Board of Health for the Peterborough
County-City Health Unit
AGENDA
Board of Health Meeting
4:45 p.m. Wednesday, March 13, 2013
(Council Chambers, County Court House
County of Peterborough, 470 Water Street)

1. Call to Order

1.1. Recognition of Service – Mr. Paul Jobe

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. **Presentation: A Day In The Life – Oral Health Screening Team**
Joanne Leach, Dental Assistant
Tracey Stevens, Dental Hygienist

4.2. **Delegations: Casino Expansion**
Received and confirmed as of March 8, 2013:
- Hans Vink
- Casey Ready, Executive Director, Community Counselling and Resource Centre

5. Confirmation of the Minutes of the Previous Meeting

5.1. **February 13, 2013**

6. Business Arising From the Minutes

7. Correspondence

8. Program Reports

9. New Business

9.1. **Staff Report: Executive Summary - The Potential Health Impacts of a Casino in Peterborough**
Dr. Rosana Pellizzari, Medical Officer of Health
Additional Links: ***Technical Report***

9.2. **Presentation: Small Drinking Water Systems Update**
Chris Eaton, Public Health Inspector

9.3. **Presentation: Mental Health in the Public Health Mandate - The Peterborough Experience**
Melinda Wall, Public Health Nurse

9.4. **Presentation: Chief Medical Officer of Health 2011 Annual Report**
Dr. Rosana Pellizzari, Medical Officer of Health

9.5. **Approval: Appointment of Acting Medical Officer of Health (March 24 – 31, 2013)**
Dr. Rosana Pellizzari, Medical Officer of Health

9.6. **alPHa Winter Symposium Update**
David Watton
Chief Phyllis Williams

9.7. **Strategic Plan Update**
David Watton

9.8. **Committee Report: Property**
Deputy Mayor Sharpe, Chair, Property Committee

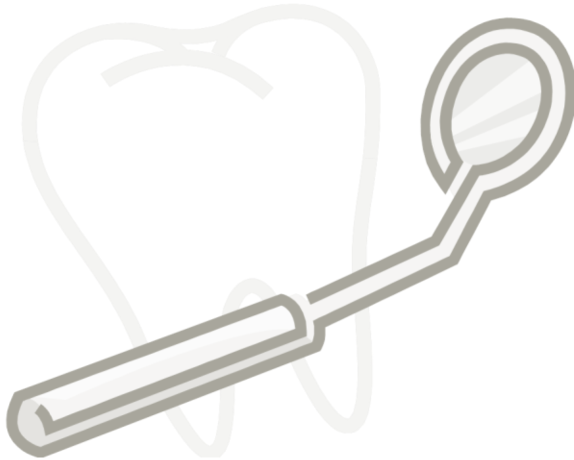
10. By-Laws

11. In Camera to Discuss Confidential Personal and Property Matters

12. Date, Time, and Place of the Next Meeting
4:45 p.m. Wednesday, April 10, 2013; Council Chambers, County Court House
County of Peterborough, 470 Water Street)

13. Adjournment

c: All Members, Board of Health
Medical Officer of Health
Directors



A Day in the Life:
Oral Health Screening Team

Presentation to: Board of Health
By: JoAnne Leach, Dental Assistant
Tracey Stevens, Dental Hygienist

Date: March 13, 2013

Peterborough County-City
HEALTH UNIT
...because health matters!

School Oral Health Screening

- Oral Health Screening Team - part of the Health Unit's Oral Health Program
- Mandated under OPHS to provide OH screening in elementary schools
- Oral Health Assessment and Surveillance (OHAS) protocol
- Oral Health Guidance Document

School Oral Health Screening

- 48 elementary schools locally
- Specific grades which are screened in a particular school, depends on the *screening intensity level*

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School Oral Health Screening

- **High** screening intensity – 14% or more of Grade 2 students exhibit d+D of ≥ 2
- **Medium** screening intensity – 9.5-13.9% of Grade 2 students exhibit d+D of ≥ 2
- **Low** screening intensity – fewer than 9.5% of Grade 2 students exhibit a d+D of ≥ 2

School Oral Health Screening

- High screening intensity - JK, SK, Grades 2, 4, 6 and 8
- Medium screening intensity - JK, SK, Grades 2 and 8
- Low screening intensity - JK, SK and Grade 2

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School Oral Health Screening

Stats for the 2011-2012 school year

- # students screened – 4,215
- # students requiring **urgent care** – 301

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School Oral Health Screening

Peterborough County-City
HEALTH UNIT
...because health matters!

School Oral Health Screening

PROCESS

- Schedule schools
- Class lists
- Parent/Guardian letters
- Consent
- Screening session prepared

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School Oral Health Screening

Peterborough County-City
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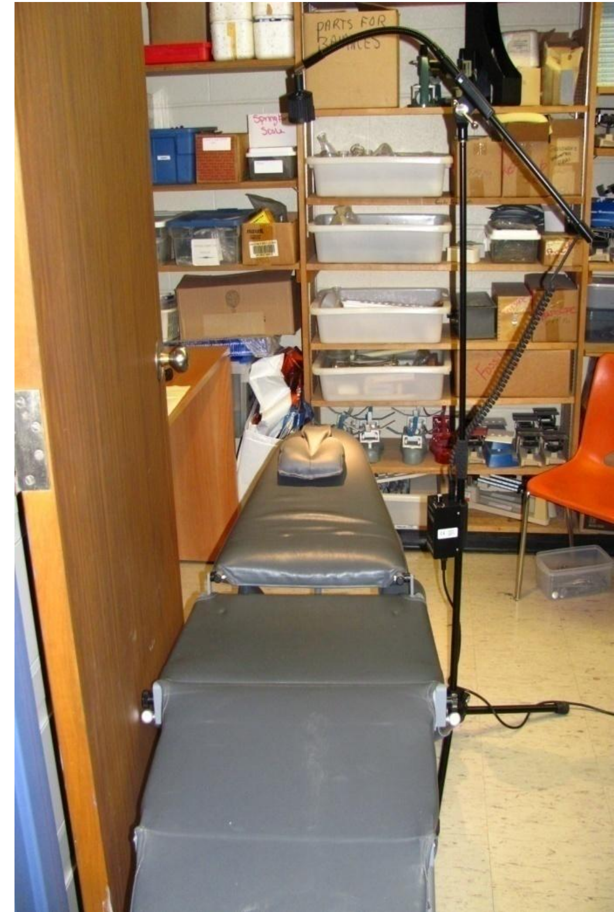
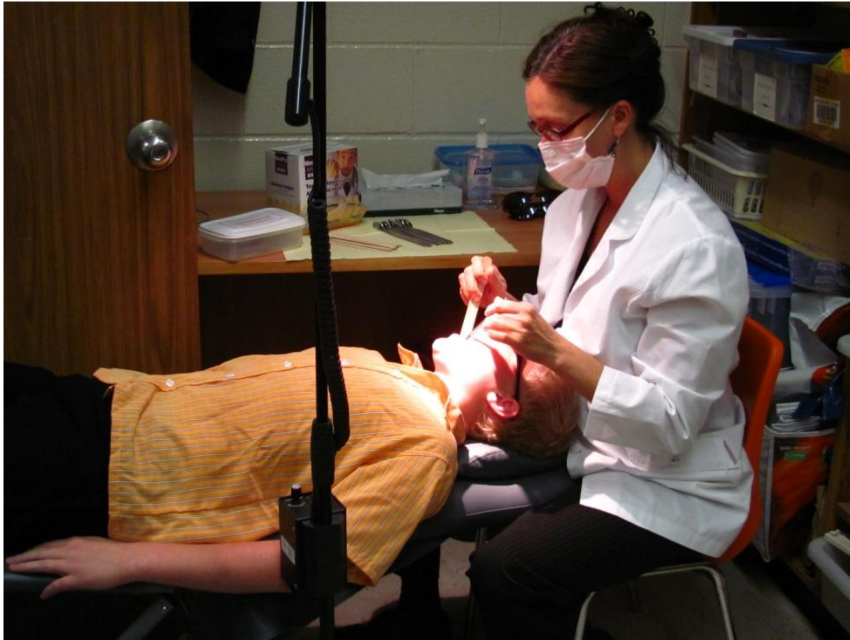
...because health matters!

School Oral Health Screening



School Oral Health Screening

School Oral Health Screening



School Oral Health Screening

Peterborough County-City
HEALTH UNIT
...because health matters!

School Oral Health Screening

Peterborough County-City
HEALTH UNIT
...because health matters!

School Oral Health Screening

We welcome your questions!

Peterborough County-City HEALTH UNIT ...because health matters!

Board of Health for the
Peterborough County-City Health Unit
Minutes
4:45 p.m., Wednesday, February 13, 2013
(Council Chambers, County Court House
County of Peterborough, 470 Water Street)

Present:

Board Members: Councillor Andrew Beamer
Councillor Henry Clarke
Mr. Jim Embrey
Mayor John Fallis
Councillor Lesley Parnell
Deputy Mayor Andy Sharpe
Mayor Mary Smith
Chief Phyllis Williams
Mr. David Watton, Chair

Regrets: Mr. Paul Jobe

Staff: Mrs. Brittany Cadence, Supervisor, Communications Services
Mrs. Carolyn Doris, Public Health Nutritionist
Ms. Patti Fitzgerald, Manager, Clinical Services
Mrs. Wendy Freeburn, Administrative Assistant, Recorder
Mrs. Susan Marino, Public Health Nurse
Dr. Rosana Pellizzari, Medical Officer of Health
Mr. Larry Stinson, Director, Public Health Programs
Ms. Kerri Tojcic, Computer Technician Analyst

DRAFT

1. Call to Order

1.1 Recognition of Past Chair – Deputy Mayor Andy Sharpe

Mr. David Watton acknowledged, thanked and presented a gift to Deputy Mayor Andy Sharpe for his past two years of service as Chair to the Board of Health. Mr. Watton made special mention of the work Deputy Mayor Sharpe did with the Property Committee.

2. Confirmation of the Agenda

Moved by	Seconded by
Mayor Fallis	Mr. Embrey

That the agenda be approved as circulated.

- Carried (M-13-14) -

3. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

4. Delegations and Presentations

4.1 A Day in the Life – Sexual Health Nurse
Presenter: Susan Marino, Public Health Nurse

5. Confirmation of the Minutes of the Previous Meeting

Moved by	Seconded by
Councillor Clarke	Councillor Parnell

That the minutes of the Board of Health meeting held on January 9, 2013, be approved.

- Carried (M-13-15) -

6. Business Arising From The Minutes

None.

7. Correspondence

Moved by	Seconded by
Mayor Fallis	Mr. Embrey

That the following documents be received for information and acted upon as deemed appropriate.

- Carried (M-13-16) -

1. Letter dated January 11, 2013 from Dr. Pellizzari to Minister Aglukkaq and Dr. Butler-Jones, with copies to MP Del Mastro regarding food insecurity.
2. Letter dated January 22, 2013 from Chairman Watton to MPP Leal regarding social assistance benefits.
3. Letter dated January 30, 2013 from Dr. Pellizzari to Mayor Bennett and City Council Members, with copies to Brian Horton, CAO, regarding a Mandatory Food Handler Certification By-Law.

DRAFT

4. Letter dated January 31, 2013 from Gordon Fleming, Association of Local Public Health Agencies (alPHa), regarding sodium.
5. Letter dated February 1, 2013 from Minister Milloy to Dr. Pellizzari, in response to her original letter dated January 4, 2013, regarding social assistance benefits.
6. Letter dated February 5, 2013 from alPHa regarding the Winter Symposium and Board of Health Section meeting.
7. Resolutions from other Health Units:
   - Northwestern (Oral Health)

Dr. Pellizzari requested that Board members on City Council familiarize themselves with the contents of the letter to Brian Horton , CAO, City of Peterborough, regarding a Mandatory Food Handler Certification By-Law (#3) to improve food safety in the City.

8. Program Reports

8.1 Q4 2012 Program Report

Presenter: Larry Stinson, Director, Public Health Programs

Mr. Stinson gave an overview of the Health Unit's activities during the last quarter of 2012.

Deputy Mayor Sharpe questioned whether the Health Unit had an opportunity for input into the Ministry of Transportation survey regarding Off Road Vehicles. Deputy Mayor Sharpe will forward this survey to the Medical Officer of Health following the meeting.

8.2 Q4 2012 Financial Report

Bob Dubay, Accounting Supervisor

Moved by Councillor Clarke — Seconded by Mr. Embrey

That the Board of Health for the Peterborough County-City Health Unit receive the Q4 (Fourth Quarter) 2012 Program and Financial Report, for information.

- Carried (M-13-17) -

9. New Business

Prior to the commencement of new business, the Chair noted the recent appointment of MPP, Jeff Leal as the Minister of Rural Affairs. He sought support from the Board to send a letter of congratulations.

Moved by Councillor Parnell — Seconded by Deputy Mayor Sharpe

That the Board of Health send a letter of congratulations to MPP, Jeff Leal for his recent appointment as Minister of Rural Affairs.

- Carried (M-13-18) -

9.1 <u>Staff Report: Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action</u>

Presenter: Carolyn Doris, Public Health Nutritionist

Ms. Doris provided an overview of the Food For Kids Peterborough and Student Nutrition Programs and Call to Action purposes.

Moved by
Councillor Clarke

Seconded by
Councillor Parnell

That the Board of Health for the Peterborough County-City Health Unit:

1. Endorse the background report, *Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action for Food For Kids Peterborough and County*
2. Endorse the vision of Student Nutrition Programs (SNP), delivered in Peterborough County and City schools by Food For Kids Peterborough and County so that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.
3. Send a letter to the provincial Ministers of Children and Youth Services, Health and Long-term Care and Education to request continued and increased support and funding for SNPs.

- Carried (M-13-19) -

Moved by
Mr. Embrey

Seconded by
Mayor Fallis

That the Board of Health for the Peterborough County-City Health Unit request to make a presentation at County Council, with the possibility of follow-up at the Township Councils if necessary.

- Carried (M-13-20) -

Moved by
Councillor Parnell

Seconded by
Mr. Embrey

That the Board of Health for the Peterborough County-City Health Unit send a letter to Jeff Leal, Rural Affairs Minister and Premier Kathleen Wynne, Minister of Agriculture to ask for an endorsement of School Nutrition Programs and support for use of locally grown food, with a specific request for a pilot of Farms to Schools.

- Carried (M-13-21) -

DRAFT

9.2 Staff Report: Audit Letter of Engagement

Dr. Rosana Pellizzari, Medical Officer of Health

Moved by Mayor Smith

Seconded by Councillor Clarke

That the Board of Health for the Peterborough County-City Health Unit engage the auditing services of Collins Barrow Kawarthas LLP and authorize the Chair and Vice-Chair to sign the Letter of Engagement.

- Carried (M-13-22) -

9.3 Committee Report: Governance

Mr. David Watton, Chair, Board of Health

Moved by Mayor Smith

Seconded by Mr. Embrey

That the Board of Health for the Peterborough County-City Health Unit:

- receive for information, meeting minutes of the Governance Committee for November 26, 2012, approved by the Committee on February 1, 2013; and
- approve the designation of Chief Phyllis Williams as Chairperson of the Committee;

- Carried (M-13-23) -

Moved by Deputy Mayor Sharpe

Seconded by Chief Williams

That the Board of Health for the Peterborough County-City Health Unit approve the following document referred by the Committee at the February 1, 2013 meeting:

- Revised Policy #2-348, Committee, Governance, Terms of Reference.

- Carried (M-13-24) -

Moved by Mayor Smith

Seconded by Mayor Fallis

That the Board of Health for the Peterborough County-City Health Unit approve the following document referred by the Committee at the February 1, 2013 meeting:

- New Policy #2-374, Contractor Performance and Litigation.

- Carried (M-13-25) -

DRAFT

9.4 Committee Report: Property

Mr. David Watton, Chair, Board of Health

Moved by	Seconded by
Mr. Embrey	Mayor Smith

That the Board of Health for the Peterborough County-City Health Unit:

- approve the designation of Deputy Mayor Sharpe as chairperson of the Committee; and
- approve the following documents referred by the Committee at the February 1, 2013 meeting: Revised Policy #2-350, Committee, Property, Terms of Reference

- Carried (M-13-26) -

10. By-Laws

Nil.

11. In Camera to discuss Confidential Personal and Property Matters

Moved by	Seconded by
Mayor Fallis	Councillor Beamer

That the Board of Health go In Camera to discuss confidential Personal and Property matters.

- Carried (M-13-27) -

Moved by	Seconded by
Councillor Clarke	Chief Williams

That the Board of Health rise from In Camera

- Carried (M-13-28) -

12. Date, Time, and Place of the Next Meetings

4:45 p.m., Wednesday, March 13, 2013; Council Chambers, County Court House County of Peterborough, 470 Water Street

13. Adjournment

Moved by	Seconded by
Mr. Embrey	Councillor Clarke

DRAFT

That the meeting be adjourned.

- Carried (M-13-29) -

The meeting adjourned at 7:48 p.m.

_______________________________ _____________________________
Chairperson Medical Officer of Health

DRAFT

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: March 13, 2013

Recommendation:

That the following documents be received for information and acted upon as deemed appropriate.

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1. Email received February 22, 2013 from the Association of Local Public Health Agencies (alPHa) regarding notice for the upcoming Annual General Meeting which takes place on June 2-4, 2013. **REF: P. 2-9** *(Note: Nominations forms not included).*

2. Letter dated March 8, 2013 from Dr. Pellizzari to MPP Jeff Leal on his recent appointment as Minister of Rural Affairs. **REF: P. 10**

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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Toronto ON M5B 1J3
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E-mail: info@alphaweb.org

Providing leadership in public health management

N O T I C E

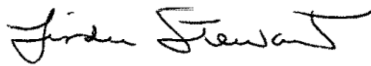
2013 ANNUAL GENERAL MEETING

NOTICE is hereby given that the 2013 Annual General Meeting of the **ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES** will be held at the Radisson Admiral Toronto Harbourfront, 249 Queen's Quay West, Ontario on Monday, June 3, 2013 at 8:00 AM at the alPHa Annual Conference for the following purposes:

1. To consider and approve the minutes of the 2012 Annual General Meeting in Niagara Falls, Ontario;
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 Statement for 2012-2013;
4. To appoint an auditor for 2013-2014; and
5. To transact such other business as may properly be brought before the meeting.

DATED at Toronto, Ontario, February 21, 2013.

BY THE ORDER OF THE BOARD OF DIRECTORS.



Linda Stewart
Executive Director

alPHa
Association of Local
PUBLIC HEALTH
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Providing leadership in public health management

Call for Resolutions

alPHa members are invited to submit resolutions for consideration at the upcoming June 2013 alPHa Annual Conference.

It is important that resolutions are drafted using the "**Procedural Guidelines for alPHa Resolutions**" found by **clicking here.**

We request that resolutions be limited to ***one*** operative clause per issue (other than specific directions on whom to advise) to allow for focused advocacy and monitoring.

Who may submit?

- a member board of health
- a Section Executive Committee, or general meeting of a Section
- the alPHa Board of Directors, its Executive Committee or a Standing Committee of the Association; or
- an Affiliate member organization

What is required?

- resolutions must first be endorsed by a properly constituted body, i.e. a board of health, a Section of alPHa, etc.
- a covering letter specifying your submission must accompany the resolution(s)
- proper formatting according to procedural guidelines, including clearly-worded introductory and operative clauses
- any concise background material to help prepare members voting on the issue

When is the deadline to submit?

- ***Friday, April 12, 2013, 4:30 PM for all resolutions that do not request a change in alPHa's Constitution.***
- ***For resolutions to amend the alPHa Constitution, the deadline is Wednesday, April 3, 2013, 4:30 PM.***
- Taking into account that a late resolution may be necessary in response to a current event, you may bring a late resolution to the Resolutions Session of the June 2012 conference. These late resolutions, however, will not have the benefit of being reviewed by alPHa's Executive Committee and there will be a vote during the Resolutions Session to determine ***if*** the membership will consider late resolutions. If the vote is successful, your resolution will be brought forward and considered.

When will resolutions be debated by the alPHa membership?

- There will be a special session to consider resolutions on June 3 at the 2013 annual conference.

How may I submit the resolutions?

- only electronic submissions will be accepted
- e-mail to: Susan Lee, Manager, Administrative & Association Services, alPHa
  susan@alphaweb.org

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CALL FOR BOARD OF HEALTH NOMINATIONS TO 2013-14 alPHa BOARD OF DIRECTORS

*alPHa is accepting nominations for **two** Board of Health representatives on its 2013-2014 Board of Directors, i.e. one representative from each of the following regions: **Eastern** and **South West.** See the attached appendix for boards of health in these regions.*

Each position is for a 2-year term, beginning June 2013 and ending June 2015, and will fill a seat on the Board of Health Section Executive and a seat on the alPHa Board of Directors.

Qualifications:

- *Active member of an Ontario Board of Health or regional health committee;*
- *Background in committee and/or volunteer work;*
- *Supportive of public health;*
- *Able to commit time to the work of the alPHa Board of Directors and its committees;*
- *Familiar with the Ontario Public Health Standards and its Organizational Standards.*

An election to determine the four representatives will be held at the 2013 alPHa Annual Conference, June 2-4, 2013, Radisson Admiral Toronto Harbourfront Hotel, Toronto, ON.

*Nominations close **4:30 PM, Monday, May 27, 2013**.*

Why stand for election to the alPHa Board?

- Help make alPHa a stronger leadership organization for public health units in Ontario;
- Represent your colleagues at the provincial level;
- Bring a voice to discussions reflecting common concerns of boards of health and health unit management across the province;
- Expand your contacts and strengthen relationships with public health colleagues;
- Lend your expertise to the development of alPHa position papers and official response to issues affecting all public health units; and
- Learn about opportunities to serve on provincial ad hoc or advisory committees.

What is the Board of Health Section Executive Committee of alPHa?

- This is a committee of the alPHa Board of Directors comprising seven (7) *Board of Health representatives*.
- It includes a Chair and Vice-Chair who are chosen by the Section Executive members.
- Members of the Section Executive attend all alPHa Board meetings and participate in teleconferences throughout the year.

How long is the term on the Board of Health Section Executive/alPHa Board of Directors?

- Two (2) years with no limit to the number of consecutive terms.

How is the alPHa Board structured?

- There are 22 directors on the alPHa Board: 7 from the Board of Health Section, 7 from the Council of Ontario Medical Officers of Health (COMOH), 1 from each of the 7 Affiliate Organizations of alPHa, and 1 from the Ontario Public Health Association Board of Directors.
- There are 4 committees of the alPHa Board: Executive Committee, Board of Health Section Executive, COMOH Executive, and Advocacy Committee.

What is the time commitment to being a Section Executive member/Director of alPHa?

- Full-day alPHa Board meetings are held in person 4 times a year in Toronto; a fifth and final meeting is held at the June Annual Conference.
- Board of Health Section Executive Committee teleconferences are held 5 times throughout the year.
- The Chair of the Board of Health Section Executive participates on alPHa Executive Committee teleconferences, which are held 5 times a year.

Are my expenses as a Director of the alPHa Board covered?

- Any travel expenses incurred by an alPHa Director during Association meetings are *not* covered by the Association but are the responsibility of the Director's sponsoring health unit.

How do I stand for election on the alPHa Board of Directors?

- Submit a completed Form of Nomination and Consent along with a biography of your suitability for candidacy and a copy of the motion from your Board of Health supporting your nomination to alPHa by **May 27, 2013**.
- Attend the alPHa conference where the election will be held and prepare a 2-minute speech outlining your statement of position in an address to the Board of Health delegation at the June annual conference.

When does the election take place? Who may vote?

- The election takes place during the Board of Health Section General Meeting at the alPHa Annual Conference. The exact date and time will be announced.
- Only members of the Board of Health Section will be eligible to vote for Board of Health Section nominees to the alPHa Board of Directors.

Who should I contact if I have questions on any of the above?

- Susan Lee, alPHa, Tel: (416) 595-0006 ext. 25, E-mail: susan@alphaweb.org

Board of Health Vacancies on alPHa Board of Directors

*alPHa is accepting nominations for **two** Board of Health representatives to fill positions on its 2013-2014 Board of Directors, i.e. one representative from each of the following regions: **Eastern** and **South West**. See below for boards of health in these regions.*

Each position is for a 2-year term, beginning June 2013 and ending June 2015, and will fill a seat on the Board of Health Section Executive and a seat on the alPHa Board of Directors.

An election will be held at alPHa's annual conference in June to determine the two new representatives (one from each of the regions below).

If you are an active member of a Board of Health/Regional Health Committee who is interested in running for a seat, please consult the list below to determine which region you belong to:

1. **Eastern Region**
   Boards of health in this region include:

   Eastern Ontario
   Hastings & Prince Edward
   Kingston, Frontenac Lanark & Addington
   Leeds Grenville
   Ottawa
   Renfrew

2. **South West Region**
   Boards of health in this region include:

   Chatham-Kent
   Elgin St. Thomas
   Grey Bruce
   Huron
   Lambton
   Middlesex-London
   Oxford
   Perth
   Windsor-Essex

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CALL FOR NOMINATIONS
alPHa Distinguished Service Award

The Distinguished Service Award (DSA) is awarded annually by the Association of Local Public Health Agencies to individuals in recognition of their outstanding contributions made to public health in Ontario.

How many awards are given yearly?

- One award per Section and Affiliate organization may be presented in any given year.
- On occasion, an award may be given to individuals outside alPHa for their contributions to public health.

Who is eligible to receive the DSA?

- Members of alPHa who fall under the following categories are eligible:
    - an elected/appointed member of a local board of health or regional health committee;
    - a medical officer of health or associate medical officer of health;
    - one of alPHa's seven affiliated organizations (i.e. ANDSOOHA, AOPHBA, APHEO, ASPHIO, HPO, OAPHD, OSNPPH).
- An individual outside the alPHa membership who has made outstanding contributions to public health in Ontario.

Who deserves the DSA?

- Eligible recipients have:
    - demonstrated exceptional qualities of leadership in his/her own milieu;
    - achieved tangible results through lengthy service and/or distinctive acts; and
    - displayed exemplary devotion to public health at the provincial level.

What are the eligibility criteria for nominees?

- Nominees:
    - currently hold a position of significant responsibility in one of alPHa's member agencies (i.e. board of health/local public health unit/affiliated organization) and have been a member in alPHa for at least three years; and
    - have been nominated by at least three voting members from the **nominee's Section or Affiliate organization** who are in good standing of alPHa.

Note:
1. good standing refers to members who have paid their membership dues;
2. voting members are individuals representing a member health unit. These individuals include board of health chairs, medical and associate medical officers of health, representatives appointed to the alPHa Board of Directors by the seven alPHa Affiliate organizations.

continued on next page

Who can nominate?

- Any member of alPHa including Board of Health members, medical and associate medical officers of health, and Affiliate representatives may nominate. Please note that three Section or Affiliate members of alPHa must sign the nomination form.
- In the case of nominations of *non-members of alPHa*, nominations must come from any three active members of alPHa; only alPHa members may nominate potential candidates.
- The Award is presented on behalf of each of alPHa's various membership groups, i.e. the Boards of Health Section, Council of Ontario Medical Officers of Health (COMOH), and the seven Affiliate organizations of alPHa. **Therefore, nominations must be issued by the nominee's Section or Affiliate organization** (i.e. nominations of Board of Health members must come from the Board of Health Section; nominations of medical/associate medical officers of health must come from the Council of Ontario Medical Officers of Health; and nominations of senior public health staff must come from the nominee's respective Affiliate organization). If you want to recommend an individual for nomination by their Section or Affiliate organization, please contact the Chair or President of the respective Section or Affiliate organization.

What material must accompany the nomination form?

- Include signatures of the nominator and two other supporting voting members of alPHa.
- Include a **cover letter explaining why the nominee is deserving of this award** must be included with the form. Since the members of the Selection Committee more than likely will not know the nominee, they will base their assessment on what is conveyed to them in the cover letter. The letter should tell the Selection Committee what the nominee has achieved and why it is outstanding.
- A service record or curriculum vitae must also accompany the nomination form and could include the following:
    - personal achievements at the local level;
    - special or distinctive services on behalf of public health provincially;
    - leadership and contributions on behalf of alPHa and/or one of its Sections; an affiliated organization; or a provincial public health organization

Where should I send the nominations to?

- Nomination forms along with all relevant accompaniments should be e-mailed to Susan Lee, Administrative Assistant, alPHa, at susan@alphaweb.org

When is the deadline to submit nominations?

- **Friday, April 12, 2013, 4:30 PM**

Who selects the DSA recipients?

- All nominations are reviewed by the Executive Committee of alPHa.
- In the event of a tie, the alPHa Board of Directors will determine the Award recipient.

How are Award recipients notified?

- Award recipients are notified in writing by alPHa approximately one month prior to the conference date.
- Award recipients are invited to attend as guests of the association at the Annual Awards Banquet, which is held in conjunction with the Annual Conference.

Who can I contact if I have further questions on the Awards?

- Susan Lee, Manager, Administrative and Association Services, alPHa
  - tel: (416) 595-0006 ext. 25
  - e-mail: susan@alphaweb.org

March 8, 2013

Mr. Jeff Leal, M.P.P. Peterborough
236 King Street
Peterborough, ON K9J 7L8

Dear Mr. Leal,

On behalf of the board and staff of the Peterborough County-City Health Unit, I would like to extend our sincere and heartfelt congratulations on your recent appointment as Minister of Rural Affairs. You have been a strong advocate for your constituents of Peterborough, many who live in rural communities, and we look forward to the leadership and guidance that you will bring to your government colleagues on important rural matters. In addition, you bring your recent experience in aboriginal affairs to this portfolio, which will serve us all well.

Jeff, you have a proven track record as a responsive, responsible and committed representative for this community. In particular, you have been a strong partner and advocate for public health.

We thank you for all your past efforts and we wish you well as Cabinet Minister. We hope that we can be at your service on issues that impact on the health and wellbeing of rural communities. We are confident in your abilities and look forward to your continued success.

Yours in health,

Original signed by

David Watton
Chair, Board of Health
Peterborough County-City Health Unit

10 Hospital Drive, Peterborough, ON K9J 8M1 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

Staff Report

Executive Summary – The Potential Health Impacts of a Casino in Peterborough

Date:	March 13, 2013	
To:	Board of Health	
From:	Dr. Rosana Pellizzari, Medical Officer of Health	
Approved by		***Approved by***
Rosana Pellizzari, M.D.		Monique Beneteau, Health Promoter

<u>Recommendations</u>

That the Board of Health for the Peterborough County-City Health Unit:

1. Receive this report for information.
2. Direct staff to forward this report to all City and Cavan Monaghan Township Council members for their consideration.
3. Write a letter to the Premier, the Ontario Minister of Finance, and the Minister of Health and Long-Term Care, with copies to the Alcohol and Gaming Commission of Ontario, MPPs Leal and Scott, the Association of Local Public Health Agencies (alPHa) and Ontario Boards of Health, to request that the provincial government:
   a) reconsider its position on expanding gambling throughout the province given its public health impact, and;
   b) direct the Ontario Lottery and Gaming Corporation to implement stronger harm reduction policies and criteria, including the use of tools such as a casino social contract that would hold host municipal governments, casino operators and the provincial government accountable for the adoption of measures and strategies to prevent or mitigate the increased harm that would arise from enhanced gaming access.
4. Write a letter to the Ontario Lottery and Gaming Corporation, with copies to the Minister of Finance, advocating for a greater proportion of provincial revenues to be

directed to prevention, treatment, research, and a public awareness campaign to reduce the stigma of gambling addiction and increase the numbers of individuals seeking assistance.

5. Direct staff to prepare a resolution for the alPHa 2013 Annual General Meeting that encourages provincial advocacy to minimize the public health impacts of gaming.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

The Board of Health has not previously made a decision with regards to this matter.

Background

In 2012, the Ontario Lottery and Gaming Commission (OLG) released a report entitled "Modernizing Lottery and Gaming in Ontario" describing the outcome of a comprehensive strategic review of their operations. The recommended actions include the expansion of gaming throughout the province. OLG divided the province into zones and "gaming bundles." Peterborough is one of three identified locations in Gaming Bundle 2 (East). The other two locations include Belleville and Kingston. The OLG believes that the Peterborough area has not been fully exploited and, to this end, OLG is seeking a service provider to include up to 600 Electronic Gaming Machines (EGMs) and 180 Live Table Gaming Positions (18 – 36 tables). This would increase the access to gambling, above what is currently located at Kawartha Downs in Fraserville.

Rationale

Recognizing that gambling activities can lead to addiction and other health and social consequences, this report was written to address the health impacts of gambling. It is anticipated that any deliberation around the pros and cons of hosting a gaming venue would include careful consideration of all the social and health impacts on individual gamblers and the community as a whole.

This report will provide highlights from the Technical Report attached. Information will be shared on: a) prevalence rates; b) the effects of access and proximity on gambling behaviour; c) a description of at-risk populations; d) the health and financial costs of gambling; e) the impact of gambling on broader social health issues, and f) strategies for mitigating the risk of problem gambling.

Prevalence Rates

Two-thirds of Ontarians reported in a Canadian Community Health Survey (CCHS) in 2007/08 that they have gambled at least once in the last 12 months. The CCHS (2007/8) asked questions

to those respondents who indicated that they had gambled in the previous year. For Peterborough, 4.1% (95% Confidence Intervals of 2.7 – 6.3%) were determined, from these additional questions, to be at-risk for problem gambling. Due to a small sample size this estimate must be interpreted with caution. In addition, such a small sample prohibits differentiation between low-risk, moderate-risk and problem gamblers.

Prevalence rates for problem gamblers have ranged from between 1.2% to 5.9% of gamblers, depending on the tool used and the method of collecting information.

The prevalence rate for problem gambling among youth between the ages of 18 and 24 has been calculated to be as high as 6.9% which might represent up to 900 young adults dealing with moderate to severe gambling problems in the City and County of Peterborough.

Although prevalence rates that range from 1.2% to 5.9% may appear low, as Dr. McKeown, Medical Officer of Health for Toronto Public Health has pointed out, other health problems such as colorectal cancer, irritable bowel disease, and eating disorders all have prevalence rates of 2%.

Access and Proximity

The two gambling activities most reported by problem gamblers seeking treatment are Electronic Gaming Machines (EGMs) (also known as slot machines) and live gaming tables. A new casino in Peterborough, with a proposed additional 600 slot machines and 180 live gaming positions, would increase access to this type of gaming, possibly resulting in more problem gamblers. A research study showed that prevalence rates for problem gamblers may have doubled in Niagara Falls the year following the introduction of a new casino (from 2.2% to 4.4%). Other Ontario communities have experienced similar increases. These rates level off after a year or two, once the casino loses its novelty.

The closer a gambler is to a gambling facility, the greater the risk of becoming a problem gambler. In one study, it was found that

> *"…a problem gambler was significantly associated with living closer to gambling venues. People who live in neighbourhoods within walking distance (800m) or close driving distance (5 km) to a gambling venue were more likely to have gambled in the last year, and be a problem gambler who had gambled at a gambling venue in the past year*."[1]

At-risk Populations

Research evidence shows a positive correlation between alcohol use and gambling: that is, the heavier the alcohol consumption, the riskier the gambling and vice versa. Since alcohol consumption rates in Peterborough are higher than the Ontario average, having a casino in the community may exacerbate an already problematic trend.

In addition, the research is clear that problem gamblers are over-represented within certain populations including seniors, youth, First Nations people and people living on low incomes. For many people in these groups, their income levels are lower than average and they are more

likely to take financial risks. Peterborough boasts a large older adult population and the risks to gambling for this population is exacerbated by the limited amount of time that an older problem gambler would have to recoup their losses. In addition, older adults may already have chronic health issues that would be worsened by the stresses of problem gambling.

Recent research proposes that gambling among youth has become a rite of passage similar to drinking underage. Peterborough youth already have gambling rates similar to those of young people in Las Vegas.[2] First Nations people are four times more likely to become problem gamblers than non-First Nations people.[3] Part of the explanation for the increased rates among First Nations people is due, in part, to the fact that First Nations people already live with higher unemployment, lower incomes, lower education levels and discrimination. According to reports, people living on low incomes spend a disproportionately higher amount of their income on gambling than people who are middle and high income earners.

Finally, the casino workers themselves are at greater risk of becoming problem gamblers. Research shows that casino workers are three times more likely to become problem gamblers than the rest of the population.

Health and Financial Costs

Problem gamblers experience a myriad of health issues including stress, anxiety, depression, suicide, addiction, migraines, chronic bronchitis, fibromyalgia, intestinal disorders and sleep disorders. Due to these health issues, 25% of problem gamblers report being under the care of a health care practitioner. A summary list of various health issues, with supporting information, can be found in Table 1 of the Technical Report (pp. 10-11).

The consequences of problem gambling, both financial and social, extend beyond the individual to affect family, friends, co-workers, employers, and other members of the community. One report mentioned that for every problem gambler, three to four individuals are also affected. Some of the more common problems faced by problem gamblers and the people in their lives include divorce, family breakdown, compromised child development through neglect and poverty, lost productivity and job loss.

As for the cost of problem gambling to our community and province, it is estimated that every problem gambler costs our systems between $20,000 and $56,000 annually.

A 2003 study found that problem gamblers represented 4.8% of all gamblers in Ontario yet they represented 36% of all gambling revenue. Two-thirds of the revenue generated in Ontario by EGMs comes from problem gamblers. If this is still the case, problem gamblers probably contributed $1.3 billion in gaming revenues in 2012. That same year, OLG provided funding for prevention, treatment and research initiatives in the amount of $53.9 million. This represents just under 1.5% of the total gambling revenue of $3.7 billion.

According to Donna Rogers, Executive Director of FourCAST, a local addictions treatment service in Peterborough, 49 problem gamblers were admitted for treatment in 2012. This

number is consistent with the research that shows that only 1 – 2% of problem gamblers seek treatment. Clearly, problem gamblers are not seeking treatment and gambling addictions are one of the many chronic and undertreated problems in the community.

Broader Social Health Issues

Toronto Public Health recently summarized the potential impact of a casino on select social issues including employment, economic development, crime, neighbourhood impacts and social safety net.[4] By introducing a casino in the community, the potential predicted change in impact was calculated to be, for the most part, negative. For instance, Toronto Public Health predicted that there would be an increase in traffic volume and congestion, air pollution, and motor vehicle collisions, all of which would worsen health. Other negative impacts included the potential for an increase in property and violent crime. On the other hand, a casino could have a positive impact on employment levels and local tourism. The value of any job gains could be compromised, however, by the nature of the employment (e.g., part-time, no benefits, shift work).

Strategies for Mitigating the Risk of Problem Gambling

There are strategies for assisting those problem gamblers who seek treatment. Certain interventions seem more successful than others, including “talk” and drug therapy.[5]

As for preventing problem gambling, one study showed that a program targeted to youth focusing on probability and chance has shown some promise.[6] In the Technical Report from Toronto Public Health, it was stated that “literature suggests that public information/awareness campaigns may improve people’s knowledge, but there is no direct evidence of effectiveness as a primary prevention tool for problem gambling.”[7]

One approach that may be worthwhile may be to influence the policy makers to adopt public policies that will reduce the harms of problem gambling. Toronto Public Health has outlined a number of strategies including:

1. *Limiting hours of casino operation: no 24-hour access to venues, closed at least 6 hours per day;*
2. *Restricting the number of electronic gaming machines (EGMs) and slowing down machine speed of play and features that promote false beliefs of the odds of winning;*
3. *Eliminating casino loyalty programs;*
4. *Prohibiting ATMs on the gambling floor;*
5. *Prohibiting casino credit and holding accounts;*
6. *Reducing maximum bet size;*
7. *Mandating a daily loss maximum;*
8. *Implementing strong casino self-exclusion programs, including a mandatory player card system;*
9. *Issuing monthly individual patron statements which include full membership medians and averages to compare against personal record of loss, frequency and duration of play;*

10. *Designating areas for alcohol purchase and not providing alcohol service on casino floors to reduce impaired judgement.*[8]

Advocating the implementation of these strategies could reduce the risk of harm for all gamblers, should access to gaming be expanded locally. If one of Peterborough's municipalities is successful in hosting a casino, using a tool such as a social contract that is being contemplated by Toronto City Council could ensure that economic, health and social concerns are addressed. Appendix A included in the Technical Report is a document from the City of Toronto describing the various components that could be included in a casino social contract.

Strategic Direction

Addressing the health impacts of a casino in our community falls under two strategic directions:

- Continue to Meet Our Mandate
- Build on Our Leadership Role

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Attachments:

Attachment A – Technical Report: The Potential Health Impacts of a Casino in the City of Peterborough

References:

[1] Toronto Public Health (TPH). (2012). *The Health Impacts of Gambling Expansion in Toronto – Technical Report.* November 2012, p. 11.

[2] Parker, J.D.A. (Professor, Trent University). (2013). Personal communication with Monique Beneteau, February 6.

[3] Toronto Public Health (TPH). (2012). *The Health Impacts of Gambling Expansion in Toronto – Technical Report.* November 2012.

[4] McKeown, D. & Vanderlinden, L. (2013). *Public health impact of Casino Gambling Expansion*. Public Health Ontario webinar, February 5.

[5] Toronto Public Health (TPH). (2012). *The Health Impacts of Gambling Expansion in Toronto – Technical Report.* November 2012.

[6] Ibid.

[7] Ibid., p. 20

[8] Toronto Public Health. (2012). *Position statement: gambling and health*. Retrieved on February 14, 2013 from http://www.toronto.ca/legdocs/mmis/2012/hl/bgrd/backgroundfile-51872.pdf.

ATTACHMENT A

Peterborough County-City
HEALTH UNIT
...because health matters!

Technical Report:

The Potential Health Impacts of a Casino in Peterborough

Monique Beneteau
Health Promoter
Peterborough County-City Health Unit

March 13, 2013

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Background

In 2012, the Ontario Lottery and Gaming Commission (OLG) released a report entitled "Modernizing Lottery and Gaming in Ontario" describing the outcome of a comprehensive strategic review of their operations. The strategic review was requested by the provincial government in an effort to explore a number of issues such as reducing the capital costs of running gaming facilities, addressing the demands from consumers for products and providing employment opportunities.[1] The recommended actions moving forward included the expansion of gaming throughout the province. OLG divided the province into zones and "gaming bundles." Peterborough is one of three identified locations in Gaming Bundle 2 (East). The other two locations include Belleville and Kingston.

A number of steps in the expansion process have included:

1. Requests for Information from potential service providers published in May 2012 which closed on July 2, 2012.
2. OLG-hosted information briefings with the municipal sector in June 2012.
3. Requests for Pre-Qualification (RFPQ) from potential service providers published in November 2012 which closed on March 7, 2013.

The next step will be for OLG to select service providers from the RFPQ round to invite them to complete a Request for Proposal.

In the Request for Pre-Qualification, it states "*…that Gaming Bundle 2 (East) represents a valuable commercial opportunity that has not been fully exploited*."[2] To this end, OLG is seeking a service provider to replace or augment the existing Peterborough gaming facility (located at Kawartha Downs) to include up to 600 Electronic Gaming Machines (EGMs) and 180 Live Table Gaming Positions (18 – 36 tables). The successful service provider will be responsible for the operations in the three communities that make up Gaming Bundle 2. The type of facilities and where they are located is at the discretion of the service provider.

Throughout this process, it is clear that expansion of gaming facilities cannot happen without approval from the municipal government. According to the City of Peterborough's Report PLPD13-013, "*City Council passed a resolution on April 2, 2012 endorsing the principle of Peterborough becoming a host for the new gaming facility*."[3] More recently, potential service providers have met with municipal representatives in January and February 2013 to discuss possible locations for a casino.

A staff report[4] outlining four possible locations was presented at a Planning Committee meeting on February 11, 2013. The Planning Committee approved the three recommendations put forward which include:

1. Informing OLG of their support for a casino in the community;
2. Providing the opportunity for public consultation at a meeting on March 5, 2013, and
3. Should Council decide to go ahead, informing OLG that they are prepared to move forward with identified preferred locations.

Recognizing that gambling activities can lead to addiction and other health and social consequences, this report has been written to highlight the health impacts of gambling. It is anticipated that any deliberations on the risks and benefits of increasing access to gaming in Peterborough would include careful consideration of the social and health impacts on individual gamblers and the community as a whole.

Please note that for the purposes of this report, only the information relevant to on-site gaming operations will be included. Other forms of gaming such as on-line gambling, video lottery terminals (VLTs), bingo, and lotteries will not be directly addressed. In addition, a "whole of Peterborough" approach has been used in this paper and all references to populations, unless otherwise indicated, refer to the entire population of the health unit.

Rationale

As part of the analysis of the health impacts of gambling on individuals and the community, it is essential to examine the prevalence rates of gambling in our community including specific at-risk populations; the effects of access and proximity to a gaming venue on gambling behaviour; the social and health costs of gambling and the impact of gambling on broader social health issues. This report will also highlight existing and required supports for problem gamblers and strategies for reducing or mitigating the harms of gambling.

Section 1: Prevalence Rates

Adults

According to the 2007/08 Canadian Community Health Survey (CCHS), two-thirds, or 62% of Ontarians 18 years of age or older gambled at least once in the previous 12 months.[5] In Peterborough a significantly greater proportion of the population 18 years and older reported gambling at 69.5%. The CCHS data also showed that "*…85% of Canadians have gambled at some point in their lifetime*."[6] The CCHS (2007/8) asked questions to those respondents who indicated that they had gambled in the previous year. For Peterborough, 4.1% (95% Confidence Intervals of 2.7 – 6.3%) were determined, from these additional questions, to be at-risk for problem gambling. Due to a small sample size this estimate must be interpreted with caution. In addition, such a small sample prohibits differentiation between low-risk, moderate-risk and problem gamblers.

Many people who gamble will suffer no long-term negative financial or health consequences from their activity. Low-risk gamblers are identified by three characteristics: a) they gamble infrequently (2 - 3 times per month); b) spend under $1,000 in a year and c) risk no more than one percent of their family's gross income.[7]

A problem gambler, on the other hand, is at a much higher risk of experiencing negative financial and health consequences. There are different definitions for problem gambling. One

such definition would consider a problem gambler to be an individual who exceeds one or more of the characteristics exhibited by a low-risk gambler (as mentioned above). Another definition from the Canadian Public Health Association describes problem gambling as *"…a progressive disorder characterized by 'a) continuous or periodic loss of control over gambling; b) preoccupation with gambling and money with which to gamble; c) irrational thinking; d) continuation of the activity despite adverse consequences'*."[8]

When determining the prevalence rates for problem gamblers, various researchers use different markers and may combine at-risk and problem gamblers into one group. As a result, the prevalence rates range from 1.2% to 3.4% of gamblers.[9] Some researchers argue that the prevalence rate for problem gamblers may be even higher due to the methodology used for obtaining the information. For instance, Williams and Wood (2007) argued that the response rate for the CCHS is artificially low because the respondents are less anonymous due to the face-to-face administration of the tool.[10] The same survey questions were used in telephone surveys in various provinces in the early 2000s and resulted in a doubling of the rate of reported problem gambling. The prevalence rates from these provincial surveys ranged from 1.6% to 5.9%, averaging 3.6%.[11]

A characteristic of problem gamblers is that they are more likely to participate in a variety of gaming activities. In 2007/08, Ontario obtained extra data from the CCHS on gambling activity. It showed that problem gamblers are four times more likely than non-problem gamblers to engage in at least five different gambling activities including electronic gaming machines (EGMs).[12] According to the Toronto Public Health report,

> *"[c]ertain gambling modalities may carry a higher risk that their users will develop gambling problems or that existing gambling problems will be exacerbated. Evidence points to continuous forms of gambling, such as EGMs including slot machines and video lottery terminals (VLTs) (currently not permitted in Ontario), as most problematic."*[13]

Interestingly, with greater access to the Internet, one might think that on-line forms of gaming would be high and would be contributing to the problem gambling rates. Research shows, however, that Internet gambling is low and *"…is the least common form of gambling among adult Canadian gamblers."*[14] It is clear that those forms of gambling found in casinos (i.e., EGMs and tables) contribute most to problem gambling rates.[15,16]

Youth

While many youth are not of legal age to engage in gambling activities, the results from the 2011 Ontario Student Drug Use and Mental Health Survey[17] from the Centre for Addiction and Mental Health showed that many youth between the ages of 12 and 18 engaged in such activities. Students were asked to report how often they participated in the following ten gambling activities: "gambled in other ways," cards, sports pools, lottery tickets, dice, bingo, sports lottery tickets, video gambling machines, any Internet gambling, gambling in an Ontario casino. The following were some of the key findings:

- *"Among all students, 38% report at least one gambling activity during the past 12 months."*
- *"Males (47%) are more likely to report any gambling activity than females (30%)."*
- *"Males are significantly more likely to report multi-gambling activity than females (4% vs. 2% respectively)."*
- *"When we look only among students who report gambling at one or more activities in the past year, 4% may have a gambling problem."*
- *"Males (2%) are more likely than females (1%) to have a gambling problem."*[18]

While this study identified 2% of students as problem gamblers, a study of students in Lethbridge, Alberta found the prevalence rate to be as high as 7.5%.[19]

Looking at the young adult population, Trent University professor, Dr. Jim Parker, published results from a study, indicating that *"…prevalence rates for severe gambling problems were highest among young adults (where 6.9% of adults aged 18 to 24 years had moderate to severe gambling problems)."*[20] In the City and County of Peterborough, we have 13,105 young adults between the ages of 18 and 24. If we assume that Peterborough young adults are comparable to other young adults, there may be as many as 900 young adults dealing with moderate to severe gambling problems.

Prevalence rates for gambling, although low, are still significant. Dr. McKeown, Medical Officer of Health for Toronto Public Health commented recently that a prevalence rate of 2% is similar to the prevalence rates for colorectal cancer, irritable bowel disease, and eating disorders.[21]

Section 2: Access and Proximity to Gaming Venues

The OLG is expanding their operations in an effort to generate more revenue. At the moment, Ontario sits ninth amongst the provinces in the per capita net profit returned to the province ($149 per person) as opposed to Alberta which has the highest return at $463 per person. Expansion means closer and greater access to gaming opportunities in our communities.

As mentioned above, certain gaming activities lend themselves to greater risk of problem gambling including electronic gaming machines (EMGs), also known as slot machines. With the possible introduction of a casino in Peterborough, and a proposed additional 600 slot machines, it can be predicted that the prevalence of problem gamblers will rise as a direct result of having greater access to these gaming activities. Research supports that the most common gaming activities cited when seeking treatment is slot machines and gaming tables.[22]

In the shift to modernize gaming, OLG wants to bring the casinos to the people rather than make the people go to the casino.[23] Research shows, however, that when casinos are readily accessible, more people will become problem gamblers.[24,25] A study in Niagara Falls, showed that problem gambling increased following the opening of the casino.[26] This trend was found in other communities across Ontario (i.e., Sarnia, Sault Ste. Marie, Brantford, and Thunder Bay).[27]

It is important to note that the prevalence rate for problem gambling tends to level off after the first year of operation once the novelty of having a casino wears off. Toronto Public Health's Technical Report stated that, "*[w]hile not all studies have consistently reported negative effects associated with gambling expansion, the overall conclusion is that increased availability of gambling is associated with increased rates of problem gambling*."[28] Adding to the issues of accessibility, many casinos remain open 24 hours a day, seven days a week making gambling accessible all the time.

The greater proximity to a casino also means that the majority of gamblers will be local. A study by the Ministry of Health in New Zealand, found that people living within 80 kilometers of a casino were at greater risk for a gambling problem than those that lived 400 kilometers away. In addition, the study found

> *"…a problem gambler was significantly associated with living closer to gambling venues. People who live in neighbourhoods within walking distance (800m) or close driving distance (5 km) to a gambling venue were more likely to have gambled in the last year, and be a problem gambler who had gambled at a gambling venue in the past year."*[29]

Although it can be anticipated that a new casino will be frequented by tourists, research shows that casinos are populated by local residents. One can assume then, that the majority of problem gamblers will also be local and that the social, health and economic crises that problem gamblers experience will be felt locally.

Section 3: At Risk Populations

Not all gamblers face the same risk of becoming problem gamblers. There are individual and population level factors that make some gamblers more vulnerable. At the individual level, the characteristics that may predict greater risk include "*experiencing an early big win; having mistaken beliefs about the odds of winning; experiencing financial problems; and having a history of mental health problems*."[30] In addition, the problem gambler is more likely to be male, young, with no more than a high school education.[31]

Research has also shown a link between alcohol and gambling. According to one study, the individual with a propensity to heavier drinking was more likely to also be a problem gambler.[32] The results indicate a correlation between the two behaviours rather than a causal relationship. This is of particular note, given that the 2009/10 CCHS survey showed that residents of the City and County of Peterborough consumed more alcohol than the average Ontarian.[33] Since our region already has higher than average alcohol consumption rates, increased gambling in our community may lead to the risk of greater alcohol consumption as well as greater risk of problem gambling. Finally, the combination of both problem drinking and problem gambling may increase the risk of intimate partner violence.[34]

At the population level, there are certain groups at greater risk of becoming problem gamblers including people living on low income, seniors, youth, First Nations people and New

Canadians.[35] The common denominator amongst these groups is financial precariousness which leads to financial risk taking.[36]

Older Adults

It is estimated that 2.2% of older adults in Ontario are problem gamblers.[37] It is common knowledge that the City and County of Peterborough boast a larger than average population of seniors in our community. The latest census shows that there are 27,050 residents over the age of 65 years in the City and County. Assuming that the older adults in Peterborough are no different than other Ontario seniors, we can estimate that there are 595 older adults in Peterborough dealing with problem gambling. At issue for older problem gamblers is that they are less likely to be able to 'bounce back' from the negative consequences. Toronto Public Health reported that,

> "*While older adults do not have higher prevalence of problem gambling compared to other age groups, a number of studies report that problem gambling is associated with worse physical and psychosocial health among older adults. This has been theorized to be related to complex co-morbidities and co-dependencies and lessened ability and time to recover from the health complications, psychological and social problems, and financial difficulty that may follow problem gambling*."[38]

Youth (12 to 24 years)

In a telephone conversation with Dr. Parker from Trent University, he indicated that some research conducted in 2005 with young adults in their first year at Trent and Fleming showed that gambling at a casino has become the new rite of passage for youth who are yet "of age." [39] It is a challenge for them to see if they are able to gain entry despite being underage. He also indicated that the current youth gambling rates seen locally are similar to the youth gambling rates among young students attending colleges and universities in Las Vegas. Introducing a casino, with its easy access and proximity, may contribute to an increase in rates of problem gambling among local youth. Finally, for many people the onset of mental health and addictions issues happens in early adulthood and it appears that young problem gamblers are *"…more likely to report concurrent substance abuse problems, experience mental health problems, and attempt suicide."*[40]

First Nations

Based on information taken from a book entitled, *Gambling and problem gambling in North American indigenous peoples* (2011)[41], Toronto Public Health cited that First Nations people in Canada are approximately four times as likely to become problem gamblers as non-aboriginal people.[42] Toronto's Technical Report suggests that a number of socio-demographic characteristics play a role including: a "*…younger average age and a range of disadvantageous social conditions (e.g., poverty, unemployment, lack of education, cultural stress).*"[43]

People Living on Low Income

As mentioned above, individuals living with financial insecurity are more likely to take financial risks. "*A review of gambling studies reported that lower income people contribute a higher proportion of their income to gambling than people in middle and high income groups*."[44]

Casino Workers
It is estimated that there may be 600 full- and part-time jobs available if a casino opens in our community. This work is somewhat different from other employment opportunities. Granted, many jobs come with certain risks of physical or psychological harm, however, casino workers run the risk of becoming problem gamblers. According to research conducted in Ontario, casino workers are three times more likely to become problem gamblers.[45,46]

While Peterborough has one of the highest unemployment rates, one might assume that many of those individuals looking for work fall into one of the other at-risk populations (i.e., youth, First Nations people and people living on low income), thus amplifying this risk to them.

Section 4: Health Impacts of Problem Gambling

Problem gamblers experience a myriad of health issues including stress, anxiety, depression, suicide, addiction, migraines, chronic bronchitis, fibromyalgia, intestinal disorders and sleep disorders.[47,48] Due to these health issues, 25% of problem gamblers report being under the care of a health care practitioner.[49] Using the work from Toronto Public Health,[50] a list of specific health issues along with supporting information have been summarized in Table 1.

In addition, the consequences of problem gambling, both financial and social, extend beyond the individual to affect family, friends, co-workers, employers, and other members of the community. One report mentioned that for every problem gambler, three to four individuals are also affected.[51] Some of the more common problems faced by problem gamblers and the people in their lives include divorce, family breakdown, compromised child development through neglect and poverty, lost productivity and job loss.[52]

It seems the impact of problem gambling will be passed along to the next generation as well. One report indicated that, *"[r]esearch also shows that the health impacts of problem gambling can be intergenerational with the children of problem gamblers being more likely to use tobacco, alcohol or drugs, and develop psychosocial problems, educational challenges, and emotional disorders throughout their lives. Children of problem gamblers are also at greater risk of becoming problem gamblers themselves*."[53]

Section 5: Financial and Social Costs of Gambling Behaviour

In 2003, Ontarians spent just over $4 billion on gambling, or $427.60 per capita that year.[54] However, gambling expenditures are not divided up equally amongst all Ontarians. One study found that in 2003, problem gamblers represented 4.8% of all gamblers in Ontario yet they represented 36% of all gambling revenue.[55] Another study in 2006 found that problem gamblers accounted for between 30 and 40% of all gambling revenue.[56] As previously mentioned, problem gambling is more likely to occur when electronic gaming machines are accessible. Almost two-thirds of revenue generated in Ontario by these machines comes from problem gamblers.[57] If problem gamblers still represent 36% of the gambling revenue, they contributed $1.3 billion in 2012.

Table 1. Health Impacts Associated with Gambling Reported in the Literature

Health Issue	General Summary of Findings	Supporting quotes
General Health	✓ Lower self-reported general health and well-being ✓ Colds and influenza ✓ Headaches, including severe and chronic headaches and migraines ✓ Fatigue and sleep problems ✓ Health conditions such as chronic bronchitis and fibromyalgia ✓ Other miscellaneous health symptoms (including cardiovascular, cognitive, skin and gastrointestinal problems, heart burn, backache) that may be stress-related	▪ *"…61% of non-problem gamblers rated their health as excellent or very good compared to 49% of low to moderate-risk gamblers and 33% of problem gamblers. Seventy-seven percent of problem gamblers reported gambling as the cause of health problems compared to 11% of low to moderate-risk gamblers."* ▪ *"Many of the health impacts are theorized to be a function of stress and strain."*
Mental Health	✓ Stress ✓ Depression ✓ Mood, anxiety and personality disorders	▪ *"…76% of non-problem gamblers rated their mental health as excellent or very good compared to 69% of low to moderate-risk and 35% of problem gamblers."*
Co-dependencies	✓ Alcohol, tobacco and drug use ✓ Problematic substance use/addiction	▪ *"According to TPH analysis of CCHS data, 33% of problem gamblers in Ontario reported using alcohol or drugs while gambling in the previous 12 months."* ▪ *"…low to moderate-risk (30%) and problem gamblers (38%) are significantly more likely to be daily smokers compared to non-problem gamblers."* ▪ *"The existence of co-dependencies and related morbidities underlines the complex causality of problems experienced by problem gamblers, where problem gambling may exacerbate other dependencies, and they in turn may exacerbate problem gambling."*

Health Issue	General Summary of Findings	Supporting quotes
Suicide		▪ *"According to TPH analysis of 2007/08 CCHS data for Ontario, a significantly higher proportion of problem gamblers reported having thoughts of committing suicide in their lifetime compared to non-problem gamblers."*
Family and Community Impacts	✓ Financial problems (increase in bankruptcies) ✓ Alcohol or fatigue-related traffic fatalities ✓ Family breakdown and divorce ✓ Family/intimate partner violence ✓ Familial psychological problems including stress and loss of trust ✓ Child development, neglect and poverty	▪ *"…it has been estimated that the proportion of people whose quality of life may be negatively impacted by problem gambling is actually three or four times the rate of problem gambling prevalence in the general population."* ▪ *"Financial difficulties can produce adverse effects such as the inability to pay for essentials such as food or housing, which are issues of public health concern."* ▪ *"Research has revealed a link between the presence of a casino and an increase in driving while impaired or extremely tired."* ▪ *"In the previous 12 months, 75% of problem gamblers reported gambling as the cause of financial problems for their families, 62% of problem gamblers reported lying to their family members and others about gambling, and 30% reported gambling as the cause of problems with relationship with family or friends."* ▪ *"…indirect consequences for the problem gambler's friends and families, such as emotional distress, depression, and even suicide. It may also negatively affect child development and well-being."*

Of the $3.7 billion generated by OLG in 2012, $53.9 million (1.46%) of the profits are directed to prevention, treatment and research.[58] Other provincial level expenditures generated by problem gambling have not been quantified but would include additional costs for *"…medical care, policing, courts, prisons, and social assistance, all of which represent significant public costs."*[59] At the individual and community level, problem gambling costs the individual (e.g., bankruptcy, job loss, homelessness), families (e.g., divorce, family breakup), workplaces (e.g., lost productivity, job loss), and the community (e.g., fraud, theft).[60]

One report stated that the estimated *"…annual cost associated with each problem gambler ranges from $20,000 to $56,000, including loss of work and court and treatment costs*."[61]

Supports for Problem Gamblers

According to Donna Rogers, Executive Director of FourCAST, a local addictions treatment service in Peterborough, 49 problem gamblers were admitted for treatment in 2012.[62] This number is consistent with the research that shows that only 1 – 2% of problem gamblers seek treatment.[63]

The research also shows that the problem gambler who seeks treatment does not fit the profile of the average problem gambler. Those who reach out are more like to have higher education and to be middle-aged (35 - 44 years) while the typical problem gambler is young, has a low income and less education. As a result, those gamblers most at risk are slipping through the cracks. One could argue that gambling addiction is where alcohol addiction was a few decades ago where stigma and shame present barriers to seeking treatment. Interestingly, research shows that if the treatment intervention is further away than the gambling venue, the problem gambler is less likely to seek help.[64]

Section 6: Social Health of the Community

Table 2, developed by Toronto Public Health, provides a summary of a number of broader social issues that may be affected by having a casino in our community.[65]

Employment

With the strong emphasis placed on the value of bringing jobs to the Peterborough area it seems appropriate to address the health impacts of this type of employment. Employment and working conditions are social determinants of health and it is important to look at the types of jobs available in a casino to determine their impact on employee health.

First, it has already been stated that casino workers are three times more likely to become problem gamblers. The exposure and familiarity with the gambling activities may make some workers more vulnerable.

Table 2. A summary of the Impact of a Community Casino on Select Social Issues

Social Issue	Potential Area of Impact	Predicted Change	Predicted Impact	Explanatory Notes
Employment	Local jobs increase	Increase	Positive	Improve health
	Shift work	Increase	Negative	Decrease in benefits of increased employment
	Regional unemployment rate	No change	No effect	No effect on health
Economic Development	Tourism	Increase	Mildly positive	May be new jobs; could be good for health
	Local business development	Increase or decrease (depends on cannibalization of businesses)	Inconclusive	Either positive or negative
Crime	Property crime	No change or possible increase	Neutral or negative	Possibly worsen or leave health unchanged
	Violent crime	No change or possible increase	Neutral or negative	Possibly worsen or leave health unchanged
Neighbourhood impacts	Traffic volume and congestion	Increase	Negative	Worsen health
	Air pollution (e.g., diesel from idling buses)	Increase	Negative	Worsen health
	Motor vehicle collisions (from fatigue, alcohol)	Increase	Negative	Worsen health
Social safety net	Public service funding	Increase	Positive	Improve health
	Public service demand	Increase	Negative	Worsen health

Second, a poverty reduction group in Hamilton scanned OLG job ads on-line *"…and found that many positions within the OLG pay scale fall below a living wage: part-time servers start at $10.84 per hour, coat check attendants start at $11.64, housekeepers start at $13.64*."[66] At the moment, casino workers in Ontario are employees of OLG. With OLG shifting its role as an overseer rather than employer, the workers in the new facilities will be employed by the casino operators. We do not know what the wage ranges will be and whether or not these workers will have healthy employment (i.e., full-time, permanent, with benefits and pensions). The research is very clear that workers who are precariously employed (i.e., part-time, temporary, contract work with no pension or benefits) have the worst health outcomes of all workers.[67]

Finally, casinos operate many hours (if not 24 hours) a day which requires shift work. Shift and night workers experience poorer health than workers who work during the day due to disruptions in sleep which can lead to fatigue, insomnia and other sleep disturbances. This fatigue results in greater injuries on the job and on the road commuting to work.[68] In addition, shift workers are more prone to develop certain chronic illnesses especially cancer. According to the report from the Institute for Work and Health, "*[t]he International Agency for Research on Cancer (IARC) classified 'shift work that involves circadian disruption (i.e., night shift work) as a probable human carcinogen (Group 2A)*."[69]

In one study, a number of risk factors that could affect casino employees were identified.[70] Some of these risk factors include: normalized gambling and heavy gambling; high alcohol consumption; workplace stress creating urges to gamble; limits on social life (due to shift work); increased access to gambling; socio-demographic characteristics of staff (young which means fewer family and financial obligations). Conversely, the same study identified some protective factors: exposure to problem and heavy gamblers; awareness of gambling losses; knowledge of responsible gambling; awareness of poor odds.

A discussion about the possibility that a casino would take jobs away from other similar businesses is not appropriate for this report but an issue that should be considered.

Section 7: Current Practices In Dealing With Gambling

A number of measures at a variety of levels are needed to prevent problem gambling, to promote responsible gambling and to help those people who are addicted to gambling.

Prevention

While one youth-based education program focused on probability and chance has shown some promise,[71] public health initiatives have shifted to focus on public policy which seems to have a broader, more sustainable impact. In the case of gambling policy, the focus would need to be at the provincial level rather than the individual casino level. Public policies change our environment *"…through the alteration of external environmental controls on the availability and provision of gambling. Typically these policies take the form of restrictions on the general availability of gambling, who can gamble, and how gambling is provided."*[72] More will be said about policies in the harm reduction section.

Problem Gambling Responses

As in many instances of health risks, early detection is paramount. Given the shame and stigma that a problem gambler may feel, it is imperative that primary health care providers stay alert to the signs of a gambling addiction.[73]

There are different treatment modalities used to support a problem gambler including cognitive-behavioural therapy, drug therapy, "talk" therapy, on-line and self-help support. Research indicates that talk and drug therapies seem be effective.[74]

The casinos also have different programs geared to supporting problem gamblers. The most notable are self-exclusion programs. The challenge with self-exclusion programs is that the problem gambler is relying on the casino staff to recognize and bar them entry to the establishment. For this reason, self-exclusion programs in general are not very effective.[75] OLG does have a number of strategies in place to keep self-excluders out of their casinos. The strategies include: "*face recognition at casino entry, removing self-excluders' names from the corporation's marketing database, and connecting individuals with available treatment providers*."[76] In addition, the program is used by a very small number of problem gamblers: "*It is estimated that 0.6 - 7.0% of problem gamblers sign up to self-exclude in Canada*."[77]

Other strategies implemented by OLG include: clocks at the gaming floors, not extending credit, and "…*introducing and implementing a fatigue impairment policy, which trains gaming staff to assess patrons for signs of fatigue, and respond according to escalation procedures*."[78]

Funding

As previously mentioned, a portion of the gambling revenue (1.5%) is directed to treatment, prevention/awareness and research. In 2005/06, $36.7 million was allocated to treatment ($24.17M - 66%), prevention/awareness ($8.47M - 23%), and research ($4.01M - 11%).[79] Some of the initiatives that continue to receive this funding include: OLG (www.knowyourlimit.ca), Responsible Gambling Council Ontario (http://www.responsiblegambling.org/), CAMH's Problem Gambling Institute of Ontario (http://www.problemgambling.ca), the Ontario Problem Gambling Research Centre (http://www.gamblingresearch.org/), and more than 50 community agencies (including FourCAST in Peterborough) located throughout the province.[80]

Harm Reduction Strategies

As Williams and Wood stated,

> "*It is also not clear that a massive increase in the amount of money redirected to prevention and treatment is needed, as the waiting lists are short. Rather, what is needed is the implementation of effective policies to minimize the negative impacts of gambling and substantially reduce the disproportionate financial draw from problem gamblers*."[81]

Harm reduction, the practice of identifying possible risks and developing strategies to mitigate those risks, is part of a public health response. It is important to recognize that some people will

take risks and that we need to provide strategies for reducing or eliminating those risks. With respect to gambling behaviour, many of the changes would be best applied at a provincial level through policy change. By adopting new public policies, we can contribute to reducing the harms of gambling at a provincial level which also benefits our community and the individuals who live in it.

Toronto Public Health has recommended the following practices for mitigating the risks of gambling:

1. *Limiting hours of casino operation: no 24-hour access to venues, closed at least 6 hours per day;*
2. *Restricting the number of electronic gaming machines (EGMs) and slowing down machine speed of play and features that promote false beliefs of the odds of winning;*
3. *Eliminating casino loyalty programs;*
4. *Prohibiting ATMs on the gambling floor;*
5. *Prohibiting casino credit and holding accounts;*
6. *Reducing maximum bet size;*
7. *Mandating a daily loss maximum;*
8. *Implementing strong casino self-exclusion programs, including a mandatory player card system;*
9. *Issuing monthly individual patron statements which include full membership medians and averages to compare against personal record of loss, frequency and duration of play;*
10. *Designating areas for alcohol purchase and not providing alcohol service on casino floors to reduce impaired judgement.*[82]

The policy strategies above would reduce the risk for all gamblers. There are also harm reduction strategies that could be adopted to protect the employees working in the casino. Some of the strategies presented by Hing and Breen include: more staff training, a stronger culture of responsible gambling, promoting staff wellbeing, no gambling in the workplace, limiting access to cash, limiting exposure to gambling, having supportive management attitudes, providing alternative jobs and assisting with help-seeking.[83]

If a Peterborough municipality chooses to move ahead with hosting a casino, a “social contract” with the casino operator could be considered. The contract would include a variety of conditions that would address local economic, health and social concerns. A document from the City of Toronto describing the various components that could be included in a casino social contract has been included in Appendix A.

Conclusion

Initiated by the provincial government via OLG, it is the province that will receive the greatest benefit from revenues generated by gaming. While our local municipalities may receive a portion of the revenues, our communities will also experience greater costs as rates of problem gambling increase. These costs will not only be borne by the people who will gamble but the employees of the casino, family and friends of the gamblers, as well as co-workers and workplaces, local businesses (especially in the service and hospitality industries), law enforcement and justice system.

When making the decision whether or not to host a gambling facility, the social and health impacts should be weighed alongside any economic and employment benefits. Gambling impacts certain vulnerable sectors of the population and takes disproportionate amounts of money away from the people who can least afford to spend it. Williams and Wood stated very clearly that *"[g]ambling revenues largely come from a transfer of wealth, rather than a creation of wealth*."[84] They also said: "*If a substantial portion of gambling revenue is derived from problem gamblers, then it creates serious ethical problems for governments involved in this business.*"[85]

A new casino in the Peterborough area could have important positive and negative community impacts. Available evidence indicates that the introduction of a casino is likely to have greater adverse health-related impacts than beneficial impacts.

Appendix A – Toronto Casino Social Contract

Toronto Casino Social Contract:

WHAT IS A TORONTO CASINO SOCIAL CONTRACT?

City Council's Executive Committee directed the City Manager to give consideration to the establishment of a signed "social contract" between the City of Toronto and the Ontario Lottery and Gaming Corporation (OLG), should Council decide to proceed with the establishment of a new casino in Toronto.

A Social Contract would lay out expectation and ensure commitments between government, the private sector, institutions and society on how the social benefits of a casino will be realized and the negative societal impacts will be addressed. The Contract would clearly define the relationship between a potential casino operator, the provincial and municipal governments and the greater community.

A Toronto Casino Social Contract would emphasize commitment from all parties towards:

- **Partnership** – working together to build sustainable community and city-wide relationships and initiatives which benefit Toronto residents
- **Open and Inclusive Dialogue** – identifying priorities, developing solutions and avoiding marginalization of residents throughout the development and operation of a new Toronto casino.
- **Strengthening Toronto through Investment** – supporting economic opportunities for individuals, communities and the city, with a focus on vulnerable groups disproportionately impacted by economic uncertainties (e.g. youth, unemployed and underemployed individuals and newcomers).
- **Addressing Impacts on Toronto's Social Fabric** – proactively addressing the negative impacts of problem gambling through prevention, intervention, treatment and harm mitigation initiatives based on internationally recognized 'best practices'.
- **Independent Monitoring and Analysis** – supporting regular independent monitoring and analysis of the social, health and economic impact of casino operations on Toronto communities and residents to keep the Toronto Casino Social Contract relevant, transparent and accountable to Torontonians.

The Toronto Casino Social Contract would support sustainable social development, expanded economic opportunity and contribute to the vitality of Toronto's neighbourhoods.

JANUARY 2013 | TORONTO

Appendix A – Toronto Casino Social Contract (cont.'d)

Toronto Casino Social Contract:
WHAT WOULD A CASINO SOCIAL CONTRACT ADDRESS?

SOCIAL PROCUREMENT – When businesses use their purchasing power to add social and economic benefits to communities including:

- Increased employment and training opportunities during construction and operations of a casino - Targeted employment and apprenticeship opportunities for groups disproportionately impacted by economic uncertainties as part of casino construction contracts. Employment strategies for casino operations which also provide meaningful employment and skills training opportunities for groups disproportionately impacted by economic uncertainties.

- Opportunities for local businesses to compete for the delivery of goods and services, and fair and equitable access to purchasing contracts by diverse business suppliers - Suppliers which reflect the diversity and multicultural heritage of Toronto so that diverse businesses are considered during the procurement, development and operations of a Toronto casino without compromising cost or quality.

COMMUNITY USE OF SPACE: Under planning and development legislation and related agreements, the City could seek agreement with casino operators and OLG to provide free/low-cost access to facilities such as live entertainment venues, meeting spaces and support services to communities.

HARM MITIGATION STRATEGY: The Toronto Medical Officer of Health identified a number of measures and strategies to mitigate the negative social and public health impacts of problem gambling associated with expanded gaming opportunities. As a condition of operating a casino in Toronto, a comprehensive strategy to proactively address problem gambling and its related impacts on residents will be developed and implemented by casino stakeholders including both orders of government, the casino operator, independent problem gambling experts and community service providers.

MONITORING AND ASSESSMENT: Part of the harm mitigation strategy requires the ongoing assessment of the social, economic and health impacts of a casino on Toronto communities and residents. Regular assessments by an independent body will include measuring and publicly reporting the impacts on residents and efforts to mitigate problem gambling.

The Ontario Lottery and Gaming Commission (OLG) collects data on the activities of casino patrons to support its responsible gaming programs and other business activities and provides this anonymous data to researchers as part of the Ontario Problem Gambling Strategy. As a condition of operating a casino in Toronto, the Toronto Casino Social Contract would include access to this data, funding for independent casino research and a robust independent body to monitor, analyze and support the development of 'best practices'. A monitoring body would include independent experts (e.g. the Centre for Addiction and Mental Health), the provincial and municipal governments, casino operators, private sector organizations, addiction services sector, labour sector, and community-based service planners and providers.

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Appendix A – Toronto Casino Social Contract (cont.'d)

Toronto Casino Social Contract:
A FOUNDATION OF EXPERIENCE:

The City of Toronto has a proven history in social procurement practices and social contract agreements including:

1652 COMMUNITY HUB

As part of the 2006 redevelopment of a youth-focused community hub at 1652 Keele Street in Weston-Mount Dennis, the City of Toronto and its partners secured socio-economic benefits for local youth. The funding agreement stipulated that an employment strategy targeted to local, unemployed youth was to be incorporated into the redevelopment. HSI Solutions, the successful proponent under the procurement process, hired 10 local youth into construction positions.

REGENT PARK REVITALIZATION

In 2003, Toronto City Council approved the Regent Park Revitalization plan which included the revitalization of Toronto Community Housing Corporation residential buildings and the development of new market-value residential facilities and amenities. The redevelopment process promised significant employment and training opportunities. Through the Regent Park Employment Engagement Initiative over 1600 residents received services, 38 employers have been engaged, and approximately 570 residents have been hired into positions.

PAN/PARAPAN AM GAMES TORONTO 2015

City staff have provided advice and support to TO2015 and other Games partners regarding the creation of plans which aim to increase access to employment and training opportunities for underemployed and unemployed City residents. It is expected the Pan/Parapan Am Games will create approximately 15,000 jobs in the Greater Toronto Area through the development of the infrastructure and operations required to deliver the Games.

WOODBINE ENTERTAINMENT GROUP

Working with the Woodbine Entertainment Group, who owns the racetrack and gaming facility on Rexdale Boulevard near Highway 427, the City reached a Community Improvement Plan agreement that involved a local hiring and employment strategy. The Plan included advance notice of new jobs and priority hiring for local residents as well as apprenticeship programs.

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Small Drinking Water Systems Update

Presentation to: Board of Health
By: Chris Eaton,
Public Health Inspector
Date: March 13, 2013

Peterborough County-City
HEALTH UNIT
...because health matters!

Legislative History

- 2007 HPPA amended – oversight of SDWS transferred from MOE to MOHLTC
- Ontario Regulation 318/319 took effect December 1, 2008
- OPHS, Drinking Water Protocol, 2008 reflected these new responsibilities

Examples of Premises That Are SDWS

- Community centre
- Arena
- Library
- Church
- Restaurant
- Resort
- Rental cottages
- Motel
- Bed and breakfast
- Seasonal trailer park
- Gas station
- Other public facilities

Examples of Premises That Are Not SDWS

- Municipal systems such as Peterborough, Lakefield or Norwood
- Smaller municipal systems such as Crystal Springs or Alpine Village
- Schools, nursing homes or daycares not on municipal systems

Peterborough County-City HEALTH UNIT
...because health matters!

Phase 1 of Implementation of SDWS Program

- Identify, assess and issue a directive for every SDWS in Peterborough County and City
- MOHLTC set a deadline of Dec. 31, 2011
- We did it!
- 310 SDWS as of the deadline
- 2.5 PHIs to accomplish this

Peterborough County-City
HEALTH UNIT
...because health matters!

Phase 2 of Implementation of SDWS program

- Routine reassessments
  – high risk every 2 years
  – medium and low risk every 4 years

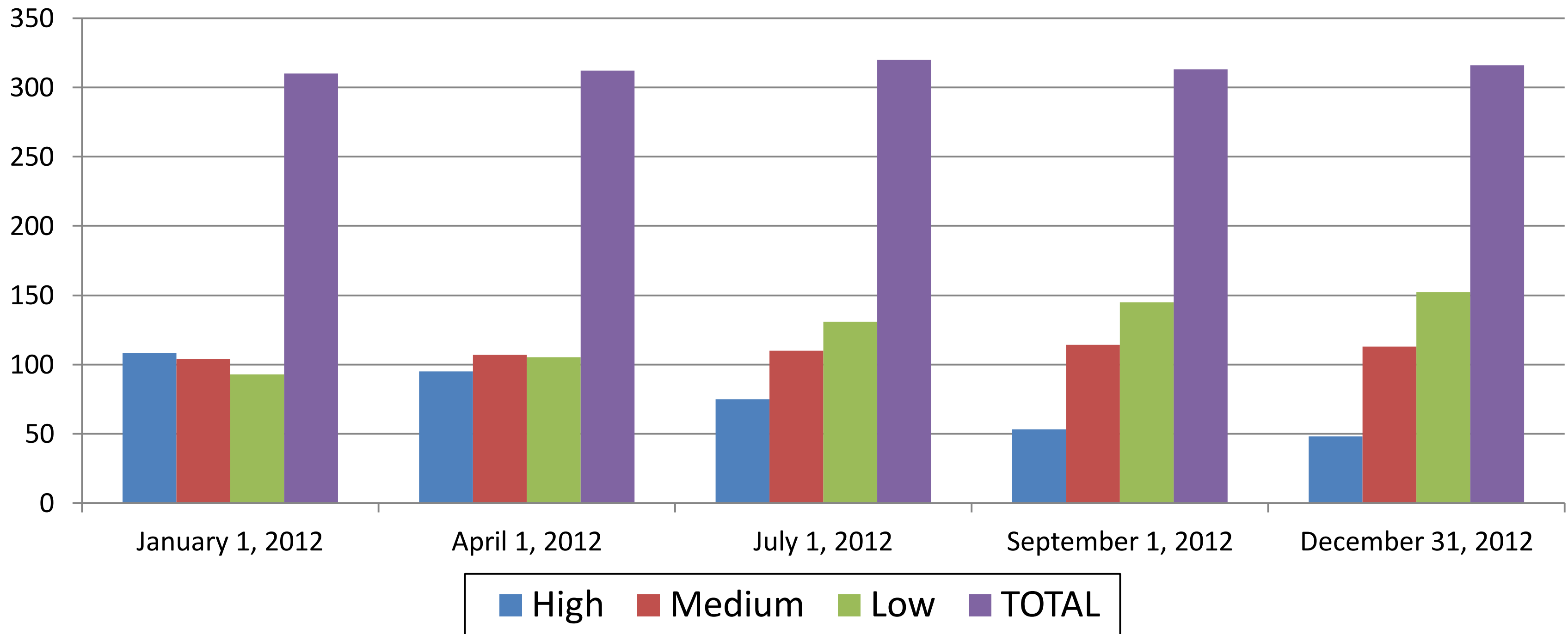
	2013	2014	2015	2016
High	22	26	?	?
Medium	5	48	24	36
Low	4	36	53	59
Total	31	110	?	?

Peterborough County-City HEALTH UNIT ...because health matters!

Phase 2 of Implementation of SDWS program

- Routine assessments
  - – high risk every 2 years
  - – medium and low risk every 4 years
- Compliance with requirements of directives
- Sampling compliance
- Monitoring inventory of SDWS

Number of SDWS by Risk Category by Quarter, 2012



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Trailer Park (30 sites)

Peterborough County-City
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Trailer Park (30 sites)

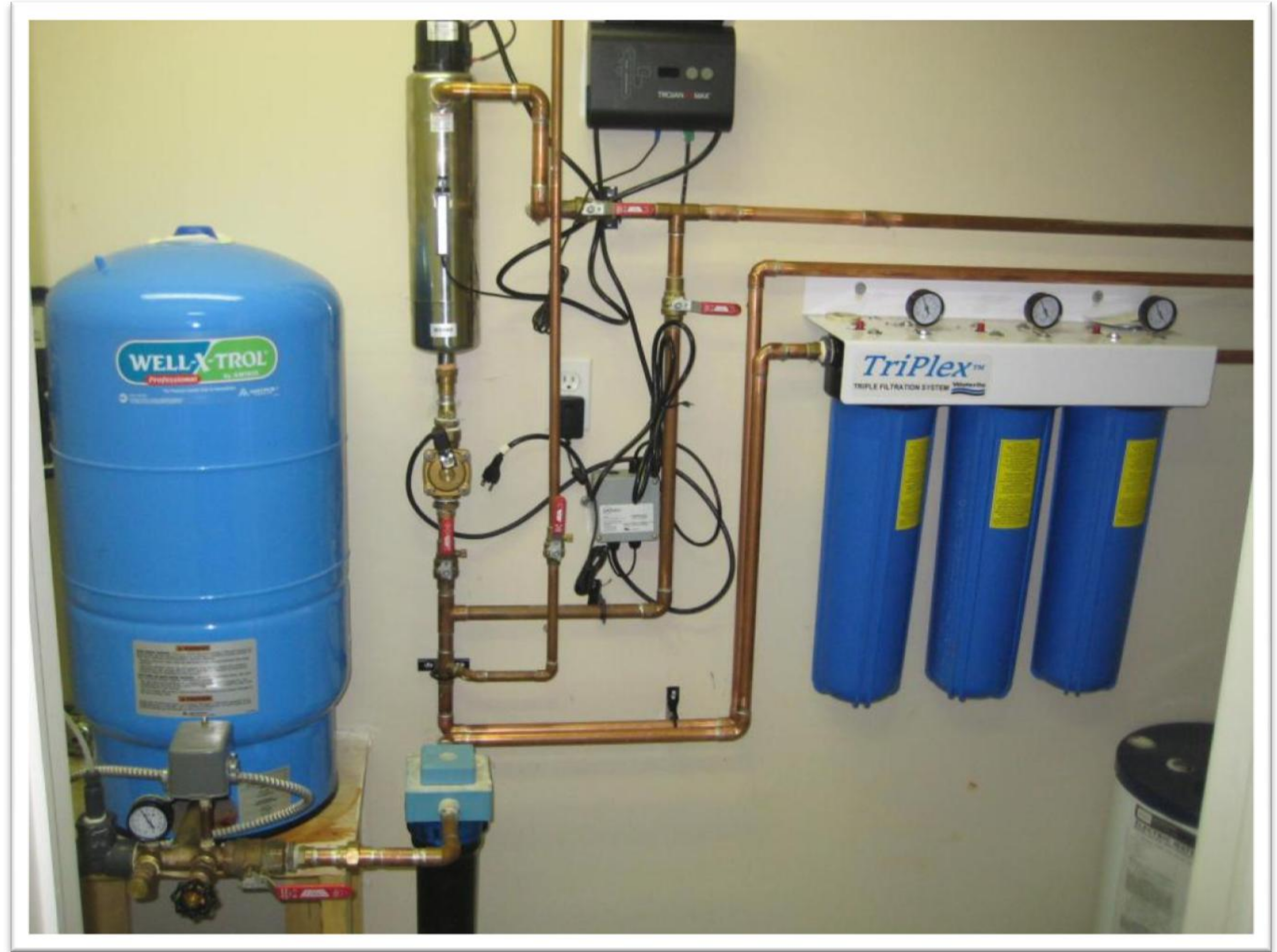
Recreational Facility

Recreational Facility

Municipal Building

Peterborough County-City HEALTH UNIT ...because health matters!

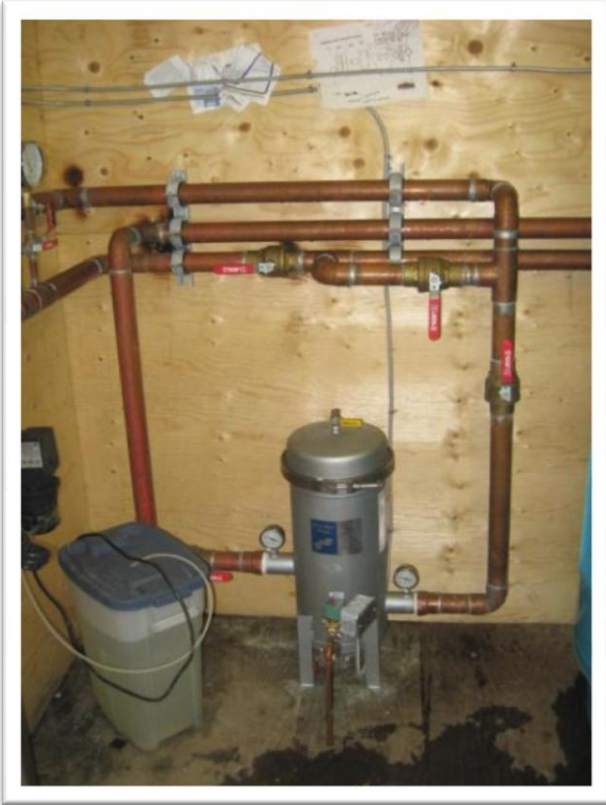
Municipal Building



Church (with a private school)

Resort – 15 rental cottages

Trailer Park – 100+ Sites



Questions?

2011 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

Maintaining the Gains, Moving the Yardstick:

Ontario Health Status Report, 2011

<u>Maintaining the Gains, Moving the Yardstick:</u>

2011 Annual Report of the Chief Medical Officer of Health, Dr. Arlene King.

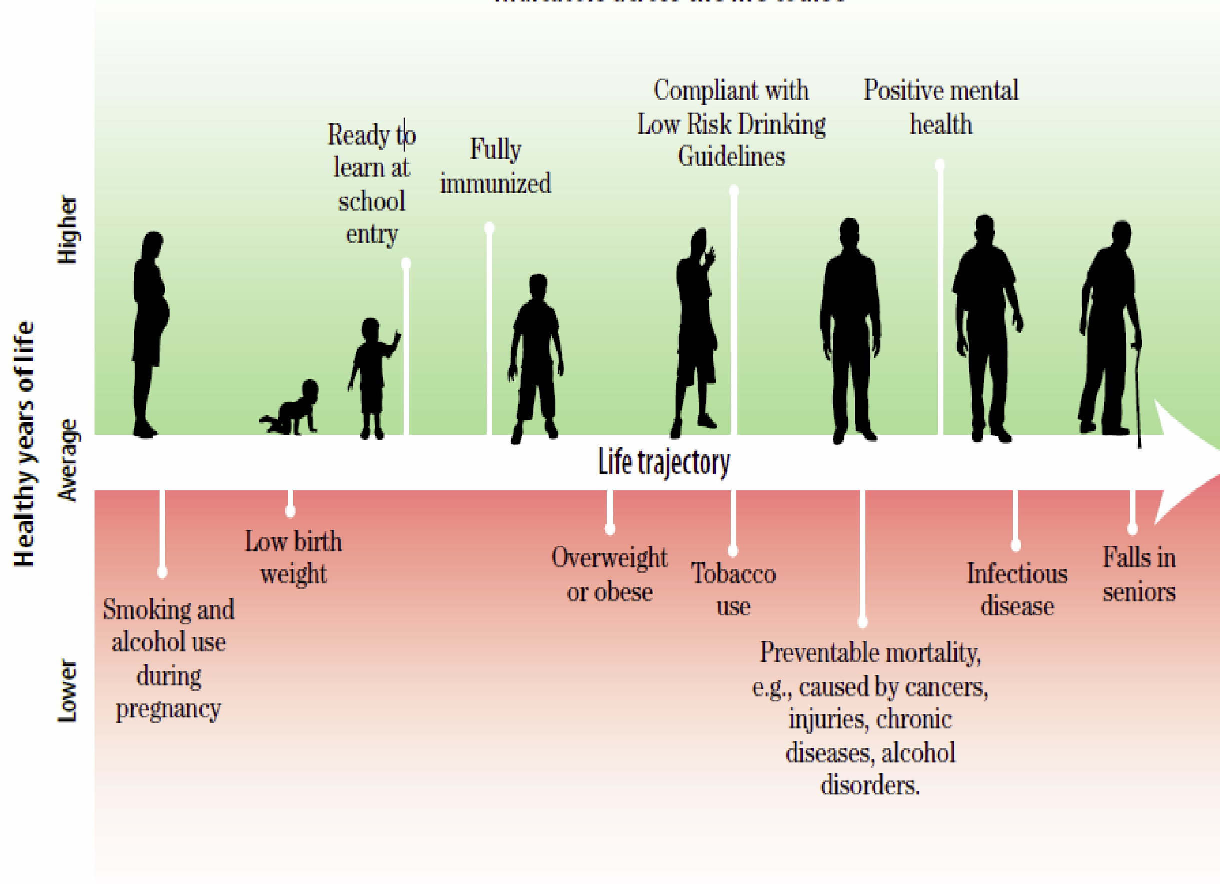
Ontario Health Status Report

Overview

- CMOH 2011 Annual Report, identifies 12 health indicators which address some key current health challenges.
- The selected indicators track the 'life course' of Ontarians, to show that an individual's health at any given point is influenced by a variety of factors throughout life.
- The report offers baseline measurements for these indicators against which progress can be measured over time, and which can be revisited in future reports.

Vision

- The vision for Ontarians is that:
  - Babies are born healthy;
  - Pre-school children are able to achieve their potential;
  - Children and young people are healthy and equipped for adulthood;
  - Working adults live longer, healthy lives; and,
  - Seniors are able to enjoy a long and healthy retirement.
- How well we do in achieving the above goals can be measured by the 12 health indicators presented in the CMOH 2011 annual report.


Indicators across the life course
Healthy years of life
Higher
Average
Lower
Ready to learn at school entry
Fully immunized
Compliant with Low Risk Drinking Guidelines
Positive mental health
Life trajectory
Smoking and alcohol use during pregnancy
Low birth weight
Overweight or obese
Tobacco use
Preventable mortality, e.g., caused by cancers, injuries, chronic diseases, alcohol disorders.
Infectious disease
Falls in seniors

Indicators

- Smoking and alcohol use during pregnancy
- Low birth weight
- Healthy child development at school entry
- Immunizations coverage of school pupils
- Smoking prevalence
- Overweight and obesity
- Preventable mortality
- Compliance with the Canadian Low-Risk Drinking Guidelines
- Self-reported positive mental health
- The burden of infectious diseases
- Hospitalizations for falls in seniors
- Life expectancy at birth

Indicators II

- Each indicator relates to one of the priority themes from previous reports such as: healthy human development, preventing injuries and chronic diseases and reducing health inequities.
- Indicators are discussed in terms of:
  - significance to the health of Ontarians;
  - why it is important from a life course perspective;
  - activities underway to address it;
  - opportunities for improvement;
  - differences by sex and age group;
  - differences related to socioeconomic status, and
  - how they relate to First Nations, Inuit and Métis Ontarians.

Indicator: Low Birth Rate

	Ontario	Peterborough	+/-
Both Genders	48.5	41.7	(6.8)
Male	46.5	49.0	2.5
Female	50.6	33.8	(16.8)

Note: LBW/1,000 Births

Source: Supplementary Public Health Unit Data
Tables for the 2011 CMOH Annual Report (originally released February 7, 2013)
Prepared by: Analytic Services Unit, Knowledge Services, Public Health Ontario

Indicator: Daily, Occasional Smokers

	Ontario	Peterborough	+/-
Both Sexes Combined	19.0	19.5	0.5
Males	22.6	19.4	(3.2)
Females	15.5	19.6*	4.1

Note: Figures are weighted %

**interpret with caution due to high sampling variability*

Source: Supplementary Public Health Unit Data Tables for the 2011 CMOH Annual Report (originally released February 7, 2013)
Prepared by: Analytic Services Unit, Knowledge Services, Public Health Ontario

Indicator: Body Mass Index

	Ontario	Peterborough	+/-
Youth (12 – 17)	27.1	35.3*	8.2
Adults (18+)	52.5	55.4	2.9

Note: Figures are weighted %

**interpret with caution due to high sampling variability*

Source: Supplementary Public Health Unit Data
Tables for the 2011 CMOH Annual Report (originally released February 7, 2013)
Prepared by: Analytic Services Unit, Knowledge Services, Public Health Ontario

Indicator: Deaths from Preventable Causes

		Ontario	Peterborough	+/-
Both Genders Combined	Cases	15218	223	
	Crude Rate	124.6	178.1	
	Age Std. Rate	106.3	127.7	21.4
Males	Cases	9988	140	
	Crude Rate	163.8	225.8	
	Age Std. Rate	144.2	170.4	26.2
Females	Cases	5320	83	
	Crude Rate	85.5	131.3	
	Age Std. Rate	70.5	86.9	16.4

Source: Supplementary Public Health Unit Data
Tables for the 2011 CMOH Annual Report (originally released February 7, 2013)
Prepared by: Analytic Services Unit, Knowledge Services, Public Health Ontario

Indicator: Low Risk Drinking Guidelines

	Ontario	**Peterborough**	**+/-**
Compliance with Guideline #1 (risk of chronic disease)	77.7	68.5	(9.2)
Compliance with Guideline #1 (risk of injury)	64.2	52.9	(11.3)
Compliance with Both Guidelines	59	49.4	(9.6)
Compliance with Neither Guideline	17.1	28	10.9

Note: Figures are weighted %

Source: Same as previous

Indicator: Positive Mental Health Status

	Ontario	Peterborough	+/-
Both Genders Combined	74.1	72.1	(2)
Male	75.2	67.6	(7.6)
Female	73	76.3	3.3

Note: Figures are weighted %

Source: Supplementary Public Health Unit Data
Tables for the 2011 CMOH Annual Report (originally released February 7, 2013)
Prepared by: Analytic Services Unit, Knowledge Services, Public Health Ontario

Indicator: Hospitalization for Falls among Seniors

		Ontario	Peterborough	+/-
Both Genders Combined	Cases	25253	393	
	Crude Rate	1377	1481.4	
	Age Std. Rate	1186.9	1226	39.1
Males	Cases	7814	112	
	Crude Rate	967.4	954.3	
	Age Std. Rate	926.5	883.7	(42.8)
Females	Cases	17439	281	
	Crude Rate	1669.4	1899.7	
	Age Std. Rate	1368.2	1462.5	94.3

Source: Supplementary Public Health Unit Data
Tables for the 2011 CMOH Annual Report (originally released February 7, 2013)
Prepared by: Analytic Services Unit, Knowledge Services, Public Health Ontario

Indicator: Life Expectancy at Birth

	Ontario	Peterborough	+/-
Both Genders Combined	81.5	80.9	(0.6)
Male	79.2	78.8	(0.4)
Female	83.6	82.9	(0.7)

Source: Supplementary Public Health Unit Data
Tables for the 2011 CMOH Annual Report (originally released February 7, 2013)
Prepared by: Analytic Services Unit, Knowledge Services, Public Health Ontario

Some Key Messages

- We have much to be proud of in Ontario, and have made significant strides in improving our health.
- However, for almost all the indicators, disadvantaged and Aboriginal Ontarians bear a disproportionate burden of poor health, disease and premature death.
- The good news is that the right supports and interventions throughout the lifespan can improve negative life trajectories.
- To maintain the gains, we must continue to provide and advocate for core public health activities like immunization, drinking water fluoridation and enhanced food safety.

Moving Forward

- The challenges highlighted by the health indicators are not simple ones to overcome
- They will require *co-ordinated*, government-wide and multi-sectoral approaches.
- In many instances, current programs/activities related to each indicator will need to be identified and aligned “vertically” (at federal, provincial, regional and local levels) and “horizontally” (across the health and non-health sectors)
- This is not about spending more money – it is about getting better value for money through better alignment and integration of current efforts

Strategic Plan for the Public Health Sector

- The CMOH, in cooperation with the Public Health Leadership Council (PHLC) are working on a strategic plan for the public health sector in Ontario, which will be released through a special report in the Spring of 2013.
- The strategic plan will address many of the issues and priority areas identified in the Annual Report, including stronger collaboration with the health care, as well as non-health sectors.

APPENDICES

Indicator Definitions

- **Smoking and alcohol use during pregnancy**: estimates of the proportion of women aged 15-55 years who smoked or consumed any alcohol during their most recent pregnancy.
- **Low birth weight**: estimates the rate of singleton births (not babies born in multiple births) at a low birth weight (500-2,499 grams).
- **Healthy child development at school entry**: measures the percentage of children who are "ready to learn" at school entry.
- **Immunization coverage of school pupils**: measures the immunization coverage for school pupils for the required immunizations under the Immunization of School Pupils Act.

Indicator Definitions II

- **Smoking prevalence**: an estimate of the proportion of people 12 and older who are current smokers (daily or occasional cigarette smokers).
- **Overweight and obesity**: estimates the number of people aged 12-17 (youth) who self-reported to be overweight or obese according to WHO BMI-for age, and adults 18+ who self-reported to be overweight or obese according to WHO/Health Canada guidelines.
- **Preventable mortality**: measures the number of deaths of Ontarians, younger than 75, from preventable causes.
- **Compliance with Canada's Low-Risk Alcohol Drinking Guidelines**: identifies the number of people 19 or older who are complying with Canada's Low-Risk Alcohol Drinking Guidelines; that is, not consuming alcohol at levels that exceed the guidelines.

Indicator Definitions III

- **Self-reported positive mental health**: measures the population aged 12 and over who report perceiving their own mental health status as being good or very good.
- **The burden of infectious diseases**: measures cases of the most burdensome infectious diseases in Ontario.
- **Hospitalizations for falls in seniors**: measures the number of seniors who were admitted to hospital as a result of a fall.
- **Life expectancy at birth:** the number of years a person is expected to live, starting at birth.

Advisory Committee Members

External Members

- Dr. Adalsteinn Brown, Director, Institute of Health Policy, Management & Evaluation, University of Toronto
- Dr. Charles Gardner, Medical Officer of Health, Simcoe Muskoka District Public Health Unit
- Dr. Vivek Goel, President and Chief Executive Officer, Public Health Ontario
- Dr. Ben Levin, Professor and Canada Research Chair in Education Leadership and Policy, Ontario Institute for Studies in Education, University of Toronto
- Dr. Doug Manuel, Senior Scientist, Clinical Epidemiology, Ottawa Hospital Research Institute

Advisory Committee Members II

Provincial Government Members

- Sarah Cox, Senior Advisor, Office of the Chief Medical Officer of Health and Executive Director, Public Health Division
- Sheree Davis, Director, Community and Population Health Branch, Ministry of Health and Long-Term Care
- Anne-Joyelle Occhicone, Program and Standards Advisor, Health Promotion Division, Ministry of Health and Long-Term Care

Other Support

- Technical Advice, Indicator Derivation and Data, provided by Public Health Ontario
- Review and support provided by Ministry of Children & Youth Services, Ministry of Health and Long-Term Care

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Approval: Acting Medical Officer of Health (March 24 – 31, 2013)**

Date: March 13, 2013

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit appoint Dr. Jim Pfaff, Associate Medical Officer of Health, Simcoe Muskoka District Health Unit, to the position of Acting Medical Officer of Health from March 24 – 31, 2013 to provide coverage during the vacation period of Dr. Rosana Pellizzari.

Dr. Pfaff has provided coverage for Dr. Pellizzari in the past. Terms of this coverage include:

- an on-call stipend of $100.00 per day during the specified time period; and,
- reimbursement for time and any travel expenses (e.g., mileage, hotel) if the Acting Medical Officer of Health is required to travel to Peterborough for an urgent matter.

To: All Members
Board of Health

From: Deputy Mayor Sharpe, Chair, Property Committee

Subject: **Committee Report: Property**

Date: March 13, 2013

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Property Committee for October 26, 2012 and February 1, 2013, approved by the Committee on March 6, 2013.

Please refer to the attached.

Board of Health
for the
Peterborough County-City Health Unit
Property Committee
MEETING MINUTES
October 26, 2012 – 12:00 p.m. to 1:00 p.m.
VIA TELECONFERENCE

Present: Councillor Andrew Beamer
Councillor Henry Clarke
Dr. Rosana Pellizzari
Deputy Mayor Andy Sharpe, Chair
Mrs. Alida Tanna, Recorder
Chief Phyllis Williams
Mr. Brent Woodford

1. Call To Order

Deputy Mayor Sharpe called the meeting to order at 12:07 p.m.

2. Declaration of Pecuniary Interest

Nil.

3. Approval of the Agenda

Deputy Mayor Sharpe requested that the item 4.0 be moved to the In Camera Session.

Moved by Councillor Clarke
Seconded by Councillor Beamer
That the agenda be approved as amended.
Carried

4. Approval of the Minutes – July 24, 2012

Moved to the In Camera Session, please refer to item 3.0 for details.

5. Business Arising from the Minutes

Nil.

6. Correspondence

Nil.

7. New Business

Nil.

8. In Camera / Closed Session

Moved by Councillor Beamer — Seconded by Councillor Clarke

That the Committee go In Camera to discuss confidential property matters.

Carried

Moved by Councillor Clarke — Seconded by Chief Williams

That the Committee rise from In Camera.

Carried

9. Items to be referred to:

9.1 Board of Health

Nil.

9.2 Other

Nil.

10. Agenda Items for Next Meeting

No further items were identified.

11. Date, Time and Place of Next Meeting

The next meeting will be scheduled at the call of the Chair.

12. Adjournment

Moved by Councillor Clarke — Seconded by Councillor Beamer

That the meeting be adjourned.

Carried

The meeting adjourned at 1:03 p.m.

________________________ ________________________

Chair Recorder

Board of Health
for the
Peterborough County-City Health Unit
PROPERTY COMMITTEE
MEETING MINUTES
February 1, 2013 – 12:00 p.m. to 1:00 p.m.
VIA TELECONFERENCE

Present: Councillor Henry Clarke
Councillor Lesley Parnell
Dr. Rosana Pellizzari
Deputy Mayor Andy Sharpe
Mrs. Alida Tanna
Mr. David Watton
Mr. Brent Woodford

1. Call To Order

Mr. Watton called the meeting to order at 12:06 p.m.

2. Declaration of Pecuniary Interest

Nil.

3. Approval of the Agenda

Deputy Mayor Sharpe requested that the item 4.0 be moved to the In Camera Session.

Moved by Seconded by
Councillor Clarke Councillor Parnell
That the agenda be approved as amended.
Carried (M–13–01–PR)

4. Approval of the Minutes – October 26, 2012

Moved to the In Camera Session, please refer to item 3.0 for details

5. Business Arising from the Minutes

Nil.

6. Correspondence

Nil.

7. New Business

7.1 Recommendations for Chair and Vice Chair (Watton)

Mr. Watton called for nominations for the position of Chairperson of the Board of Health Property Committee for 2013.

Moved by Councillor Parnell
Seconded by Councillor Clarke

That Deputy Mayor Andy Sharpe be nominated Chairperson of the Board of Health Property Committee for 2013.

Carried (M–13–02–PR)

Mr. Watton asked again if there were any further nominations for the position of Chairperson.

Mr. Watton asked one last time if there were any further nominations for the position of Chairperson.

There being no further nominations for the position of Chairperson, Mr. Watton declared nominations closed and asked Deputy Mayor Sharpe if he accepted the nomination. Deputy Mayor Sharpe agreed to let his name stand for the position of Chairperson for the Board of Health Property Committee.

Mr. Watton called for nominations for the position of Vice-Chairperson of the Board of Health Property Committee for 2013.

Moved by Mr. Embrey
Seconded by Mayor Smith

Councillor Parnell be nominated Vice-Chairperson of the Board of Health Property Committee for 2013.

Carried (M–13–03–PR)

Mr. Watton asked again if there were any further nominations for the position of Vice-Chairperson.

Mr. Watton asked one last time if there were any further nominations for the position of Vice-Chairperson.

There being no further nominations for the position of Vice-Chairperson, Mr. Watton declared nominations closed and asked Councillor Parnell if she accepted the nomination. Councillor Parnell agreed to let her name stand for the position of Vice-Chairperson for the Board of Health Property Committee.

As per Board of Health By-Law #3, the Board must appoint a Chair to its Committees.

ACTION: A recommendation will be made to the Board of Health at its next meeting to accept the nomination of Deputy Mayor Sharpe as Chair of this Committee.

7.2 Review of Terms of Reference

A draft of proposed changes was presented to the Committee. A number of issues were noted. **ACTION: The Terms of Reference will be revised and brought forward to the next Board of Health meeting for approval.**

Councillor Parnell advised that training may be available through the City for administrative supports to Boards and Committees; she noted that a number of supports for City Committees and Boards would benefit from this training to ensure proceedings are consistent with the Municipal Act. She recommended that Councillor Clarke approach the Mayor to inquire whether this would be possible.

ACTION: David Watton will follow up through alPHa to confirm whether Board Committees are subject to the Municipal Act.

8. In Camera/Closed Session

Moved by	Seconded by
Councillor Parnell	Councillor Clarke

That the Committee go In Camera to discuss confidential property matters.

Carried (M–13–04–PR)

Moved by	Seconded by
Councillor Clarke	Councillor Parnell

That the Committee rise from In Camera.

Carried (M–13–05–PR)

9. Items to be referred to:

9.1 Board of Health

- Recommendation for Chair
- Revised Terms of Reference

9.2 Other

Nil.

10. Agenda Items for Next Meeting

No further items were identified.

11. Date, Time and Place of Next Meeting

To be determined.

12. Adjournment

Moved by
Councillor Parnell
That the meeting be adjourned.

Seconded by
Councillor Clarke

Carried (M–13–06–PR)

The meeting adjourned at 12:45 p.m.

c: BOH Property Committee Members
Dr. Rosana Pellizzari
Brent Woodford

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Chair

____
Recorder