE MINISTRY OF HEALTH.
CARRIED.

Sincerely,
CORP. OF THE TOWN OF BRUCE MINES

Jamie Hunter, AMCT
EXECUTIVE ASSISTANT

cc: Michael Mantha, MPP, Carol Hughes, MP, AMO, Sally Hagman, Chair APH, René Lapierre, Chair PHSD

Public Health
Santé publique
SUDBURY & DISTRICTS

March 1, 2024

Dear community partner,

I am writing in follow-up to the letter dated January 18 that provided a process update on work underway between Public Health Sudbury & Districts and Algoma Public Health to explore a potential merger between our respective agencies within the context of the Ontario government initiatives to strengthen the public health system. Thank you to all who reached out following receipt of that letter to share feedback or to inquire about next steps.

As many of you will have seen in the news media last week (please see our news release issued on this matter), the Board of Health for Public Health Sudbury & Districts, at its meeting held on February 21st, voted in favor of developing a joint business case to propose to the Ministry of Health a merger of the two public health agencies. Earlier that same day, however, the Board of Health for Algoma Public Health voted against a merger. As one board of health has decided against a merger, a merger of our two agencies will not be proposed to the Ministry.

Our Board's decision was informed by a comprehensive feasibility study that described potential benefits and risks of a new merged agency. The Board assessed the potential impact of a merger on the ability of our agency to deliver public health programs and services to area communities. Throughout the process, the Board was committed to ensuring a responsive, local public health service so we can respond to the health issues of today and the unexpected surges in demand of tomorrow. While our respective boards have decided differently, the diversity of perspectives shared during this exploration has enriched our relationships and mutual understanding. We remain committed to building on our agency's nearly 70 years of delivering programs

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f: 705.677.9611

Sudbury East / Sudbury-Est
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Box / Boîte 58
St.-Charles ON P0M 2W0
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Unit / Unité 100 C
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f: 705.377.5580

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and services to communities in Sudbury and districts and to ongoing collaboration with all partners to collectively work towards healthier communities for all.

Should you have any questions, please contact me at quesnelr@phsd.ca.

Thank you,

René Lapierre
Board of Health Chair

Briefing Note

To: René Lapierre, Chair, Board of Health for Public Health Sudbury & Districts

From: M. Mustafa Hirji, Acting Medical Officer of Health and Chief Executive Officer

Date: April 11, 2024

Re: Recommendations for Government Regulation of Nicotine Pouches

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
Nicotine pouches have become widely available to youth. These flavoured pouches can be legally purchased by anyone under 18 years of age in Canada. The unrestricted sale, display, and promotion of nicotine pouches contribute to their accessibility, the normalization of nicotine use, and potential health hazards, especially among vulnerable populations such as youth. Nicotine is highly addictive and its use, in any form, is unsafe for children[1] and youth.[2] Exposure to nicotine can have adverse effects on the developing brains of adolescents and young adults[2] and increases the likelihood of initiation and long-term use of tobacco products.

Recommended Action:
THAT the Board of Health urge Health Canada to implement their proposal to create additional safeguards to reduce access and appeal of nicotine replacement pouches to youth. It is recommended that Health Canada

- Close the regulatory gap that permits the sale of nicotine pouches to youth under 18 years of age.
- Restrict sale to behind pharmacy counters.
- Have plain packaging and warning labels.
- Restrict colours, flavours, and advertising.
- License for use only by adults.
- Strengthen regulations to restrict the sale of new and emerging tobacco and nicotine products, ensuring that nicotine availability to children and youth never occurs.

THAT the Board of Health strongly encourage the Government of Ontario to take immediate action to implement the following:

- Restrict sale to behind pharmacy counters.
- Enact regulations limiting display in retail settings.
- Restrict promotion of nicotine pouches, especially to youth.
- Expand the current regulatory framework to include non-tobacco nicotine products, defining a minimum legal purchase age (19 years of age) to align with Smoke-Free Ontario Act.

2024–2028 Strategic Priorities
1. Equal opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

Background:
In July 2023, Health Canada authorized Imperial Tobacco Canada to sell Zonnic under the Natural Health Product Regulations as Nicotine Replacement Therapy (NRT). The rationale for the classification of this product is that Zonnic does not contain tobacco; it only contains nicotine. Zonnic is now sold under Health Canada approval without requiring adherence to the restrictions of the federal *Tobacco and Vaping Products Act, 1997* and the *Smoke-Free Ontario Act, 2017*. This is concerning as nicotine pouches currently require

- No minimum age for purchase. Regardless of product packaging indicating for use by those 18+ only, nicotine pouches can be sold legally to anyone of any age, including children, thus exposing youth to nicotine
- No plain and standardized packaging requirements
- No flavour restrictions
- No restrictions on in-store promotions and product displays

Until tighter restrictions on nicotine pouches are imposed, this widely available and accessible product continues to expose youth to nicotine. Nicotine is highly addictive and use in any form is unsafe among children[1] and youth.[2] Exposure to nicotine can have negative consequences, especially for the young developing brain. These include attention deficits, cognitive changes, mood disorders, and increased chance of addiction to other substances.[2] Additionally, exposure can contribute to future tobacco use including cigarettes.[3]

Canadian health organizations, including the Canadian Cancer Society, Action on Smoking & Health, Canadian Lung Association, Heart and Stroke, Physicians for a Smoke-Free Canada, and Coalition Québécoise pour le contrôle du tabac are urging Health Ministers to reclassify nicotine pouches as a prescription product or to suspend sales until regulations are enacted to prevent sales to youth under 18 years of age.

In March 2024, Public Health Sudbury & Districts released an advisory alert to local health system partners sharing concerns related to nicotine pouches. Additionally, letters were sent to education directors, educators, and parents to increase awareness of the availability and risks of nicotine pouches to children and youth.

As of February 2024, the Government of British Columbia has taken proactive steps to solely sell nicotine pouches from behind counters in pharmacies. Additionally, the Government of Québec has only permitted the sale of nicotine pouches in pharmacies. This decision limits product availability and allows for a consultation with a pharmacist before purchasing nicotine pouches. This additional measure ensures these products are only sold for their intended purpose, nicotine replacement therapy. Currently, in Ontario, nicotine pouches can be legally purchased at convenience stores and gas stations by those under 18 years of age.

In response to concerns, the federal Minister of Health, Mark Holland, acknowledged that Health Canada approved the sale of flavoured nicotine pouches without restrictions on advertisements or sales.

He pledged to take action by reviewing the approval process. Health Canada is currently evaluating further legislative and regulatory measures to enhance public safety.

On March 20, 2024, Health Canada issued an advisory stating nicotine pouches should only be used as directed and that unauthorized nicotine pouches should not be used. Further, the advisory emphasized that nicotine pouches are only intended to be used as nicotine replacement therapy to help adults quit smoking. It also recommended that nicotine pouches be kept out of the reach of children and teenagers at all times.

Public Health Sudbury & Districts applauds Health Canada's decision to impose tigher restrictions on nicotine pouches to protect children and youth. Additionally, Public Health Sudbury & Districts supports Health Canada in their assertion to halt the legal purchasing loophole and ensure that nicotine availability to children and youth never occurs with new and emerging products.

Financial Implications:
There are no financial implications for Public Health Sudbury & Districts.

Ontario Public Health Standard:
Substance Use and Injury Prevention
Chronic Disease Prevention

Strategic Priority:
Healthy Communities for All

Contact:
Stacey Gilbeau, RN BScN, Director, Health Promotion and Vaccine Preventable Diseases Division and Chief Nursing Officer

References

1. U.S. Department of Health and Human Services. (2014). *"The Health Consequences of Smoking-50 Years of Progress: A Report of the Surgeon General."* https://www.ncbi.nlm.nih.gov/books/NBK294308/#ch5.s2
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3. National Institute on Drug Abuse [NIDA] (2023). *"Tobacco, Nicotine, and E-Cigarettes Research Report."* Retrieved on November 23, 2024 from www.nida.nih.gov/publications/research-reports/tobacco-nicotine-e-cigarettes/how-many-adolescents-use-tobacco.

March 22, 2024

The Honourable Mark Holland
Minister of Health
House of Commons
Ottawa, ON
K1A 0A6

Re: Recommendation for Provincial and Federal Restrictions on Nicotine Pouches

Dear Minister Holland:

The Middlesex-London Health Unit (MLHU), on behalf of Ontario's Southwest Tobacco Control Area Network (SWTCAN), wishes to express our sincere, wholehearted support of Health Canada's recent announcement to address the increasing interest and non-therapeutic use of nicotine-containing products, including nicotine pouches, among youth. This announcement deeply resonates with our shared commitment to safeguard the health and well-being of our communities, and is in line with our support and endorsement of the Windsor-Essex County Board of Health Resolution Report entitled "*Steps Toward Limiting Nicotine Addiction in Youth*", attached as Appendix A. The SWTCAN, comprised of Chatham-Kent Public Health, Grey Bruce Public Health, Huron Perth Public Health, Lambton Public Health, Middlesex-London Health Unit, Southwestern Public Health, and the Windsor-Essex County Health Unit, applauds Health Canada's determined pursuit of regulatory measures to tackle youth appeal, access, and use of nicotine products.

Currently, the administrative decision by Health Canada to approve Zonnic nicotine pouches for sale under the *Natural Health Products Regulations* has meant that flavoured nicotine pouches are now available for purchase in all kinds of retail settings, primarily convenience stores and gas stations, displayed alongside candy, chips, and gum. The pouches come in colourful packaging and in a variety of sweet and fruity flavours, which are particularly appealing to younger consumers. Other brands of nicotine pouches, including "Zyn" and "KlinT" have found their way to the retail shelves in southwestern Ontario. Large video advertisements and branded display units promote the sale of nicotine pouches in the same retail settings where commercial tobacco and vaping products are available for purchase. The spectrum of available nicotine products is growing as the commercial tobacco and vapour product industry capitalize on gaps in the current regulatory framework.

The rapid emergence of nicotine pouches in the market has meant that provincial governments have had insufficient time to establish their own regulatory frameworks to respond to the sale of these products, with the exception of British Columbia and Quebec. On March 20, 2024, Health Canada issued a public advisory to (a) use authorized nicotine pouches only as directed for quitting smoking, and (b) avoid unapproved nicotine pouches in Canada. As Health Canada works to create a regulatory framework, the SWTCAN continues to express its support for the implementation of federal and provincial regulations targeting the retail sale and promotion of flavored nicotine pouches, and other nicotine-containing products that have not yet been proven effective as cessation aids. Specifically:

- that the federal government takes swift action to close the regulatory gap that permits the sale of nicotine pouches and other nicotine-containing products that have not yet been proven effective as cessation aids to individuals under 18 years of age; and,
- that the provincial government consider taking action to embed restrictions on the flavouring, sale, display, and promotion of nicotine pouches and other nicotine-containing products under the *Smoke-free Ontario Act, 2017.*

To provide the necessary time for provincial governments to work with Health Canada to respond to this emerging nicotine delivery device, the SWTCAN further recommends that Health Canada reclassify nicotine pouches as a prescription product or enact a suspension and temporary moratorium on the approval and sale of all nicotine pouches until appropriate regulatory measures are in place.

Nicotine is a highly addictive substance, with substantial evidence documenting the adverse effect of nicotine on the developing brains of youth and young adults. The Middlesex-London Health Unit and the public health units within SWTCAN remain committed to working collaboratively with our school, municipal, provincial, and federal partners to prevent nicotine dependence, to promote cessation, and to protect communities through the promotion and enforcement of health protective policies.

The Middlesex-London Board of Health reviewed further information, which has been attached to this letter (Report No. 16-24 and Appendix A).

Sincerely,

Matthew Newton-Reid	Dr. Alexander Summers MD, MPH, CCFP, FRCPC	Emily Williams BScN, RN, MBA, CHE
Board Chair	Medical Officer of Health	Chief Executive Officer

Cc: Ontario Boards of Health
Hon. Sylvia Jones, Ontario Minister of Health
Arielle Kayabaga, Member of Parliament, London West
Karen Vecchio, Member of Parliament, Elgin-Middlesex-London
Lianne Rood, Member of Parliament, Lambton-Kent-Middlesex
Lindsay Mathyssen, Member of Parliament, London-Fanshawe
Peter Fragiskatos, Member of Parliament, London North Centre
Teresa Armstrong, Member of Provincial Parliament, London-Fanshawe
Hon. Rob Flack, Member of Provincial Parliament, Elgin-Middlesex-London
Terence Kernaghan, Member of Provincial Parliament, London North Centre
Peggy Sattler, Member of Provincial Parliament, London West

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

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 16-24

TO: Chair and Members of the Board of Health

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

DATE: 2024 March 21

RECOMMENDATION FOR PROVINCIAL AND FEDERAL RESTRICTIONS ON NICOTINE POUCHES

Recommendation

It is recommended 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.*

Report Highlights

- Health Canada authorized nicotine pouches containing 4 mg of nicotine under the *Natural Health Products Regulations,* raising concerns nationwide due to their accessibility, marketing, and appeal to youth.
- The Windsor-Essex County Board of Health Resolution Report, attached as Appendix A, calls for swift federal action to curb sales to those under 18 years of age and calls for provincial restrictions on the flavoring, sale, display, and promotion of nicotine pouches under the *Smoke-Free Ontario Act, 2017.*
- Health Unit staff prepared a letter for submission to Health Canada on behalf of the seven public health units in southwestern Ontario, attached as Appendix B, endorsing the Windsor-Essex County Board of Health Resolution Report.

Current Landscape of Nicotine Products in Canada

Nicotine pouches made by Imperial Tobacco Canada Ltd. were officially authorized for sale by Health Canada as a natural health product on July 18, 2023, under the *Natural Health Products Regulations* as nicotine replacement therapy and a smoking cessation aid. Each package contains 10 or 24 pouches, and each pouch contains up to 4 milligrams of nicotine. The amount of nicotine in a cigarette can vary, depending upon the brand (11.9 to 14.5 mg of nicotine); however, those who smoke will only absorb 1 to 1.5 mg of nicotine from a single stick. This means that one pouch may contain nicotine that is the equivalent of up to 4 cigarettes.

The classification of nicotine pouches as a natural health product allowed the pouches to fall beyond the scope of the federal *Tobacco and Vaping Products Act (TVPA*) and the provincial *Smoke-Free Ontario Act (SFOA), 2017*, which regulate the marketing, retail sale and display, and public use of commercial tobacco and vaping products. Presently, in Ontario, nicotine pouches are available for purchase at convenience stores and gas stations, displayed alongside candy, chips, and gum. The pouches come in colourful packaging and in a variety of sweet and fruity flavours, which are particularly appealing to younger consumers. Large video advertisements and branded display units promote the pouches as a quitting aid, while the producers of these products continue to manufacture and market commercial tobacco and vaping products. The spectrum of available nicotine products is growing as the tobacco industry capitalizes on gaps in the current regulatory framework.

Reaction and Regulatory Approaches Across Canada

Due to nicotine's highly addictive nature and its adverse effects on the developing brains of youth and young adults, the approval by Health Canada sparked significant concern among health organizations across Canada. The advertising of nicotine pouches is governed federally; however, where these products can be sold, including age and advertising restrictions at retail, rest with provinces and territories. Youth-friendly advertising, substantial marketing and distribution strategies, and flavoured nicotine products that lack age restriction regulations are a local public health concern. Retailers are reporting that they are challenged to keep the different brands of nicotine pouches and gum produced by the tobacco industry in stock across Middlesex-London, and packaging is being littered in schools and in parks.

Until recently, Québec was the sole Canadian province with a regulatory framework limiting the sale of nicotine replacement therapy products, including nicotine pouches to pharmacies. However, on February 7, 2024, British Columbia enacted regulation to restrict the sale of nicotine pouches to behind the counter at pharmacies, requiring consultation with a pharmacist prior to purchase. At the time of drafting this report, no additional measures have been taken by other provinces.

Next Steps

In January 2024, the Windsor-Essex County Board of Health passed a resolution report, attached as Appendix A, calling for immediate federal and provincial regulatory action. The Resolution Report calls on the federal government to take swift action to address the regulatory gap allowing nicotine pouch sale to individuals under 18 years of age. Furthermore, the resolution calls on the provincial government to regulate the retail sale of nicotine pouches under the *Smoke-free Ontario Act, 2017.* An endorsement letter was prepared by Health unit staff on behalf of the Southwest Tobacco Control Area Network (i.e., the seven public health units in southwestern Ontario), attached as Appendix B. With Board of Health direction, the letter would be submitted to Health Canada and copied to the Ontario Ministry of Health.

This report was prepared by the Social Marketing and Health System Partnerships Team.

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 Substance Use and Injury Prevention Standard (requirements 2 and 3) as outlined in the *Ontario Public Health Standards*
- The *Tobacco and Vaping Products Act*
- The *Smoke-free Ontario Act, 2017*
- 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.

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: An Organizational Plan, specifically ensuring the use of culturally appropriate language.

Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT

Steps toward Limiting Nicotine Addiction in Youth;

Local, Provincial, and Federal Restrictions on Nicotine Pouches

Date: Thursday, January 18th, 2024

ISSUE/PURPOSE

The recent availability of Nicotine Pouches under the brand name "Zonnic" has triggered widespread concern from health organizations across Canada, including the Canadian Cancer Society, Heart and Stroke, and the Canadian Lung Association, who have issued calls for immediate federal action to regulate their sale to youth (von Stackelberg, 2023). Health Canada has approved the products under their *Natural Health Products* designation as a Nicotine Replacement Therapy (NRT) which can be used to quit smoking. Each package contains either 10 or 24 pouches with each pouch contains up to 4mg of nicotine, the equivalent of up to 2 cigarettes (Marsh, 2023).

Nicotine is highly addictive and has permanent adverse effects on the developing brains of youth and concerns regarding the nicotine pouches are rooted in their marketing and distribution approach being attractive to young people. An approach which includes attractive colours and targeted promotions, fruity flavouring which includes sweeteners, and a lack of regulations which makes it legal for children and youth to purchase these products. The similarities in purpose, advertising, and the range of flavors offered by nicotine pouches relative to the already popular vaping products poses a significant risk of sparking a trend comparable to rapid uptake of vaping amongst youth.

BACKGROUND

Nicotine pouches were approved for sale in Canada on July 18, 2023 as a *Natural Health Product*. The nicotine pouches are currently outside the scope of the federal *Tobacco and Vaping Products Act* (TVPA) and the provincial *Smoke-free Ontario Act (SFOA) 2017* which regulate tobacco and vaping products by restricting their advertisement, display, and public use. As a result, the nicotine pouches are currently being sold at convenience stores and gas stations, placed alongside items such as candy and chips. The pouches are sold in vibrant packaging and various sweet and fruity flavours which are attractive to younger populations.

The recent growth in popularity of vaping products serves as an example of the importance of moving quickly to mitigate the risk of these new products (University of Waterloo & Brock University, 2023). Although research on the health effects of using nicotine pouches is still emerging, the effects of using oral NRTs include mouth ulcers, mouth and throat soreness, and coughing (M. Jackson et al., 2023). For youth and young adults who develop a dependence on nicotine, lasting negative impacts on the cognitive abilities, growth, and development can also occur (Stein et al., 1998; Ren & Lotfipour, 2019). Most concerningly, given the highly addictive nature of nicotine, dependence can lead to further use of vaping product, tobacco products, or other drugs (Leslie, 2020).

The Windsor-Essex County Health Unit (WECHU) has consistently engaged businesses, school administrators, students, parents, and municipalities to inform these groups about the health consequences of tobacco and vaping

and has worked closely with them to develop policies, and enforce provincial regulations pertaining to smoking and vaping in public areas. The WECHU is committed to working closely with these same partners to better understand the best ways to keep residents, in particular young people, safe from these products however, until such time that a regulatory framework is established at the federal and provincial levels it is possible that the uptake of these products in Windsor and Essex County will escalate in a similar manner to vaping products.

PROPOSED MOTION

Whereas, Health Canada has approved Nicotine Pouches for sale under a *Natural Health Product* designation which does not provide restrictions on advertising or sale to minors; and

Whereas, there is no evidence to demonstrate the efficacy of Nicotine pouches as a smoking cessation aid; and

Whereas, the emergence of nicotine pouch products produced by Imperial Tobacco Canada, under the brand name "Zonnic" has occurred rapidly without the same regulations applied to other nicotine products; and

Whereas, the marketing and accessibility of Zonnic Pouches raises concerns regarding its appeal to youth populations; and

Whereas, the Nicotine Pouches fall outside existing provincial regulations on tobacco and vaping products; and

Whereas, there are significant concerns regarding the risks to youth and young adults who do not smoke and parallels between nicotine pouch use and vaping.

Now therefore be it resolved that the Windsor-Essex County Board of Health strongly encourages the federal government to take immediate action to close the regulatory gap that permits the sale of nicotine pouches to people under the age of 18; and

FURTHER THAT, the Windsor-Essex County Board of Health strongly encourages the province of Ontario to take immediate action to embed restrictions on the flavouring, sale, display, and promotion of nicotine pouches under the provincial *Smoke-free Ontario Act, 2017;* and

FURTHER THAT, the Windsor-Essex County Health Unit works closely with local municipalities to review tobacco/vape-free public place bylaws to include additional nicotine products; and

FURTHER THAT, the Windsor-Essex County Health Unit works closely with local schools and boards to update policies to ensure products like nicotine pouches, and other emerging products that are tobacco or nicotine related are prohibited on school property.

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RECOMMENDATIONS FOR GOVERNMENT REGULATION OF NICOTINE POUCHES

MOTION:

WHEREAS Health Canada approved nicotine pouches for sale under the Natural Health Product regulations providing no restrictions on advertising or sale to children and youth; and

WHEREAS the unrestricted sale, display, and promotion of nicotine pouches contribute to their accessibility, the normalization of nicotine use, and potential health hazards; and

WHEREAS nicotine is highly addictive and its use, in any form, is unsafe for children and youth; and

WHEREAS exposure to nicotine can have adverse effects on the developing brains of adolescents and young adults and increases the likelihood of initiation and long-term use of tobacco products; and

WHEREAS the emergence of nicotine pouch products occurred rapidly without requiring adherence to the restrictions of the federal *Tobacco and Vaping Products Act, 1997*, and the *Smoke-Free Ontario Act, 2017*; *and*

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts strongly encourage Health Canada to take immediate action to close the regulatory gap that permits the sale of nicotine pouches to youth under 18 years of age; and

FURTHER THAT the Board of Health urge Health Canada to strengthen regulations to restrict the sale of new and emerging tobacco and nicotine products, ensuring that nicotine availability to children and youth never occur again; and

FURTHER THAT the Board of Health for Public Health Sudbury & Districts strongly encourage the Government of Ontario to exclusively sell nicotine pouches from behind pharmacy counters, limit their display in retail settings, and restrict their promotion, especially to youth; and

FURTHER THAT the Government of Ontario expand the Smoke-Free Ontario Strategy to create a comprehensive, coherent public health-oriented framework for the regulation of vaping and all nicotine-containing products.

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Briefing Note

To: Rene Lapierre, Chair, Public Health Sudbury & Districts Board of Health

From: Dr. M. Hirji, Acting Medical Officer of Health and Chief Executive Officer

Date: April 11, 2024

Re: 2024–2028 Accountability Monitoring Plan

☐ For Information ☒ For Discussion ☒ For a Decision

Issue:

In November 2023, the Board of Health for Public Health Sudbury & Districts (the Board) endorsed the 2024–2028 Strategic Plan (motion 65-23). With this approval, the Board directed the Medical Officer of Health and Chief Executive Officer to operationalize the Strategic Plan and to ensure regular monitoring reports to the Board. The 2024–2028 Accountability Monitoring Plan has been developed and is being presented to the Board of Health for approval.

Recommended Actions:

1. That the Board of Health for Public Health Sudbury & Districts approve the 2024–2028 Accountability Monitoring Plan as presented.
2. That the Board of Health for Public Health Sudbury & Districts direct the Chair of the Board to re-instate the Joint Board of Health/Staff Accountability Working Group and identify board members for participation.

Background:

Accountability Monitoring Plan

Per the *Public Health Accountability Framework* in the Ontario Public Health Standards, boards of health are required to provide the Ministry with regular performance reports on program achievements, finances, and local challenges or issues in meeting outcomes. The Public Health Sudbury & Districts 2024–2028 Accountability Monitoring Plan supports these provincial requirements and outlines how Ministry reporting requirements align with local planning and reporting mechanisms.

The 2024-2028 Accountability Monitoring Plan serves to ensure organizational accountability and monitoring to show the value of public health investment and its contribution to population health and well-being.

The 2024-2028 Accountability Monitoring Plan, which is an evolution of previous accountability monitoring efforts, provides a framework for monitoring and reporting on provincial requirements and local priorities including the Public Health Sudbury & Districts 2024–2028 Strategic Plan.

The Plan includes three main categories of reporting: 1) organizational requirements, 2) foundational and program requirements, and 3) strategic planning. It contributes to the Board's commitment to transparency with all stakeholders in creating healthier communities for all. As per the Strategic Plan, the values of humility, trust, and respect guide the implementation and reporting mechanisms of this plan.

In keeping with previous Accountability Monitoring Plans and processes, the data, attestations, and narratives gathered as part of the Accountability Monitoring Plan will be rolled up into an annual Public Health Sudbury & Districts Accountability Monitoring Report. The Board will receive this annual report each February following the reporting year. For example, January to December 2024 reporting will be shared in February 2025.

Given the changing landscape of public health and the transformation of the health system, this Plan has been developed to allow for some flexibility and future adaptations as more information is provided from the Ministry of Health, other funding ministries, and our local communities.

Joint Board of Health/Staff Accountability Working Group

A Joint Board of Health/Staff Accountability Working Group previously existed to support the work of accountability and monitoring. To support the current accountability efforts, including the review of the annual Accountability Monitoring Reports, and, as needed, other reporting mechanisms, the creation of a 2024-2058 joint Board of Health/Staff Working Group is recommended.

The joint Board of Health/Staff Accountability Working Group assists the Board in meeting its accountability and reporting requirements. The Working Group reviews draft accountability monitoring reports, provides comments and direction to finalize, and presents reports to the full Board of Health for approval.

Per the previous Working Group's Terms of reference, membership includes a combination of Board of Health members and Public Health Sudbury & Districts staff. Board of Health membership include up to three Board of Health members.

Financial Implications: There are no direct financial implications of this recommendation, however staff time will be needed to operationalize the plan and reporting processes. Staff time will vary throughout the year and, at peak times, select staff will be prioritized towards this and away from other activities.

Ontario Public Health Standard: Public Health Accountability Framework

Strategic Priority: Excellence in public health practice

Contact: Renee St Onge, Director, Knowledge and Strategic Services

Public Health Sudbury & Districts

Accountability Monitoring Plan 2024–2028

Public Health Sudbury & Districts
April 2024

Public Health
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Contact Information

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Introduction

In November 2023, the Board of Health for Public Health Sudbury & Districts (the Board) endorsed the 2024–2028 Strategic Plan and directed the Medical Officer of Health (MOH) to operationalize the Strategic Plan and develop a monitoring process for the Board's approval.

The Public Health Sudbury & Districts 2024-2028 Accountability Monitoring Plan (AMP) is an essential framework for the agency:

- It is a focal point for the Board's commitments to transparency, accountability, and public reporting.
- It aligns with the 2021 Ontario Public Health Standards (OPHS): Requirements for Programs, Services, and Accountability.
- It is an overarching framework for comprehensive performance measurement and continuous quality improvement.

The 2024-2028 Accountability Monitoring Plan serves as an overarching framework for organizational accountability and monitoring which also shows the value of public health investment and its contribution to population health and well-being.

The 2024-2028 AMP provides a framework for monitoring and reporting on provincial requirements and local priorities including the Public Health Sudbury & Districts 2024–2028 Strategic Plan (Strategic Plan).

The 2024-2028 AMP includes three main categories of reporting: 1) organizational requirements, 2) foundational and program requirements, and 3) the Strategic Plan. It contributes to the Board's commitment to transparency with all stakeholders in creating healthier communities for all. As per the Strategic Plan, the values of humility, trust, and respect guide the implementation and reporting mechanisms of this plan.

Board of Health Role

The Board of Health plays an important role in local and provincial accountability and monitoring efforts. The *Public Health Accountability Framework* of the 2021 Ontario Public Health Standards (OPHS) articulates the scope of the accountability relationship between boards of health and the Ministry and establishes expectations for boards of health.

Per the *Public Health Accountability Framework* of the OPHS, boards of health are required to provide the Ministry with regular performance reports on program achievements, finances, and local challenges/issues in meeting outcomes. This outlines what and how boards of health are held accountable for the work they do, how they do it, and the results they get. It also identifies what the Ministry expects from the boards of health to promote transparency and accountability.

This increased accountability is designed to ensure boards of health have the necessary foundations to deliver programs and services, financial management, governance, and public health practice ultimately supporting a strong public health sector and leading to better health for our communities.

The Public Health Sudbury & Districts 2024-2028 Accountability Monitoring Plan supports these provincial requirements by outlining how Ministry reporting requirements align with local planning and reporting mechanisms. The 2024-2028 AMP provides an overview of the monitoring and reporting of organizational and program requirements as well as the Board's Strategic Plan.

The Joint Board of Health/Staff Accountability Working Group assists the Board in meeting its accountability and reporting requirements. The Working Group reviews draft reports, provides comments and direction to finalize, and presents reports to the full Board of Health for approval.

Monitoring Framework

Overview

The 2024-2028 Accountability Monitoring Plan explains how we comply with legal, funding, and program requirements and contributes to the Board's commitment to transparency with all stakeholders. The 2024-2028 AMP includes three main monitoring and reporting categories that collectively demonstrate accountability for provincial mandates and local commitments:

1. Organizational requirements
2. Foundational and program requirements
3. Strategic Plan

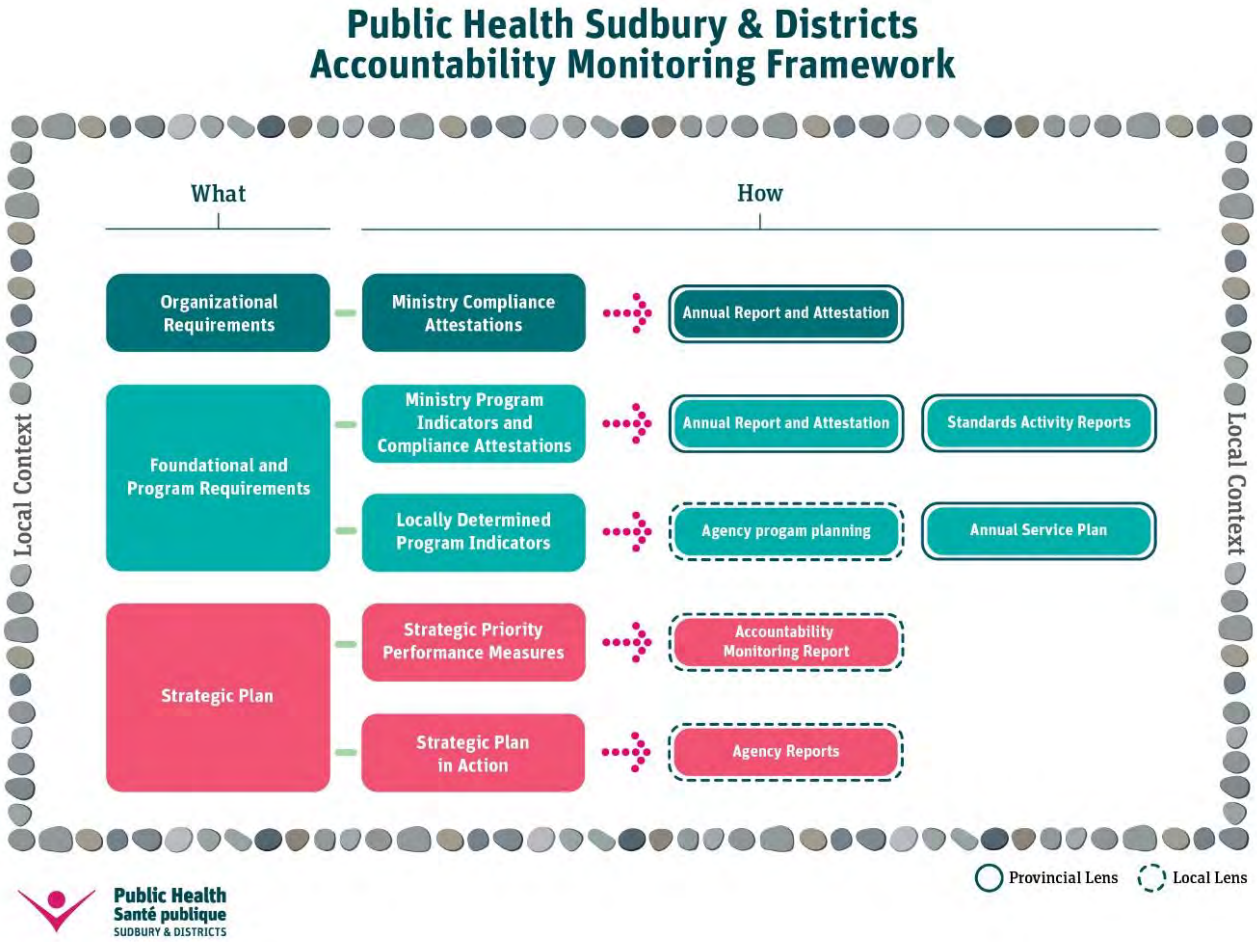
Organizational requirements: Within the **organizational requirements** category, we monitor and/or report on the four domains of accountability in the OPHS: delivery of programs and services, fiduciary requirements, good governance and management practices, and public health practice. We also monitor other requirements that the OPHS identifies as common to all domains. Reporting for the organizational requirements includes Ministry of Health compliance attestations grouped by the domains of accountability.

Foundational and program requirements: Within the **foundational and program requirements** category, we monitor progress and measure success with provincial and locally developed reporting mechanisms relating to the 2021 OPHS Foundational Standards and Program Standards. We report on Ministry of Health program indicators and compliance attestations for program activities, outcomes, and contributions to population health. We also monitor, and report as needed, on locally determined indicators in accordance with local program plans and Ministry of Health planning requirements.

Strategic Plan: Finally, we measure performance and progress as it relates to the **2024–2028 Strategic Plan** and the implementation of our Board of Health strategic priorities: equal opportunities for health, impactful relationships, excellence in public health practice, and healthy and resilient workforce. Reporting includes performance measures for each strategic priority as well as agency reports and stories that show the Strategic Plan in action.

These three categories collectively form the 2024–2028 AMP. The Accountability Monitoring Framework is also supported by planning documents (the agency's Strategic Plan, internal program plans, and the Annual Service Plan and Budget Submission), and by reporting documents (including performance reports and annual reports and attestations) which align with one or more of the three reporting categories.

The diagram below illustrates the relationship between each category and how together, they provide an overview of the organizational performance to which we hold ourselves accountable. The sections following the diagram explain each category in further detail.



Organizational Requirements

The Ministry of Health outlines parameters and requirements to hold boards of health accountable for the work they do, how they do it, and the results they achieve.

Reporting and monitoring of the organizational requirements allows for boards of health to demonstrate accountability and compliance with these requirements as outlined in the OPHS.

The 2021 OPHS Public Health Accountability Framework categorizes organizational requirements into four domains of accountability:

1. Delivery of programs and services
2. Fiduciary requirements
3. Good governance and management practices
4. Public health practice

Additional organizational requirements, which are "common to all domains" are also outlined in the OPHS. In Ministry reporting, additional attestation statements are included as "other general requirements".

Using the four domains as a lens for organizational accountability, boards of health complete an attestation of their achievements relating to key statements grouped by the four accountability domains of the Ministry of Health organizational requirements.

Guided by the organizational requirements in the 2021 Ontario Public Health Standards, Public Health Sudbury & Districts reports on organizational requirements directly to the Ministry through:

A. Ministry Compliance Attestations

A. Ministry of Health compliance attestations

The OPHS organizational requirements outline monitoring and reporting areas for boards of health to show accountability and compliance to the Ministry.

Components of the organizational requirements are reported on to the Ministry of Health through the **Annual Report and Attestation**. Attestation questions/items may vary year to year and are identified in Ministry reporting templates.

Within the OPHS, there are 51 organizational requirements within the four domains of accountability as well as six additional requirements in the 'common to all domains' category. These organizational requirements are reported through attestation statements in the Ministry of Health Annual Report and Attestation document. While not all attestation statements align

directly with the OPHS language, in the last iteration of the Annual Report and Attestation, there were 62 attestation questions/items categorized within the four domains of accountability and an additional two general requirements in the "other" category.

Reporting mechanism

Reporting on the OPHS Public Health Accountability Framework organizational requirements is completed through the **Annual Report and Attestation**. Each year customized templates are issued to the local public health unit by the Ministry of Health.

The purpose of the Annual Report and Attestation is for boards of health to complete a certificate of attestation to demonstrate compliance with the organizational requirements outlined in the OPHS. If the board reports that the agency complies with the question/item, no further details are required. If the board reports non-compliance, then a high-level explanation describing circumstances, impacts, and corrective action is required.

A summary of Ministry reporting requirements, including the Annual Report and Attestation will be included in the Public Health Sudbury & Districts Accountability Monitoring Report which will be presented annually to the Board of Health.

Data collection

Data collection requires a coordinated effort by all divisions to capture information from all parts of the organization as it relates to the attestation questions/items. A centralized data collection tool, reflecting the data required to complete the Ministry template, is developed annually to streamline tracking and avoid duplication. Data collection processes for Ministry reporting is led by Knowledge and Strategic Services.

Reporting on the organizational requirements grouped by the domains of accountability reflects compliance data collected for the reporting year (January to December) and is therefore retrospective in nature.

Reporting timeline

The Organizational Requirements will be reported on annually through the Ministry of Health compliance attestations in the Annual Report and Attestation reporting document. This report is typically due to the Ministry between June and September each year and includes attestations for the previous calendar year.

A summary of Ministry reporting, including the Annual Report and Attestation, will also be reported on annually through Public Health Sudbury & Districts Accountability Monitoring Report. The Board will receive this annual report each February following the reporting year (i.e. January to December 2024 reporting will be shared in February 2025).

Foundational and Program Requirements

Boards of health are not only responsible for demonstrating accountability related to organizational requirements, but they are also tasked with demonstrating the value that Ontarians receive from investment in public health programs and services.

Per the *Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes* in the 2021 OPHS (p.74), boards of health are required to monitor progress, measure success, and assess public health's contribution to population health. Foundational and program standard requirements outline opportunities for monitoring and reporting on performance of interventions, programs, and services and well as contributions to population health outcomes.

Foundational Standards and Program Standards are monitored and reported through Ministry program indicators and compliance attestations as well as locally determined program indicators. The Ministry of Health indicators provide an evidence-informed basis for monitoring and measuring success in achieving program outcomes and understanding the contribution of boards of health to population health outcomes. Select program areas also require compliance attestations to ensure accountability of program development and delivery. In addition to these Ministry reporting requirements, boards of health are required to develop locally determined program indicators to monitor programs and public health interventions as part of their planning efforts.

Guided by provincial and local requirements outlined in the 2021 OPHS, Public Health Sudbury & Districts will monitor and report on foundational and program requirements through

A. Ministry program indicators and compliance attestations
B. Locally determined program indicators

These indicators, and compliance attestations, which are further discussed below, are reflective of requirements relating to the Foundational Standards and Program Standards as outlined in the 2021 OPHS.

A. Ministry of Health program indicators and compliance attestations

Ministry program activity and program outcome indicators are provincially defined indicators to help monitor success of programs as referenced in the 2021 Ontario Public Health Standards. Attestation statements also help to demonstrate compliance with program requirements for select

topic areas or indicators that may not collect numerical program indicator data. Both Ministry program indicators and compliance attestations are collected from the local board of health and reported to the Ministry for oversight of ongoing monitoring of public health programs and services.

Ministry program indicators and compliance attestations are reported to the Ministry of Health in three separate reports: (1) the **Annual Report and Attestation**; (2) the **Q3 Standards Activity Report**; and (3) the **Q4 Standards Activity Report**.

Reporting mechanism

The Ministry of Health issues **Standards Activity Reports (STAR)** and **Annual Report and Attestation (ARA)** templates to each public health unit for the purposes of reporting results. The information reported reflects results covering either an annual reporting period from January to December or from September to August, to match the school year. Each report has a unique set of provincially defined indicators. Note that Ministry reporting requirements for the STAR and ARA have on occasion been updated, and as such, some indicator reporting and compliance attestations may vary year to year.

A summary of these Ministry program indicator and compliance reporting requirements will also be reported annually to the Board of Health in the Public Health Sudbury & Districts Accountability Monitoring Report. Detailed indicator data and details will be reported to the Ministry only.

Data collection

Data pertaining to provincial indicators represent information from all parts of the organization and collection requires a coordinated effort by program divisions. A centralized data collection tool is developed to streamline tracking and avoid duplication. The tools are based on Ministry reporting templates so data can be collated for agency-wide reporting.

Foundational and Program Standard data collection processes for the STAR and ARA are led by Knowledge and Strategic Services with data provided by the respective program teams.

Reporting timeline

Ministry program indicators will be reported on several times per year through the Standard Activity Reports and for some, in the Annual Report and Attestation. Ministry compliance attestations will be reported annually through Ministry of Health Annual Report and Attestation reporting document. Reporting to the Ministry of Health will follow their reporting requirements and timelines (i.e. the Q4 STAR is generally due annually in January and the Q3 in October, and the ARA is generally due annually between June and September).

A summary of these Ministry reporting requirements will also be included in the annual Public Health Sudbury & Districts Accountability Monitoring Report. The Board will receive this annual report each February following the reporting year (i.e. January to December 2024 reporting will be shared in February 2025) subsequent to the Joint Board of Health/Staff Accountability Working Group review.

B. Locally determined program indicators

In alignment with the 2021 OPHS and agency accountability commitments, additional locally determined program indicators are developed in order to monitor progress and measure success in achieving program outcomes. These indicators reflect work carried out under the OPHS Program Standards and are identified, reviewed, and monitored through local and provincial planning documents. Foundational Standards do not require locally developed indicators for the Ministry however, indicators for these areas of work are also developed locally, within team plans, to use as metrics and monitor progress as needed.

Locally determined program indicators are outlined in **agency program plans** and a selection are submitted to the Ministry in the agency's **Annual Service Plan and Budget Submission (ASP)** which is prepared by boards of health to communicate program plans and budgeted expenditures for a given year.

Planning and reporting mechanisms

Locally determined indicators are identified and monitored through local and provincial planning documents. If locally determined indicator data is used beyond planning and monitoring, mechanisms for reporting are determined as needed.

For example, locally determined program indicator data may be used, to inform Medical Officer of Health reporting updates to the local Board of Health for featured program and foundational standard work. Locally determined program indicators may also sometimes appear in Ministry program indicator reporting templates (such as the STAR or ARA) however, there is currently no formal reporting mechanism for all locally determined program indicators. Instead, these indicators are submitted in the ASP and monitored locally.

Formalized reporting mechanisms for locally determined program indicators will be developed if additional reporting requirements are directed by the Ministry of Health.

Data collection

Locally determined program indicators represent information from all program areas and, as such, collection requires a coordinated effort. All locally determined program indicators are identified by program areas and then gathered through a centralized data collection tool to collate

submission to the Ministry for the Annual Service Plan and Budget Submission. Collation of the ASP content, including determined program indicators, is led by Knowledge and Strategic Services.

For reporting, teams responsible for program development and implementation monitor and track data on locally determined indicators through team tracking tools in alignment with their program plans. If required, a centralized data collection process and tool will be developed to collate all agency information for Ministry reporting.

Planning and reporting timeline

Given that locally determined program indicators are monitored through planning documents that support agency accountability, they are submitted annually through local program plans or the provincial Annual Service Plan and Budget Submission.

Agency program plans, including activity and evaluation plans, are typically due at the end of the calendar year. These plans are then collated to inform the annual submission of the Annual Service Plan and Budget Submission which is typically due to the Ministry of Health early April.

Additional reporting timelines will be determined if direction is received for Ministry of Health reporting requirements. Also, as relevant, select locally determined program indicators may be included in a summary of all agency reporting requirements in the annual Public Health Sudbury & Districts Accountability Monitoring Report. The Board will receive this annual report each February following the reporting year (i.e. January to December 2024 reporting will be shared in February 2025) subsequent to the Joint Board of Health/Staff Accountability Working Group review.

Board of Health Strategic Plan

As per the 2021 Ontario Public Health Standards, boards of health are required to develop a Strategic Plan and operationalize strategic directions over three to five years.

Public Health Sudbury & Districts will report on the 2024–2028 Strategic Plan through

A. Strategic priority performance measures

B. Strategic Plan in action

A. Strategic priority performance measures

The 2024–2028 Strategic Plan includes four strategic priorities. These priorities focus on creating healthier communities for all and build on past successes and direct future actions. They aim to establish impactful relationships that lead to strong partnerships and engagement. They also strive for ongoing excellence in public health service and programming, delivered by a healthy and resilient workforce.

The strategic priorities are

1. Equal opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

Ongoing monitoring of the integration of the strategic priorities within programs and services provides an opportunity to gauge progress on these key areas. The priorities guide our work, and the strategic priority performance measures help paint a rich picture of the commitments and diverse approaches and practices for implementing our Strategic Plan.

Reporting mechanism

While the strategic priority performance measures are still under development, it is expected there will be approximately four to six performance measures per priority to showcase how Public Health actions the Strategic Plan.

Reporting on the strategic priority performance measures to the Board of Health will be included in the agency's annual **Accountability Monitoring Report**.

Data collection

Designated program staff and managers will be responsible for monitoring and collecting data as it relates to the strategic priority performance measures. A technical specification document will be developed following the finalization of performance measures. The technical document will further define each measure and the criteria for data collection and reporting.

Reporting timeline

The Joint Board of Health/Staff Accountability Working Group will review the draft annual report prior to the Board of Health. The Board will receive an annual report each February following the reporting year (i.e. January to December 2024 reporting will be shared in February 2025). Interim reports may be prepared as needed to guide in-year decision-making.

B. Strategic Plan in action

Each year, Public Health issues various **agency reports** where content can be connected back to the components of the Strategic Plan. These reports include content from various program areas to highlight agency contributions and commitments to building healthier and stronger communities. They also help to demonstrate the Strategic Plan in action.

Reporting mechanism

Existing agency reports will use content to demonstrate the connection between day-to-day public health work and the various components of the Strategic Plan (mission, vision, values, and priorities). Information or stories within these agency-wide reports reflect components of the Strategic Plan in action. Examples of these reports include, but are not limited to, the Annual Report, monthly Reports of the Medical Officer of Health / Chief Executive Officer to the Board of Health, Year in Review Reports, Risk Management Reports, Continuous Quality Improvement Reports, and program plans.

Data collection

The agency identifies a most responsible director or manager to lead the development of the respective agency reports. This lead works closely with designated program staff and other managers who, in turn, provide program specific examples or content that connect to the Strategic Plan in action. Depending on the report, content may be collated and circulated for feedback through an agency wide process or led independently by each division. For example, the Annual Report is led by the Communications Team with content provided by other program staff and managers. Meanwhile, each division contributes program updates for the Report of the Medical Officer of Health / Chief Executive Officer to the Board of Health.

Reporting timeline

Agency reports showcasing the Strategic Plan in action are issued at various times throughout the year. For example, the year in review is typically presented to the Board of Health in February of the following calendar year, whereas the agency's Annual Report is typically issued between June and September each year.

A selection or summary of agency report content that highlights the Strategic Plan in action will be included in the annual Public Health Accountability Monitoring Report. The Board will receive this annual report each February following the reporting year (i.e. January to December 2024 reporting will be shared in February 2025) subsequent to the Joint Board of Health/Staff Accountability Working Group review.

Summary of Accountability Reports

Ministry reports

Organizational requirements and foundational and program requirements within Public Health Sudbury & Districts Accountability Monitoring Framework are reported on directly to the Ministry of Health.

Each year customized templates are issued to local public health units by the Ministry of Health. Public Health Sudbury & Districts then uses these templates to complete an Annual Service Plan and Budget Submission (ASP), an Annual Report and Attestation (ARA), and Standard Activity Reports (for Q3 and Q4).

The **Annual Service Plan and Budget Submission (ASP)** is prepared by public health staff to communicate program plans and budgeted expenditures for a given year. This document includes a summary of agency program plans to demonstrate overarching plans to meet foundational and program requirements, including locally determined program indicators. This document is submitted annually in April following approval and signatures from the Medical Officer of Health and the Chair of the Board of Health.

The **Annual Report and Attestation (ARA)** is an accountability reporting tool that boards of health are required to submit annually as per the OPHS and Public Health Funding and Accountability Agreement. Components of the organizational requirements and the foundational and program requirements are reported on to the Ministry of Health through the ARA. For the organizational requirements, the ARA includes attestation questions/items categorized within the four domains of accountability and additional general requirements. Boards of health must assess whether they fully met a requirement and if not, they must provide a high-level explanation. For program requirements, provincially defined indicators and compliance attestations help monitor success of program outcomes as referenced in the OPHS whereas select locally developed indicators help monitor the success of programs that vary due to population needs. Once again, this report is submitted annually (generally between June and September) following approval and signatures from the Medical Officer of Health and the Chair of the Board of Health.

Standards Activity Reports (STARs) are also completed using templates issued by the Ministry of Health, specifically the **Q3 Standards Activity Report** and the **Q4 Standards Activity Report**. The STARs are used to report on program indicators that support Ministry oversight of ongoing monitoring of foundational and program requirements as outlined in the

OPHS. Reporting timelines are outlined by the Ministry of Health with the Q4 STAR generally due annually in January and the Q3 in October. These reports are submitted following approval of the Medical Officer of Health.

Agency reports

One mechanism to demonstrate the Strategic Plan category of Public Health Sudbury & Districts Accountability Monitoring Framework is through agency reports.

Public Health issues various **agency reports** to demonstrate transparency and accountability to members of the public, community partners, and key stakeholders. These reports include content from various program areas to highlight agency contributions and commitments to building healthier and stronger communities. Information or stories within these agency-wide reports reflect components of the Strategic Plan in action. Examples of these reports include, but are not limited to, the Annual Report, monthly Reports of the Medical Officer of Health / Chief Executive Officer to the Board of Health, Year in Review Reports, and Risk Management Reports. These agency reports are presented to the Board of Health for review at various times throughout the year and are included in meeting packages.

Accountability Monitoring Report

The Public Health Sudbury & Districts Accountability Monitoring Report is an overarching accountability report for Public Health Sudbury & Districts to illustrate how we are meeting our accountability monitoring goals as outlined in the Accountability Monitoring Plan (AMP). This report includes new content on the Strategic Plan through reporting on strategic priority indicators as well as a roll-up of all components of the AMP framework: 1) organizational requirements, 2) foundational and program requirements, and 3) strategic planning.

Within the Accountability Monitoring Report will be a section on locally developed Strategic priority performance measures. The Strategic Priority performance measures will demonstrate effort and progress relating to the four strategic priorities. These measures are currently under development.

In addition to the content on Strategic priority performance measures, a summary of all Ministry reports and agency reports will be included in the Accountability Monitoring Report to highlight additional accountability efforts on the organizational requirements, foundational and program requirements, and the strategic plan in action.

The Public Health Sudbury & Districts Accountability Monitoring Report will be presented to the Board of Health each February following the reporting year (i.e. January to December 2024 reporting will be shared in February 2025). The Joint Board of Health/Staff Accountability

Working Group will review the draft annual report prior to the Board of Health. Interim reports may be prepared as needed to guide in-year decision-making.

Conclusion

The Public Health Sudbury & Districts 2024–2028 Accountability Monitoring Plan is a framework that provides an overview of our excellence in public health practice as it relates to our provincial mandate, the 2024–2028 Strategic Plan, and local programs and services. Provincial and local monitoring and reporting provide a snapshot of our performance and contribute to our commitment to transparency to all stakeholders.

The AMP is depicted using the Accountability Monitoring Framework which incorporates key categories of accountability and the lenses within which we apply this work. This Plan serves as a tool to report on organizational requirements, foundational and program requirements, and strategic planning. Further details will be outlined in the Accountability Monitoring Plan Technical Specification document to guide data collection.

Given the changing landscape of public health and the transformation of the health system, this AMP has been developed to allow for some flexibility and future adaptations as more information is provided from the Ministry of Health, other funding ministries, and our local communities.

ACCOUNTABILITY MONITORING PLAN, 2024–2028

MOTION:

WHEREAS the Board of Health motion #65-23 endorsed the 2024–2028 Strategic Plan and directed the Medical Officer of Health to operationalize the Strategic Plan, ensuring regular monitoring reports to the Board of Health; and

WHEREAS the 2024-2028 Accountability Monitoring Plan is an essential monitoring framework for comprehensive performance measurement related to the provincial mandate, the Board of Health's 2024–2028 Strategic Plan, and local programs and services;

THEREFORE BE IT RESOLVED that the Board of Health approve the 2024–2028 Accountability Monitoring Plan for Public Health Sudbury & Districts and direct the Medical Officer of Health to operationalize the Plan, ensuring an annual report to the Board of Health; and

FURTHER THAT the Board of Health endorse the establishment of a joint Board of Health/Staff Accountability Working Group for 2024–2028 for the purpose of guiding the reporting of the Accountability Monitoring Plan to the full Board of Health.

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

IN CAMERA

MOTION: **THAT this Board of Health goes in camera to deal with labour relations or employee negotiations, advice that is subject to solicitor-client privilege, including communications necessary for that purpose, and 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 Board. Time: _____**

RISE AND REPORT

MOTION:

THAT this Board of Health rises and reports. Time: _____

ADJOURNMENT
MOTION: THAT we do now adjourn. Time: _____